Volume 5, No. 6 June 2026
p-ISSN 2980-4868 | e-ISSN 2980-4841
https://ajesh.ph/index.php/gp

Mental Health Interventions for Refugees and Forcibly Displaced Populations: A Systematic Review of Effectiveness, Implementation, and Nursing Implications

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Keyword:
Refugees; Forcibly Displaced Populations; Mental Health Intervention; Systematic Review; Nursing Practice

ABSTRACT

This report presents a detailed analysis of 10 peer-reviewed articles examining mental health interventions for refugee populations published between 2020 and 2025. The reviewed literature encompasses diverse methodological approaches, including randomized controlled trials (20%), qualitative studies (30%), and mixed-methods designs (30%), with sample sizes ranging from 17 to 2,021 participants (mean = 458.5). The analysis reveals a growing emphasis on evidence-based interventions targeting depression, post-traumatic stress disorder (PTSD), and functional impairment among refugee populations across different age groups and cultural contexts. Key findings indicate that while several interventions demonstrated short-term efficacy, particularly WHO-developed programs such as Self-Help Plus and Step-by-Step, as well as trauma-focused therapies such as eye movement desensitization and reprocessing (EMDR) and empowerment group therapy, challenges remained regarding long-term sustainability, cultural adaptation, and implementation in resource-constrained settings. The Patient Health Questionnaire-9 (PHQ-9) depression scale emerged as the most frequently used outcome measure, appearing in 40% of the studies and reflecting the field's focus on depressive symptoms. This review identifies critical gaps in sustained intervention effects, the need for culturally responsive implementation frameworks, and the importance of addressing contextual stressors that affect refugee mental health outcomes.

INTRODUCTION

The number of people forced to flee persecution, conflict, violence, human rights violations, and events seriously disturbing public order increased in 2024, reaching a record 123.2 million. During 2024, millions of people were displaced, including an estimated 20.1 million within their own countries and 5.4 million as refugees and asylum seekers (United Nations High Commissioner for Refugees, Global Data Service, 2025). Refugees and migrants exposed to adversity have diverse mental health needs shaped by experiences in their countries of origin, migration journeys, host countries' entry and integration policies, and living and working conditions. Refugees and migrants also face significant barriers that hamper social inclusion and limit the accessibility and acceptability of mental health services. Addressing these challenges typically requires targeted, multidisciplinary action, including culturally sensitive and integrated mental health care, social

support, legal assistance, and community engagement (World Health Organization, Fact Sheet, 2025).

The mental health of refugees and migrants is a critical issue because of elevated trauma and stress resulting from war, displacement, and resettlement challenges (Carrol et al., 2023). This population is at increased risk of mental health disorders, notably post-traumatic stress disorder (PTSD), depression, anxiety, suicidal behavior, and psychosis, resulting from exposure to multiple traumatic events before and during migration (Verhulsdonk et al., 2021; WHO, 2025). At the same time, migrants and refugees encounter considerable obstacles to accessing mental health care, such as limited service availability and cultural and linguistic differences (Priebe et al., 2016; Salami et al., 2019).

Refugee populations worldwide face disproportionate mental health challenges stemming from pre-migration, migration-related, and post-migration stressors. The global refugee crisis has intensified the need for evidence-based, scalable, and culturally appropriate mental health interventions (Sijbrandij et al., 2017; Silove et al., 2017). This analysis examines recent scholarly contributions from 2020 to 2025 to understand the current state of mental health intervention research for refugee populations, identify effective approaches, and highlight areas requiring further investigation (Mabil-Atem et al., 2024; Marchi et al., 2024; Peterson et al., 2020).

The reviewed literature spans multiple intervention modalities, ranging from trauma-focused therapies and group-based psychological interventions to digital health solutions and mental health literacy programs. Studies were conducted across diverse geographical contexts, including high-income countries hosting refugee populations and low- and middle-income countries (LMICs) experiencing large-scale displacement. This report synthesizes findings from 10 carefully selected articles to provide a comprehensive overview of intervention effectiveness, implementation challenges, and future research directions. Therefore, this study aimed to provide an evidence synthesis of mental health interventions implemented among refugee populations in several host-country contexts. In this study, the research question was developed using the PICO strategy. The PICO framework is presented in Table 1.

Table 1. PICO

Population (P)	Refugees, Asylum Seeker, Internally Displaced People, mixed sample, not limited to age and sex.
Intervention (I)	Mental health intervention including psychotherapy, psychosocial support, Pharmacotherapy, Community Based Intervention, integrated health service to primary health facility.
Comparison (C)	Control group or treatment without intervention
Outcomes (O)	Decreased PTSD symptoms, Depression and Anxiety, increasing wellbeing and quality of life, intervention acceptances, problem identification, and implementation supporting factor.

Furthermore, the research questions that have been prepared will be answered at the conclusion of this research. Specifically, this review addressed the following questions as presented in table 2.

Tabel 2. Research Question

No	(Research Question)
RQ 1	What types and characteristics of interventions have been implemented?
RQ 2	How effective are these interventions in reducing symptoms of depression, PTSD and anxiety?
RQ 3	What was the obstacles and supporting factors found in the implementation?

METHOD

This systematic review was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021).

Four electronic databases were searched: PubMed, Scopus, Web of Science, and Google Scholar. The search strategy consisted of three keyword clusters related to refugees, asylum seekers, and forcibly displaced individuals; mental health symptoms; and interventions. The search used a combination of Medical Subject Headings (MeSH) terms and free-text keywords, with terms adjusted according to each database.).

