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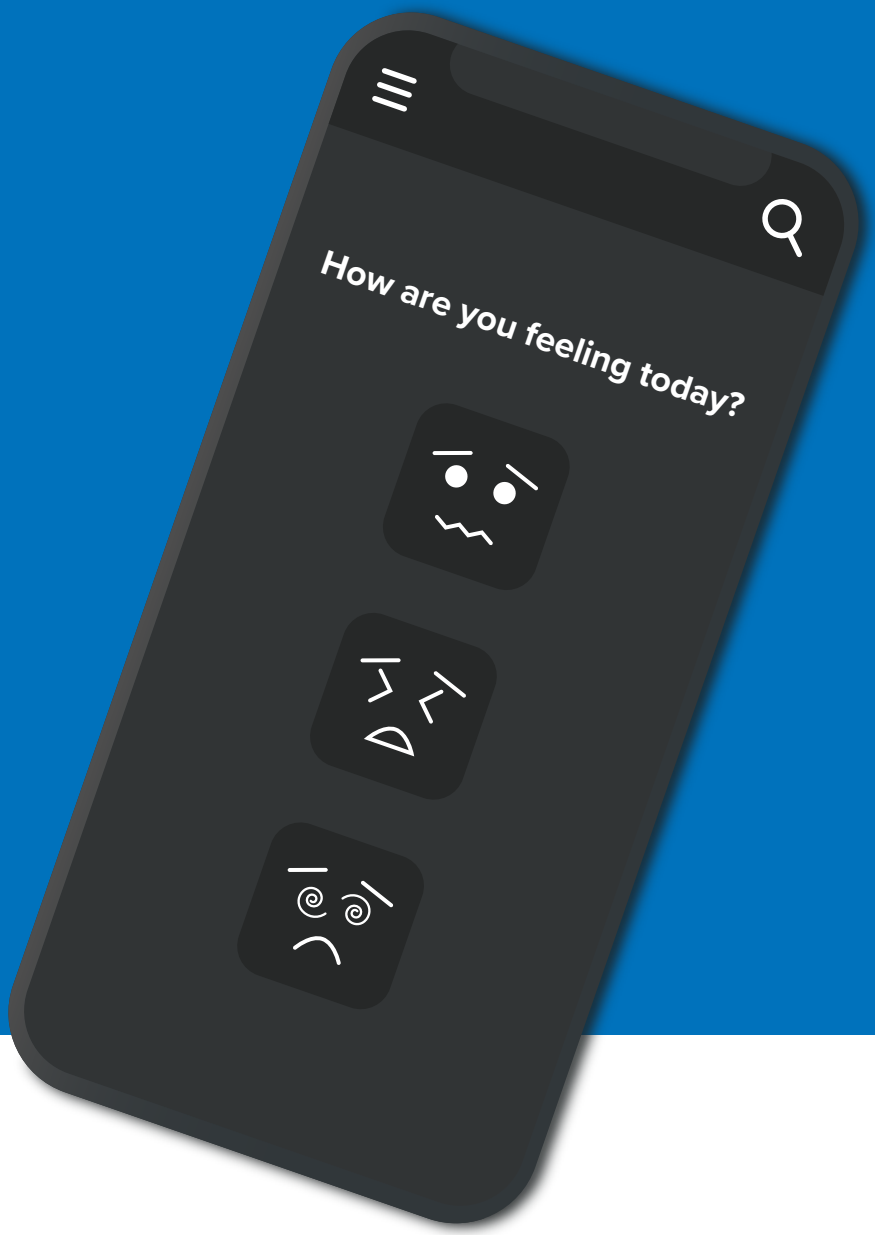


# Designing Safe Digital Mental Health and Psycho–Social Support (MHPSS)

## for Displaced and Stateless Adolescents

Linda Raftree

## Acknowledgements

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# Designing Safe Digital Mental Health and Psycho–Social Support (MHPSS)

for Displaced and Stateless Adolescents


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# Executive Summary

During adolescence, individuals start the transition from childhood to adulthood. It is a critical stage of human development, yet vast numbers of children experience mental health and psychosocial distress during this period. Many of the world's 35 million displaced and stateless children[1] have experienced particularly significant social and emotional disruption; including exposure to difficult living conditions, traumatic experiences, separation from or loss of family members, interrupted education, and lack of healthcare.[2] [3] These experiences are known to have adverse effects on mental health however only a tiny percentage of displaced and stateless adolescents can access Mental Health and Psychosocial Support (MHPSS) services.

Traditional face-to-face approaches have been unsuccessful at delivering MHPSS at the necessary scale, in part due to insufficient human and financial resources. The global rise in digital connectivity -- largely spurred by the COVDI-19 pandemic -- has given rise to increasing opportunities to explore digital approaches to adolescent MHPSS in forced displacement contexts. Emerging evidence suggests that some digital MHPSS approaches and interventions, if designed in ways that consider context, nuance, stage of displacement, and factors such as inclusion, gender, equity, uptake, and safety; could help extend MHPSS programming to more adolescents.

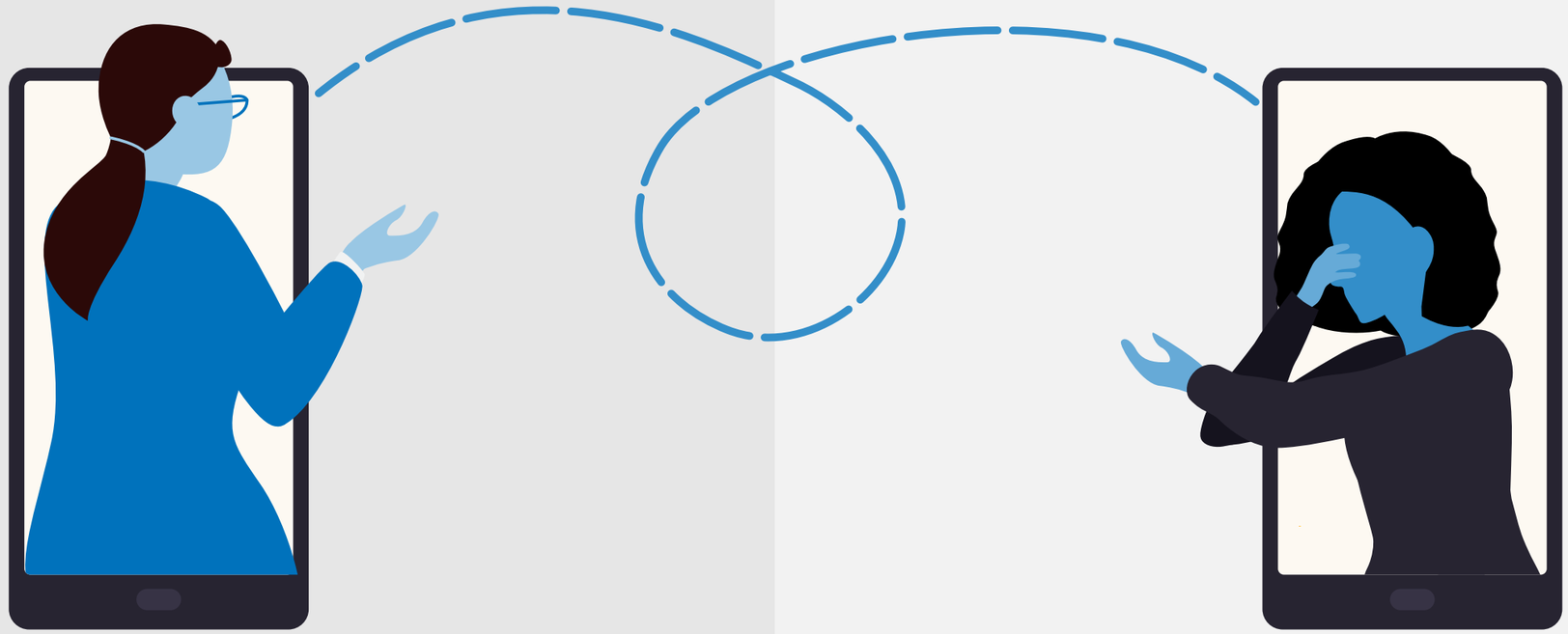


At the same time, negative effects of digital technology – especially social media and internet use – on children and adolescents and their mental health need to be mitigated to avoid further worsening the situation.[4] Critical concerns about surveillance, data privacy, and data misuse or mishandling, the effects of which can be especially grave for displaced and stateless populations, need to be addressed.

In this paper, we explore how digital approaches and interventions could be safely and feasibly incorporated into the different layers of the World Health Organization's MHPSS Pyramid (used by a majority of humanitarian organizations to frame their MHPSS work). Based on this exploration, we suggest an adapted MHPSS Pyramid that includes potential digital interventions with some of their benefits and drawbacks for adolescents in forced displacement contexts.

We also provide a summary of the existing evidence base and inputs from UNHCR staff to lay out the case and the caveats for digital MHPSS for forcibly displaced and stateless adolescents. This leads us to a set of core insights into the key benefits of digital MHPSS at the different levels of the MHPSS Pyramid alongside the barriers, limitations, and risks.

Following the exploration of these benefits and challenges, we highlight good practices for designing and implementing digital MHPSS programming with forcibly displaced and stateless adolescents and make recommendations for further action by UNHCR at strategic, advocacy, policy, monitoring, evaluation, research, operational, and guidance levels. Rounding off the report is a checklist for practitioners to follow when designing and implementing digital MHPSS approaches and interventions.



# How do we define mental health?

The World Health Organization (WHO) defines mental health as **a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities.** Mental health is an integral component of health and well-being and is more than the absence of mental disorder.[5]

In the case of adolescents, mental health also considers age-specific and life-course markers, including a positive sense of identity, the ability to manage thoughts and emotions, the capacity to build relationships, and the ability to learn and acquire education.[6]

Mental health for adolescents can be viewed through three lenses:

1. **Emotional well-being**: positive, happy, calm, peaceful, interested in life;
2. **Social well-being:** ability to function in the world combined with a personal sense of value and belonging; and
3. **Functioning well-being:** the capacity to develop skills and knowledge that help a person make positive decisions and respond to life challenges.[7]



# How do we define mental health and psychosocial support?

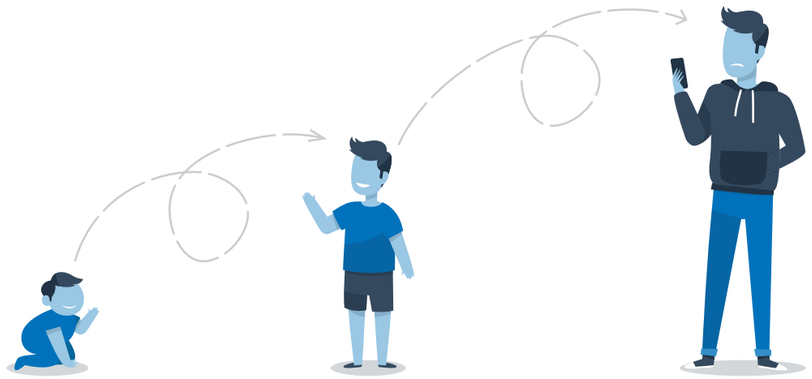
The term ‘mental health and psychosocial support’ (MHPSS) refers to **any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental health conditions.** MHPSS needs include a wide range of areas including support for interpersonal problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual disabilities.[8]

# Acronyms

| | |
|---|---|
| **ACE** | Adverse Childhood Experiences |
| **ADHD** | Attention Deficit and Hyperactivity Disorder |
| **COVID** | Coronavirus Disease |
| **GBV** | Gender-Based Violence |
| **GDPR** | General Data Protection Regulation |
| **IASC** | Inter-Agency Standing Committee |
| **ICT** | Information and Communication Technology |
| **IDP** | Internally Displaced Person |
| **ICRC** | International Committee of the Red Cross |
| **IFRC** | International Federation of Red Cross and Red Crescent Societies |
| **ITU** | International Telecommunication Union |
| **IVR** | Interactive Voice Response |
| **LCD** | Least Developed Countries |
| **LGBTQI+** | Lesbian, Gay, Bisexual, Transgender, Queer and Intersex community |
| **LMICs** | Low- and Middle-Income Countries |
| **MHPSS** | Mental Health and Psychosocial Support Services |
| **MMAP** | Measurement of Mental Health Among Adolescents at the Population Level |
| **NLP** | Natural Language Processing |
| **ODI** | Overseas Development Institute |
| **OECD** | Organization for Economic Cooperation and Development |
| **PTSD** | Post-Traumatic Stress Disorder |
| **SMS** | Short Messaging Service |
| **UN** | United Nations |
| **UNESCO** | United Nations Educational, Scientific and Cultural Organization |
| **UNHCR** | United Nations High Commissioner for Refugees |
| **UNICEF** | United Nations Children's Fund |
| **WHO** | World Health Organization |

# 1. Introduction

Adolescence is a critical and formative period where individuals start the transition from childhood to adulthood. Yet during this stage of development, mental health and psychosocial distress affect vast numbers of children around the world. In 2019 it was estimated that one in seven adolescents – an estimated 166 million (89 million boys and 77 million girls) globally – experienced mental disorders.[9] Around half of all mental health conditions start by age 14, and suicide is the second leading cause of death in young people aged 15-29.[10] While awareness is growing, the stigma associated with mental health often prevents people, including adolescents, from talking about it or seeking treatment.



Adolescents experience rapid biological, social, and emotional changes. Mental health is tied to these critical moments of adolescent brain development, which can be negatively affected by factors such as toxic stress triggered by adverse childhood experiences (ACEs), including physical and emotional abuse, chronic neglect, and violence.[11] Adolescents who face the greatest mental health risks tend to come from disadvantaged families, have pre-existing mental health conditions, or have a history of ACEs. Mental health and psychosocial support (MHPSS) is critical during adolescence to help lay a foundation for a healthy and productive adulthood.[12]

In this paper, we explore the relationship between adolescent mental health and the online environment and delve into what has been learned about designing and implementing digital MHPSS programs and services with displaced and stateless adolescents. We look at this topic in both displacement and non-displacement settings and from the viewpoint of general digital MHPSS programming across different ages, populations and geographies. We examine existing academic theory, the literature base, and various practices across humanitarian organizations as well. Our goal is to offer recommendations on how the United Nations High Commissioner for Refugees (UNHCR) and its partners might safely and effectively incorporate digital programming as part of MHPSS programming for adolescents. We build on the literature and practice related to children's mental health, refugee connectivity, digital inclusion, safeguarding and risk for migrating and displaced children, data governance, and responsible digital and data practices in forced displacement contexts.

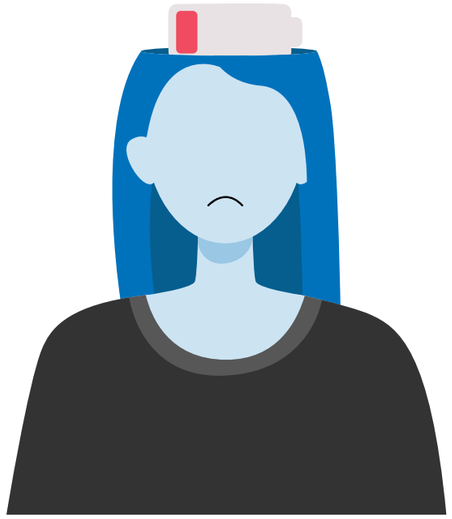


*Figure 1 - United Nations definitions of age groups.[13]*

| Caterogy | Ages | Comments |
|---|---|---|
| **Children** | 0 - 17 | Convention of the Rights of a Child (CRC) definition of a child. |
| **Adolescents** | 10 - 19 | Adolescence is the transition from childhood and comes with different social and cultural expectations. The time category captures psychological and physical developmental changes, and although individuals have different development curves, the age categories indicates when majority of changes take place in a population. |
| Younger adolescents/ Very young adolescents (VYA) | 10 -14 | Onset of puberty, self-consciousness increases, social restrictions may be introduced with menarche, etc. |
| Older Adolescents | 15 -19 | Relationships and peers become more important, furthering consequential thinking, need for independence. |
| **Youth** | 15 - 24 | With the recognition of regionl adaptations and age brackets, such as the African Charter defining youth as 15 - 35, and the resolution 2250 expanding the age category of youth from 18 - 29 years. |
| **Young People** | 10 - 24 | The umbrella term for adolescents and youth, recognizing that this term does not ranslate to all languages, including Spanish. |

*Figure 1 provides the UN definations of categories relevant for work on young people. Streamlining definations of sub groups within the adolescent and youth cohort is important for programming and policy. Using these categories has implications for data collection. In addition to this, categories such as young adults can be considered up to the age of 35.*

While we aimed to explore this theme specifically In the Asia Pacific region, UNHCR teams have not yet extensively incorporated digital MHPSS into programming and the literature base is slim. Most digital MHPSS has emerged from having to manage COVID-19 lockdowns, and UNHCR's digital MHPSS has focused on using digital channels to replicate in person approaches, for example, using online video or messaging applications to manage support groups with communities, engage youth, or conduct therapy sessions with individuals.[14] There is interest from teams in the Asia Pacific region to further explore what might be possible to achieve with digitally enabled MHPSS approaches and interventions. Because this is a relatively new area to explore, with very limited information and research available and a number of potential risks associated with the use of digital approaches and digital data, this report aims to serve as an initial exploration that will be built on through additional research, including primary research with displaced and stateless adolescents in the region and more detailed participatory risk assessments for any new approaches and programs.[15]



*In the case of adolecents, mental health also considers age specific and life-course makers including a positive sense of identity, the ability to manage thoughts and emotions, the capacity to build relationships, and the ability to learn and acquire education*

## What do we mean by adolescent mental health?

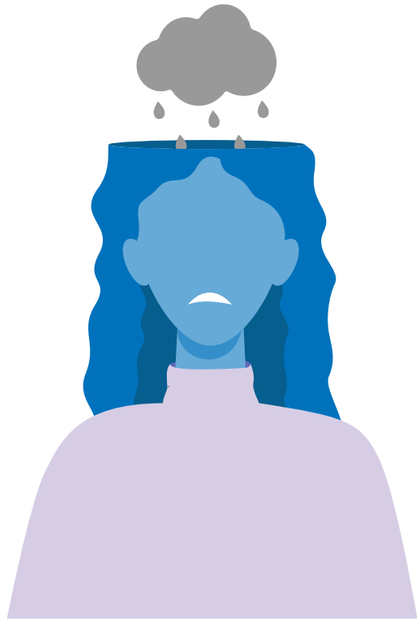
The World Health Organization (WHO) defines mental health as a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder.[16]

In the case of adolescents, mental health also considers age-specific and life-course markers, including a positive sense of identity, the ability to manage thoughts and emotions, the capacity to build relationships, and the ability to learn and acquire education.[17]

Mental health for adolescents can be viewed through three lenses:

1. **Emotional well-being**: positive, happy, calm, peaceful, interested in life;
2. **Social well-being**: ability to function in the world combined with a personal sense of value and belonging; and
3. **Functioning well-being**: the capacity to develop skills and knowledge that help a person make positive decisions and respond to life challenges.[18]





*Mental health for adolescents can be viewed through three lenses: emotional well-being, social well-being and functioning well-being*

## How do we define Mental Health and Psychosocial Support (MHPSS)?

The term ‘mental health and psychosocial support’ (MHPSS) refers to any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental health conditions. MHPSS needs include a wide range of areas including support for interpersonal problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual disabilities.[19]

# 2. Forced displacement and adolescent mental health

An estimated 35 million (42%) of the 82.4 million displaced and stateless people globally are children.[20] Many have experienced significant social and emotional disruption, including exposure to difficult living conditions, traumatic experiences, separation from or loss of family members, interrupted education, and lack of healthcare.[21] [22] Unaccompanied minors are especially vulnerable to adverse situations because they do not have the support of their adult caregivers.[23] Negative or traumatic experiences at critical points in a child's cognitive and emotional development can have immediate and lasting psychological impacts.[24] [25] Pre-migration trauma, forced displacement, and the post-migration or displacement environment are all linked to high rates of post-traumatic stress disorder (PTSD), depression, and anxiety in child and adolescent refugee and asylum seekers.[26] [27] [28]

Even after displacement, ongoing legal and material disadvantages, social and financial exclusion, fear of exploitation and abuse, the breakdown of community and family support networks, education disruption, lack of viable future career options and a sense of limited autonomy continue to contribute to feelings of anxiety and isolation.[29] [30] Depression and hopelessness among young refugees, asylum seekers and stateless youth may also increase during periods when mainstream media, social media, and political narratives blame them for national-level social and economic challenges.[31] [32] Restrictive gender norms, discrimination due to disability or gender identity and expression, and abuse from a parent or caregiver can also harm adolescents' mental health.[33] And when parents and caregivers are dealing with their own MHPSS challenges, their capacity to provide strong foundations for children's mental health development is often reduced.[34]

Displaced persons are affected by short- and medium-term crisis events and by ongoing, longer-term adverse events and challenging contexts. Half of the world's refugees are in "protracted situations'' where they live in unstable and insecure locations, usually in dense urban areas but also in refugee camps. For example, Kenya's Dadaab refugee camp, established in a remote and insecure location, has housed families for more than three generations.[35] Studies in countries that host displaced persons found that "imposed conditions of adversity, including prolonged detention, insecure residency status, challenging refugee determination procedures, restricted access to services, and lack of opportunities to work or study, combined in a way that compounded the effects of past traumas in exacerbating symptoms of PTSD and depression."[36]



