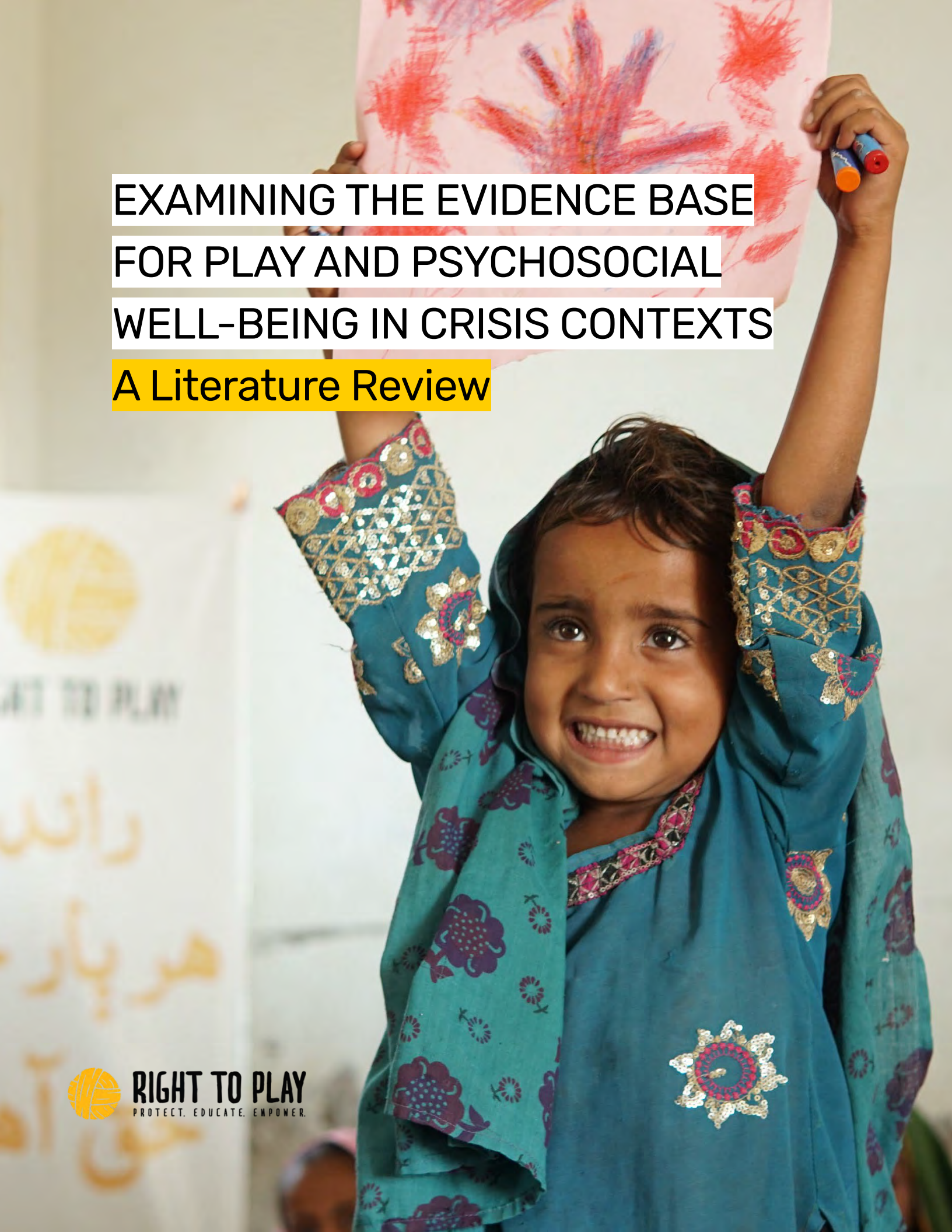

EXAMINING THE EVIDENCE BASE FOR PLAY AND PSYCHOSOCIAL WELL-BEING IN CRISIS CONTEXTS

A Literature Review

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A Literature Review

2024

This research was conducted by the Fjell Collective for Right To Play (RTP). The report was prepared and authored by Jennifer Flemming, PhD; Ashley Nemiro, PhD; Tarek Tamer; and Cole White. Significant RTP guidance, support, and inputs were led by Henry Gathercole.