Sources and search strategy

Four electronic databases were searched: PubMed, Scopus, Web of Science, and Google Scholar. The search strategy consisted of three keyword clusters related to refugees, asylum seekers, forcibly displaced individuals, mental health symptoms, and interventions. A combination of Medical Subject Headings (MeSH) terms and free-text keywords was used, with the search terms adjusted according to each database.

Eligibility criteria

Publications were included if they met the following criteria:

a. Involved forcibly displaced people including refugees, asylum seeker or internally displaced people based on the definitions provided by the United Nations High Commissioner for Refugees.
b. Mixed samples not limited to age and sex.
c. Focus on mental health intervention that implemented to reduce psychological symptoms.
d. Quantitative Study: RCT, Quasi-Experimental, Pre-post.
e. Outcome had a prospective design which examined at least one mental health outcome variable related to changes in psychology condition, implementation and implementation supporting factor or obstacles.
f. Publication year 2020-2025, in English or Bahasa Indonesia translation and accessible in full-text.

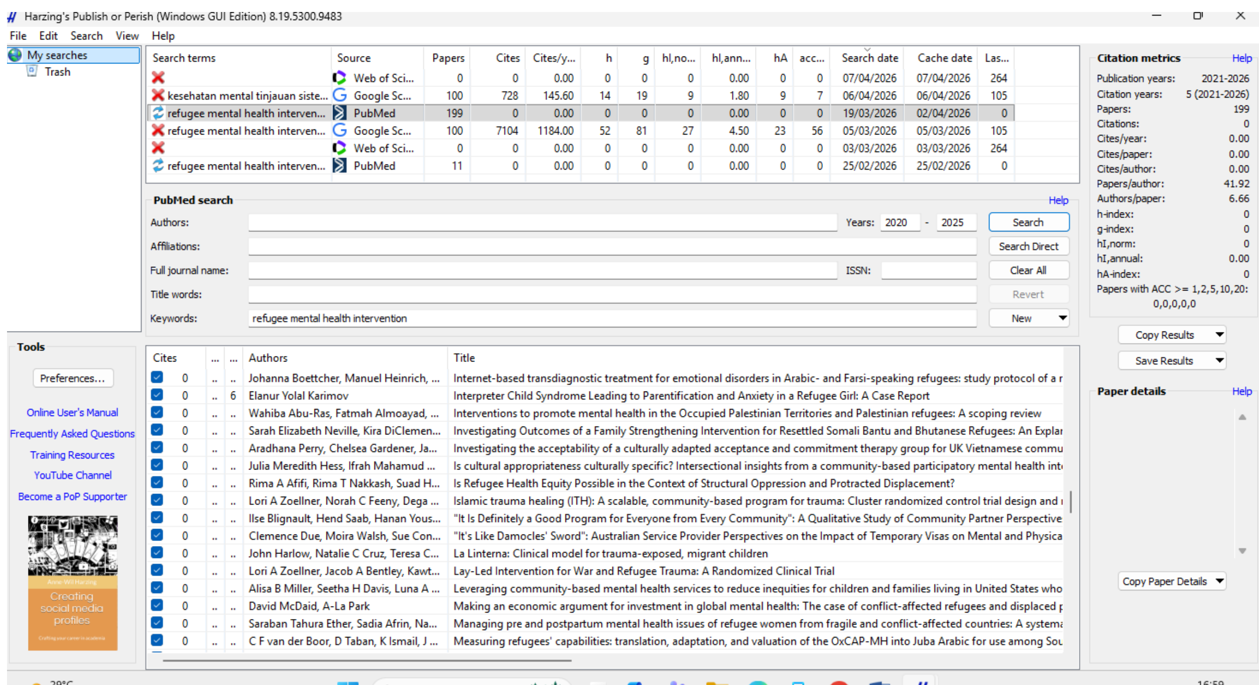
Study will be excluded if they met the following criteria:

a. Study sample consisted of individuals without background of forced migration.
b. Studies are opinion article, editorial, conceptual essay or report guideline report without empiric.

c. Studies only reported mental health problem prevalence or risk factor without intervention, and not measuring primary outcomes mental health variable as outcomes.
d. Studies only available in abstract.
e. Publication duplicate from the other study.

Selection process and data extraction

Article generated using an online software Harzing's publish or perish, where duplicates were identified and deleted. Information extracted from the included studies comprised details such as description of population and participant characteristics, study design, outcome measurements, and result. A customized data extraction sheet was developed for this review. Data extracted by one reviewer and checked by second reviewer. Any disagreements were resolved through discussion or consultation of third reviewer. Data extraction showing in the figure 1.



Picture 1. Harzing's Publish or Perish Software Data Extraction

Quality of appraisal

All systemic reviews incorporate a process of critique or appraisal of the research evidence. The purpose of this appraisal is to assess the methodological quality of a study and to determine the extent to which a study has addressed the possibility of bias in its design, conduct and analysis. The JBI Critical appraisal checklist are shown in the figure below.

JBI CRITICAL APPRAISAL CHECKLIST FOR
SYSTEMATIC REVIEWS AND RESEARCH SYNTHESES

Reviewer________________________________ Date__________________________

Author________________________________ Year________ Record Number________

	Yes	No	Unclear	Not applicable
1. Is the review question clearly and explicitly stated?	□	□	□	□
2. Were the inclusion criteria appropriate for the review question?	□	□	□	□
3. Was the search strategy appropriate?	□	□	□	□
4. Were the sources and resources used to search for studies adequate?	□	□	□	□
5. Were the criteria for appraising studies appropriate?	□	□	□	□
6. Was critical appraisal conducted by two or more reviewers independently?	□	□	□	□
7. Were there methods to minimize errors in data extraction?	□	□	□	□
8. Were the methods used to combine studies appropriate?	□	□	□	□
9. Was the likelihood of publication bias assessed?	□	□	□	□
10. Were recommendations for policy and/or practice supported by the reported data?	□	□	□	□
11. Were the specific directives for new research appropriate?	□	□	□	□

Overall appraisal: Include □ Exclude □ Seek further info □

Comments (Including reason for exclusion)

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Critical Appraisal Checklist for Systematic Reviews and Research Syntheses - 3

Figure 2. The JBI Critical appraisal checklist for Systemic Reviews and Research Synthesis

Appraisal result table from the article that has been screened and extracted in the table 3 below.