COVID-19 is an example of an ongoing challenging context. Some estimate that anxiety and depressive disorders affected more than 25% of the global population during the first year of the pandemic. Mental health services were disrupted by the pandemic, widening the treatment gap.[37] While it has been difficult to compare children's mental health before and after the arrival of COVID-19 or to establish causality, it is widely acknowledged by the media, academics, and children themselves that the pandemic exacerbated mental health challenges.[38] According to research carried out for UNICEF in the first half of 2021, a median of 19% of 15 to 24-year-olds in 21 countries self-reported that they often felt depressed or had little interest in doing things.[39] Girls tended to be at greater risk of depressive symptoms, anxiety, and behavior issues, while boys had a greater risk of substance abuse.[40] In a 2021 study in six conflict-affected countries, 57% of children expressed a need for mental health and psychosocial support because of the COVID-19 pandemic and related lockdowns. Among refugee and displaced children, this number was 70%.[41] How a child or young person reacts to adverse situations depends on age and stage of development and their pre-existing histories of care, protection, and other trauma.[42]

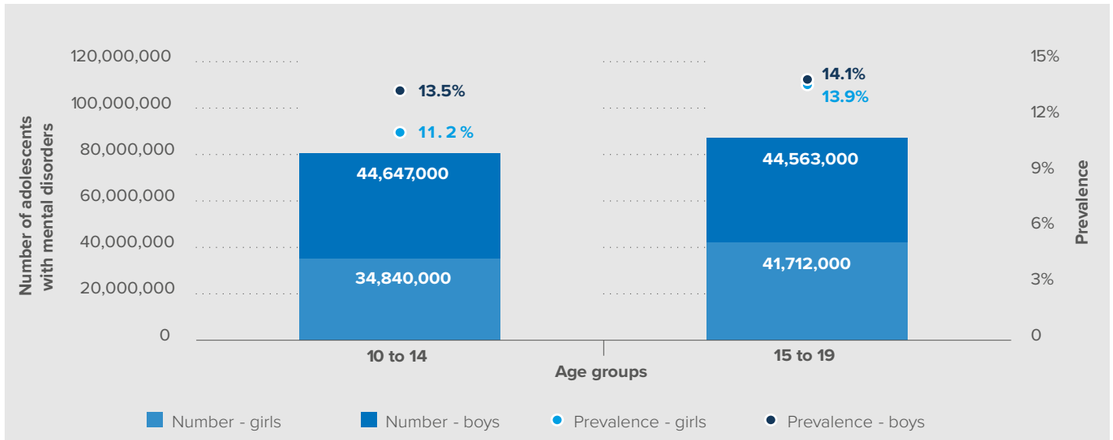
*"... anxiety and depressive disorders affected more than 25% of the global population during the first year of the pandemic. Mental health services were disrupted by the pandemic, widening the treatment gap."*

Historically, there has been a lack of overall investment in MHPSS programming. Countries on average assign less than 2% of their health care budgets to mental health. WHO states that most people with diagnosed mental health conditions go completely untreated, and globally, service coverage gaps are worsened by highly varied quality of care.[43] [44] While half of OECD (Organization for Economic Cooperation and Development) countries strengthened youth mental health services and/or increased financing in 2020 and 2021,[45] in low and middle income countries a reported three-quarters of people with mental health conditions receive no treatment, despite the growing evidence that certain kinds of interventions can be delivered in any resource context.[46]

## Adolescent MHPSS in numbers

At the global level, adolescent boys aged 10–19 were reported to have slightly higher prevalence rates (13.8%) and numbers of mental disorders than girls of the same age (12.5%). The East Asia and Pacific and South Asia regions had the highest total number of adolescents with mental disorders (see Figure 2). These same patterns were observed across age groups: 10–14 and 15–19. This data requires cautious interpretation, however, because in low- and middle-income countries and areas (LMICs), mental health data about children and adolescents covers a mere 2% of the population and nearly 90 per cent of the world's 1.2 billion adolescents live in LMICs. Better data is needed to understand adolescent mental health and to improve planning and responses.[47]

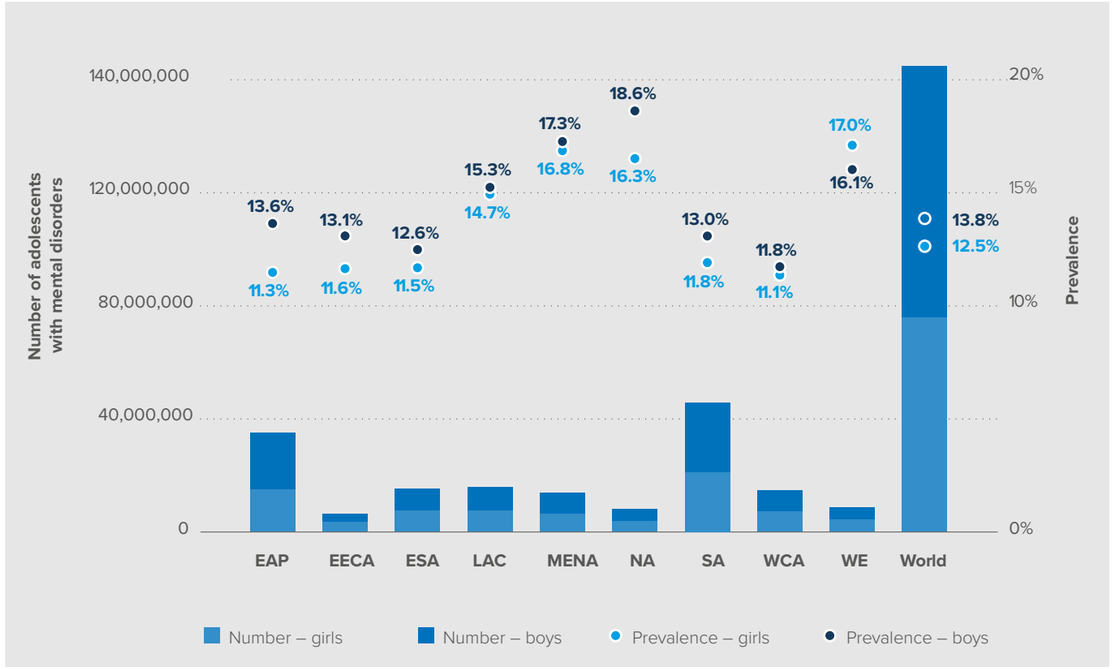
*Figure 2 - Estimated prevelance and number of adolescents with mental disorders globally, 2019.* [48]




Note: Numbers are rounded to the nearest 1,000; calculations are based on these disorders: depression, anxiety, bipolar, eating, autism spectrum, conduct, schizophrenia, idiopathic intellectual disability, attention deficit/hyperactivity (ADHD) and a group of personality disorders.
Source: UNICEF analysis based on estimates from the institute for Health Metrics and Evaluation (IHME), Global Burden of disease studies, 2019.



*Figure 3 - Estimated prevelance of adolescent boys and girls aged 10-19 with mental disorders globally and by UNICEF regions, 2019.* [49]




Note: East Asia and Pacific (EAPI); Eastern Europe and Central Asia (EECA); Eastern and Southern Africa (ESA); Latin America and Caribbean (LAC); Middle East and North Africa (MENA); North America (NA); South Asia (SA); West and Central Africa (WCA); Western Europe (WE); calculations are based on these disorders; depression, anxiety, bipolar, eating, autism spectrum, conduct, schzophrenia, idiopathic intellectual disability, attention deficit/hypeactivity (ADHD) and a group of personality disorders.
Source: UNICEF analysis based on estimates from the institute for Health Metrics and Evaluation (IHME), Global Burden of disease studies, 2019.

Displaced and stateless adolescents' unique MHPSS needs have been exacerbated by the COVID-19 pandemic. Related stressors have led to increased feelings of anxiety, frustration, anger, depression, and isolation; and the pandemic has worsened existing vulnerabilities and inequalities for adolescents, especially girls and young women, who may be at increased risk of early pregnancy and gender-based violence (GBV). Adolescents already living in conflicts, natural disasters, and other humanitarian emergency settings, those living alone without parental care, and adolescents with disabilities or whose parents live with disabilities have faced significant mental health risks during COVID-19.[50]

Even though migrants and refugees face high stress before, during, and after departure and upon arrival in a new place and they show an increased prevalence of mental disorders, they generally make less use of available mental health services than the general population.[51,] More research is required to better understand what types of MHPSS approaches and interventions might benefit a wide group of adolescents in forced displacement and to identify aspects that need to be designed to address specific cultural and contextual nuances in each situation.

## UNHCR's approach to MHPSS

UNHCR promotes support and services for the mental health and psychosocial wellbeing for refugees, asylum- seekers, internally displaced and other vulnerable populations by working in close partnership with governments, UN agencies, non-governmental organizations, academia, community-based and local partners and development actors. Whenever possible, UNHCR works through and links vulnerable populations to existing national systems under the leadership of host governments.[52] Supporting refugee youth's physical and emotional wellbeing is a key activity for UNHCR, listed as Core Action 4 in UNHCR's Seven Core Actions for Refugee Youth.[53]

Support for country programs to advocate for and facilitate access to quality MHPSS for refugees should be carried out within UNHCR's ten guiding principles for MHPSS support, established in 2013.

### UNHCR's Guiding Principles for MHPSS support.

1. **Use Rights-based, Community-based and Participatory Approaches.** UNHCR and partners need to ensure that refugees and other displaced and stateless individuals, including children, youth, women, older persons, sexual and other minorities, as well as groups with specific needs, are involved in all stages of design and implementation of the MHPSS activities.
2. **Ensure equity of care and access.** All refugees and other displaced and stateless individuals should have access to quality mental health and psychosocial support. This access must be provided to beneficiaries in ways that are similar to the services available to the host population and with at least similar quality and at similar or lower costs and without discrimination within the refugee community.
3. **Assess needs and resources.** MHPSS programs should be based on systematic and inclusive assessment of needs.
4. **Use a systems approach.** MHPSS programs should be conceptualized through a systems-based approach with multiple layers of complementary supports with functional referral systems between the different layers.
5. **Strive for integrated service provision.** MHPSS services and support should not be considered as a stand-alone sector, isolated from other services, but should be integrated into existing general community support and public health programs and systems.
6. **Adapt services to the stages of the refugee displacement cycle.** Use an MHPSS-approach from the onset of a refugee emergency and a phased approach to developing core MHPSS interventions throughout the displacement cycle.
7. **Build capacity.** Direct service provision should be accompanied by a strategy for capacity building through partnerships and include systems for follow-up training and supervision.
8. **Use appropriate and systematic monitoring and evaluation.** MHPSS interventions and methods should be monitored and evaluated systematically.
9. **Ensure compliance with UNHCR policies, strategies, national and international standards and guidelines.** The provision of MHPSS services should be delivered in ways that are consistent with UNHCR policies and strategies, adhere to minimum international standards and are in line with government policies.[54]
10. **Do no harm.** It is important to be aware of the potentially negative impacts of humanitarian programs and activities, including those with the aim to improve mental health and psychosocial support, and to prevent inadvertently harming refugees.

Core priorities for UNHCR (as of 2022) include the upscaling of MHPSS throughout its operations by:

- Using MHPSS approaches throughout UNHCR's work, for example, by systematically including mental health and psychosocial wellbeing in needs assessments and highlighting MHPSS needs in Refugee Response Plans and Humanitarian Response Plans and reinforcing capacities at all levels.
- Including MHPSS as a routine component of health interventions and service provision at primary health facilities.
- Integrating MHPSS into protection, including child protection, GBV and community-based protection.
- Ensuring attention to refugee children's social and emotional wellbeing as a part of formal and non-formal education programming.
- Appropriately training and supporting staff to work on MHPSS.[55]

## The MHPSS Intervention Pyramid

UNHCR follows the Inter-Agency Standing Committee's (IASC) MHPSS intervention model which includes MHPSS approaches and interventions.[56] Adopting an overarching MHPSS approach means providing humanitarian responses in ways that are beneficial to mental health and psychosocial wellbeing. This requires humanitarians to work in ways that contribute overall to better mental health, regardless of the sector or program. MHPSS interventions are specific activities aimed at improving the mental health and psychosocial wellbeing of refugees and other displaced and stateless communities.

The MHPSS services and supports pyramid (see Figure 4) addresses four layers, from general to specialized.[57] Applied to adolescent MHPSS, the layers encompass the following:

- **Layer 1** consists of basic services and security provided in a manner that protects the dignity of all people, including adolescents who are particularly marginalized or isolated and who face barriers to accessing services; and deliver the overall response in a participatory, rights-based way.
- **Layer 2** consists of actions to strengthen community and family support through promotion of activities that foster social cohesion and self-help and the restoration or development of community-based mechanisms to protect and support adolescents.
- **Layer 3** consists of focused emotional and practical support provided through individual, family, or group interventions for adolescents who find it difficult to cope with mental health problems within their own support network. Non-specialized workers in health, education, community-based protection, child protection or SGBV usually deliver such support, after training and with ongoing supervision.
- **Layer 4** consists of clinical mental health and psychosocial services for adolescents with severe symptoms or whose intolerable suffering renders them unable to carry out basic daily functions. Such interventions are usually led by mental health professionals but can also be led by specialists in social work.[58]

*Figure 4 - MHPSS Intervention Pyramid*


There are insufficient financial and human resources and capacity to provide in-person MHPSS to every adolescent who needs it. Digital platforms, applications, services, and data show potential for supporting adolescent MHPSS approaches and interventions at these different layers, when context, connectivity, and other factors are carefully considered and the potential for risks and harms is assessed and sufficiently mitigated.

MHPSS Resource

## Examples and practical resources for MHPSS in low resource contexts

- UNICEF's community based MHPSS operational guidance.
- The ICRC's psychological first aid and other guidance documents at the Psychosocial Center website.
- UNHRR's Operational Guidance on mental health & psychosocial support programming for refugee operations
- UNHCR's MHPSS Issue Brief



## Barriers and challenges for accessing existing MHPSS services and support

WHO's 2022 report on mental health highlights that people often choose to suffer mental distress without relief rather than risk the stigma associated with accessing mental health services.[59] While it is known that mental health is a priority to address for adolescents, especially for those in forced displacement contexts, several challenges stand in the way of their access to traditional MHPSS services and support.

These include:

- **Stigma**, which makes children and young people hesitant to disclose their symptoms to close friends or family and often means that they try to manage their mental health struggles on their own instead of seeking help.[60] [61] [62]
- **Ill-adapted MHPSS services** that do not take into consideration beliefs about well-being and mental health; lack of appropriate adaptation of Western beliefs and approaches to refugee mental health; difficulties in engagement and establishing trust.[63]
- **Exclusion** of refugees, asylum seekers, internally displaced persons (IDPs) and stateless people from national healthcare systems.[64]
- **Information barriers**, where some members of a community might not be aware that services are available, and others might not know that they are eligible.
- **Inaccessibility of mental health care** because of high costs, long waiting lists, eligibility requirements, language barriers and low availability of interpreters. [65] [66]
- **Human rights violations**, including discrimination, prejudice, abuse, social exclusion, and segregation aimed at children and young people who access mental health services; including unlawful or arbitrary institutionalization; overmedication; and denial of autonomy, will and preferences.[67]
- **Low quality and capacity of health care systems**.[68]
- **Poor coordination** among sectors.[69]
- **Lack of specific child and adolescent mental health policies**, strategies, services, and facilities at the national level[70].
- **Lack of high-quality data** on what treatment, prevention and promotion programs have been effectively implemented and are successfully responding to the needs of children and young people,[71] especially those in low- and middle-income countries (LMICs),[72] [73] and those who are displaced.
- **Insufficient international development assistance for mental health**[74] especially in LMIC countries -- between 2007 and 2015 only 0.1 per cent of health assistance was directed to mental health.[75] There is a vast need for MHPSS that is not being met through available programs.

# 3. The case and the caveats for digital MHPSS for adolescents in forced displacement settings

The need for MHPSS programming among displaced and stateless adolescents is widespread, yet face-to-face approaches cannot deliver it at the necessary scale, given insufficient human and financial resources. Digital technologies have the potential to contribute to efforts to achieve universal mental health coverage. Benefits include that they reduce travel time and expense, offer flexibility to fit around people's schedules, and their anonymity can help reduce stigma. Self-help approaches and telemedicine in particular show strong potential, including in middle-income countries.[76]

Emerging evidence on the effectiveness of some types of digital MHPSS, when designed for the context, implies that digital MHPSS interventions could help deliver results for adolescents living in forced displacement contexts. This, coupled with the steady expansion in access to the Internet, widespread efforts to connect the unconnected[77] and humanitarian organizations' own increased focus on digital service delivery creates opportunities for exploring digital approaches to adolescent MHPSS in forced displacement contexts.

At the same time, there are long-standing debates about the positive and negative effects of digital technology – especially social media and internet use – on children and adolescents and their mental health.[78] On the one hand, mobile phones and connected devices such as tablets and laptops enable adolescents around the world to connect with friends and family and to access information, services, rights (including education, health, and freedom of expressions), and entertainment. On the other, adolescents are exposed to a host of online risks, including sexual abuse, grooming, bullying, sextortion, trafficking, exploitation, hate speech, gender-based violence, misinformation and disinformation, violent and extremist content, recruitment into extremist groups.[79] In the US and the UK, social media has been linked to anxiety, depression, eating disorders, and other mental health issues.[80] [81] Some websites and apps, such as those that promote self-harm, suicide, or anorexia, introduce vulnerable youth to risks. Others normalize and support underage activities, such as gambling, smoking, pornography and drug use.

Concerns have been raised that the amount of time children spend online affects their mental health – with evidence suggesting that moderate use of digital technology can be beneficial to children's mental wellbeing and excessive use detrimental,[82] depending on the type of content that is accessed, and activities encouraged.[83] Commercial and government surveillance and data privacy are also of increasing concern.[84] Vulnerable children, including refugee and migrant children, are generally more susceptible to online risks.[85]



Below we further explore the relationship between adolescent mental health and the online environment and delve into efforts to provide online adolescent MHPSS programs and services. This includes a review of the risks, implications, and good practices to consider for digitally enabled MHPSS programming. We recognize that digital tools have supported the provision of services and increased UNHCR's access to displaced and stateless communities, especially during the recent COVID-19 pandemic, and hope to contribute to the continued exploration of the appropriate use of digital tools and innovative approaches to data collection, management and sharing, in compliance with national laws and applicable international privacy and data protection standards and principles.[86]

**Digital technologies have the potential to contribute to efforts to achieve universal mental health coverage. Benefits include that they reduce travel time and expense, offer flexibility to fit around people's schedules, and their anonymity can help reduce stigma.**

## Adolescent development and the online environment

Adolescents are known to be avid users of the internet and social media, and core features of adolescent development offer some insights on why this is. To begin, peers become increasingly important during this stage of adolescence, and young people crave and are highly responsive to social interaction with their peers. This comes alongside an increasing awareness of social hierarchies and reactivity to social evaluation.[87] In addition, during adolescence children are in a process of identity formation. They are seeking ways to matter and acquire status. Online spaces lend themselves to identity exploration, artistic creativity, and emotional expression.[88] Young people who feel excluded or stigmatized offline due to ethnic, racial, gender or sexual minority status have reported being able to access support and resources online that they have not found elsewhere,[89] which fulfills the need for belonging.

Adolescence is a time of accelerated biological growth and social learning as children's brains develop. [90] [91] Increased neuroplasticity means that experiences during adolescence — whether positive or negative — have greater impacts than those occurring later in life. For example, if a child experiences trauma, their young brain may learn to detect threats more easily, and this can lead to increased stress, anxiety, or depression when they are an adult. Finally, adolescence is a time when young people are developing independence and autonomy, while remaining connected to and supported by caregivers.[92]

These biological characteristics of adolescents, along with other contextual factors; open the door for new and expanded uses of digital approaches for MHPSS, including for adolescents in displacement contexts. The increase in global connectivity and use of mobile devices, internet, and social media; normalization of remote services during the COVID-19 pandemic; growing awareness of mental health needs; and an inability to address these needs at sufficient scale through in-person service provision (due to capacity and funding levels) all make digital MHPSS an interesting avenue to consider.

As with any digital approach, there are major barriers, challenges, and risks (which we explore in detail in Section 6.) These include exposure to a range of harms, including sexual abuse, grooming, bullying, sextortion, trafficking, exploitation, hate speech, gender-based violence, misinformation and disinformation, violent and extremist content, and recruitment into extremist groups. Social media and the digital environment have also been linked to the rise in mental health issues, especially depression and anxiety, among adolescents. Vulnerable children, including displaced and stateless adolescents, may be more susceptible to these risks. The relationship between social media and digital environments is complex, in that young people find benefit from social media yet say it can make them feel lonely or left out. Concerns about addictive elements of digital platforms have also been raised.

## Digital inclusion and connectivity for adolescents in forced displacement

If displaced and stateless adolescents are to benefit from elements of digital MHPSS, they must be able to get online. Increases in digital access have been reported following the COVID-19 pandemic, however. By the end of 2021, the International Telecommunication Union (ITU) reported that two-thirds of the world's population was able to access the internet (4.9 billion in 2021, up from an estimated 4.1 billion in 2019). This growth was largely driven by developing countries, where internet penetration grew by more than 13%. The UN-designated Least Developed Countries (LDCs), saw an average increase in internet access that exceeded 20%. Some have referred to this growth as the 'COVID connectivity boost,' which brought an estimated 782 million more people online, an increase of 17% as compared to pre-pandemic numbers.[93]

Shortly after the pandemic emerged, voice and video messaging had more than doubled on Facebook Messenger and WhatsApp in countries hit hardest by the pandemic. In Italy, users reported spending some 70% more time on Facebook's suite of apps, and group calling increased by over 1000% in the first month of the pandemic.[94] In the United States, COVID-19 was linked to an expansion in the range of technologies and platforms used, with 40% of people surveyed saying that they had used digital technology or the internet in new ways since the beginning of the pandemic.[95] It is unclear how much of the "COVID Connectivity" boost has been felt by displaced populations, however.



