




When, where and for whom is digital MHPSS suitable?


This factsheet provides an overview of the evidence for when and how digital MHPSS can be used, as well as for whom and in what settings. It is a daunting task to cover all aspects of this and we have selected a few important themes to be considered in humanitarian and fragile settings. If you want to read more about how this applies to the MHPSS pyramid and its four different layers, see the factsheet [What digital MHPSS interventions fit which layer of the MHPSS-pyramid?](#)

 **When** – The evidence for DMHI and DPSI (digital psychosocial interventions)

There is plenty of research supporting the use of digital mental health interventions (DMHI) for mental health problems as this has been studied extensively over the last 20 years^{1,2}. The evidence even points towards digital interventions being as effective as face-to-face alternatives in direct comparisons³. DMHI have been provided for a plethora of problems, including depression, anxiety, worry, post-traumatic stress, substance abuse, insomnia, eating disorders and even for distress related to somatic problems such as tinnitus and chronic pain and cancer. The list is long and studies on digital interventions for mental health problems are continuously being conducted as it is currently one of the most frequently researched topics in psychology, with findings being implemented in real-world settings around the globe⁴. It is safe to say that we know a lot about how digital formats for mental health problems can be delivered and that the results are showing DMHI to be an effective way to provide mental health services.

While there are many studies on Internet-based mental health treatment that have targeted common non-clinical problems such as loneliness, procrastination, everyday stress, self-esteem and more, showing positive

effects⁵⁻⁷, there are to date only very few studies on digital psychosocial interventions. And this despite the fact that it is more common to provide psychosocial and resource-building support such as stress management, self-care, social support, resilience-building and psycho-education than specialized mental health interventions in humanitarian and fragile settings⁸. Even though there is evidence that MHPSS-programmes (non-digital) are effective in improving functioning and alleviating symptoms of post-traumatic stress when applied in humanitarian emergencies in low- and middle-income countries⁹, the evidence for lower-level psychosocial interventions is not as strong as for specialized mental health interventions.

 **Where** – DMHI and DPSI in humanitarian and fragile settings with limited resources

Although we know quite a lot about DMHI for mental health problems, there is a systematic bias in research on psychological treatment and psychosocial interventions in general as most scientific studies have used samples from WEIRD (Western, educated, industrialized, rich, democratic) countries, not considering cultural variations and the perspective of marginalized groups such as culturally and linguistically diverse (CaLD) populations. Recent reviews have shown that trials from non-Western countries differ in that they have larger sample sizes, include a younger population and use more group-based interventions and alternative recruitment methods¹⁰. Arguments have been put forward that we need more research conducted by non-Western researchers in non-Western settings¹¹, and there are promising examples of this in the last few years^{12,13}.

Although far less data has been collected in low- to low-middle income settings in comparison to high-income settings¹⁴, the effects of DMHI are not exclusive to high-income settings and accordingly, digital MHPSS interventions do represent a viable alternative in a variety of contexts. A 2017 Lancet publication¹⁵ reviewed the evidence for the use of mobile, online and other remote technologies for the treatment and prevention of mental disorders in low- and middle-income countries. The 49 studies including technology-supported interventions for clinical care, detection of mental disorders, self-help programmes and substance abuse prevention, showed promising findings and positive results. Another scientific review including only highly controlled studies in the same settings points in the same direction, showing that only highly controlled studies in the same settings, evidence pointed in the same direction, showing that DMHI can increase quality of life and be effective for anxiety and depression, even including self-guided interventions¹⁶.

It is obvious that digital MHPSS services can only be provided if the receiver has access to technology in the form of hardware (e.g. computer or phone) and connectivity (e.g. access to Wi-Fi or mobile coverage). Even though access rates to the Internet are growing fast in low-income countries, they are still significantly higher in high-income countries, and there is a gap in mobile phone ownership even between low-income and low-to middle-income countries of 47% vs 70%¹⁷. With that in mind, there is a need to provide digital interventions that are suitable for the context in low- and low-to middle-income countries and unstable settings, where connectivity is unstable, power outages can be frequent, digital literacy is lower, technology is shared and access to new devices is lacking. Low-barrier digital MHPSS solutions such as SMS interventions can have potential in these settings, although the effects are smaller, and the quality of evidence needs to be improved¹⁸.

It is sometimes difficult to conduct the same type of assessments and diagnostic procedures in unstable, unstructured and fragile settings as in stable and structured healthcare systems. Therefore, choosing transdiagnostic. Broad digital MHPSS interventions should be considered whenever possible, as the effects are similar to diagnosis-focused interventions¹⁹. Transdiagnostic approaches are recommended in reports on digital interventions for refugee populations^{20, 21}. These broad scope interventions are used in WHO programmes such as Problem Management Plus (PM+) for adults impaired by distress in communities who are exposed to adversity and Self-Help Plus (SH+) for adults who experience stress, wherever they live and whatever their circumstances.



For whom – DMHI and DPSI to bridge the provision gap and access the most vulnerable

There are more than 110 million forcibly displaced individuals in the world, estimated to reach 130 million by the end of 2024²². This leads to a dire need for interventions need for interventions targeting refugee and migrant groups, as we know that there is an increased risk for mental health problems such as anxiety, depression, post-traumatic stress and insomnia related to pre-, peri- and post-migration experiences. Targeting refugees with digital MHPSS interventions can have many advantages, such as increasing reach during transitioning, bridging language problems and providing help when most needed and in difficult conditions. To make these interventions work, there are many variables to take into consideration, such as place of settlement, Internet access, phase of displacement, digital literacy, language capacity and cognitive capacity²¹. There are studies on depression showing, for example, that lower educational levels can increase the risk for dropout in self-guided interventions²³ and lead to symptom deterioration during treatment²⁴, which is something to be aware of. Nevertheless, there has been a shift in the last few years with more studies showing that digital alternatives are a viable option for more diverse groups²⁵, including lower age groups such as adolescents²⁶, also including parental support as an add-on.

Even if conditions are difficult, there are also studies on refugees and migrants showing that DMHI can help in the treatment of depression²⁵ and common mental health problems²⁷ as well as in the screening of mental health problems²⁸. However, a common problem is that studies have been struggling with recruitment and compliance to treatment²⁹.

The most efficient way of increasing the probability of adherence and compliance to treatment is to culturally, contextually and linguistically adapt digital interventions to be compatible with the receivers' meanings and values³⁰. By culturally adapting interventions, these can be

delivered with increased effects³¹, which also goes for interventions with minimal guidance³². By adapting available digital tools to new contexts, the development and range of digital alternatives can be increased in a less time- and resource-consuming manner³³. This type of strategy was also recommended in the 2022 Digital Mental Health and Psychosocial Support report³⁴, which stated that the RCRC Movement should build on and adapt existing DMHI to fit the regional and cultural context in which National Societies are working.



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