Table 3. Extraction data table

Authors	Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8	Q 9	Q1 0	Q1 1	Tota l YES	Include/exclud e
Heynen et al	Y	Y	Y	Y	N	Y	Y	Y	U	Y	Y	9	Include
Wiecher et al	Y	Y	Y	Y	Y	N	Y	Y	U	Y	Y	9	Include
Serra et al, 2024	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include
N Chauliac et al, 2025	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include
Rosenberg et al, 2024	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include
Bruhn et al, 2022	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include
Cuijpers et al, 2022	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include
Bryant et al,	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include
Slewa-Younan et al, 2020	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include
Attardo et al, 2025	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10	Include

Data analysis

This analysis is based on a systematic review articles, the review process involved:

1. Data Extraction: Comprehensive extraction of 21 variables per article, including publication year, study design, intervention type, population characteristics, sample size, outcome measures, key findings and methodological limitations.
2. Descriptive Analysis: Quantitative analysis of publication trends, study design distribution, sample size characteristics, intervention types, target populations, and outcome measurement approaches.
3. Thematic Synthesis: Qualitative synthesis of intervention approaches, implementation factors, implementation factors, cultural adaptation strategies, and sustainability consideration.
4. Visualization: Generation of eight figures illustrating key patterns and relationships within the dataset, including temporal trends, methodological distributions, and feature matrices.

The analysis employed both quantitative descriptive statistics and qualitative thematic synthesis to provide a comprehensive understanding of the current evidence base for refugee mental health interventions.

RESULTS AND DISCUSSION

1. Search outcomes

Database yielded 388 records, and 4 duplicates were removed. Of 384 records screened at full-text level. Moreover 354 records was identify not eligible and 30 reports sought for retrieval was screened and 10 studies was not retrieved. 20 studies was assessed for the eligibility and 10 was excluded 10 studies was eligible for review. The PRISMA flow chart illustrating the study selection process in figure below.

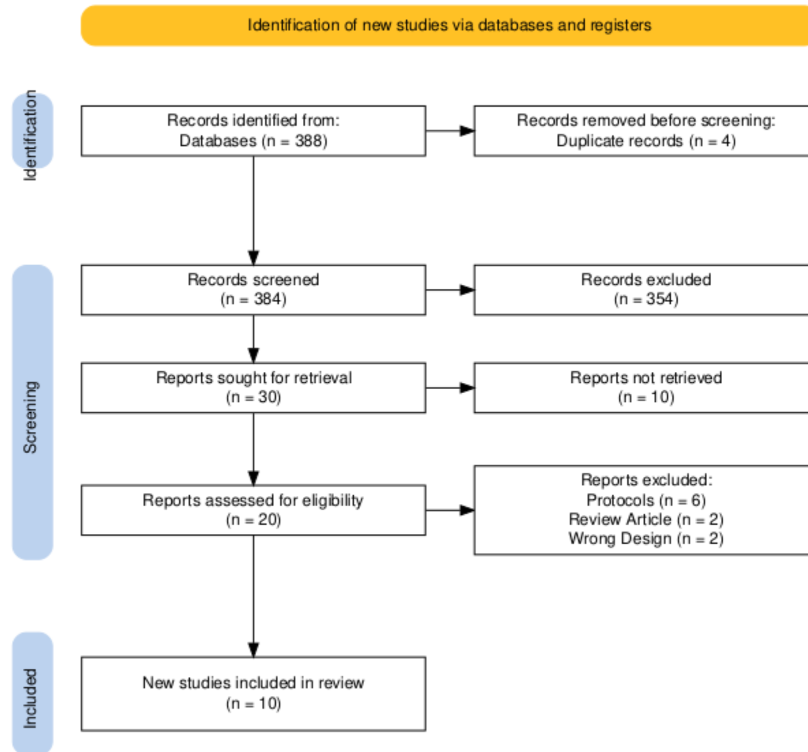


Figure 3. PRISMA flow chart

Tabel 4. Article by article summary

#	Study	Year	Design	Intervention	Population	N	Key Outcomes	Main Findings
1	Heynen et al.	2022	Mixed Methods	Music Therapy (Safe & Sound)	Children/ Adolescents (6-17 years)	17	SECCI, Negative Affect	School-based music therapy reduced negative affect and fostered social connectedness; emphasized professional collaboration and understanding specific needs of refugee children.
2	Wiechers et al.	2023	RCT	Empowerment Group Therapy	Adults with depression	149	PHQ-9 (d=0.68)	First depression-specific group intervention for refugees showed moderate effect size; culturally adapted empowerment approach