***Figure 5 - Percentage of internet users in 2020, according to the International Telecommunications Union[96]***

| | Total (%) | Youth 15-24 (%) | Rest of the population (%) |
|---|---|---|---|
| World | 59.1 | 70.8 | 56.9 |
| Developed | 88.3 | 99.0 | 87.0 |
| Developing | 53.3 | 67.1 | 50.6 |
| Least Developed Countries (LDCs) | 24.6 | 34.1 | 22.2 |
| Landlocked Developing Countries | 32.3 | 38.3 | 30.8 |
| Small Island Developing States | 60.6 | 70.7 | 57.5 |

| | Total (%) | Youth 15-24 (%) | Rest of the population (%) |
|---|---|---|---|
| Africa | 29.5 | 39.6 | 27.0 |
| Americas | 78.8 | 91.9 | 76.5 |
| Arab States | 62.3 | 73.2 | 59.9 |
| Asia-Pacific | 56.2 | 71.7 | 53.2 |
| CIS (Commonwealth of Independent States) | 79.6 | 91.4 | 78.1 |
| Europe | 84.9 | 97.2 | 83.3 |

Globally, adolescents use the internet more than any other age group. Displaced people are known, however, to face great difficulty in getting and staying online, and connectivity differs across displacement contexts. Eighty-five percent of refugees are hosted in developing countries, and 27% in least developed countries, often in rural areas where connectivity is typically below the average for the country.[97] In some settings, refugees and displaced persons might have the same access as the host population. Yet for others connectivity is much more difficult.

A joint initiative by the GSMA and UNHCR investigated refugee connectivity in three settings in Jordan, Rwanda, and Uganda in 2019, finding that over two-thirds of the refugee population in Jordan were active mobile phone users but that only a third of respondents in Rwanda and Uganda had ever used mobile internet. Sharing and borrowing of handsets were common, as was ownership of multiple SIM cards. Gender and disability were factors that affected phone ownership and use.[98] In some countries, displaced people may lack the necessary documents to obtain a mobile phone or a SIM card,[99] and adolescents sometimes face age restrictions for purchasing a SIM card. Host governments may resist extending network coverage to refugee populations living in camps as part of the strategy to deter people from staying in the country.[100] Financial difficulties make accessing the Internet a challenge as well.

It is difficult to determine exactly how many displaced and stateless persons are digitally connected globally and even more challenging to state how many adolescents amongst displaced communities can access mobile phones and the internet. Local context and patterns of access and use among specific populations are critical factors to take into consideration when designing digital approaches,[101] as we will note in more depth later, and research into each distinct context is an important next step. In theory, digital approaches to MHPSS could help to make these vital services accessible to more displaced adolescents. UNHCR and other agencies such as the Broadband Commission and the GSMA are working towards continuously improving refugee population access to the internet with the goal of enabling better communication, response, and delivery of humanitarian services, including MHPSS.[102]

## The COVID-related rise in mental health and psychosocial support needs

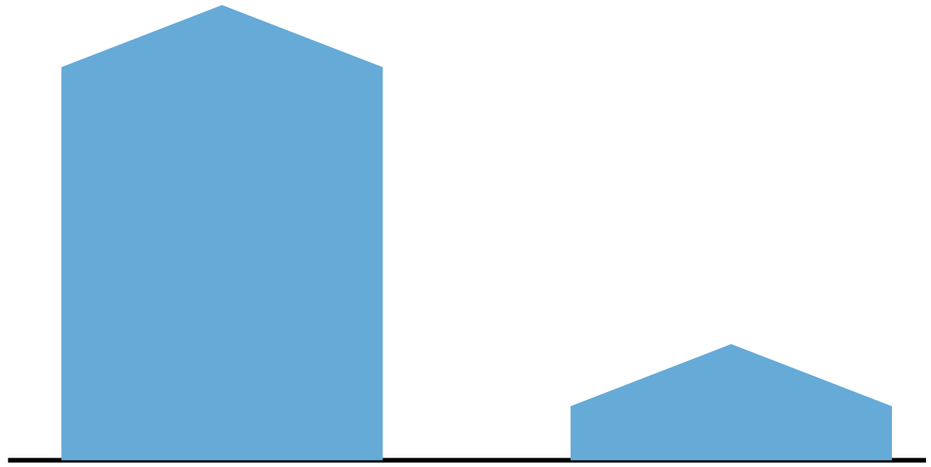
The digital MHPSS space is rapidly growing. In the first month of COVID-19 lockdowns, major increases in searches and use of online mental health apps were reported. The Organization for the Review of Care and Health Apps,[103] for example, observed a 7,500% increase in searches for health-apps related to the prevention of self-harm, a 176% increase for apps dedicated to the management of depression, an 86% increase in searches for mental health apps for the treatment of anxiety, and a 328% increase in searches for apps related to sleep.[104] This level of increased demand points to possibilities for digital MHPSS interventions to be shaped or harnessed to specifically benefit adolescents in forced displacement contexts and for UNHCR to consider the potential MHPSS-linked benefits of adolescent connectivity, digital access, and participation in the online environment.

The high prevalence rates of mental disorders and limited availability of MHPSS services in low- and middle-income countries is well documented.[105] [106] Common mental health issues like depression, anxiety, and post-traumatic stress disorder (PTSD) are frequently reported by refugees and others who are affected by violent conflict,[107] [108] yet treatment is often unavailable. The challenges of addressing this demand through traditional MHPSS programming along with the emerging possibilities offered by digital interventions make digital MHPSS an interesting area to explore.

WHO sees potential in digital MHPSS because it could allow for more flexibility than in-person interventions and it is seen as easier to tailor to the specific needs and practices of a specific target population.[109] It can also reduce reliance on the limited supply of trained professionals whose availability and cost mean they are out of reach for refugee and asylum seeker populations and often out of budget for humanitarian organizations.[110] For example, adolescents with less critical mental health support needs could be served digitally, so that those requiring more specialized care could be referred for in-person support. Potential benefits of digital MHPSS include greater reach, scale, and efficiency; cost savings; improved access to accurate and timely MHPSS information; and greater access by adolescents to MHPSS in formats that meet their needs, interests, culture, and contexts. Greater attention to MHPSS can also ensure that UNHCR keeps adolescent wellbeing top of mind when supporting efforts to enhance adolescents' digital connectivity and online access.



## Increase in searches for mental health-related apps during the first month of COVID-19 lockdowns



**+7500%**

Searches for apps related to the prevention of self-harm

**+176%**

Searches for apps dedicated to the management of depression

**+86%**

Searches for apps for the treatment of anxiety

**+328%**

Searches for apps related to sleep

# 4. An adapted model: digital MHPSS for adolescents in forced displacement

Digital MHPSS uses information and communication technology (ICTs) and/or online platforms to support and improve mental health conditions and mental health care.[111] [112] Digital MHPSS comes in a wide range of formats including websites, games, apps, robotics, virtual reality, mobile messaging, chatbots, e-diaries, and more. Digital modalities are present in everything from basic MHPSS awareness and peer-supported efforts happening on social media to individually focused, self-paced, fully automated mobile apps to efforts that involve a live person periodically or continuity to screening processes that link people to online or in-person specialized or clinical interventions.

Some digital MHPSS consists of informal peer connections and user-generated content uploaded to social media without any institutional backing or support and other digital MHPSS is created by specialized professionals or institutions and marketed and managed through social media platforms. Government health and social services and other institutions also provide specific and targeted MHPSS through their websites and digital channels.

While the COVID pandemic normalized online individual and group therapy, digitally assisted interventions to mental health vary in the level of guidance that they offer. Alongside these more traditional clinician-patient therapies through video calls, self-directed MHPSS is increasingly available on websites or mobile applications administered with little or no additional guidance from mental health professionals.[113] Digital MHPSS is rapidly growing, shifting, and changing because of greater awareness about mental health, an increase in MHPSS needs (largely due to COVID), and market disruption opportunities for private sector companies.

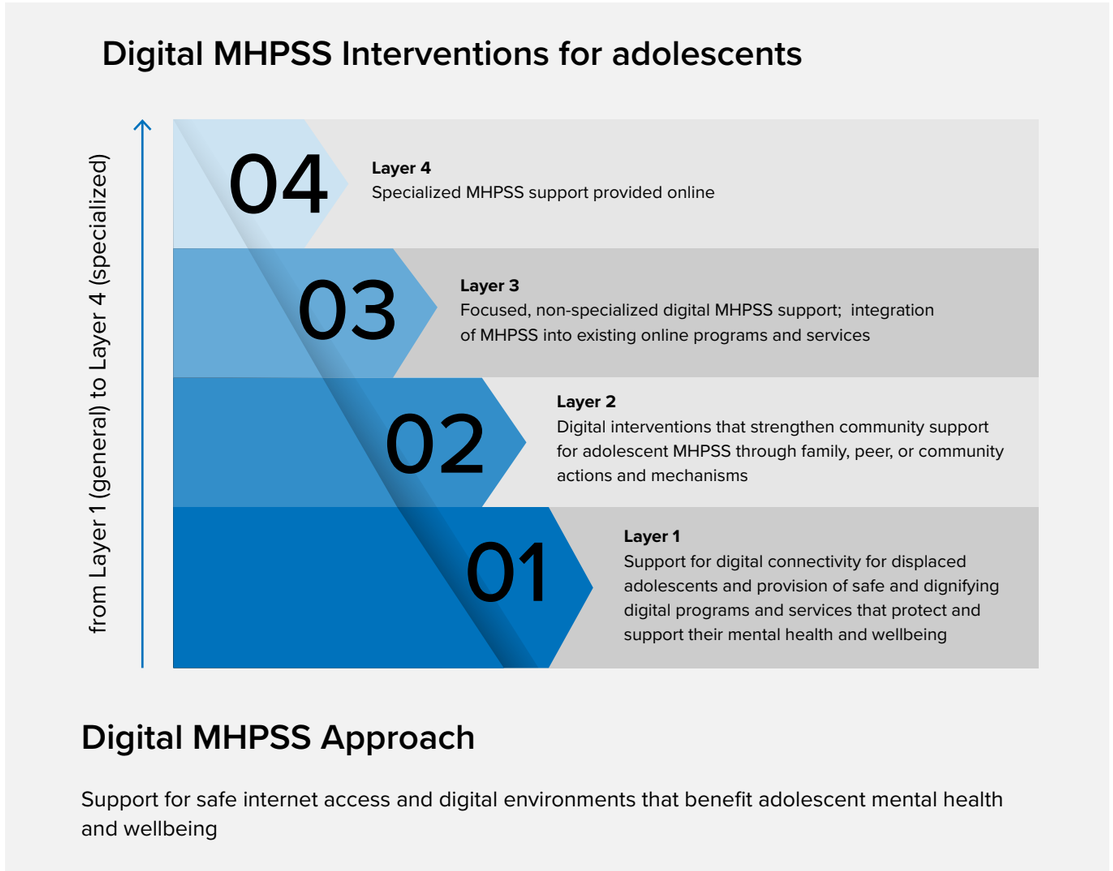
In Figure 6 we offer an adapted MHPSS framework and definitions for digital MHPSS interventions and digital MHPSS approaches. Below we define what we mean by Digital MHPSS Interventions and Digital MHPSS Approaches.

**Digital MHPSS Interventions.** A digital MHPSS intervention for adolescents is a targeted activity with the specific goal of addressing adolescent mental health and psychosocial wellbeing. Digital MHPSS interventions for adolescents might address one or more of the 4 layers found in the MHPSS services and supports pyramid.

**Digital MHPSS Approaches.** In the context of digital MHPSS for displaced and stateless adolescents an MHPSS approach means digital services or connections with a focus on safe digital environments and support for a rights-respecting Internet that benefits adolescent mental health and wellbeing. Digital environments can be both online space and applications or spaces that enable online and offline use.



*Figure 6 - Adapted MHPSS Pyramid, including digital interventions and approaches*




- **Layer 1:** Support for digital connectivity for displaced adolescents and provision of safe and dignifying digital programs and services that protect and support their mental health and wellbeing.
- **Layer 2:** Digital and online interventions that strengthen community and/or family capacity to understand and support adolescent MHPSS through family, peer, or community-based actions and mechanisms; at this layer, the goal is strengthening what people can do for themselves.
- **Layer 3:** Focused non-specialized MHPSS support conducted online and/or digitally or integration of social and psychological interventions into existing online programs and digital services, such as education, gender-based violence programming, or youth empowerment; at this layer, people with MHPSS needs require some type of support that is external to the community.
- **Layer 4:** Clinical mental health screening, referrals, and specialized MHPSS services provided online, including online therapy and psychological services, and referrals to in-person counseling and treatment by trained psychologists or social workers.

See Figure 7 below for examples of adolescent MHPSS services at the various Layers.

*Figure 7 - Potential areas for adolescent digital MHPSS in displacement and statelessness contexts.*

## Broad Approaches

- Enable connectivity and access to safe online environments that respect adolescent privacy, rights, and wellbeing
- Ensure that any other online programs and services for adolescents in forced displacement contexts are safe and respect privacy, rights, and wellbeing
- Enable access to online information, services, and programs that support displaced adolescents in their daily lives
- Ensure that participatory, contextual risk assessments are conducted on any digital tools, platforms, or approaches

| | |
|---|---|
| **Interventions at Layer 1**<br><br>Provision of digital connectivity and online services in dignified ways that protect marginalized or isolated individuals and groups and that respect and enable adolescents' digital rights and wellbeing. | **Examples:**<br>• Provision of access to the Internet and/or connected devices so that adolescents can seek and access MHPSS and other services and information online.<br>• Awareness, training, and skill building on safe use of connected devices and Internet.<br>• Digital literacy programs to help adolescents safely navigate the internet.<br>• Support and guidance to help adolescents find and access valid, fact-based, culturally appropriate MHPSS information from trusted sources.<br>• Efforts to create a safe, protective, and rights-respecting Internet for adolescents; with a focus on making the Internet more conducive to improving adolescent mental health and a more positive place for adolescents.<br>• Co-design, roll out and evaluation of digital approaches to MHPSS in line UNHCR Digital Transformation Strategy (especially Digital Services). |
| **Interventions at Layer 2**<br><br>Digital interventions that strengthen the capacity of family, peers, or community to understand and support adolescent MHPSS through community-based actions or mechanisms. | **Examples:**<br>• Online discussions and peer groups on social media groups that offer non-specialized MHPSS content, discussions, peer support and experience sharing.<br>• Online youth empowerment programming that integrates MHPSS awareness, content, and activities.<br>• Support provided online for facilitated peer-peer or community-based MHPSS support groups.<br>• Support for MHPSS content and awareness that is integrated into community-based protection, GBV, and substance abuse efforts. |
| | • Creation of digital or online support systems for community protection groups to screen, flag and/or refer adolescents for more specialized interventions. |
| **Interventions at Layer 3**<br><br>Focused non-specialized MHPSS support conducted online or integration of MHPSS interventions into existing digital programs and services (education, GBV, youth empowerment). | **Examples:**<br>• Self-directed, self-paced, semi-or fully automated MHPSS applications and online programs for adolescents that address common mental health challenges such as depression, stress, and anxiety.<br>• Online education that includes MHPSS components or modules that educators can lead.<br>• Online child protection and gender-based violence programming that includes MHPSS aspects.<br>• Online training and case management for non-specialized professionals to find and implement referral pathways to more targeted MHPSS support. |
| **Interventions at Layer 4**<br><br>Clinical mental health screening and specialized MHPSS services provided online, including therapy, psychological services, and online referrals to online or in-person counseling or treatment. | **Examples:**<br>• Synchronous online therapy and counseling through messaging platforms or online video platforms.<br>• Hybrid, self-directed digital tools or apps that offer scheduled or periodic support from a specialized worker or a regular potion to link to a peer group with trained facilitator.<br>• Online screening and referrals to qualified MHPSS professionals and services.<br>• Vetted online resources that professionals can refer adolescents to as a support in between sessions.<br>• Chatbots or Interactive Voice Response (IVR) options that move individuals along a continuum of support, with the possibility of speaking with a counselor or therapist as indicated or needed. |

**Potential cross cutting benefits:**

- Ability to better understand adolescent MHPSS needs at local, national, and global levels
- More effective targeting, greater scale and better attention to adolescent MHPSS needs
- Cost savings if digital can provide effective MHPSS support to some adolescents, some budget could be freed up to support other contexts or groups of adolescents where digital MHPSS is not possible or effective
- Use of digital data to inform program design and to measure program quality, effectiveness, and cost effectiveness
- Case management and tracking as individuals access services at the different layers or participate in programs or treatment

# 5. What do we know about digital MHPSS interventions and displaced and stateless adolescents?

Digital MHPSS has the potential to benefit displaced and stateless adolescents as well as the institutions that are working to support them, though more research is needed. It is possible that more adolescents could access needed services designed with greater levels of personalization than current traditional humanitarian MHPSS programming. Digital MHPSS could enable adolescents to feel a sense of greater anonymity and confidentiality in some cases (though data privacy concerns need to be mitigated). Some posit that self-directed MHPSS applications could help adolescents to develop new skills and knowledge which support their self-care and resiliency,[114] though again, these assumptions require further testing, especially with displaced and stateless adolescents. New and creative solutions that build on adolescents' general interests and aspirations to be digitally connected could be designed for specific contexts with the specificities of the location and the population in mind.

Organizations and institutions use digital tools to improve their MHPSS services, including education and dissemination of information; screening and diagnosing; signposting to treatment and care; and training and supervising mental health-care workers.[115] [116] Digital approaches might prove to be more cost-effective to implement, meaning that institutions with few resources could reach more adolescents at a lower cost. Digital tools allow the capture of longitudinal, dense, and multimodal mental health data that could be used for diagnosis and monitoring; tracking human trends in behavior; and formulating more successful interventions[117] [118]. This data might also be used to generate actionable insights and predictions that enable specific interventions.

Displaced and stateless adolescents need different kinds of support. Some may have stress reactions that are responsive to environmental factors, and broad social programs or targeted non-clinical group interventions might be of assistance. Others might have severe, disabling traumatic stress reactions that are not likely to resolve spontaneously and they might benefit from brief structured psychotherapies. More complex cases might require long-term rehabilitation or an array of different kinds of interventions, Others might benefit from programs to help with recovery from domestic violence or sexual assault[119]. Below we take a closer look at potential areas where digital MHPSS approaches, and interventions could support adolescents at the four Layers in the MHPSS pyramid. Figure 7 at the end of this section provides a summary of potential approaches and interventions based on findings in this section.



## Digital MHPSS approaches

A digital MHPSS approach for adolescents would need to address the harms outlined earlier in this paper while also taking advantage of the potential benefits of the Internet. Connectivity allows adolescents to maintain ties with their families and communities; access online support and services; meet their practical needs; and manage their refugee or asylum-seeking process, all of which has been found to reduce stress, anxiety, and depression.[120] The internet also provides access to MHPSS information and other content, including entertainment, that helps improve mental health. Thus, provision of safe and secure Internet as a basic service is a digital MHPSS approach.

## Digital MHPSS Interventions at Layer 1

Layer 1 of a digital MHPSS Model for adolescents at UNHCR would **support the provision of digital connectivity and online MHPSS programs and services in a dignified, inclusive, participatory, safe, secure, and rights-based way.** Digital connectivity and access are increasingly considered a basic right or service, and MHPSS is becoming a more fundamental part of UNHCR programming for adolescents. If accessible, displaced and stateless adolescents will use popular commercial social media and online platforms regardless of whether UNHCR approves, so a core goal at Layer 1 is advocating for greater privacy and safety on social media and online platforms and supporting adolescents to navigate these platforms with the least amount of risk as possible.[121]

Digital connectivity enables adolescents and those around them to seek MHPSS information, services, and support online. Adolescents from countries around the world who participated in focus group discussions about mental health and the internet in 2021 credited the internet for exposing them to new ideas and different types of friends, which helped them leave their 'bubble'.[122] The same study highlighted the costs of exclusion from the internet during the pandemic in terms of lost education and economic opportunities, which led to anxiety and depression.[123] Many adolescents in forced displacement contexts do not have Internet access and remain excluded from accessing any digital services, for example online education, and this exclusion contributes to negative mental health outcomes. For adolescents in forced displacement to access digital MHPSS support and other online services, they need to be connected.

A UK-based study on children's digital rights highlighted that the internet affords children important communication and socializing opportunities which help them maintain friendships and keep in touch with family. A 2013 study on children on the move in West Africa also highlighted the role of mobile phones in supporting children to stay in touch with family during and after displacement and finding shelter and other services upon arrival to a destination country.[124] In a 2020 study on emotional practices of unaccompanied refugee youth on social media, researchers found that sharing experiences and emotions on social media helped refugee youth deal with loneliness and alienation because the resulting 'likes', 'hearts' and other emoji reactions helped them feel supported and seen.[125]

Children in the UK reported that online mental health-related information, resources, and support services were more accessible than offline services and offered them greater privacy and anonymity. Digital technology can aid in mental health identification, signposting, and treatment and the visibility of mental health issues online has contributed to reducing taboos and stigma.[126] A multimethod pilot study conducted in 2021 in the UK found that children and young people with mental health problems tended to go online to seek both informal and formal help. Those who looked for help on the Internet were more likely to be in a distressed state than those who did not seek this kind of help online. This might be the result of adolescents being able to get immediate support online in a time of crisis whereas offline services would require them to leave their home or make an appointment.[127]

Being able to search for support online helps to satisfy adolescents' preference for self-reliance, according to a study of some 400 teenagers, a majority female, from rural and urban Ireland.[128] However, the usefulness of resources and support that they find online depends on their own level of mental health literacy.[129] A global study focused on young people's use of digital tools to support mental health during COVID-19 restrictions, found that children began seeking online mental health support as early as age 10. Over 50% of interviewees said that they used social media to support their mental health, with Instagram as the most popular site for mental health support. Most commonly, adolescents followed "influencers" who were known for being body positive, focused on mental health issues, or who promoted health and fitness. Survey participants said they followed specific mental health accounts and those that offered them escape such as animal accounts, inspirational quotes and art. Researchers found a similar situation on YouTube, where adolescents followed influencers who focused on mental health related themes. Adolescents reported using TikTok, Instagram and YouTube for consuming content that provided a temporary distraction or lifted their mood. They tended to use Facebook to find support groups that focused on specific issues such as eating disorders or ADHD, and some followed support services run by MHPSS-related institutions.[130]

Of the overall sample, 26% said they used a health service or charity website to support their mental health, 32% used a mobile mental health app, 71% used messaging platforms (WhatsApp, Snapchat, Instagram) to contact friends and family, and Skype or Zoom for professional support).[131] This finding shows the potential benefits of digital access so that adolescents can seek out MHPSS at Levels 2, 3 and 4.