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SUMMARY/INTRODUCTION

Background

One in six children, or 468 million, reside inr places impacted by armed conflict, a 28% rise since 2015, according to Save the Children (2023). The number of children living in displacement has increased to over 43 million (UNICEF, 2023), more than doubling in the last 10 years (ReliefWeb, 2024). According to Education Cannot Wait (2023), there are an estimated 78.2 million children who are not attending school, and only 10% of those who are attending are making progress in reading and math. These figures underline the seriousness of the situation and the ongoing obstacles children confront.

Crisis impacts children, families, and communities in dramatic ways. These include both direct and indirect effects on children's physical, psychological, and social safety caused by exposure to violence, displacement from their homes, fracturing of family and community units, and instability in their access to education and social protections. Healthy, safe, and nurturing environments – often disrupted by crisis – are necessary for optimal development.

Research shows that children exposed to conflict and displacement display a range of possible distress and stress reactions (e.g., specific fears, dependent behaviour, prolonged crying, lack of interest in the environment, and psychosomatic symptoms, as well as aggressive behaviours) (Bürgin et al., 2022). In addition to the impact on social development, neglecting to respond to these mental health and psychosocial concerns may lead to prolonged issues with both physical and emotional health (UNICEF, 2023).

Parents and caregivers, themselves exposed to the same stressors of conflict and displacement, are subject to similar mental health and psychosocial concerns, which in turn may impact their ability to offer stable, nurturing care to their children (Nemiro & Lankreijer, 2023). The effects of conflict and displacement are also experienced by communities as a whole, as they dismantle protective factors and disrupt social cohesion, along with seriously impairing social, health, and educational services that are essential for communities to function.

In the last decade, there has been increased focus and attention on mental health and psychosocial support (MHPSS) programming for children and families living in humanitarian/crisis contexts, though contextually relevant, evidence-based resources and practices remain limited. Simultaneously, the impacts of play on children's development, learning, and holistic well-being have received growing attention. A growing evidence base in largely stable, western contexts has underlined the potential for play-based interventions to positively impact children's mental health and well-being, as well as their learning (Capurso et al., 2016; Lee et al., 2020; Zosh et al., 2017). In addition, play can serve as a prevention mechanism for the development of anxiety, depression, aggression, and sleep problems in children – concerns especially relevant for children in crisis-affected contexts (UNICEF, n.d.).

Right To Play's mission is to protect, educate, and empower children to rise above adversity using the power of play.

RTP has close to 25 years of experience designing quality play-based learning programs. Since 2020, RTP has sought to deepen its expertise in play-based psychosocial support by continuing to focus on integrated programming, including training of teachers and coaches on psychosocial support activities for in-school provision, while designing, piloting, and researching a series of structured and focused, non-specialized play-based psychosocial support interventions.

In 2024, RTP finalized a refreshed global strategy and theory of change that is focused on contributing to children's improved well-being and learning. In the next strategic period, RTP will be focused on developing its approach to and building evidence on how play-based psychosocial support can contribute to the improved well-being and learning of children globally.

RTP's ambition for this study is to explore and reflect the evidence in existing literature related to play and psychosocial well-being and advance good practices related to play-based psychosocial support across the humanitarian and development nexus.

Overview

The current analysis examined the capacity of play-based approaches to improve the psychosocial well-being of children living in complex and conflict-affected contexts. The study was commissioned by Right To Play with the goals of advancing and influencing the strategic direction of RTP's play-based psychosocial support (PSS) portfolio and broadly increasing understanding of the relationship between play and psychosocial well-being across the sector. This study also builds on a growing body of knowledge that explores the additional value of play-based approaches in affecting children's well-being and learning, as well as the interconnection between children's well-being and learning itself.