								demonstrated feasibility and efficacy.
3	Serra et al.	2024	RCT	Self-Help Plus (WHO) / Trauma mediation	Adults with multiple PTEs	1,101	PTSD symptoms, psychological distress	Multiple potentially traumatic events (PTEs) reduced Self-Help Plus effectiveness; PTSD symptoms mediated intervention outcomes, suggesting need for trauma-specific components.
4	Chauliac et al.	2025	Retrospective Pilot	Group EMDR (GTEP)	Adults with CPTSD	71	PCL-5, PHQ-9	Complex PTSD prevalence reduced from 60.9% to 15.2%; group EMDR demonstrated feasibility and large effect sizes for trauma symptoms and depression.
5	Rosenberg et al.	2023	Qualitative	Implementation determinants study	Adults with PTSD	2,021	N/A (qualitative)	Identified critical implementation factors: cultural humility, linguistic support, referral networks, and organizational capacity as determinants of successful intervention delivery.
6	Attardo et al.	2025	Qualitative Longitudinal	Mental health trajectory study	Refugees (longitudinal)	24	N/A (qualitative)	Identified three distinct patterns of mental health change over time, highlighting heterogeneity in refugee mental health trajectories and need for personalized approaches.
7	Bruhn et al.	2022	RCT	Integrated Care (PTSD + employment)	Adults with PTSD	197	WHODAS (primary), PTSD symptoms	Integrated mental health and employment services showed promise for functional outcomes; addressed dual burden of psychological distress and economic integration.
8	Slewa-Younan et al.	2020	Quasi-Experimental	Mental Health Literacy Program	Arabic-speaking refugees	33	MHL (Mental Health Literacy)	Community-based mental health literacy intervention improved knowledge and reduced stigma among Arabic-speaking refugees in Sydney; demonstrated feasibility of culturally adapted psychoeducation.
9	Cuijpers, et al.	2022	RCT	Step-by-Step (WHO Digital)	Syrian refugees	569	PHQ-9 ($b=-3.63$, $p<0.001$, $g=0.61$)	WHO digital intervention delivered by non-specialists showed significant depression reduction; demonstrated scalability potential for LMIC contexts.

10	Bryant et al.	2024	Controlled Trial	EASE (Early Adolescent Skills for Emotions)	Adolescents	471	Internalizing symptoms	Initial benefits at 3 months not sustained at 12-month follow-up; highlighted need for booster sessions and ongoing support to maintain intervention gains.

2. Descriptive Statistics

Publication Trends

The temporal distribution of publications reveals a concentration of research activity in 2022 (n=3, 30%), followed by consistent output in 2023, 2024, and 2025 (n=2 each, 20% per year), with a single publication from 2020 (10%). The peak in 2022 may reflect increased research funding and attention following the COVID-19 pandemic's impact on refugee mental health services. The sustained publication rate from 2023-2025 suggests ongoing scholarly interest in this critical area.

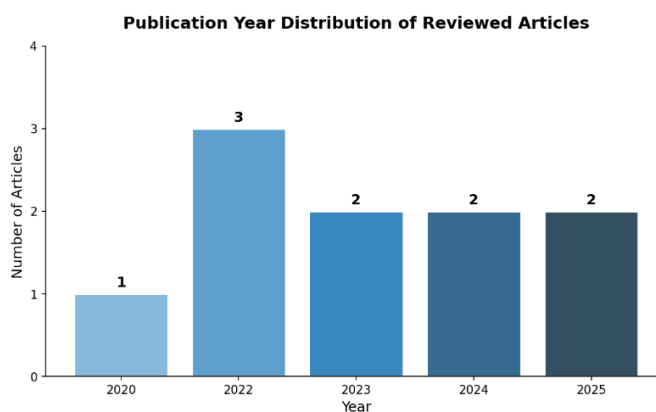


Figure 4. Distribution of Articles by publication year (2020-2025)

Study Design Distribution

The methodological landscape demonstrates considerable diversity. Qualitative studies and "others" designs each compromise 30% of the sample (n-30 each), reflecting the field's recognition that understanding refugee mental health requires both rigorous experimental designs and in-depth exploration of lived experiences. Randomized controlled trials (RCTs) account for 20% (n=2), representing the gold standard for intervention efficacy testing. Quasi-experimental and retrospective pilot studies each contribution 10% (n=1 each), indicating emerging or preliminary intervention research.

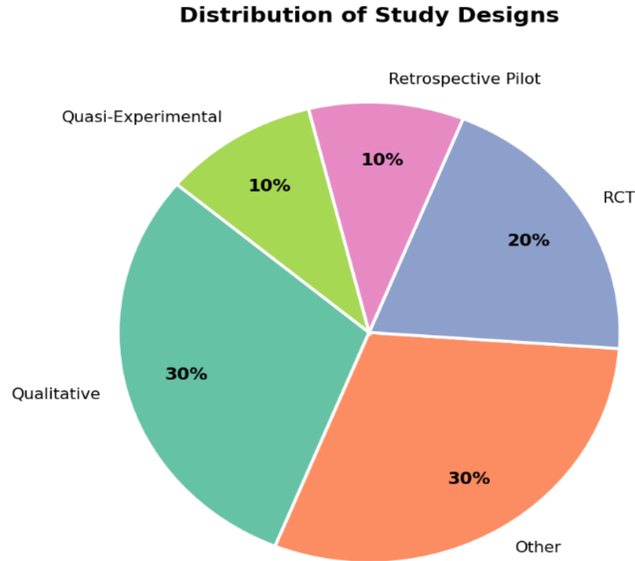
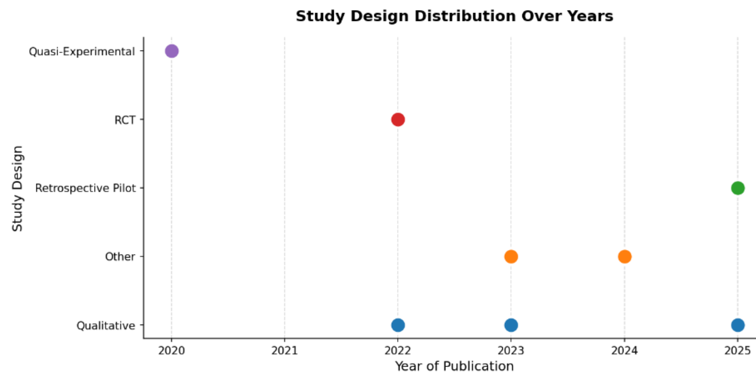