Despite this positive view of online mental support, it is well-documented that adolescents are exposed to a variety of risks and potential harms in the online environment. Digital media, like any media can both enhance and weaken efforts to support adolescent mental health.[132] [133] Social media has been linked to increased anxiety, depression and eating disorders in the US, the UK and Australia, for example.[134] [135] As adolescents scroll through social media, they are presented with a multitude of seemingly desirable yet unattainable lifestyles and beauty standards. This leads them to compare themselves to others, often resulting in feelings of envy, rejection, and the "fear of missing out" on the great time that everyone else appears to be having.[136] For displaced and stateless adolescents, these images and videos can reinforce their sense that others' have more material goods and stable environments than they do.



In late 2021, a Facebook employee and whistleblower testified that the company's own internal research showed that its Instagram platform contributed to depression and anxiety among teenage girls and that Facebook's profit motive meant that the company placed less importance on potential harms to children and others[137] This led to widespread media coverage about the site's potential contribution to adolescent mental health problems[138] as well as its inability to effectively moderate content in many lower- and middle-income countries.

Also in 2021, however, UNICEF reviewed a substantial body of research on social media's effects on children's mental health and concluded that the small size of the associations made it difficult to separate cause from effect. It is still unclear whether social media makes young people depressed or if depressed young people are more likely to use social media.[139] [140] Young people who are lonely and isolated or feeling depressed and anxious may turn to social media and the online world to find friends and seek support. While research in this area is ongoing in some countries[141] more research, including in low-income countries and among refugee populations, is needed to better understand links between mental health and social media.

In addition to social media's possible link to mental health issues among adolescents, children and young people are exposed to several other types of risk in the online environment. These include sexual abuse, grooming, bullying, sextortion, trafficking, exploitation, hate speech, gender-based violence. In addition, there has been a rise in online misinformation, disinformation and false information, violent and extremist content, and recruitment into extremist groups. Vulnerable children, including displaced and migrant children, may be more susceptible to these risks.[142]

Misinformation about health and mental health easily propagates on social media as well. The #mentalhealth hashtag on TikTok, for example, had 18 billion views by October 2021, with tagged posts ranging from users' personal experiences to influencers providing tips on how to cope with mental health challenges. While this has helped reduce stigma and made mental health information more accessible, it can also lead to inaccurate self-diagnosis and treatment.[143] TikTok has incorporated mental health resources as part of its Safety Center in an effort to reduce misinformation about health. Other social media platforms have introduced various measures to stem the tide of misinformation, disinformation, and false or fake information, however platforms have generally faced major challenges with verifying information, especially in non-dominant languages. A new wave of research conducted during the COVID-19 pandemic also found a plausible link between uncertainty, anxiety, and depression and an increased likelihood of believing conspiracy theories and fake information.[144]

The opportunity to create and provide high quality, vetted mental health information via social media platforms that are already popular amongst displaced and stateless adolescents is enormous. In addition, UNHCR could identify and partner with mental health-focused platforms that provide verifiable information and work with them to tailor content to specific languages and to the experiences of adolescents in forced displacement. Social media platforms could be used to signpost adolescents to this content or to provide high quality content directly. An approach that minimizes risks and maximizes the benefits and protective factors and which combines digital and non-digital as appropriate (see Section 6 and Figure 8) would be needed. Children, young people, and their families also play a role as responsible online participants and it's important for them to have information and skills to appropriately manage digital use and risks. Additionally, the private sector should be encouraged to produce relevant, appropriate, and accessible content and tools[145] and should be held accountable when their platforms and services negatively affect children's safety and mental health.

If we consider the internet as a basic service, and Layer 1 support for MHPSS includes approaches to the provision of basic services that are inclusive, participatory, and rights-based, and that enable improved mental health, then Layer 1 approaches and interventions should include efforts that contribute to safe internet experiences for adolescents in forced displacement. Digital tools and platforms can be used to foster participatory approaches in the delivery of all basic services, for example by online consultations and feedback mechanisms.

It should be highlighted that while this section has summarized important research on adolescent digital MHPSS, there is still insufficient information about how displaced and stateless adolescents access the internet. More research with adolescents in forced displacement settings is needed to better understand how they experience the online environment, whether they seek MHPSS support online, whether they find what they are looking for, how useful it is in helping them to cope, the potential risks and negative effects, and how the balance towards positive could be emphasized either through co-design/design or by helping young people develop their resilience, self-protection habits, and coping mechanisms, and other aspects that would be unique to their experiences.


In cases where a risk assessment determines that commercial digital platforms are not safe for displaced and stateless adolescents to use, UNHCR might consider developing specific secure tools or platforms that avoid the privacy and protection challenges that arise with commercial platforms. The benefits of developing new tools and platforms would need to be balanced with the known challenge of getting people to move to and use new channels, tools and platforms.



## Digital Adolescent MHPSS Interventions at Layer 2

Layer 2 focuses on MHPSS **interventions that involve self-help and non-specialized support from peers, families, and community members. We include in-person and online peers and communities at this level.** Globally, adolescents report that sharing their feelings with peers anonymously on social media platforms during the COVID-19 pandemic served as a powerful coping strategy, especially in places where stigma surrounding mental health was high.[146] Children said that the internet helped them to cope during difficult times and that it benefited their health and wellbeing by helping them to find online peer communities that offered support, belonging, and a place to share their experiences without judgment.[147] While these communities might not be made up of local, in-person peers that adolescents know offline, online peer groups may provide similar MHPSS experiences for adolescents.

A UK multimethod study with adolescents in 2021 focused on how children engage online with the topics of eating disorders, self-harm, or attention deficit and hyperactivity disorder (ADHD). Adolescents reported finding validation and belonging in online mental health communities, and this can support their self-care so that they can regain control over their wellbeing.[148] The researchers also found that children with experience of eating disorders or self-harm were more likely than their peers to seek out or encounter online content related to their mental health problems, but that this content could also trigger or encourage behavior that exacerbates it, and this type of content is often found in online communities that focus on eating disorders or self-harm.[149]


An important conclusion was that offline factors such as experiences of distress, depression, anxiety, low self-esteem, loneliness, hopelessness, a history of physical or sexual abuse or violence, exposure to suicidal ideation from others, or having families and friends who had self-harmed in the past needed to be considered when studying adolescents' mental health in relation to the digital environment, and that participation in mental health-focused online communities can be supportive as well as harmful for adolescents depending on prior life experiences.[150] This would be something to watch closely when designing online communities for displaced adolescents who may have multiple past experiences of trauma that could be re-triggered in an online group.

Also, important to note is that the mental health of displaced adolescents suffers when they go online and find unsettling news from their countries of origin, upsetting messages from their families,[151] or hate speech and anti-refugee sentiment expressed in their host country. UNHCR staff in Kyrgyzstan, for example, said that the mental health and wellbeing of displaced and stateless individuals is directly affected by negative attitudes expressed online towards refugees and asylum seekers.[152]

In addition to online communities, Layer 2 includes self-directed MHPSS interventions. WHO [153]and a range of others[154] [155] have identified psychological interventions that are potentially scalable among communities affected by adversity (defined as communities in which most people have experienced severe losses, traumatic events or other extreme stressors and have limited access to essential resources). These include self-help materials that draw from evidence-based psychological treatment principles and self-help accompanied by peer, family, or community support to use these materials effectively. Online self-help materials are found in a range of digital formats, including audio-visual materials, websites, interactive online tools, games, and apps).

There is evidence to support the idea that 'transdiagnostic' treatments (those that apply the same underlying treatment principles across mental disorders without tailoring them to a specific diagnosis) are as effective for addressing generalized anxiety, social anxiety, and depression as 'disorder-specific' approaches (tailored interventions based on a specific diagnosis), including in humanitarian contexts.[156] [157] Acceptability of mobile phone-based approaches tends to be strong among refugees, given the importance placed on smartphones.[158] There is also promising evidence that those affected by war and disaster are open to mHealth programming.[159] This could mean that self-help MHPSS interventions might be of interest to displaced adolescents. However more focused research and program assessment is needed to improve the evidence base for interventions specifically for this population and with attention to their varying contexts – for example, camp versus urban resettlement, easy or difficult internet access, phase of displacement, literacy and language capacity, and cognitive capacities if under severe stress.

Mental health apps have burgeoned over the past several years. A WHO survey of 15,000 mHealth apps found that in 2015, 29% of mobile health apps were focused on mental health diagnosis, treatment, or support.[160] In 2020, a systematic review of digital mental health interventions for children and young people found that young people tend to respond well to digital MHPSS if it is convenient, self-paced and anonymous, and when it uses minimal text and offers opportunities for connection with peers.[161] More trials are needed, however, because most mental health-oriented apps have not yet shown clear evidence of efficacy in general,[162] and even less so among displaced and stateless adolescents. A review of 293 commercial apps aiming to address anxiety and/or depression found that only half of them referenced an evidence-based framework in their app store description.[163] Of these, only 6% had published evidence supporting their efficacy.[164] While there is a proliferation of these apps in the marketplace, three apps (Headspace, Youper and Wysa) accounted for around 90% of downloads for depression and three others (Headspace, Calm and Youper) for approximately 90% of downloads and daily users for anxiety.[165] Sustained use is another important metric. The popular, free COVID Coach app aimed at helping people deal with stress during the pandemic had more than 140,000 downloads, yet only 1.56% of individuals who downloaded the app used it for at least two weeks.[166] These high drop-off rates are a major challenge for digital MHPSS.

A global review on the efficacy of mental health apps for depression, anxiety and schizophrenia[167] found that three elements generally reduce efficacy: poor regulation of quality and privacy; inconsistencies in engagement; and a narrow focus on only one disorder per app.



The researchers offer four recommendations to improve efficacy:

- People will normally use these apps without clinical oversight, so they need to be intrinsically motivated. Apps should aim to **generate high patient motivation and engagement** through real-time engagement; usage reminders; and gamified interactions.
- **Simple user interface and experience** help drive faster behavior change through reduced cognitive demands and an increased capacity for learning. Cognitive load can be reduced using pictures instead of text; reduced sentence lengths; nonclinical language.
- **Transdiagnostic capabilities** help to reduce the level of commitment needed to address comorbid disorders by eliminating the need to use multiple apps.
- **Features that allow people to self-monitor** their mood by periodically reporting their thoughts, behaviors, and actions can increase emotional self-awareness (the ability to identify and understand one's own emotions). This has been shown to reduce symptoms of mental illness and improve coping skills.

Based on available evidence, it is likely that in contexts where adolescents have easy access to devices and sufficient capacity to purchase data, smartphone apps could provide an accessible, scalable, and low-cost mechanism for effective self-management interventions for low level and generalized symptoms of depression and anxiety, particularly for non-clinical populations and those who cannot access face-to-face services. Low access to smart devices, poor connectivity and the need to pay for data to use MHPSS-oriented apps, however, make these kinds of interventions prohibitive for many adolescents in forced displacement situations.

In addition to self-help and emerging kinds of digital interventions, online group sessions became the norm during COVID (both community-based, Layer 2, and those led by non-specialist professionals, Layer 3). These generally use video calling and messaging platforms to support community-based discussions, safe spaces, and peer support. Participatory and scenario-based face-to-face training have been transformed for the digital environment. Where participants have a good internet connection and facilitators are trained on ways to manage online groups, these methods hold potential even beyond the pandemic.[168] Safe spaces are generally an important way to promote community-based support for mental health, especially for marginalized and disenfranchised groups such as LBGTQI+ people and ethnic or religious minorities.

A study in the Middle East on Layer 2 and 3 types of interventions found that refugees were initially skeptical about the move to remote MHPSS for different reasons, including concerns about the stability of their internet connection, doubts about being able to communicate as well with the therapist online as in person, and privacy risks when having sensitive conversations over the internet. This resistance was found to progressively fade as it became evident that a quick return to in-person services was not feasible because of the on-going pandemic, and as people adjusted to the technology. Some refugees noted advantages to remote delivery, including greater flexibility and anonymity, and reduced time and money spent accessing services. Practitioners said that adolescents in particular tended to prefer remote modalities which gave them greater independence from their caregivers and mimicked their normal habits of using technology as their primary communication tool with friends. Remote delivery was observed to mitigate gender-related barriers by expanding access to women practitioners who no longer needed to travel or work outside of the home and did not need to find childcare.[169]

The study above cites a report by Ashfaq et al. who conducted a systematic review of mobile mental health services (including focused non-specialised support and specialized services), among Syrian refugees and other vulnerable Arab populations. That study noted that the population had a positive attitude toward the use of mobile technology to monitor and bolster their mental health. The following potential for remote MHPSS services were noted:

- It's lifesaving. Remote service delivery might be the only way to get help.
- Greater anonymity. Remote modalities can help reduce personal and social stigma; which is particularly relevant for people from stigmatized groups such as LGBTQI+ people.
- More cost effective. The possibility of accessing services anywhere saves time and cost for clients. Organizations can also have practitioners work under more flexible modalities and across different locations.
- Bridges resource gaps. Remote services allow clients to be connected with practitioners elsewhere, which is especially useful where there is a shortage of mental health experts.
- Increases access. Individuals who may otherwise not access these services can be reached, for example: parents of young children, people with disabilities, elderly people with limited mobility, adolescents who depend on parents/caregivers for transportation.
- Complements in-person services by helping reduce the workload for in-person services through remote case management.[170]



More research on the effectiveness of remote MHPSS and online groups is needed, with a specific focus on adolescents in forced displacement settings, as there are varied views. A 2020 study found that while it is easy to agree on goals and tasks during online therapy groups, the quality of relationships is still questionable when "shifting from the circle to the screen" because of the lack of body contact, absence of eye contact, and the possibility of greater distractions in the individual's environment. Similar issues were reported by humanitarian practitioners when conducting online focus group discussions for research and evaluation purposes.[171] These challenges have also been identified by UNHCR and others interviewed for this report. The same 2020 study highlighted that research on online groups is not yet well developed in the psychological literature and that more study on specific elements in online group therapy is needed.[172] It is likely that research on online group therapy will be forthcoming over the next few years, given its prominence in most countries during COVID. It will be important to consider common challenges in forced displacement contexts when studying online therapy interventions.

## Online Community Safe Spaces in Malaysia

UNHCR and several partners had been working in Malaysia since 2018 to train refugee women leaders. When the COVID-19 pandemic hit, the women were invited to participate in additional training (which took place online) to learn psychological first aid so that they could run online safe spaces. Sixteen women focal points were trained, and they worked in pairs to attend to seven refugee communities and 150 participants. Focal points were provided with a smartphone, data, and a stipend.

To increase participation and reduce stigma, the group is marketed as a "community support group" that helps with stress management, not as a mental health support group. Sessions initially focused on gender-based violence and expanded over time to include any issues that refugees were facing due to COVID-19. While only 5 of the participants were under 18, with some adaptation there might be potential to conduct online safe spaces with adolescents.

There are several challenges, however, including funding, regular access to smartphones required to participate, and language barriers. In this case, moving traditional community-based approaches to a remote, online space made it possible to reach some community members during a lockdown, however the time, intensity, and budget levels appear to be similar to in person efforts, and there are issues of exclusion, meaning that there is less potential to reach great scale. Additionally, staff reported that communities would prefer a hybrid program where some face-to-face meetings continue so that those who feel uncomfortable talking in a group setting could approach the community focal point for individual support.

## Digital Adolescent MHPSS Interventions at Layer 3

Layer 3 interventions focus on **non-specialized digital MHPSS support and the integration of online social and psychological interventions into existing (digital and analog) programs and services, including education, gender-based violence programming, and youth empowerment.** Along with Layer 2 interventions (self-help with support from peers, families and community members), self-help with trained non-specialized support has been identified as scalable among communities affected by adversity. This includes brief, basic, non-specialist-delivered versions of existing evidence-based psychological treatments (e.g., basic versions of cognitive-behavioral therapy or interpersonal therapy).[173] [174] [175]

One program aimed at providing general MHPSS to students in an Indian secondary school showed positive results regarding the effectiveness of transdiagnostic approaches and common design principles in adolescent mental health.[176] However, the intervention had to be carried out in person due to limited personal ownership of digital devices and acceptability concerns from parents. Even when comics and other printed materials were used, there were challenges with participation and completion of exercises due to low literacy, availability of time, complexity of the exercise, and cognitive load required for certain tasks.[177] The authors note that as remote learning becomes more normalized, this type of intervention might be incorporated in a digital format as part of education programs. More work is needed to determine whether this could be an adequate intervention for adolescents in different phases of conflict, persecution or forced displacement settings and contexts. Generalizing findings from studies to routine global settings is also challenging, because of the strong role that local culture and resources play.

Two studies examined the potential for scaling WHO's Step-by-Step online mental health intervention to the Syrian refugee population. One looked at adapting the Step-by-Step to the needs and expectations of Syrian refugees in Germany, Sweden, and Egypt as a strategy to increase access to treatment.[178] Findings have shown that there was no measurable effect of Step-by-Step among this population, even among those who had a 'minimal effective dosage' of at least 4 sessions.[179] The second study was a Randomized Control Trial (RCT) which found that a guided, digital intervention, where participants had a weekly check-in with a support person (in addition to using the app on their own) was effective in reducing depression in displaced people in Lebanon. The RCT recommended that Step-by-Step be made available to displaced people in Lebanon who have digital access.[180]

There were high dropout rates with the app however (69% of users did not complete the intervention), which is a challenge considering that Step-by-Step is a guided intervention whose results depend on completion. While the WHO notes that the interventions that are more able to scale are those that rely less on specialist human resources, it also recognizes that some scalable models are less effective, and that increased coverage must be weighed against decreases in the quality and effectiveness of services. Evaluation and comparison of these kinds of interventions among adolescents living in forced displacement contexts is needed so that UNHCR can determine what would keep them motivated to continue with these types of interventions long enough for them to be effective.


It will also be important to define acceptable levels of quality, effectiveness, reach, and drop-out rates and determine to what degree a lapse in quality or uptake is acceptable as a trade-off for increased scale and whether UNHCR has the resources and capacity to serve those who are left behind by digital MHPSS interventions in alternative, offline ways while also providing online MHPSS services.

In addition to specific MHPSS interventions as described above, at Layer 3 we also see the potential for integrating MHPSS into existing online programs, such as education, general healthcare, gender-based violence, and child protection programming. UNESCO's Asia Pacific office, for example, reports that since March 2020 some 84% of enrolled learners in 163 countries worldwide experienced partial or full school closures. In Asia Pacific alone, school access was disrupted for 760 million children at the initial peak of the pandemic. New teaching methods, including mobile phone apps, online and hybrid learning, radio broadcasts and special television programming were adopted, and educators began using new approaches, technologies, and teaching tools. Alongside these digital approaches was a strong focus on mental health and wellbeing in UNESCO's approach to education, as noted in the agency's "Happy Schools Guide," which provides resources for learner well-being and social and emotional learning.[181] During the pandemic, UNHCR began including MHPSS in online child protection, gender-based violence, and youth empowerment programming as well.[182]

### Integrating adolescent MHPSS into online summer camp in Kyrgyzstan

As of April 9, 2020, distance schooling began in schools in the Kyrgyz Republic. Classes were taught through TV programs and platforms such as Zoom, WhatsApp, Webex, and others. To address language difficulties, online tutoring was offered and to address internet access issues, mobile network operators provided free internet for school children and teachers. Alongside this shift to distance education, the government reported that the number of teenage suicides was on the rise during lockdown.

UNHCR Kyrgyzstan is supporting 83 displaced and stateless children in the Kyrgyz Republic. UNHCR began making calls to students and monitoring the situation, offering psychological support through a partner group that provided psychological advice and conducting consultations for those who needed them. When the school year ended, UNHCR and partners offered a 2-week online summer camp to help children deal with isolation and quarantine, to distract themselves from their current situation, to share any concerns they might have, and to seek support.

Language barriers and internet access were a challenge for many adolescents who attended the summer camp, as was keeping adolescents' attention in an online format. The team adapted timing and included more games and provided additional translation services. Language barriers and interpretation were a challenge for refugee children in terms of government mental health hotlines, as well, because adolescents could not speak directly to a psychologist without an interpreter.[183]

MHPSS Resource

## Using Chatbots for Level 4 MHPSS Interventions

There has been extensive work on the use of hotlines, interactive voice response (IVR) lines and 'conversational agents' (also referred to as 'chatbots') for MHPSS. Hotlines generally connect the caller to a live operator. An IVR line offers the caller a menu of topics that they can select by pressing a number. They are served up recorded information or, depending on how the line is staffed, can eventually arrive to a live support person if needed.  Chatbots are text based. Less advanced chatbots work similarly to an IVR line but the pre-loaded content is text rather than a voice recording. More advanced chatbots use artificial intelligence to understand what the user needs and to direct them to relevant content. Hotlines, IVR lines and chatbots aim to respond to immediate mental health needs. Some chatbots have the look and feel of interacting with a human, despite being run by an automated software program.

### Chatbots for MHPSS

Proponents of MHPSS chatbots generally see three main benefits: they can enable early diagnosis and intervention through digital phenotyping; they reduce stigma of mental illness diagnosis and treatment; and they offer increased access to mental health treatment globally.[184] One study on the use of chatbots for mental health in the United States suggested that therapeutic relationships can be developed with digital technologies and that human-style interactions with a chatbot could enable change without the need for human support.[185] Some people report feeling more comfortable talking anonymously with a chatbot, which could open the possibility for improved detection of distress and provide immediate interventions to those who are not comfortable with face-to-face contact.[186]



Chatbot interfaces are a key feature of many commercial mental health apps, yet their evidence base is not well established.[187] Some researchers have both raised epistemic and ethical limitations in the diagnosis and treatment of mental illnesses based on artificial intelligence.[188] Chatbots are currently limited in terms of delivering appropriate contextual responses to complex language inputs, for example, and this raises significant concerns about safety. One study found that chatbots often fail to recognize serious mental health concerns and are not able to offer appropriate responses such as referral.[189] In situations where a chatbot is developed in a language that does not yet have strong Natural Language Processing (NLP) capacities or cannot detect different accents or slang terms, the experience for a person in distress can be frustrating and downright dangerous. Of great concern is that chatbots are often not able to recognize suicidal ideation and domestic violence problems.[190]

*One study found that chatbots often fail to recognize serious mental health concerns and are not able to offer appropriate responses such as referral.*

Bias in NLP has been a major concern in general, considering that advanced NLP and other artificial intelligence tends to work better for culturally and linguistically dominant population and for only certain "accents" on dominant languages (e.g., UK or US accents on English are more recognized than other accents on English). This could present a serious risk for displaced and stateless adolescents who do not speak main languages. Limited literacy and digital literacy among some populations also introduce challenges. Users might become frustrated with automated systems that don't understand them and this could create disengagement and drop offs. There are also concerns about the privacy of chatbots and skepticism about whether they can truly replace human interaction well enough to be effective.[191] On the other hand, satisfaction ratings drawn from pilot and feasibility studies tend to be high, and rates of adverse events have to date been low.[192] Due to the somewhat weak evidence base, chatbots are likely best used as a supportive tool in the context of a broader treatment plan.

Chatbots, like any MHPSS intervention, need to be culturally adapted. Pictures, language, dialects and accents are important parts of the chatbot creation process. Personas need to be developed and tested

to learn which type of a persona has the best uptake and trust levels among displaced and stateless adolescent users of a chatbot. The afore mentioned Step-by-Step program in Egypt, Germany, and Sweden spent a good deal of time on this aspect and then offered different personas to their users so that people could more easily relate to the persona.

**Chatbots and safeguarding**

UNICEF raises additional concerns[193] about safeguarding when using chatbots with children and adolescents, including:

- Does the adolescent know that they are interacting with a chatbot and not a real person?
- Is the option to contact a real person offered at the start of the session?
- Can the chatbot detect that a user is in a high-risk situation?
- Does the chatbot provide empathetic acknowledgement, so that the user feels heard?
- Does the chatbot provide immediate guidance on the topic and/or offer the option of communicating with a real person?

When chatbots were tested to see how well they could detect 'at risk' messages, no chatbots performed as well as hoped. Even when a chatbot recognized a potential risk to user safety, its response was often problematic. In response to the comment "*I have been raped*", for example, one chatbot replied: "*Well, I have a few stories which you can learn from!*" In response to the comment "*I want to kill myself*" a chatbot said "*Well I have a list of resources you might find helpful.*"

**UNICEF recommends:**

- Partnering with experts and ensuring at the very least that content is signed off on by child protection and subject matter experts.
- Managing expectations so that users are clear from the start that they are not engaging with a live person.
- Using key word recognition to detect trigger words (and potential misspellings of trigger words)
- Designing an effective error management process in case a user gets stuck in an "AI loop" because the chatbot did not understand how to advance the user to the next step.
- Designing a human-led service first in order to gather the necessary data to train the AI side of the chatbot
- Pooling training data across countries and languages as a way of ensuring more effective natural language processing
- Using language carefully to avoid reinforcing gender stereotypes and harmful social norms.

**Other risks when using chatbots**

UNHCR studied a range of other risks when using chatbots, including data privacy and security and the potential for disinformation and misinformation. Terms and conditions that are imposed by the platforms on which chatbots sit can also present a risk, in that their business models are geared towards maximizing user data for profit and may not have humanitarian goals and principles in mind.



## Digital Adolescent MHPSS Interventions at Layer 4

Layer 4 interventions include **clinical mental health screening and specialized MHPSS services provided online** (such as online therapy and psychological services), **and online referrals to in-person counseling and treatment.** While many of UNHCR's interventions focus on Layers 1-3, those that enable contact with or referral pathways to specialized professionals are considered Layer 4 interventions.

In the Asia Pacific region, UNHCR and partners currently provide therapeutic support to some adolescents, and this largely moved online due to COVID-19. Staff providing this support reported struggling with keeping young people and their family members engaged in remote sessions, especially when there is no video to help with connection and to gauge emotions and develop bonds. IFRC's Psychosocial First Aid center, however, reports that participatory methodologies in the online environment can largely replicate the benefits of in person therapy.[194] Contextual factors, individual factors, language, and digital access and literacy play a role in the effectiveness of these methods, which might be well-received in some contexts and not in others. Combining professional support with self-directed exercises (for example, an app) and audio-visual supports (such as YouTube videos) could be a way to make remote sessions more successful.[195]

One study found that self-help is only slightly less effective than face-to-face psychotherapy for common mental health issues,[196] and that regular contact with a therapist may be unnecessary for effective results so long as individuals can access initial and post-treatment interviews and are regularly monitored over time through some type of check-in (not necessarily in person).[197] Some studies have found that e-mental health interventions, depending on their design and the problem they are aimed at solving, may be as effective as respective face-to-face versions[198] and that they can be useful for reducing the impact of common internal and external barriers to accessing care.[199] [200] However, this may only be true under ideal conditions and there has been insufficient research and evaluation of these types of support among displaced and stateless adolescents to come to solid conclusions about the potential of app-only interventions.

A large-scale meta-analysis of 66 randomized controlled trials that explored the efficacy of smartphone apps for depression and anxiety across clinical and non-clinical populations found that smartphone apps for depression outperformed face-to- face and other computer-based interventions in the case of depression, however app interventions for anxiety did not differ significantly in efficacy. Importantly, for both depression and anxiety, where professional support was provided along with the app (for example, phone calls or personalized therapist feedback) larger effect sizes were produced as compared to studies where there was no kind of in-person support or check in.[201]

While the evidence is unclear, there appears to be potential for continuing online live support, combined with self-help applications where possible, and triage aimed at moving individuals from generalized MHPSS support at Levels 1, 2 and 3 to more direct professional support at Level 4 if needed. A note of caution is required, however, considering the ethical concerns that automated approaches and self-directed interventions might not detect serious cases or offer support in time, and the known challenges with the use of artificial intelligence (e.g. historical bias, encoded bias, less efficacy with historically marginalized groups and languages).[202] It will be necessary to carefully assess any Level 4 interventions and conduct benefits-harms assessments before testing them and to involve child protection teams, trained MHPSS professionals, and researchers. It will also be good to conduct more in-depth research with displaced and stateless adolescents to better understand at what specific stages or in which specific circumstances offline components or involvement of teams are necessary to complement online approaches.


Considering the privacy risks inherent with general commercial mental health applications[203] and the need to tailor solutions to very specific groups and communities of displaced and stateless persons, UNHCR and partners may need to develop specific, secure digital tools that reduce the protection and data privacy risks that arise with commercial tools.

There may be specific digital health service providers that provide the functionalities needed without the data processing concerns or UNHCR may decide to have secure 2-way digital messaging applications as part of its ecosystem for sensitive two-way communications, counseling and case-processing, and these channels could be used for MHPSS programming. Before any of these digital or automated approaches are trialed, UNHCR will need to conduct in-depth participatory risk assessments that with representation from displaced and stateless community members of all genders, ethnicities, and sexual orientations, (including adolescents) and consult with MHPSS staff and professionals, as well as experts on data privacy, child protection, cybersecurity, and legal.




**On-demand MSPSS Support for Adolescents through a Mobile App:**

USupportMe[204] is an online, on-demand psychological support service developed by UNICEF. It connects teenagers with free online mental health services, including information and counseling from peer-volunteers, psychologists, and professional counselors. The service covers topics such as bullying, relationships, stress, anxiety, body image, conflicts, and peer pressures and offers support for substance abuse, violence, depression, self-harm, and suicide. USupportMe will allow adolescents to access both non-professional and professional quality mental and psychological support wherever and whenever they need it.


**MMAP – collecting better data on adolescent mental health.**

UNICEF, WHO, and other partners are working on the Measurement of Mental Health Among Adolescents at the Population Level (MMAP) Initiative, which aims to capture better data on the prevalence of mental health conditions as well as risk and protective factors in order to inform the design and implementation of appropriate policies and programs and the allocation of resources to support adolescents. A lack of investment has led to lack of resources and standardized validated tools for measuring mental health in these settings. It is estimated that current data coverage on adolescent mental health only represents 2% of the adolescents living in low- and middle-income countries (LMICs).[205] This is problematic given that some 90% of the world's 1.2 billion adolescents live in LMICs,[206] and without data that represents them and their experiences, developing relevant and contextually appropriate programming will be challenging. The MMAP initiative develop a set of metrics and tools that will enable the collection of comparable data on adolescent mental health through representative national surveys, collection of equity-sensitive data that can be stratified to ensure measurement of the most vulnerable populations, monitoring and evaluation of adolescent mental health programs implemented at local and national levels, and among special population groups including adolescents on the move, pregnant or parenting adolescents, and assessment of risk and protective factors for adolescents' mental health. An MMAP toolkit will be included as a monitoring resource for the UNICEF and WHO jointly developed Helping Adolescents Thrive program for promotion of mental health and prevention of mental health conditions.[207]

# 6. Barriers, limitations, and risks of digital MHPSS

While digital approaches to MHPSS clearly have huge potential for addressing adolescent mental health needs, there are multiple barriers, limitations, and risks that need consideration when designing and implementing them, and when deciding if they should be introduced at all. Below we lay out a range of challenges and considerations in five areas: access and inclusion; relevance, trust, and credibility; user context; digital protection; and a lack of evidence-based approaches. See Figure 8 at the end of this section for a summary of benefits, barriers, limitations and risks of adolescent digital MHPSS at the four Layers.

## Exclusion and low access to digital devices and platforms

Digital inclusion is a top priority for UN agencies. The Digital Inclusion Roundtable under the Roadmap for Digital Cooperation defines digital inclusion as:

> "Digital Inclusion means providing, through intersectional, human rights-based, and whole-of- society policies and programmes, equal, meaningful, and safe access to and use of digital technologies and opportunities in the digital space for everyone, everywhere, without leaving behind those in vulnerable positions or traditionally marginalized and equity-seeking groups....[208]"

While one of the benefits of digital approaches to adolescent MHPSS is the potential for enabling greater inclusion and access to MHPSS and larger scale programming, challenges remain related to exclusion of those without stable, reliable access to digital devices, regular electricity, internet, data access, or sufficient funds to cover costs of data or devices.[209] [210]

A 2016 UN report on refugee connectivity found that refugees often pay a much higher relative cost for Internet connectivity.[211] A reported 37% of the world's population have never used the Internet, and among economically vulnerable and hard-to-reach populations, Internet use remains irregular, intermittent, or unstable. In addition, technology has been shown to replicate and even amplify social inequalities, with connectivity less available to people due to gender, socioeconomic divides, education levels, disability status or a combination of these. Low levels of digital literacy among more vulnerable or recently connected populations can also reduce their abilities to use digital tools and platforms confidently, creatively, and critically, and to guard themselves against online risks and threats.[212]

In low and middle-income countries in East Asia and the Pacific, the World Bank reports that 69% of people were able to access the Internet as of the end of 2020,[213] yet displaced persons reported in 2018 that they faced legal barriers to accessing SIM cards[214] and some countries prohibit Internet connections in refugee camps as part of a strategy to prevent settlements from becoming permanent.[215] In 2021, UNHCR reported other barriers to connectivity including: the cost of accessing the Internet, older model smart phones with lower security and outdated software, poor battery capacity, limited features, inability to charge phones, difficulty circumventing legal barriers to phone access. Connectivity might also be limited to communal locations or paid Internet cafés, which introduces other constraints, like loss of anonymity and access only being available during specific hours.[216] In some contexts, girls and young women feel unsafe or uncomfortable using the Internet in communal spaces and Internet cafes because they are the domain of men and boys. This means that adolescent girls often have to borrow or share phones belonging to male relatives which reduces their privacy and access and sets them back in terms of digital literacy and confidence to explore digital devices and platforms.[217]

Adolescents with low literacy and/or low digital literacy and those who do not speak the language that services are offered in might also be excluded from digital MHPSS support.[218] This can be a particular challenge in refugee settings with multiple language needs. Interpretation during MHPSS sessions can make trust building difficult. Additionally, adolescents, especially girls, may have less access than adults. Those with certain kinds of disabilities are also less likely to have digital access. In a study with Irish youth, respondents highlighted the need for content and services for young people from under-represented or marginalized groups, such as LGBTQI+ young people.[219] It should be noted that exclusion challenges related to literacy, language, gender, disability, identity, and social norms are also a concern with in-person MHPSS interventions, and that digital interventions often include some who were previously excluded and vice versa.

The humanitarian sector is actively working to advance digital inclusion, which will eventually help to resolve some of these basic access issues and open opportunities for self-care and for targeted MHPSS interventions. A 2022 report by the Humanitarian Policy Group criticized the sector for centering organizational drivers for digitization (delivering more assistance with fewer resources, better tracking for donor monitoring purposes, and addressing aid diversion) over addressing inclusion and prioritizing the needs of displaced communities. "This manifests in the use of aid user 'consultations', rather than participatory design, since the boundaries and uses for a digital tool and processes have been decided in advance of engagement with potential users," according to the authors. Not prioritizing inclusion can result in framing of and responses to crises that further exclude the most marginalized groups.[220]

COVID-19 accelerated efforts to advance digital inclusion with greater focus and priority. In its new draft Digital Transformation Strategy for 2022-2026 UNHCR adopted an unconditional approach to inclusion for displaced and stateless individuals and their hosting communities so that they can contribute to and benefit from a connected society and emphasizes ethical dimensions critical to inclusion. The three pillars in the Strategy aim to lay out the necessary attention to Digital Inclusion, Digital Protection and Digital Services, given that all three aspects need to work together in a balanced way to ensure refugee rights[221].

Displaced and stateless communities face varied and complex and contextually specific challenges when it comes to realizing the potential of the digital world. These include that in many countries, policies, laws and regulations exclude displaced people from digital life. In addition, community members are often

'priced-out' of inclusion when they have lower incomes than their host communities. In rural areas and remote settlements, access to hardware and services is difficult and costly. There are also infrastructure and technology barriers that stand in the way of access, including the lack of reliable power and poor cellular coverage and low speed connections make connectivity frustrating or unfulfilling. The private sector has little incentive to invest in many of these remote areas and populations with little purchasing power, and supply chain issues can make hardware difficult to come by.

All of these broad level difficulties make inclusion a challenge and an imperative for UNHCR. Within and among displaced populations, digital access differs significantly as it is not evenly distributed. Those in urban settings tend to have greater access to networks and devices than those in remote, rural areas. Some countries might prohibit refugees from purchasing phones or SIM cards. Comparatively wealthier refugees might have owned smartphones and laptops and have been highly digitally literate before displacement. Displaced adolescent girls might have a more difficult time accessing devices than their brothers in some contexts.

A local and nuanced understanding of connectivity, access and use is critical to ensuring inclusion in the digital world and to ensure inclusion in digital MHPSS for displaced adolescents. In addition to general digital exclusion, in the case of digital MHPSS it is important to avoid focusing on only one type of support. This could lead to those with more severe mental health conditions or disorders being left out because digital MHPSS services are not suitable for these more serious conditions[222] or for less serious disorders being overlooked because the focus is providing mobile apps for Layer 2 and 3 interventions. At the same time, strategic use of digital MHPSS might make it possible for lower-level screening offered through online MHPSS to help those with less severe conditions to access support, freeing up more specialized resources for those who need them.

## Stigma, lack of trust and low credibility

A study from the Overseas Development Institute lists scams as a barrier to online mental health uptake[223] and cautions that young people might not have sufficient mental health knowledge to judge which health-related information to trust. Other studies mention low credibility in online mental health services as a barrier to use.[224] [225] [226] A study on mobile mental health services among Syrian refugees and other vulnerable Arab populations highlights that there has been insufficient cultural adaptation of innovations and technologies. For example, the concept of "suffering" among Arab refugees is generally not perceived as a pathology or a medical condition as in Western norms. The authors of this study posit the need for an established theory base and an "evidence-based, consistent, gendered and culturally competent conceptual framing and grounding of m[obile] M[ental] Health development, diffusion, and transfer," noting that this lack of a non-Western frame is a major obstacle to the uptake of mobile mental health services[227]. The study also highlights that in Arab communities, strong social stigma is associated with mental illness. For example, men who seek care are considered weak and women associate care seeking with helplessness and being cursed. Additionally, the study notes that Arabs expect an authoritative style of communication where providers give concrete, specific solutions as opposed to getting involved in long-term, collaborative, dynamic processes.[228] Addressing these cultural gaps could support greater relevance, trust, and credibility of digital MHPSS.



UNICEF notes that while adolescents are known to seek mental health support and information online, there is no guarantee it will be appropriate, accurate, or helpful.[229] Irish youth in one study highlighted that online mental health services were often missing interpersonal connections, direct or indirect, that would help them develop trust. Adolescents in this study also indicated that contact with professionals and peers was of importance to them and was missing from many online resources.[230] This points to the potential of hybrid forms of MHPSS for adolescents, where digital tools are combined with live (phone calls or text message) support from an external, trained helper.

The youth in this study said that many online mental health services provided only generic advice, whereas they wanted guidance and activities that were relevant to their specific needs and varied options for content, information, activities, and formats that could meet different preferences and ways of digesting information. Many services lacked design that made them feel comfortable and young people suggested that a friendly, inviting user interface would help them feel that asking for help was acceptable.[231] Youth in this study also indicated that a pathological framing of mental health disorders was off-putting and they preferred acknowledgement that there may be periods of poor mental health that are not necessarily a mental illness.[232]

Though valuable MHPSS information from professionals is available online, there is also a great deal of user- generated content, including from young people who do not have specific training or expertise in mental health[233]. This has positive elements, as peer-peer approaches can be more relatable, contextualized, engaging, and trusted by adolescents; yet there are also risks that some of this mental health information and opinions on how to manage mental health issues is inaccurate or misinformed and can cause harm at the individual level or more broadly when amplified. Other potential risks include individuals misrepresenting themselves as experts or taking advantage of adolescents' mental health vulnerabilities to scam, groom, or harm them in some way. A lack of clarity on what content can be trusted can lead young people to mistrust any information about mental health, especially if they have had any type of negative experience with misinformation online.

Lastly, online services are less able to address emergency situations or provide immediate action for severe cases such as risk of suicide.[234] This raises ethical questions about whether offering a service that cannot address the most serious issues could lead to unacceptable levels of potential harm, and how this can be addressed during design and implementation phases of digital MHPSS services.

## Disconnect from the lives and contexts of adolescents in forced displacement

In addition to cultural relevance challenges that reduce inclusion and trust, when the integration of technology into mental health applications and services is not specifically designed for a particular context, uptake and effectiveness are reduced.[235] A study on the socio-ecological approach to understanding and designing technologically enabled mental health services for unaccompanied migrant youth residing in the European Union found that most mobile mental health applications had low uptake, primarily because they did not take young people's living situations into account.[236] Political regulations had a strong effect on the young people's mental health, and their status in the asylum-seeking process dictated the care, services, and accommodations that they could access. Their living situations strongly affect both their mental health and their ability to use self-directed online mental health support services and applications.[237] Youth involved in this study said that their living situation made it impossible to follow along and use self-directed mental health apps. The "macro-system" in which they existed as youth refugees made it hard to fit the app's recommended activities into their daily schedule, because their time was rigidly allocated to work, meals and sleep. To compound things, not being able to complete the activities on the mental health app caused them additional stress and feelings of failure. The youth's 'micro-system' was dictated by the macrosystem as well. In other words, their living location, their flat mates, and their lack of privacy made it difficult for them to be on their phones when others were sleeping or in the flat with them. Study participants were also highly concerned that others would know that they were using mental health support apps or that someone might be able to see what they were doing on their phones. Finally, as noted above in the section on inclusion, their context dictated the type of phone they could access, how much storage it had, whether and when they had use of Wi-Fi or could purchase data, whether they could use Wi-Fi in private, and whether they could access the app store to download the app.[238]

While the evidence base on digital MHPSS and MHPSS apps specifically designed for displaced adolescents and youth is very small, the importance of involving users in the design of both digital and traditional MHPSS interventions to ensure that they address contexts and specific needs and local realities is well-documented good practice. The Humanitarian Policy Group's research laments that "guaranteeing that digital tools suit the needs of affected people and are appropriate to the context and its supporting infrastructure, are basic considerations – but not ones that are universally followed in applying such tools to humanitarian contexts." Considerations recommended in the paper include translation into local languages, platforms that work with low bandwidth, and social media initiatives that are sufficiently engaging and relevant. Ensuring that digital approaches are appropriate for the context requires local staff and presence. Proximity is an essential component for understanding and overcoming context-specific exclusions, including how to ensure service coverage for people who do not use digital tools. As the author of a forthcoming paper pointed out, people may revert to non-digital technologies during a crisis because it is difficult to purchase data, and electricity to charge phones might not be available. The author also emphasized the importance of proximity in order to conduct a context-specific assessment on the risks and potential added value of digital tools, for what purposes, and for understanding who is likely to be included and excluded.[239]


Aligning with youth's daily context and routines, understanding their lives, designing for their digital, media and general literacy levels, using languages that they speak, and taking socio-cultural and technological realities into consideration are all necessary to meet challenges related to trust, credibility, uptake, sustained use, and scaling of digital MHPSS for adolescents in forced displacement.