Figure 5. Distribution of study designs across reviewed articles

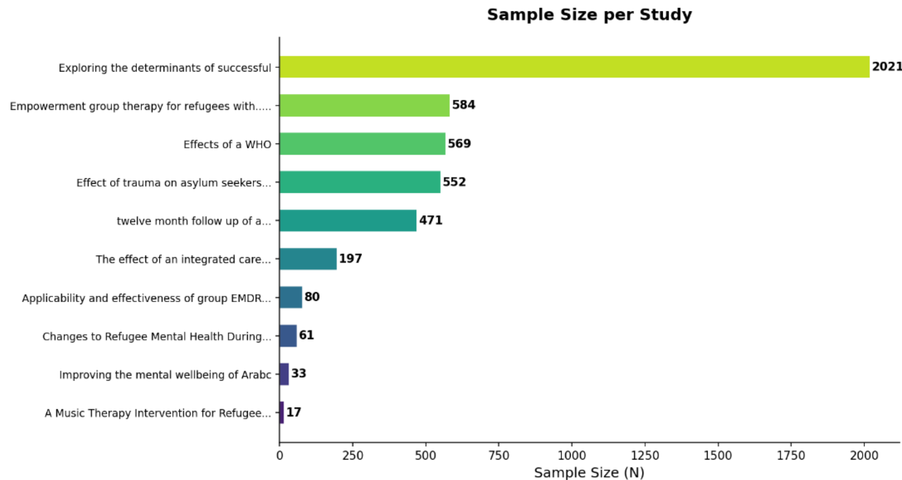
The temporal analysis reveals that qualitative research appears consistently across years (2022, 2023, and 2025), while RCTs cluster in 2024. This pattern suggests an evolving research agenda that balances experimental rigor with contextual understanding.



Picture 6. Study design distribution across publication years

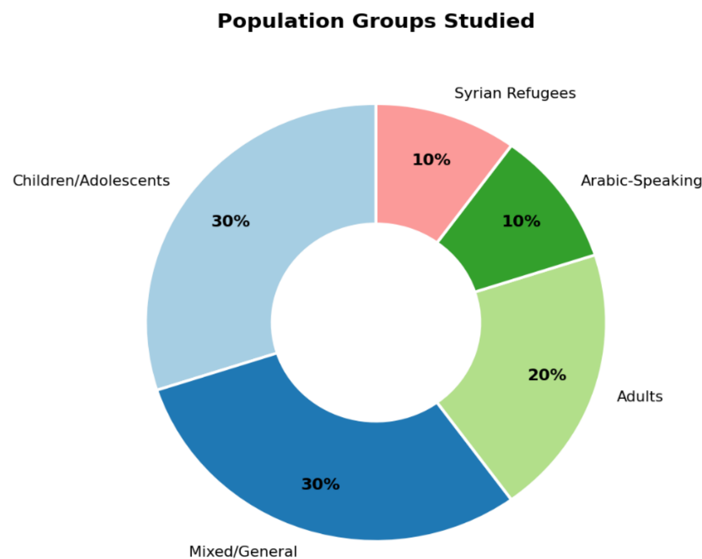
Sample Characteristics

Sample exhibit substantial variation, ranging from 17 participants in a music therapy pilot study to 2,021 in a large-scale implementation determinants study (mean = 458.5, median not specified in available data). Large-scale RCTs dominate the upper range, with studies exceeding 500 participants (n =4), while qualitative and pilot studies typically involve smaller, purposively selected samples (n<100).



Picture 7 . Sample sizes across reviewed studies

Target populations are distributed across children/adolescents (30%, n=3), mixed/general refugee populations (30%, n=3), adults (20%, n=2), with specific focus on Syrian refugees (10%, n=1) and Arabic=speaking refugees (10%, n=1). This distribution reflects both the vulnerability of younger refugees and the need for age-appropriate interventions, as well as recognition of cultural and linguistic specificity in intervention design.

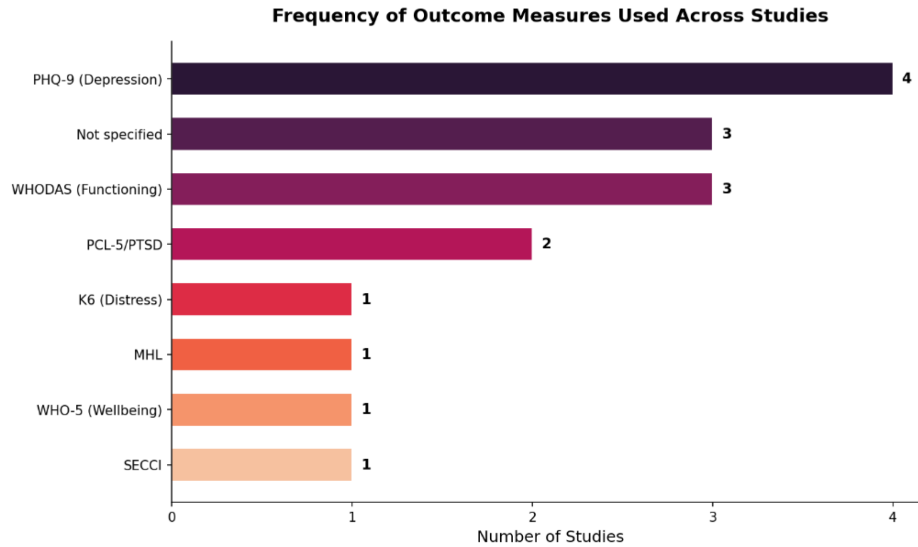


Picture 8 . Distribution of target population groups.