Because displacement contexts vary widely, as do pre-displacement languages, cultures, and experiences, designing for specific populations and individuals while also aiming for wide reach is a challenge. In the earlier mentioned 2021 study of Irish youth's use of digital tools during COVID-19, teens complained that there was insufficient individualized support and personalized advice for their specific situations.[240] This might well be the case with displaced adolescents that UNHCR is working with. Another consideration is that while self-guided interventions might be attractive due to their potential for low-cost scalability, the absence of guidance may make the intervention impenetrable and unusable for some adolescents in forced displacement situations.[241]


### Integrative Adapt Therapy (IAT)

IAT is a brief psychological intervention that helps refugees "locate their reactions within the specific histories of their group in relation to experiences of forced displacement and human rights violations." The method draws on cognitive behavioral therapy that aims to address the adaptive challenges refugees confront. The developers of this method are considering offering it as a self-help app.

IAT focuses on five domains based on the ADAPT framework for mental health programming which assists refugees to understand and adapt to the undermining of the core psychosocial systems disrupted by forced displacement. The ADAPT framework considers systems of safety and security; attachments and relationships; access to justice; roles and identity; and existential meaning. IAT employs seven cross-cutting strategies – psychoeducation, problem solving, storytelling, relaxation, emotional regulation, cognitive reappraisal ("thinking differently", "managing expectations"), and meaning-making. The strategies are tailored to the culture of the target population and work to address problems or challenges confronted within each of the five domains.

IAT was shown to be effective in reducing adaptive stress and symptoms of common mental disorders in a randomized trial undertaken with Rohingya and other Burmese refugee groups living in Malaysia. After extensive ethnographic and cross-cultural work with Rohingya communities living in Cox's Bazaar, Bangladesh, a group adaptation of IAT was subsequently piloted. Participants who received seven sessions of IAT-G reported significant decreases in symptoms of depression, anxiety, posttraumatic stress symptoms, and complicated bereavement. They also showed reduced adaptive stress levels and functional impairment from baseline to posttreatment. There was evidence of further decreases on all

outcome indices (except for resilience), with the largest effects being improvements in anxiety, depression, and functional impairment from baseline to 3-month follow-up. Researchers note that consistent findings across the RCT in Malaysia and the study conducted in the Cox's Bazaar humanitarian setting, wherein the same measures were used, offers support for both the effectiveness and feasibility of IAT in this refugee population group across different resettlement settings.

According to the authors, this study provides evidence of the effectiveness and cultural fit of IAT with Rohingya refugees Bangladesh. National staff were highly involved and UNHCR and partners in Cox's Bazar have now established a new group of Rohingya para-counselors. These para-counselors were trained to identify and refer people with mental health conditions, and they also provide basic psychosocial support. In future, refugees will be trained as psychosocial volunteers and para-counselors across the camps so that they can offer this type of brief and effective psychological therapy to other Rohingya using IAT.

The authors also note that brief psychological interventions like IAT need to have access to an interrelated system of services that can support all types of psychological needs, from low level support for mild challenges to comprehensive clinical and community manage for those with severe mental health conditions such as psychotic or manic symptoms and suicidal ideations. It was critical for this intervention that UNHCR and partner organizations had well-established referral mechanisms to ensure that persons were directed to appropriate services. Further research is needed to determine how this intervention could be replicated in similar settings of mass emergency.[242]

## Digital protection risks

Rapid digitalization, particularly since the advent of COVID 19, has exacerbated existing digital protection challenges. These include threats to the right to privacy, data security, confidentiality -- a critical expectation for MHPSS. The processing of personal and sensitive data in digital systems creates an expanding range of risks that affect displaced people's abilities to connect with confidence and fully benefit from online opportunities.[243] These digital risks have a deep impact both online and offline. Refugees' digital footprints, for example, may put them, their families, and their associates at risk of identification and real-world harm (including from authorities in the country of origin as well as in the country of asylum).[244] Identification through data trails as a displaced person or as someone who has accessed MHPSS can also lead to future discrimination and denial of rights and services.

When children use online platforms and applications, their data is collected, processed, and used by private sector technology companies often without their knowledge or understanding of how and why, exposing them to privacy related harms. Children are at an age where they are less able to consent and are generally more vulnerable than adults to rights violations, so when designing digital MHPSS, data privacy and protection is a challenge to be aware of. A 2021 report from UNICEF highlights several risks stemming from weak data governance frameworks profit-based and advertising-based business models found on social media and other Internet sites, and a lack of transparency as related to children's data[245].



In addition to privacy risks related to the private sector's use of data, government surveillance conducted through digital technologies can lead to chilling effects on freedom of expression.[246] It has been reported that law enforcement and immigration authorities use children's social media and other data to locate and detain them and their family members for immigration violations or to use as evidence in deciding the validity of asylum or immigration claims.[247] This kind of data is also used in automated decisions and predictive analytics, for example, to determine education access, social protection benefits, cash transfers, and applications for formal financial services, which can lead to bias and/or exclusion of refugees and asylum seekers from access to fundamental rights and services. Public-private partnerships where data from vulnerable adolescents is collected by humanitarian agencies and shared with private sector technology companies and/or government entities raise concerns for the above reasons.[248]


Use of these new tools requires careful and measured protection impact assessments and rigorous safeguards, especially when used in high-risk contexts with high-risk populations such as displaced adolescents.

What's more, mental health is a highly sensitive topic, adding a third reason for extra care and detailed, context-specific, participatory risk assessments that go beyond privacy to consider the myriad of potential risks that might result from the use of new technologies and collection data from vulnerable adolescents.

There is currently insufficient guidance on ethics and confidentiality when it comes to digital MHPSS support, especially when it involves adolescents,[249] [250] and data privacy regulations do not exist or are simply not applied or implemented in some contexts, including many lower and middle income countries and conflict contexts where there is inconsistent application of the rule of law. As pointed out by UNICEF, children's rights to data protection and privacy are often not respected in the online space, especially by commercial providers. There is a lack of clarity on data privacy and data use and re-use in cases where MHPSS services sit on top of or are driven by commercial platform or apps.[251] There have been reported cases of immigration enforcement bodies such as the United States' Immigration and Customs and Enforcement's use of social media data to determine whether people are eligible for immigration or asylum status and cases in the US where therapist-client relations have been breached during immigration hearings.[252] [253] Additionally, group data risks are present in that MHPSS data on adolescents in situations of forced displacement could be used to profile and discriminate against them as a group, even if their data is anonymized.[254] [255]

UNICEF and others warn that advances in technology and the potential for lucrative uses of health data have pushed the boundaries of privacy. In the past, health data for research was primarily collected through clinical research and regulated by ethics bureaus or institutional review boards. Patient health records were mainly held by local or national facilities offline. Today, however, digital health and well-being apps collect and process health data and combine clinical and consumer data for research purposes. This rapidly emerging space is largely unregulated. Mental health apps are one example of popular private sector health apps that collect highly sensitive data from children and adolescents, including real-time GPS data and reported or inferred emotional states. Because mobile phones collect large amounts of individual identifying data, it becomes nearly impossible to de-identify data to protect privacy. Even when consent for research is secured, researchers have a hard time explaining exactly where data might end up, how long it is stored, how it is used, and by whom. Adolescents often do not understand that private and personal insights are being drawn from their data and used for purposes like marketing, influencing beliefs and behavior, automated decisions and predictive analytics to determine access to current and future rights and services, and various forms of tracking.[256] Techniques such as digital phenotyping, which aims to detect and categorize a person's behavior, activities, interests, and psychological features in order to customize future communications or mental care for that individual; and neuromarketing, which tracks a person's neuronal response characteristics and uses this data to direct the person into making purchases or making consumer, social or political choices, are ethical concerns that go beyond simple data privacy questions to larger ethical questions about uses of data[257].

## Mental Health Apps under Scrutiny

In the US, where a majority of digital applications are developed for national and global use, mental health is an area where privacy regulation is under scrutiny. Apps that do not include clinical intervention are not subject to US health privacy rules, for example. A 2018 study looked at 116 apps aimed at helping people with depression and found that less than half of them included any type of privacy policy. Some popular mental health apps were found to share data with Facebook/Meta and other companies, and data was used for targeted advertising. Some apps have emerged more recently in the US that diagnose and prescribe stimulants for treating attention deficit disorders - a pandemic-era waiver allowed companies to prescribe controlled substances online. These commercial apps were advertised by social media influencers on Instagram and TikTok, with messaging targeted towards lower income adolescents and youth who could not afford health insurance, leading to questions about the ethics of these companies and their methods. The Cerebral app, for example, allows a person to pay around $30 to get a rapid diagnosis for ADHD and obtain immediate access to ADHD medication, usually stimulants. Social media users often post guidance about how to answer a nurse's screening questions so that an ADHD diagnosis is likely. Cerebral has a relationship with an online pharmacy that delivers the medications almost immediately.[258] This is just one example of how lack of regulations for digital mental health support can lead to privacy violations and harm.[259]



In addition to data privacy risks related to private sector companies and governments, the humanitarian sector is increasingly a target for state and non-state hackers, and the sector is known to collect personal and sensitive data from and about highly vulnerable populations, including refugees and other displaced persons. Recent data breaches, for example of the ICRC's Family Reunification program, have highlighted that agencies can be prime targets. A 2020 report from Save the Children lists key areas of risk that humanitarian agencies introduce through their programming with migrating and displaced children, including harm caused by humanitarian innovation and risks introduced by data misuse or mishandling.[260]

Another risk is that adolescents in displacement contexts tend to have precarious connectivity and little discretionary income, meaning that they often access any Wi-Fi that is available[261] and download and use free software and apps. This raises concerns about their communications being intercepted due to insecure Wi-Fi, and about viruses, malware and spyware being present on their devices without their knowledge. There are also risks associated with use of public or community internet centers and shared devices, such as forgetting to log out of a session or data remaining on a device. These types of risk leave an account open to hacking or access by others, which can lead to privacy and confidentiality issues for adolescents. Similarly, adolescents with limited digital literacy or awareness of privacy may post private or sensitive information in public spaces, leaving them open to abuse, harassment, or to someone taking advantage of them or tracking them down due to posting personal information or location.

Other issues include challenges with proper informed consent[262], absence of regulatory clarity around data collection and use – including for mental health data on commercial apps -- and responsibility for data leaks or breaches[263]. Privacy and ethics need to be at the forefront of any digital applications and approaches to adolescent MHPSS. As more real-time data on youth mental health is captured so that service providers can reach out with real-time/just in time interventions, it is critical that care remains safe, and youth can make informed decisions about how their data is used[264].

UNHCR has not fully defined what the relevant internal policy, standards and guidance in this space should be or what a safe digital space would look like from a protection perspective. While there is some useful guidance on risk assessments already in place, these assessments need to go beyond data protection impact assessments to cover specific digital protection risks that adolescents in different stages of displacement and in different contexts face, including specific risks for unaccompanied minors, adolescent girls, LGBTQI+ adolescents, those with disabilities, those who have experienced gender based violence, and other specific kinds of risks that intersect to create even greater vulnerability.


If UNHCR is to design MHPSS interventions for these populations, a strengthened risk management process that includes human rights due diligence needs to be part of program design but also should be ongoing and adaptive to meet constantly shifting contexts.

## Lack of evidence-based approaches

A 2019 review of smartphone apps targeting child and adolescent psychiatry found only six studies that met strict inclusion criteria[265] and other reviews have also raised concerns about lack of quality and adherence to evidence-based practices.[266] [267] This, along with the lack of specific research and trials on digital approaches to mental health with adolescents who have been displaced or are stateless and in specific regions where UNHCR works, signals a major gap that needs filling. It is critical to note the importance of context, and of exploring assumptions, possibilities, and potential pitfalls in the use of digital technologies for addressing refugee mental health with adolescent refugee populations.[268] It is also important to understand the community's exposure to persecution, violence and loss, their trajectory of displacement and their relationships to the local population cultural and social strengths, the skills base of each group; the threats, assets, and enablers in their immediate context; and the availability of external support for MHPSS services.[269]

As one study highlights, systematic baseline assessments are vital for priority-setting. They can help program designers to take key points such as the community's exposure to persecution, violence and loss; their stage of displacement; cultural and social strengths and skills in different groups; the threats, assets and enablers for social and economic recovery in the current context; and availability of external support for MHPSS services. A difficulty noted by the same author is that evidence is not the only factor that dictates an intervention. Other contextual and political considerations enter into the equation of any humanitarian initiative, including donor preferences, which are sometimes idiosyncratic, pressure from lobby groups that push certain approaches or initiatives, and strategies, approaches, capacities and resources of implementing agencies. This study calls for greater standardization of assessments, systematic decision-making and transparency in the process in order to facilitate a more rational allocation of resources in each setting.[270]

While this report was to focus on digital MHPSS for adolescents dealing with forced displacement in Asia-Pacific, there was very little evidence base for this region and this population. More evidence is needed, as well as research with adolescents themselves, as there is still a lack of understanding of how to design digital mental health resources for refugee and displaced communities, including unaccompanied minors and youth.[271]



*Figure 8. Potential benefits, risks, and challenges of digital MHPSS for adolescents in forced displacement*

| Intervention Layer | Potential benefits, risks, and challenges |
|---|---|
| **Layer 1**<br><br>Provision of digital connectivity and online services in dignified ways that protect marginalized or isolated individuals and groups and that respect and enable adolescents' digital rights and wellbeing. | **Potential benefits**<br><br>• Increases resilience and self-help capacity, allowing adolescents to seek MHPSS support online.<br>• Reduces stigma by incorporating into general activities and communication.<br>• Helps address inclusion and access by offering MHPSS information to wide audiences (if they have Internet access).<br>• Provides general, accessible information about MHPSS and existing services.<br>• Adolescents might find others on social media who share their language and experiences in forced displacement.<br>• Raises awareness about mental health and human rights among families, communities, wider society.<br><br>**Potential risks and challenges**<br><br>• Exposure to online risks in the digital environment including sexual abuse, grooming, bullying, sextortion, trafficking, exploitation, hate speech, gender-based violence.<br>• Increased depression due to "fear of missing out" and comparison to others (mimetic desires).<br>• Exposure to mis/and disinformation and false information about mental health; inaccurate self-diagnosis.<br>• Anxiety on social media due to bad news about home country or family.<br>• Data privacy risks from using commercial platforms and applications that do not protect privacy.<br>• Digital footprint risks by leaving information on social media that can be used for tracking or other types of harm. |

| Intervention Layer | Potential benefits, risks, and challenges |
|---|---|
| **Layer 2**<br><br>Implementing digital or online interventions that strengthen the capacity of family, peers, or community to understand and support adolescent MHPSS through community-based actions or mechanisms. | **Potential benefits**<br><br>• Self-paced interventions can help increase resilience and self-help capacity among adolescents, families, community groups.<br>• Some adolescents perceive self-paced, digital MHPSS as more private and anonymous, which reduces their fears of stigma for using them.<br>• Self-directed apps can serve as entry points to signpost and refer adolescents to more in-depth MHPSS services (moving them to Layer 3 or 4 interventions).<br>• Online peer-peer support can be found via social media.<br>• Online group work, safe spaces, group therapy can be conducted remotely through community mechanisms when face-to-face is not feasible.<br><br>**Potential risks and challenges**<br><br>• Exposure to triggers when joining online support groups can exacerbate mental health issues.<br>• Anxiety on social media due to bad news about home country or family.<br>• Lack of evidence on efficacy of self-directed apps.<br>• Poor regulation of privacy and safety on commercial apps.<br>• Low access to internet, devices and need to pay for data can leave out the most vulnerable.<br>• Inability to find a private place to participate in online group sessions.<br>• Low quality of relationships when doing on-line group sessions<br>• High levels of drop off.<br>• Privacy risks with commercial technologies mean bespoke applications might be needed.<br>• Difficulties in discoverability and uptake with bespoke applications. |



| Intervention Layer | Potential benefits, risks, and challenges |
|---|---|
| **Layer 3**<br><br>Focused non-specialized MHPSS support conducted online or integration of MHPSS interventions into existing online programs and digital services (education, GBV, youth empowerment). | **Potential benefits**<br><br>Same as Layer 2, and additionally:<br><br>• Provides additional trained capacity or supervision (external to the community) for online groups.<br>• Incorporating MHPSS into other digital programs can mainstream MHPSS and wellbeing and achieve greater access and scale.<br>• Self-paced interventions enriched with in-person contact (via a weekly call or SMS) with a trained and supported helper can achieve greater uptake and efficacy than self-paced apps on their own and in some cases, these are almost as effective as in-person approaches (depending on context and various other aspects.<br>• Helps standardize how mental health is addressed (to reduce potential human rights violations).<br>• Non-specialized workers can be trained online to provide MHPSS services.<br><br>**Potential risks and challenges**<br><br>• Low capacity to follow along, cognitive load too intense for highly stressed populations when conducted online and in a self-paced way.<br>• Low literacy/digital literacy and challenges navigating apps and technology.<br>• High drop off rates.<br>• Low effectiveness when completely self-driven; needs regular contact with a live helper to be effective.<br>• Privacy risks with commercial technologies mean bespoke applications might be needed.<br>• Difficulties in discoverability and uptake with bespoke applications. |

| Intervention Layer | Potential benefits, risks, and challenges |
|---|---|
| **Layer 4**<br><br>Clinical mental health screening and specialized MHPSS services provided online, including therapy, psychological services, and online referrals to online or in-person counseling or treatment. | **Potential benefits**<br><br>• Reduces stigma by enabling more private and confidential access to services from the home or community.<br>• Expands inclusion and access by making specialized services more available locally at lower cost.<br>• Substitutes specialized services with trained automated responses (AI).<br>• Helps standardize how mental health is addressed (to reduce potential human rights violations).<br>• Provides additional trained capacity or supervision (external to the community).<br><br>**Potential risks and challenges**<br><br>• Difficulty keeping youth engaged if bandwidth is low, there is no video, voice cuts out.<br>• Difficult establishing deep connection and rapport without physical contact.<br>• Requirement for in-person support makes it less scalable (yet still potentially effective).<br>• Privacy risks with commercial technologies mean bespoke applications might be needed.<br>• Difficulties in discoverability and uptake with bespoke applications. |



## Crosscutting risks and drawbacks

### Exclusion

- Increased internet access can lead to increased risk of online harm and greater data privacy risks for adolescents.
- Low knowledge of mental health means adolescents might not be able to spot false information, misinformation, disinformation, scams and these can lead to harm.
- The online environment can expose adolescents to content that triggers their mental health issues.
- Excludes those with limited or no access to the Internet, data, devices, those who have low literacy or do not speak certain languages.
- Leaving a digital footprint that identifies them as displaced and/or as having mental health issues can lead to exclusion from opportunities later in life.

### Low relevance, trust or credibility

- Peer groups on social media may share misinformation, expose adolescents to content or offer advice that is not evidence based or that makes an adolescent's mental state worse.
- MHPSS groups led by community members or peers might feel less private for adolescents than in-person groups or online peer communities, reducing participation.
- Self-paced apps might not detect serious MHPSS cases/needs in time to offer emergency support (e.g., in cases of self-harm or suicide).

### Low feasibility for the user and their context

- Self-paced interventions tend to have greater drop off rates, especially for less digital, less literate, and less-focused individuals.
- Self-directed mental health apps might not be relevant for or meet the specific needs of adolescents in forced displacement situations and contexts.
- Self-paced apps may be less feasible for adolescents living in forced displacement situations due to their high levels of stress and existing cognitive loads.
- Self-paced interventions might not be able to go deep enough to be effective.
- Lack of a culturally relevant framing, language, approach can make self-paced apps alienating, irrelevant, and reduce uptake and sustained use.
- Less confidentiality and privacy with online groups.
- Less access to one on one support.

## Crosscutting risks and drawbacks

### Confidentiality, data governance, privacy, security

- Corporate data privacy risks if using online communication sites, social media platforms, or MHPSS-focused commercial apps.
- Lack of privacy in social media groups or online community groups with peers that leads to other harms such as bullying, harassment, grooming or sexual exploitation.
- Data use / misuse or inappropriate or harmful sharing of data by commercial applications.
- Displaced adolescents may be at high risk if they leave a 'digital footprint' behind that can be used to find or track them in their home country and their host country.

### Lack of evidence-based interventions

- A majority of online and app-based are not evidence-based or have not been thoroughly evaluated to understand their benefits and potential risks and unintended negative effects.



# 7. Good practices for designing and implementing digital MHPSS programs

Below we consolidate good practices and key considerations for designing and implementing digital MHPSS interventions, with vulnerable adolescents.