Outcome Measures

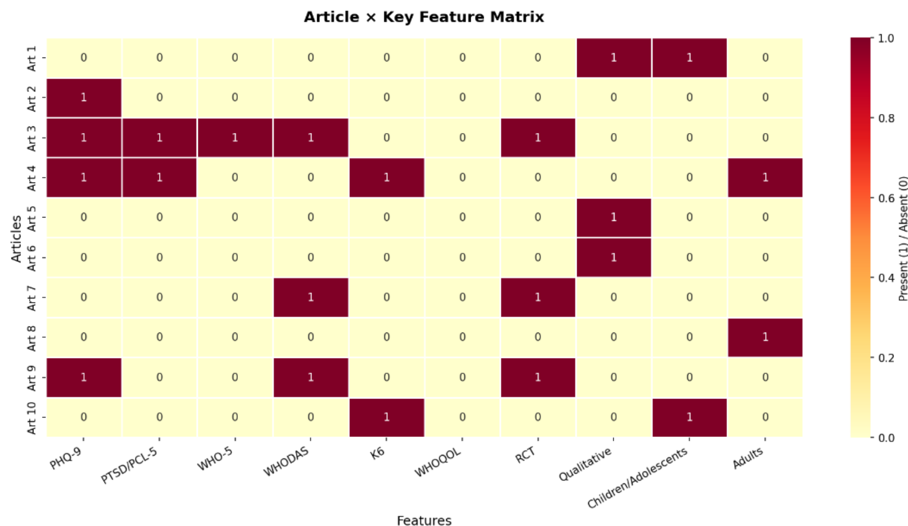
The PHQ=9 (Patient Health Questionnaire-9) for depression assessment emerges as the most frequently employed outcome measure (n = 4, 20%), followed by WHODAS (WHO Disability Assessment Schedule) for functional impairment (n = 3, 30%) and PCL-5/PTSD

measures (n = 2, 20%). Single studies employed WHO-5 (wellbeing), K6 (psychological distress), MHL (mental health literacy), and SECCI (social-emotional competence). Three studies (30%) did not specify standardized outcome measures, primarily qualitative investigations. This pattern indicates a field increasingly standardizing around depression and functional outcomes while maintaining flexibility for context-specific assessment.



Picture 9. Frequency of outcome measures used a cross studies

The feature matrix reveals clustering patterns: RCT designs predominantly employ PHQ-9 and WHODAS measures, qualitative studies focus on implementation and contextual factors, and child/adolescent interventions utilize diverse outcome approaches tailored to developmental stages.



Picture 10. Article x Key Features Matrix showing relationships between studies and key characteristics

3. Thematic analysis

Target populations

The reviewed studies demonstrate attention to developmental, cultural, and contextual specificity:

- Children and adolescents (30% of studies): Three interventions specifically targeted younger refugees, recognizing their unique vulnerabilities and developmental needs. The music therapy intervention focused on school-aged children (6-17 years), the EASE program targeted early adolescents, and one study examined adolescent mental health trajectories. These studies emphasized the importance of developmentally appropriate interventions, school-based delivery for accessibility, and caregiver involvement.
- Adults (20% of studies): Two studies focused exclusively on adult refugees, including the empowerment group therapy for depression and the integrated care model for PTSD and employment. Adult-focused interventions addressed trauma processing, functional impairment, and economic integration.
- Mixed/general populations (30% of studies): Three studies included diverse age groups, reflecting the reality that refugee families often seek services together and that community-wide approaches may be necessary for implementation success.
- Culturally specific group: Two studies targeted specific cultural-linguistic groups- Syrian refugees in Lebanon and Arabic-speaking refugees in Sydney-highlighting the importance of cultural and linguistic adaptation in intervention design and delivery.

4.2 Implementation consideration

The qualitative study by Rosenberg et al. (2023) identified critical implementation determinants that emerged across multiple studies:

- Cultural humility and adaptation: successful interventions demonstrated deep engagement with refugee communities, cultural adaptation of materials and delivery methods, and recognition of diverse cultural understandings of mental health healing.
- Linguistic support: Language barriers emerged as a significant implementation challenge. Effective programs provided interpretation services, translated materials, and trained bilingual facilitators.
- Referral networks and service integration: Interventions embedded within broader services ecosystem-including primary care social services, translated materials, and trained bilingual facilitator.
- Task –shifting and non-specialist delivery: Given the scarcity of mental health specialists in many refugee-hosting contexts, several interventions successfully employed trained non-specialist, community health workers, or peer facilitator demonstrating the feasibility of task-shifting approaches.
- Organizational capacity: Implementation success depend on organizational factors including staff training, supervision structures, resource availability, and institutional commitment to refugee mental health.