### a) Learn about displaced and stateless adolescents MHPSS needs

A first critical step for designing and developing digital MHPSS for displaced and stateless adolescents is to learn about them and their mental health and psychosocial support needs. Participatory needs assessments should be conducted to gather this information. Participatory needs assessments help to build partnerships with adolescents and community members through meaningful dialogue. They allow for a better understanding of the kinds of support that adolescents in forced displacement might need and want, and to decide priorities for action.[272] [273] They also help to identify existing community capacities, resources, and solutions; to define the roles of various stakeholders; and to understand dynamics and behaviors related to adolescents in forced displacement and MHPSS. Consultation with adolescents and their communities should happen before taking any action.[274]

Adolescent MHPSS participatory needs assessments can be done as a standalone exercise or mainstreamed into any of the various kinds of participatory needs assessments that UNHCR already conducts as part of its work - for example, in education, health, nutrition, community-based protection, child protection, and GBV. Guidance from UNHCR and WHO can help practitioners design this type of assessment in safe, sensitive and trauma-informed ways[275] [276] [277] so that the assessment itself does not cause harm or additional distress.

**MHPSS Resource**

These resources can help to design an MHPSS assessment:

- UNHCR's (2022) Emergency Handbook
- WHO (2012) Assessing Mental Health Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings
- IASC Reference Group (2012) Mental Health and Psychosocial Support Assessment Guide

## b) Gain insights into adolescents' information and digital habits and behaviors

In addition to understanding adolescent MHPSS needs, it is important to understand how adolescents and their families and communities access information, what sources of information they trust, what channels of communication they prefer, if and how they use digital communication channels, how information flows and what content is available and sought. Assessments should include a focus on the specific needs of adolescents and take into consideration social norms and ways to avoid exclusion based on gender, disability, and other factors in a particular setting. These might take different forms based on the context.

- A Rapid Information Needs Assessment in the case of a sudden emergency can help understand how adolescents in forced displacement are accessing information. If they are using online sources, this type of assessment would look at which tools and platforms and how. Key questions should include how are they accessing information (in closed or open groups?), in what format, who do they contact and who do they trust, whether there is scope for UNHCR and partners to provide added value[278]. Rapid needs assessments should also inquire about any concerns or potential risks that adolescents in forced displacement and their communities might raise about these information sources.

- A full Information Needs Assessment is a more in-depth exercise that can take place in protracted situations, long-term emergency or non-emergency settings. This type of assessment helps understand many of the same questions as above, but in a deeper and more thorough way with greater participation from adolescents and their communities.

- An Information Ecosystem Assessment includes both a review of available media and telecommunication infrastructures and people's information and communication needs, along with an analysis of information producers. This includes many of the above aspects as well as analysis of the wider information ecosystem, possible physical infrastructure weaknesses and power dynamics as related to media discourse and its effects on communities. In the cases of digital MHPSS and adolescents, it would look at their different information sources and needs and how information flows.

**MHPSS Resource**

Examples and orientation on information and digital needs assessments include:

- UNHCR (2020) Use of social media in community-based protection
- Regional Information and Communications Needs Assessment: Understanding the information and communication needs of refugees and migrants in the Venezuela Situation
- Digital Access, Community Needs and Community Practices: How digital inclusion can improve the protection of refugees, the internally displaced, and stateless people in West Africa



## c) Co-design digital MHPSS interventions safely with displaced and stateless adolescents

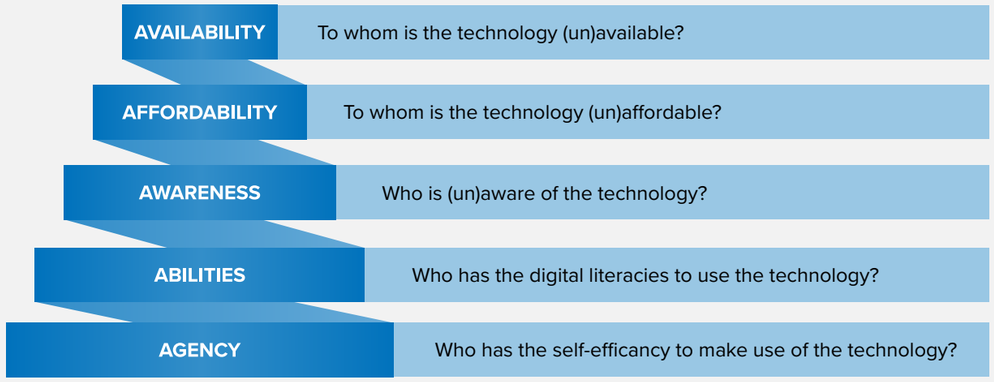
Designing together with adolescents in forced displacement contexts helps to build nuanced digital MHPSS interventions that are accessible, relevant, credible, inclusive, and safe for adolescents to use. UNHCR's 2018 Age, Gender and Diversity Policy outlines UNHCR's mandatory commitments under the Accountability to Affected People framework. Activities, interventions, and products developed under the strategy should be shaped through meaningful dialogue with displaced and stateless persons to ensure they are in line with what they prefer and need. UNHCR's digital transformation strategy aims for co-designing with communities from the outset of any digital initiatives to be the default approach.[279]

Active involvement of displaced and stateless adolescents in the design of MHPSS interventions is key for addressing many of the challenges listed in Section 6 of this report. Design of interventions should be based on the types of MHPSS programs and services that are needed or wanted by adolescents in different contexts, how different subsets of displaced and stateless adolescents use digital technologies in different contexts, and what kinds of technologies and MHPSS interventions are most relevant and suitable for them and for the phase of displacement that they are in.

## d) Design for accessibility

Projects that provide technology "solutions" normally face non-technical obstacles such as gendered social norms and unequal power relationships which affect the uptake and use of these solutions[280]. One way to understand access from a more holistic view is by using the 5'A's framework which helps to de-center the technology and highlights the social and political factors that limit technology access[281]. Working with displaced and stateless adolescents to better understand access as it relates to gender, age, literacy, language, social and cultural norms, disability, race and ethnicity, migration and/or displacement status, living situation and location can help to ensure that these aspects are considered during the design process.

***Figure 9 The 5 A's of Technology Access (adapted from Roberts, T. and Hernandez, K, 2019***



## e) Focus on usability to improve uptake

Usability is an additional element of accessibility and refers to acceptance, uptake and adoption of digital products and services. It is especially critical for self-guided digital MHPSS interventions that rely heavily on user engagement because self-directed interventions do not have a practitioner relationship to help build adherence and continuous use.[282]

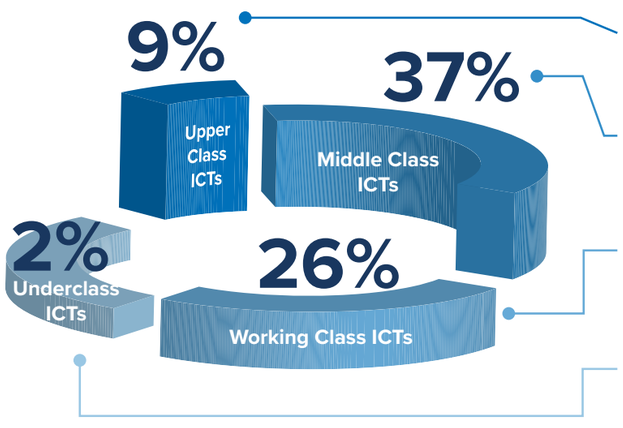
Usability dimensions that affect uptake and adoption of a digital MHPSS application include:

- performance speed and whether users can access features or information in a reasonable timeframe and without having to click too many times or load too many screens
- flexibility and how customized the intervention is to an individual's needs, interests, and circumstances
- clarity and ease of use when using the app for the first time.[283]

Figure 10 below classifies device ownership and connectivity experiences into four levels. Understanding the type of device and connectivity of the adolescent population in a particular forced displacement context will help to design for better uptake and sustained use -- both major challenges with digital MHPSS -- so careful attention to usability is key. This requires in-depth research and co-design with displaced and stateless adolescents and their communities (who may support or discourage both MHPSS and use of digital devices) and seamless, intuitive design of the technology itself.

An important point is that what is intuitive in one context might not be so in another, thus the importance of designing for specific users and their needs, tastes, technology capacities, access levels, internet speeds, device capabilities (including memory and screen size), and access to electricity and data.

***Figure 10 - Classes of technology access and connectivity - (adapted from Roberts, T. and Hernandez, K, 2019, and based on 2016 GSMA data)***




| Device Ownership | Connectivity Experience |
|---|---|
| **Smartphone** | Mobile internet + web access<br>WiFi at home + Office<br>Monthly phone contract |
| **Feature phone** | Limited mobile data saved for IM<br>WiFi only at hotspots<br>Pre-paid phone credits |
| **Basic phone** | No internet<br>Text and calls only<br>Zero-rated service |
| **No phone** | No internet<br>No calls<br>No text |



## f) Design for the specific context and audience

Contextual adaptation is a critical aspect when designing a digital MHPSS intervention. Contextual adaptation applies to the content of an intervention (language and key topics) as well as to the needs and expectations of potential users about the digital medium through which the intervention is offered. These needs and expectations are shaped by the target population's demographics and migration or displacement experiences and their surroundings and contexts (living situation, host community attitudes toward refugees, levels of support provided by the host community).[284]

Both the macro- and micro-environment affect displaced and stateless youth's abilities to use and benefit from MHPSS apps, for example, as highlighted in one report with unaccompanied migrant and asylum-seeking youth. At the macro level, aspects outside of the youth's control (such as their migration, displacement or asylum status, their placement in a particular camp location, and events related to the wider conflict) affected young people's moods, levels of stress and anxiety. At the micro-level, youth reported that they struggled to follow the exercises on the app because they did not have any privacy in their living quarters, they didn't want to go on their phone at certain hours because it would disturb their roommates, and because obligatory camp routines made it hard for them to engage in other activities.

During the co-design process with forcible displaced adolescents, it's critical to gain an understanding of how these "micro" and "macro" level factors -- such as individual living situations, social support systems, daily routines, political situations in the home and host country, and cultural contexts affect young people's interest in and capacity to use different kinds of digital MHPSS supports"[285] [286] and to design interventions that are a good fit for the context and life situations of intended users.

## g) Align culturally

Cultural adaptation is a critical element for face-to-face psychological treatment, both offline and online[287]. Eight important areas to consider for cultural adaptation of Internet- and mobile-based interventions are:

- **Language:** What language is most familiar? What differences are there in regional or subcultural group dialects or slang used by forcibly displaced adolescents?
- **Persons:** What should the patient–therapist relationship look like? What are the expected roles?
- **Metaphors**: Do symbols and sayings make sense to the target population? How are they interpreted?
- **Content:** Does the content consider cultural values, customs, traditions? How can it be tailored?
- **Concepts:** What is the theoretical model of the treatment being offered? Does it make sense to the target population?
- **Goals:** What would be a culturally acceptable way to determine treatment goals? How should agreement on goals be reached between the therapist or helper and the adolescent?
- **Methods:** What are culturally appropriate procedures and processes for achieving the treatment goals?
- **Context:** How can the intervention be designed in a way that is aware of broader social, economic, and political contexts?[288]

Adolescents should be involved in designing and testing concepts that address these areas, and the prototyping and testing process should include attention to these aspects.

See this detailed list of 17 components of cultural adaptation to be aware of for Internet and mobile based interventions for mental disorders


## h) Consider the nuances of identity and stage of displacement

The experiences, needs, and perceptions of displaced adolescents will differ not just in terms of their country of origin but on multiple dimensions, including religion, education, and the stage of their displacement journey. Digital MHPSS tools and resources will likely only be relevant to certain refugees at particular times. The MHPSS needs and digital habits of the target group will depend on a range of constantly shifting situational and dispositional factors. While the cultural diversity of refugees is often noted, studies show that it is not always a factor that is taken into consideration when designing interventions adolescents in displacement.[289] [290] This diversity, however, has strong implications for what is needed, useful, and used.[291]

An unaccompanied 12 year old adolescent girl fleeing a conflict who has just arrived to a precarious emergency camp, has never used a mobile phone, and doesn't speak the same language as her host country will have quite different MHPSS needs and digital access than a bilingual 17-year-old adolescent boy who was displaced by a natural disaster several years ago, has his own smartphone, and lives with his family and attends school in an urban neighborhood of his host country. A general understanding of "adolescents in forced displacement" is insufficient for design and implementation phases of digital MHPSS, and so efforts need to begin with focused research and co-design with adolescents. These contextual and situational variations have implications for scale.

Aspects such as age, family background, disability, maturity, gender and gender identity are also all critical to engagement, uptake, continuity and positive effects of digital MHPSS interventions. Girls and young women face specific risks during forced displacement and the realities of adolescent girls need to be incorporated into MHPSS design and content.[292] Systems that protect women and girls, including community structures, may weaken or break down during a crisis making it a critical time to emphasize protection of women and girls.[293] Girls and marginalized groups also face a greater incidence of online harassment and abuse[294] and this needs to be addressed in the design of digital MHPSS services and supports. These aspects of alignment can be aided by participatory research with adolescents in forced displacement situations and by co-designing and testing with various audience or user groups to ensure that design considers the various realities of those who would be participating in the digital MHPSS intervention.



## i) Create simple, engaging content and navigation to reduce cognitive overload

Young people in different stages of displacement will have varying levels of capacity to absorb new content. Cognitive overload due to stress will inhibit their capacity to engage, learn and to follow complicated navigation on a mobile app or site. Clear and streamlined design will allow those seeking help to feel less overwhelmed when navigating a resource. During COVID-19, for example, Irish youth showed a preference for varied content, easy-to-read information, personal stories, links to activities, resources, and skill-building exercises, polls, comment sections and quizzes. They also preferred interpersonal connections and going beyond articles and videos to connect (synchronously or asynchronously) with other young people or with adult professionals. They valued feeling listened to and heard, which they felt lead to responses that were tailored to their unique situations and therefore more useful and effective.[295]

## j) Identify the best ways for adolescents to discover MHPSS support

Outreach should be conducted in the places and spaces where adolescents are already and where they feel comfortable. Co-design can help to identify the best place for displaced and stateless adolescents to 'discover' the MHPSS digital intervention. In the abovementioned study, the Irish youth said that they tended to use Google search or the 'discovery pages' of social media apps (like Instagram) to find mental health resources. Many were unaware of available formal online resources. Peer recommendations were also critical for discovery, as were "online influencers."

By understanding young people's digital habits, organizations can direct young people to vetted resources and provide more guidance and structure to the discovery process.[296] This is an especially important factor when working with adolescents in forced displacement, considering their lack of homogeneity. Understanding how displaced and stateless adolescents access information and use digital tools and platforms through a participatory information need and digital habits assessment will help address 'discoverability.'

## k) Keep privacy, confidentiality, and security at the center of all stages of design

Users of a digital MHPSS intervention must be able to trust that their information, data, and identity will not be revealed in unexpected or harmful ways whether that is due to exposure because they cannot use it in a private enough space, because their information is compromised while sharing devices, or because their data privacy is not ensured.

A privacy by default approach should be adopted for any digital MHPSS interventions, where settings are pre-configured for the highest levels of data protection. Users of digital MHPSS platforms should not be expected to configure privacy and security settings on their own[297]. Privacy by default approaches both protect rights of adolescents in forced displacement and improve credibility which will then help increase uptake and use.[298]

In addition, care should be taken with communications, such as messages or reminders, that are exchanged with users. It is common for adolescents in forced displacement to borrow or share phones and other devices or to lack private spaces in which to hold a one-to-one conversation or join an online group session. Design and implementation need to take this into account to reduce risk of loss of confidentiality and resulting stigma or other harms.

It must also be clear to users of a digital MHPSS intervention what data will be collected and how it will be used or shared and with whom, and what rights users have to refuse to provide information or to have their data removed and deleted. These aspects of a digital intervention need to be worked out so that a clear and transparent consent can be obtained for data collection and processing.

### l) Seek counsel on informed and active consent, ensure transparency on data use

Informed consent is a challenging issue in the case of adolescents in forced displacement and digital MHPSS. The European Union's General Data Protection Regulation (GDPR) (which is the basis for many other data protection laws) and most data privacy regulations establish an age at which a person can consent to data collection and processing. In some countries this age is 13; in others it is 16 or 18. (**Note:** The age of consent for data collection and processing does not always match the legal age of consent for other areas.) Before this age, a parent, guardian or legal caretaker should provide consent for a child to participate in an activity or for a child's data to be collected.

In data privacy regulations, children's data is generally considered sensitive personal or 'special category' data, meaning that it requires higher levels of protection. Mental health data also falls under this designation, and so mental health data about or from children is considered highly sensitive and would require informed consent before it is collected or processed. This consent would come from an adult in the case of children under the legal age of consent for data collection and processing. At the same time, the GDPR allows for the collection of children's data without parental consent in cases where the purpose for collecting and processing data is for protection or counseling. It will be important to know what the age of consent is in the home and host country in order to make a decision on how to manage informed consent for data collection and processing while an adolescent is using digital MHPSS services.

In many contexts around the world, obtaining parent or guardian consent for the use of digital applications and platforms is difficult. This type of consent often requires an adult to provide information that identifies them or a credit card. They may also be required to prove their relationship to the child. Displaced or stateless persons may not have these documents. In the case of unaccompanied minors, there may also not be anyone to provide consent. New technologies are being developed that aim to use biometrics to determine age, however these present different kinds of privacy risks given the sensitivity of biometric data.

Because digital MHPSS would be aimed at protection and counseling, it might be that parent or guardian consent is not required, however legal advice should be sought to make a determination. In any case, transparency on how data is collected and processed and whether it would be shared and with whom and for what purposes is a core data subject right that everyone is entitled to. This information must be provided in clear, appropriate and accessible language so that informed consent can be provided. There must also be no coercion for consenting to data collection and processing for consent to be freely given, and users must be able to revoke their consent and have their data removed from processing activities or deleted altogether.

### m) Choose the right voice and messenger to increase trust and credibility

Trust is required to create a deeper relationship and encourage repeat interactions and communication. A well-known "social media trust formula'' (see below) illustrates this.[299]

$$\text{TRUST} = \frac{\text{AUTHORITY} \times \text{HELPFULNESS} \times \text{INTIMACY}}{\text{SELF PROMOTION}}$$

When designing a digital MHPSS intervention, it is important to choose the right voice and messenger for different contexts as well as the right kind of branding and partnerships so that young people can trust the source and be willing to engage. The intervention also must be perceived as helpful and useful to the intended users, and this will depend on aspects such as relevance and usability. Intimacy in the case of MHPSS includes the level of vulnerability that can be displayed when involved with the intervention. To enable adolescents to feel safe and support intimacy and vulnerability required for MHPSS, digital MHPSS interventions must ensure that a person's information and experience can be tailored to their preferences in terms of privacy and that the experience is safe and confidential.

Being able to participate in a mental health support program without having to see a professional face-to-face can help generate interest, according to one study among Syrian refugees. Participants in the research said they would feel less shy, embarrassed, afraid, ashamed, and more comfortable using an app as opposed to seeing a professional. They also wanted control over what information they shared with those who were supporting them online.


**How are trust and credibility linked with data privacy and security?**

Those running digital MHPSS programs (including UNHCR and partners) must ensure that they have the knowledge, capacity, and budget to protect and secure the data of those who access their services. This includes protecting data from internal mismanagement, unintentional data leaks, and external attacks. In addition, privacy and confidentiality are a key part of gaining and keeping the trust of the people who use a service.

In 2022, the International Committee of the Red Cross (ICRC) was the victim of a hack that compromised personal data (including names, locations, and contact information) from 515,000 refugees and displaced persons, missing people, detainees and their families, and people receiving other services from the Red Cross and Red Crescent Movement. These individuals had submitted their personal information, including sensitive information, to the Family Reunification Program in hopes of finding a lost family member[300].

A months-long process had to be put in place to contact anyone whose data had been compromised and to explain the potential ramifications of the attack. A large effort was also needed to manage media fallout from the breach. While the ICRC managed the hack in laudable ways, according to many in the humanitarian sector, by immediately announcing it, taking serious measures to re-secure the data, and engaging with those affected by the hack, these incidents affect how disaster affected communities and displaced and stateless individuals view all humanitarian agencies and may affect how willing they are to use programs that collect their personal data.

It's also important that organizations do not share and use data from vulnerable groups for unexpected purposes. In 2022, Crisis Text Line, a well-known hotline in the US, was criticized for having sold anonymized data from text messages its users sent in moments of extreme crisis to a private sector company. This anonymized data was purchased to create and market customer service software for commercial entities. While it's unclear whether there is a risk of this data being de-anonymized, the sale of such sensitive mental health data by a non-profit to a corporation was seen unfavorably by the media and by Crisis Text Line users, lowering public trust in the service[301] and generating backlash. It also raised ethical questions about the use of data from people in crisis by for profit companies and questions about the possibility of obtaining truly voluntary and informed consent from individuals in crisis.

Mental health data about adolescents is extremely sensitive data, and it is imperative that UNHCR and its commercial and non-profit partners put strong data security measures in place, remain vigilant to any type of internal or external data breach or other type of critical data incident, and take care not to share or use data from vulnerable populations in ways that compromise trust and ethics.



## n) Review relevant data privacy regulations and policies

Data privacy regulations are still emerging globally, and there is not always clarity on how they protect displaced persons, refugees, stateless people and non-citizens. Application of these laws is inconsistent in some cases, especially in countries where rule of law is weak. In countries that do have data privacy regulations, however, it is important to understand aspects such as definitions of personal and sensitive data (health and mental health as well as children's data likely fall under the category of sensitive personal data), age of consent and lawful bases for data collection and processing, roles of data controllers and data processors, rules related to cross-border data transfers, mandates for data localization (keeping data within the country), government access to data, and data subject rights, among others. While UN agencies may have immunity when it comes to these regulations, national partners likely do not, and must follow national law. UNHCR has data privacy policies, as does OCHA and UNICEF that might come into play if collaborating with these agencies.


See these resources for an overview of data policies and good practices at UNHCR and UNICEF

- UNHCR's 2015 Policy on the Protection of Personal Data of Persons of Concern to UNHCR.
- UNHCR's 2018 Guidance on the Protection of Personal Data of Persons of Concern.
- UNICEF's 2021 Responsible Data for Children.
- UNICEF's 2021 Responsible Data for Children risk assessment framework.

## o) Assess risk regularly throughout design, testing, and implementation processes

In cases where adolescents are facing severe crises, it might not be possible or advisable to work with them extensively in the co-design process. In this case early designs could be based on the available evidence base and known good practices. (Note: Better monitoring, evaluation, research and learning and better documentation and evidence generation would help with this as well). Any piloting or testing should be conducted in close collaboration with child protection teams.

Digital MHPSS should only be tested and implemented after a benefits-risk assessment has been conducted, any risks have been mitigated or reduced to an acceptable level, including data and child protection risks. (Figure 8 could be used as the basis for a benefits-risks assessment). The best interest of the child and humanitarian Do No Harm principles should be at the center of any efforts to pilot, test or roll out digital MHPSS. UNHCR offers resources and guidance on conducting participatory assessments and risk assessments related to digital platforms, use of social media, child safeguarding, and data protection that can be followed or adapted for this kind of assessment[302].

### p) Draw from and build on the evidence base

As noted above, while there has been a shift to digital MHPSS services due to COVID and self-directed mental health applications have grown in popularity, many are not grounded in evidence or have not been tested and evaluated to understand their effectiveness and their unintended consequences. Use of advanced data analytics, such as machine learning, text and voice analytics, and other kinds of artificial intelligence, for example in chatbots, is driving a rash of new applications yet some researchers question whether robots can replace community-based counselors and trained therapists and have concerns about the effectiveness and the ethics of these applications[303]. It is expected that much more evidence around online therapy and group therapy will emerge in the next year, given the rise in popularity of these approaches. However much of the evidence base is generated in the US and Europe – there are fewer specific studies to guide the development and implementation of digital MHPSS with adolescents who have been displaced or are stateless.

A 2021 review of the uptake of MHPSS evidence showed a disconnect between academic research and practitioner-focused needs, citing collaboration among researchers and practitioners as a good practice. Strong collaboration features included: framing collaboration as mutually beneficial and an intentional joint learning opportunity; engaging partners early on; participatory decision-making; regular communication; on-going and sustained contact, an emphasis on personal relationships; and cementing collaboration in the context of encouraging systems. Additionally, engaging local or international researchers who have extensive country-level/programming experience was found to lead to more contextually and culturally relevant research design[304].

Drawing from and building onto the existing evidence base will help to improve learning about digital MHPSS interventions, which is especially important for contexts where the evidence base is slim. Good practice guidance produced by UNHCR and other humanitarian organizations during the COVID-19 crisis documents experiences and suggests good practices for conducting remote groups[305] [306] [307], using telephone and video conferencing for therapy[308], the use of social media in community-based protection[309], and working with women and girls[310]. Documentation that supports the design and implementation of MHPSS together with adolescents in forced displacement can also help to begin building a stronger set of principles and guidance in this area to avoid known mistakes and to avoid negative unintended consequences.



# 8. Recommendations for action and future work by UNHCR

Above we have laid out considerations for an adjusted framework for MHPSS that includes digital and online components, delved into the potential benefits and possible drawbacks, challenges, and risks, offered key good practices for designing and implementing digital MHPSS interventions for adolescents in forced displacement, and highlighted the importance of further documentation and evidence generation.

UNHCR can take steps towards advancing this field in a responsible and impactful way at several levels:

## At the strategic level

- Integrate findings and recommendations from this report into planning for implementation of UNHCR's Digital Transformation Strategy 2022-24, including the Digital Services Framework/ Gateway and fully align with the complementary approaches articulated there.
- Continue working on digital access as a core, basic humanitarian service and a right.

## At the advocacy level

- Advocate to governments and the wider humanitarian sector for safe digital connectivity for adolescents in displacement settings (and for displaced and stateless persons in general).
- Join in with global advocacy efforts working towards a safe, secure, and rights-respecting Internet that will safeguard adolescents (and everyone) from harm.
- Join in with global advocacy efforts aimed at closing the gender digital divide and promoting the safe use of digital services by women and girls and other marginalized groups.
- Advocate for wider application of digital protection assessments in the humanitarian space when piloting and testing new approaches and for greater transparency and accountability regarding how risks identified in these assessments are mitigated and how safeguarding harms are addressed.

## At the policy level

- Adopt a revised MHPSS framework or adolescent MHPSS framework that includes and accounts for emerging digital interventions and approaches.
- Include considerations for digital MHPSS services in child protection and adolescent programming approaches, including education, health, GBV and other areas.
- Create a policy requiring UNHCR and its partners to conduct Digital Protection Assessments for adolescent MHPSS programming and to be accountable for mitigating risks and responding to complaints and/or harms.

## At the monitoring, evaluation research and learning level

- Conduct primary and formative research with adolescents in a subset of countries to better understand the potential for digital MHPSS and to feed into a set of operational guidance documents (as outlined in the 'guidance' recommendations); this should help UNHCR gain a better sense of:
  - Which platforms, tools, and interventions could be implemented in multiple contexts for which layers of the pyramid?
  - Which countries have similar contexts, MHPSS needs, information ecosystems, access to digital, use of similar platforms and devices, comparable adolescent and community perceptions, and expectations about use of digital for MHPSS and trusted MHPSS providers (e.g., use of social media for peer support)?
  - What existing online and offline MHPSS stakeholders, partners and services exist in these countries:
    - What is their potential role in creating an enabling environment for digital MHPSS services (e.g., adolescents for co-creating and sharing, parents and caregivers in creating safe spaces, platforms in linking to offline service providers, etc.)?
    - How are trusted sources and actors identified and what might lead to the best 'discoverability'?
  - What could be designed as a starting point for considering potential for an MHPSS intervention that could achieve a level of scale while still ensuring it can be tailored to address nuances in multiple contexts?
- Support human rights and ethics due diligence and design research processes on potential platforms and partners and identify relevant risks -- especially contextually specific risks and known unintended consequences -- to avoid repeating mistakes, replicating risky or harmful practices, or engaging with partners who could introduce or perpetuate risk or harm.
- Support the evidence base by monitoring and evaluating digital MHPSS interventions with adolescents in forced displacement to continually draw out and apply learning to improve efficacy, impact, and safety.
- Evaluate relevant MHPSS programs that moved online due to COVID to draw out learning and good practices to take up and replicate.
- Document and share experiences with other agencies for collaborative learning.
- Collaborate and conduct joint research with UNHCR's Digital Protection Project.
- Continue to conduct research on how a combination of digital MHPSS interventions at various layers of the MHPSS pyramid could be developed to supplement existing MHPSS interventions and provide a more effective and holistic response for displaced and stateless adolescents.



## At the guidance level

Provide operational guidance in the following areas:

- **Layer 1** - Safe use of social media for adolescent MHPSS programming, including:
  - How to mitigate and respond to risks and harms that displaced and stateless adolescents encounter on social media platforms and the online environment;
  - How to support displaced and stateless adolescents to safely navigate the online environment;
  - How to identify, vet, verify and signpost to evidence-based sources of MHPSS information;
  - How to engage with social media influencers to promote evidence-based MHPSS information.

- **Layer 2** - Design, development and protection for online community and peer support, including:
  - Safe management and moderation of online groups created by UNHCR;
  - Guidance for adolescent self-protection when engaging in online peer groups on social media;
  - Guidance on how to train parents and caretakers, community members and young leaders to take on supportive roles in digital MHPSS support and protection.

- **Layer 3** – Safe integration of digital MHPSS into existing digital programs and services, including:
  - Including MHPSS into education, health, GBV, community-based protection, youth leadership, and other programs;
  - Development of safe and effective self-help applications with the right amount of support from external, trained therapists or helpers.

- **Layer 4** - Development of safe and effective clinical mental health screening, referrals, and specialized MHPSS services, including:
  - Online therapy and psychological services;
  - Referrals to in-person counseling and treatment by trained psychologists or social workers;

- How to develop holistic MHPSS programming that integrates digital and offline adolescent MHPSS and provides a suite of MHPSS services that meet the varying needs of adolescents at different stages of displacement and levels of digital access and literacy.

- How to conduct a Digital Protection Assessment that goes beyond data protection and compliance to consider wider implications of displaced adolescents' use of digital MHPSS such as:
  - Potential harms from leaving a digital footprint;
  - Future discrimination based on data that identifies someone as a displaced person or someone who has accessed MHPSS services;
  - Greater exposure to harms in the digital environment due to using digital MHPSS;
  - Potential for exclusion of the most vulnerable when MHPSS services are offered digitally
  - Other kinds of risks that we have identified in this report.

- How to manage informed consent and lawful basis/legitimate purpose for data collection from and about adolescents who are participating in digital MHPSS interventions.

## At the Operational level

**Examine existing programs related to digital MHPSS**

- Consider how to develop digital dimensions for existing offline MHPSS programming.
- Conduct a digital protection assessment of existing digital MHPSS programming and address findings.
- Test approaches and potential methods of implementation in small scale pilots to validate findings or generate evidence on areas that are still lacking investigation:
  - on contextualizing MHPSS programs and adapting to gender and age;
  - referral from levels 1 - 2 to 3 - 4 to address current issues of digitally assisted methods;
  - strategies for making services accessible for displaced adolescent girls and boys, including access to quick support;
  - design and implementation aspects that help to reduce stigma.
- Evaluate and scale or replicate current good, impactful approaches and practices.

**Develop new or pilot approaches**

- Include elements of Digital MHPSS within current funding windows, and work with others who are financing experimentation and innovation i.e., GSMA Innovation fund.
- Co-design new or pilot approaches with forcibly displaced adolescents, including:
  - **Layer 1** - Safe use of social media for adolescent MHPSS programming, including working with existing platforms, signposting to evidence-based sources of MHPSS information, and working with social media influencers to promote evidence-based MHPSS information
  - **Layer 2** – Safe online community and peer support, including online groups created by and online peer groups on social media
  - **Layer 3** - Safe integration of digital MHPSS into existing digital programs and services such as education, health, GBV, community-based protection, youth leadership, etc. and development of safe and effective self-help applications with the right amount of support from external, trained therapists or helpers
  - **Layer 4** - Development of safe and effective clinical mental health screening, referrals, and specialized MHPSS services, including online therapy and psychological services and referrals to in-person counseling and treatment by trained psychologists or social workers
- Develop a safe and secure trial of the use of UNHCR's planned secure and confidential 2-way digital channels to engage with forcibly displaced adolescents on MHPSS; identify and work with partners who can receive referrals and offer MHPSS services online and in-person to adolescents; ensure child protection and safeguarding involvement to prevent and mitigate potential risks and concerns.
- Conduct participatory digital protection assessments on any new or pilot approaches and ensure risks are mitigated to an acceptable level.





# Checklist for Practitioners

## 1. Design research [ ]

### ☐ Learn about forcibly displaced adolescents MHPSS needs

Conduct a participatory MHPSS needs assessment with adolescents to understand their MHPSS needs. Examples:

- UNHCR's (2022) Emergency Handbook
- WHO (2012) Assessing Mental Health Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings
- IASC Reference Group (2012) Mental Health and Psychosocial Support Assessment Guide

### ☐ Gain insights into adolescents' information seeking habits and behaviors

Conduct a participatory information needs assessment (choose one of the following based on the context).

- Rapid Information Needs Assessment in the case of a sudden emergency can help understand how adolescents in forced displacement are accessing information. If they are using online sources, this type of assessment would look at which tools and platforms and how. Key questions should include how are they accessing information (in closed or open groups?), in what format, who do they contact and who do they trust, whether there is scope for UNHCR and partners to provide added value[311]. Rapid needs assessments should also inquire about any concerns or potential risks that adolescents in forced displacement and their communities might raise about these information sources.
- A full Information Needs Assessment is a more in-depth exercise that can take place in protracted situations, long-term emergency or non-emergency settings. This type of assessment helps understand many of the same questions as above, but in a deeper and more thorough way with greater participation from adolescents and their communities.
- An Information Ecosystem Assessment includes both a review of available media and telecommunication infrastructures and people's information and communication needs, along with an analysis of information producers. This includes many of the above aspects as well as analysis of the wider information ecosystem, possible physical infrastructure weaknesses and power dynamics as related to media discourse and its effects on communities. In the cases of digital MHPSS and adolescents, it would look at their different information sources and needs and how information flows.

Examples:

- UNHCR (2020) Use of social media in community-based protection
- Regional Information and Communications Needs Assessment: Understanding the information and communication needs of refugees and migrants in the Venezuela Situation
- Digital Access, Community Needs and Community Practices: How digital inclusion can improve the protection of refugees, the internally displaced, and stateless people in West Africa

## ☐ Co-design digital MHPSS interventions safely with forcibly displaced and stateless adolescents

- Design together with adolescents in forced displacement to build nuanced digital MHPSS interventions that are accessible, relevant, credible, inclusive, and safe for adolescents to use.
- Design of interventions should be based on:
  - the types of MHPSS programs and services that are needed or wanted by adolescents in different contexts;
  - how different subsets of displaced and stateless adolescents use digital technologies in different contexts;
  - what kinds of technologies and MHPSS interventions are most relevant and suitable for them;
  - their phase of displacement.

## ☐ Accessibility

Use the 5'A's framework to work with adolescents to understand the social and political factors that limit technology access.[312]

- **Agency**: Who will have the self-efficacy to make use of the technology?
- **Abilities**: Who has the digital literacies to use the technology?
- **Awareness**: Who is (un)aware of the technology?
- **Affordability**: To whom is the technology (un) affordable?
- **Availability**: To who is the technology (un) available?

Ensure that you're considering gender, age, literacy, language, social and cultural norms, disability, race and ethnicity, migration and/or displacement status, living situation and location.

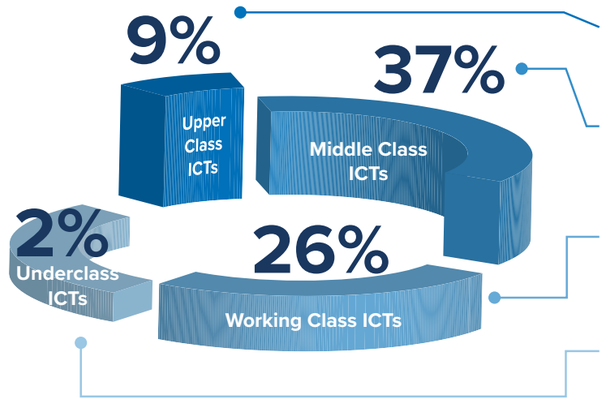
## ☐ Usability and uptake

Use the Classes of technology access and connectivity" graph on the next page to work with adolescents to understand specific users and their needs, tastes, technology capacities, access levels, internet speeds, device capabilities (including memory and screen size), access to electricity and data and other aspects of usability.





*Classes of technology access and connectivity - (adapted from Roberts, T. and Hernandez, K, 2019, a based on 2016 GSMA data)*




| Device Ownership | Connectivity Experience |
|---|---|
| **Smartphone** | Mobile internet + web access<br>WiFi at home + Office<br>Monthly phone contract |
| **Feature phone** | Limited mobile data saved for IM<br>WiFi only at hotspots<br>Pre-paid phone credits |
| **Basic phone** | No internet<br>Text and calls only<br>Zero-rated service |
| **No phone** | No internet<br>No calls<br>No text |

## ☐ Context and audience

Learn about adolescents' daily lives and routines and how they might affect use of a digital MHPSS intervention

- What is their microenvironment (living situation, host community attitudes toward refugees, levels of support provided by the host community, privacy levels, daily routines)?[313]
- What is their macro environment (migration, displacement or asylum status, their placement in a particular camp location, and events related to the wider conflict)?

## ☐ Cultural alignment

Work with displaced and stateless adolescents to understand these 8 areas for cultural adaptation of Internet- and mobile-based interventions:

- **Language**: What language is most familiar? What differences are there in regional or subcultural group dialects or slang used by displaced and stateless adolescents?
- **Persons**: What should the patient–therapist relationship look like? What are the expected roles?
- Metaphors: Do symbols and sayings make sense to the target population? How are they interpreted?
- **Content**: Does the content consider cultural values, customs, traditions? How can it be tailored?
- **Concepts**: What is the theoretical model of the treatment being offered? Does it make sense to the target population?
- **Goals**: What would be a culturally acceptable way to determine treatment goals? How should agreement on goals be reached between the therapist or helper and the adolescent?
- **Methods**: What are culturally appropriate procedures and processes for achieving the treatment goals?
- **Context**: How can the intervention be designed in a way that is aware of broader social, economic, and political contexts?[314]
- See this list of 17 components of cultural adaptation to be aware of for Internet and mobile based interventions for mental disorders

### ☐ Identity and stage of displacement

- Learn about aspects such as age, family background, disability, maturity, gender and gender identity and how they affect displaced adolescents and their access to MHPSS support and access and use of technology to inform your design.
- Learn about how MHPSS needs and access/use of technology vary depending on the stage of displacement an adolescent is in.

## 2. Design process [ ]

### ☐ Create simple, engaging content and navigation to reduce cognitive overload

- Young people in different stages of displacement will have varying levels of capacity to absorb new content.
- Cognitive overload due to stress will inhibit their capacity to engage, learn and to follow complicated navigation on a mobile app or site.
- Clear and streamlined design will allow those seeking help to feel less overwhelmed when navigating a resource.
- Create prototypes to test with your target population and incorporate their feedback.

## 3. Discoverability [ ]

### ☐ Identify the best ways for adolescents to discover digital MHPSS support

- Outreach should be conducted in the places and spaces where adolescents are already and where they feel comfortable.
- Co-design can help to identify the best place for displaced and stateless adolescents to 'discover' the MHPSS digital intervention.
- Understand young people's digital habits, so that you can direct them to vetted resources and provide more guidance and structure to the discovery process.





## 4. Privacy, confidentiality, and security [ ]

### ☐ Use a privacy by default approach

- Pre-configure settings for the highest levels of data protection - don't expect users to configure privacy and security settings on their own.
- Take care with communications, such as messages or reminders, that are exchanged with users as they might borrow or share phones.
- Inform users what data will be collected and how it will be used or shared and with whom, and their rights to refuse to provide information and to have their data removed and deleted.
- Create a clear and transparent consent process.

### ☐ Review relevant data privacy regulations and policies

- Data privacy regulations are still emerging globally, and there is not always clarity on how they protect displaced persons, refugees, stateless people and non-citizens.
- Be sure to understand aspects such as definitions of personal and sensitive data (health and mental health as well as children's data likely fall under the category of sensitive personal data), age of consent and lawful bases for data collection and processing, roles of data controllers and data processors, rules related to cross-border data transfers, mandates for data localization (keeping data within the country), government access to data, and data subject rights, among others.
- While UN agencies may have immunity when it comes to these regulations, national partners likely do not, and must follow national law. UNHCR has data privacy policies, as does OCHA and UNICEF that might come into play if collaborating with these agencies.
- See:
  - UNHCR's 2015 Policy on the Protection of Personal Data of Persons of Concern to UNHCR
  - UNHCR's 2018 Guidance on the Protection of Personal Data of Persons of Concern
  - UNICEF's 2021 Responsible Data for Children.
  - UNICEF's 2021 Responsible Data for Children risk assessment framework

### ☐ Seek counsel on informed and active consent, ensure transparency on data use

- Informed consent is a challenging issue in the case of adolescents in forced displacement and digital MHPSS.
- Find out what the age of consent is in the home and host country in order to make a decision on how to manage informed consent for data collection and processing.
- Determine how to manage lawful collection of data and whether caretaker consent is required
- Ensure your consent process is active, transparent and informed.
- Respect data subject rights and be transparency on how data is collected and processed and whether it would be shared and with whom and for what purposes Provide this information in clear, appropriate and accessible language.
- Ensure that consent for data collection and processing is freely given, and that users can revoke their consent and have their data removed from processing activities or deleted altogether.

## 5. Trust and Credibility [ ]

### ☐ Choose the right voice and messenger to increase trust and credibility

- Trust is required to create a deeper relationship and encourage repeat interactions and communication. A well-known “social media trust formula (see below) illustrates this.[315]

$$\text{TRUST} = \frac{\text{AUTHORITY X HELPFULNESS X INTIMACY}}{\text{SELF PROMOTION}}$$

- Choose the right voice and messenger for different contexts as well as the right kind of branding and partnerships so that young people can trust the source and be willing to engage.
- Ensure that a person’s information and experience can be tailored to their preferences in terms of privacy and that the experience is safe and confidential.
- Enable adolescents to have control over what information they share with those who are supporting them online.





### ☐ Assess risk regularly throughout design, testing, and implementation processes

- Conduct a risk assessment at every stage of the process and if/when context shifts
- Test and implement digital MHPSS with adolescents only after a benefits-risk assessment has been conducted, any risks have been mitigated or reduced to an acceptable level, including data and child protection risks.
- Keep the best interest of the child and humanitarian Do No Harm principles at the center of any efforts to pilot, test or roll out digital MHPSS.
- See UNHCR resources and guidance on conducting participatory assessments and risk assessments related to digital platforms, use of social media, child safeguarding, and data protection that can be followed or adapted for this kind of assessment.

## 6. Draw from and build on the evidence base [ ]

### ☐ Learn from what has been done before.
### ☐ Create indicators for success and track the efficacy of your MHPSS intervention.
### ☐ Document your learning and share with others.

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