Methodological approaches

The methodological diversity reflect the field's maturation an recognition that multiple forms of evidence are necessary:

- Randomized Controlled Trial (20%): Two large-scale RCTs (n = 569 and n = 1,101) tested WHO-developed interventions, providing high quality efficacy evidence. These trials employed standardized outcome measures (PHQ-9, PTSD scales) and intention – to- treat analyses, representing the gold standard for intervention research.
- Qualitative studies (30%): three qualitative investigations explored implementation determinants, mental health trajectories, and contextual factors affecting intervention delivery. These studies provided rich insight into the "how" and "why" of intervention success or failure, complementing quantitative efficacy data with understanding of mechanism and context.
- Mixed-methods designs (10%): The music therapy evaluation integrated quantitative outcome measurement with qualitative interviews of teachers and therapist, capturing both measurable effects and stakeholder perspectives and feasibility and acceptability. (Haynen et al., 2022)
- Quasi-experimental and pilot studies (20%): These designs represented emerging intervention or contexts where randomization was not feasible, providing preliminary evidence to guide future rigorous trials. (Chauliac et al.,2025)
- Longitudinal and follow-up studies (20%): Two studies examined longer-term outcomes (12-month follow-up for EASE; longitudinal trajectories over extended periods), addressing the critical question of intervention sustainability. (Bryant et al., 2024)

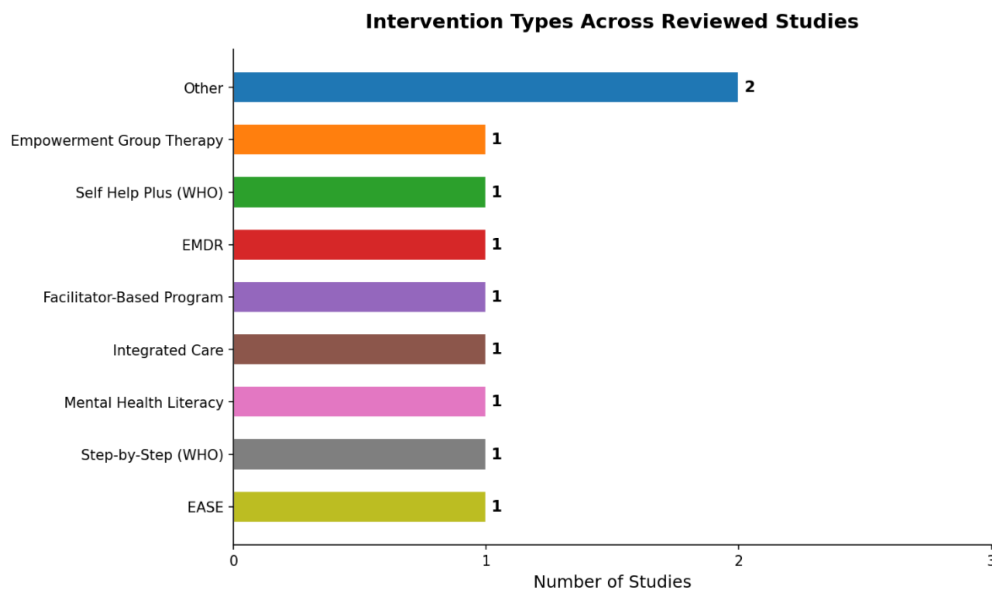
Research question analysis

What types and characteristics of interventions have been implemented?

The reviewed literature encompasses eight distinct intervention approaches, with two studies categorized as 'other" due to their focus on implementation or longitudinal observation rather than specific therapeutic modalities. Key intervention characteristic include:

- Trauma- Focused Therapies: Group Eye Movement Desensitization and Reprocessing (EMDR/GTEP) demonstrated substantial efficacy in reducing complex PTSD symptoms, with CPTSD prevalence declining from 60.9% to 15.3% in a retrospective pilot study. The trauma-mediation analysis in the Self-Help Plus RCT revealed that multiple potentially traumatic events (PTEs) attenuate intervention effectiveness, suggesting that trauma-specific components may be necessary for refugees with extensive trauma histories. (Chauliac et al., 2025)
- WHO-Developed Scalable Interventions: Two studies evaluated World health Organization programs designed for task-shifting in resource-limited settings. Step-by-Step, a digital intervention for Syrian refugees in Lebanon, achieved significant depression reduction (PHQ-9 $b= -3.63$, $p<0.002$, $g=0.61$) when delivered by trained non-specialist. Self-Help Plus, tested with 1,101 participants, showed promise but highlighted the moderating role of trauma burden on outcomes. (Cuijpers et al.,2022)

- Group –Based Psychological Interventions: Empowerment Group Therapy represented the first depression-specific group intervention tailored for refugees, achieving a moderate effect size (d=0.68) on PHQ-9 scores. This approach emphasized cultural adaptation and empowerment principles, addressing bot symptom reduction and agency restoration. (Wiechers et al., 2024)
- Integrated Care Models: One RCT examined integrated mental health and employment services for refugees with PTSD, using WHODAS as the primary functional outcome. This holistic approach recognized that psychological recovery occurs within broader contexts of economics integration and social participation.
- Creative and School-Based Intervention: Music therapy (Safe & Sound program) for refugee children and adolescents in schools demonstrated feasibility and preliminary efficacy in reducing negative affect and fostering social connectedness, though the small sample size (n=17) limits generalizability. (Heynen et al., 2022)
- Psychoeducation and Literacy Programs: A mental health literacy intervention for Arabic-speaking refugees improved knowledge and reduced stigma, representing a preventive approach that addresses help-seeking barriers and community-level mental health awareness.
- Adolescent-Focused Programs: the EASE (Early Adolescent skills for Emotions) program, adapted for Syrian refugee adolescents, showed initial promise but failed to maintain benefits at 12-month follow up, raising critical questions about intervention durability. (Bryant et al., 2024)



Picture 11. Distribution of intervention types across reviewed studies

How effective are these interventions in reducing symptoms of depression, PTSD and anxiety?

- Short –term effectiveness: Multiple interventions demonstrated significant short-term efficacy across diverse outcomes. The Step-by-Step digital intervention achieved a moderate effect size (g = 0.61) for depression reduction (Cuijpers et al., 2022). Empowerment Group Therapy

showed comparable depression reduction. Empowerment Group Therapy showed comparable effect (d = 0.68). Group EMDR produced dramatic reductions in complex PTSD prevalence (60.9% to 15.2 %). These findings provide robust evidence that culturally adapted, evidence-based interventions can effectively reduce mental health symptoms among refugees in the short term. (Wiechers et al., 2024).

- Trauma-Specific consideration: The Self-Help Plus mediation analysis revealed that intervention effectiveness varies based on trauma burden. Refugees with multiple potentially traumatic events (PTEs) showed attenuated treatment response, with PTSD symptoms mediating outcomes. This finding suggests that generic stress interventions maybe insufficient for refugees with extensive trauma histories, who may require trauma-focused therapeutic components. (Serra et al., 2024).
- Functional outcomes: the integrated care prioritized functional impairment (WHODAS) as the primary outcome, reflecting growing recognition that symptom reduction alone is insufficient. Refugees face multifaceted challenges – economic insecurity, social isolation, legal uncertainty-that affect daily functioning. Interventions addressing both psychological symptoms and functional capacity (e.g., employment support) may produce more meaningful improvements in quality of life. (Bruhn et al., 2022).

What was the implementation barriers and facilitator of successful implementation?

Facilitator of successful implementation:

- Cultural humility and community engagement in intervention design and delivery.
- Linguistic support through bilingual staff, interpreters, and translated materials.
- Integration with existing service systems (healthcare, social services, education)
- Task-shifting to trained non-specialists, expanding intervention reach.
- Organizational commitment and adequate resources allocation

Barriers to implementation:

- Limited mental health specialist availability, particularly in LMICs and rural areas.
- Stigma associated with mental health services in some refugee communities
- Competing priorities (basic needs, legal status, employment that may supersede mental health care
- Funding constraints and sustainability of donor-dependent programs
- Participant attrition due to ongoing displacement, resettlement, and unstable living conditions.

Limitations

This analysis is subject to several limitations that should be considered when interpreting findings:

- Sample size and scope: The review encompasses only 10 articles, representing a small fraction of the broader literature on refugee mental health interventions. This limited sample may not capture the full diversity of intervention approaches, population, and contexts.
- Publication bias: The reviewed articles represent published research, which may over represent studies with positive findings. Interventions that failed to demonstrate efficacy or encountered significant implementation challenges may be underrepresented.

- Methodological Heterogeneity: The diverse study designs outcome measures, and populations preclude formal meta-analysis or quantitative synthesis of effect sizes. Comparisons across studies should be interpreted cautiously given this heterogeneity.
- Geographical and cultural representation: While the reviewed studies span multiple contexts, certain regions and refugee populations may be overrepresented (e.g., Syrian refugees) while others remain understudied. Generalizability to all refugee populations and contexts is limited.
- Outcome measurement variability: Despite the prominence of PHQ-9 and WHODAS, outcome measurement approaches varied considerably. There studies did not specify standardized measurement, limiting comparability. Additionally, most studies focused on symptom reduction rather than broader indicators of wellbeing, resilience, or social integration. (Bruhn et al., 2022).
- Follow-up duration: Most studies assessed short term outcomes (immediate post-intervention or 3-month follow-up). Only one study examined 12-month outcomes, revealing non-sustained effects. The long-term durability or intervention benefits remain largely unknown.
- Implementation context: Several studies were conducted in controlled research contexts that may not reflect real-world implementation challenges. The effectiveness of interventions when scaled up and delivered though routine service systems requires further investigation.
- Lack of economic evaluation: none of the reviewed studies included cost-effectiveness analysis, limiting understanding of the economic feasibility and sustainability of interventions, particularly in resource-constrained settings.

CONCLUSION

This comprehensive analysis of 10 recent studies published between 2020 and 2025 on mental health interventions for refugees revealed a maturing field characterized by methodological diversity, attention to cultural adaptation, and growing evidence of intervention efficacy. The key conclusions are as follows:

Evidence of short-term efficacy: Multiple interventions, including WHO-developed programs, such as Step-by-Step and Self-Help Plus, trauma-focused therapies, such as eye movement desensitization and reprocessing (EMDR), and group-based psychological interventions, such as empowerment therapy, demonstrated significant short-term reductions in depression, post-traumatic stress disorder (PTSD), and functional impairment among refugee populations.

Critical role of cultural adaptation: Successful interventions consistently demonstrated cultural humility, linguistic accessibility, and adaptation to refugee communities' values, communication styles, and help-seeking norms. General interventions without cultural tailoring were unlikely to achieve optimal engagement and outcomes.

Sustainability challenges: The lack of sustained intervention effects at the 12-month follow-up in the EASE study highlighted a critical gap. Future research should prioritize long-term follow-up, investigate mechanisms of sustained change, and develop maintenance strategies, such as booster sessions and ongoing support, to preserve intervention gains (Bryant et al., 2024).

Trauma burden as a moderator: Refugees with extensive trauma histories, including multiple potentially traumatic events (PTEs), showed attenuated responses to general stress management interventions, suggesting the need for trauma-specific therapeutic components for this subgroup.

Implementation science imperative: Understanding "what works" is insufficient without understanding "how to deliver" interventions effectively in real-world contexts. Implementation research identifying facilitators and barriers, such as cultural humility, linguistic support, service integration, and organizational capacity, is essential for translating efficacy evidence into population-level impact.

Task-shifting potential: Trained nonspecialists can effectively deliver mental health interventions, expanding reach in contexts with limited specialist availability. However, adequate training, supervision, and quality assurance are critical for maintaining intervention fidelity and effectiveness.

Need for holistic approaches: Refugee mental health is shaped by multifaceted stressors, including trauma, displacement, economic insecurity, legal uncertainty, and social isolation. Interventions that address both psychological symptoms and broader determinants, such as integrated mental health and employment services, may produce more meaningful and sustained improvements.

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