In order to address the research objectives below, the review synthesizes findings from 36 research studies, program documentation, and grey literature, with a focus on the different elements (or inputs) of the interventions and measurable outcomes:[1]

- What is the relationship between play-based psychosocial support activities and approaches and the psychosocial well-being of children in complex and conflict-affected contexts?
- What are the mechanisms by which play-based approaches and activities impact psychosocial well-being in crisis contexts?
- What is the existing evidence on how play-based PSS interventions contribute to children's psychosocial well-being outcomes in complex and conflict-affected contexts?

[1] We additionally review RTP program documents, including program-specific literature for five play-based PSS programs, in order to examine the coherence between the evidence base and a selection of RTP programming. RTP documents were not included in the literature review as described here.

Key Operational Definitions

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

"The composite term 'mental health and psychosocial support' (MHPSS) is used in the Inter-Agency Standing Committee (IASC) Guidelines for MHPSS in Emergency Settings to describe 'any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions" (WHO, n.d.).

The IASC (2007) intervention pyramid for MHPSS, shown in Figure 1 below, outlines the four layers in the system of supports for people's recovery and well-being in humanitarian emergencies. For the purpose of this report, play is seen as an accelerator for any MHPSS approach or intervention, relevant to all layers of the pyramid.

Figure 1: *The IASC MHPSS Pyramid*

MHPSS Pyramid of Intervention, IASC 2007

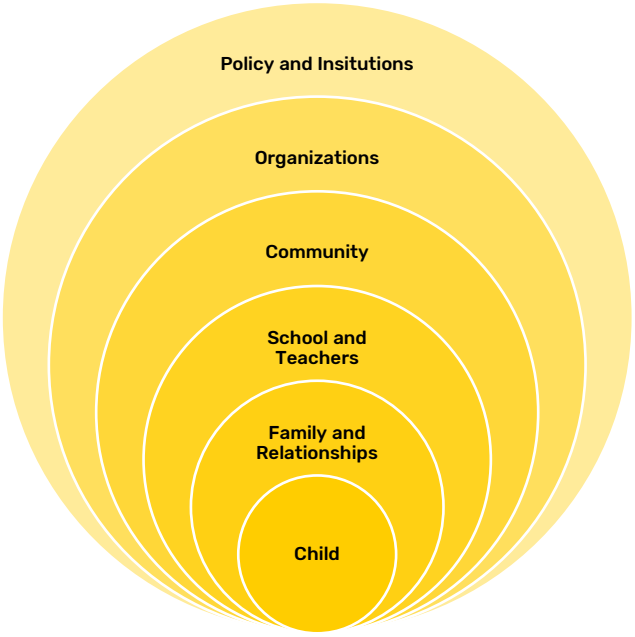
PSYCHOSOCIAL WELL-BEING

Psychosocial refers to both the psychological and social dimensions of a person, and the relational dynamic between the two. There are a myriad of definitions that describe psychosocial well-being, reflecting how context-specific and culturally specific the term is. The most important consideration in adopting a working definition is to assure that responses or interventions seeking to impact psychosocial well-being use the IASC guidelines and contextualize MHPSS appropriately.

Right To Play uses a well-researched working definition of psychosocial well-being, which includes the descriptions of *inner* (thoughts, emotions, perceptions) and *outer* (relationships, community, culture) worlds and emphasizes that the psychosocial focuses on how these two worlds interconnect and influence each other.

Many MHPSS actors use the social-ecological framework to understand psychosocial well-being. This framework, shown in Figure 2 below, places the child at the centre and surrounds them with systems and supports when it comes to psychosocial well-being. The framework demonstrates the complexity of psychosocial well-being and how it is impacted by societal and community systems and structures in addition to individual considerations.

Figure 2: *The social ecological model, adapted from Bronfenbrenner, 1970*



SOCIAL EMOTIONAL SKILLS AND HOW THESE RELATE TO CHILDREN'S PSYCHOSOCIAL WELL-BEING

Social emotional learning (SEL) sits under the broader umbrella of mental health and psychosocial support and includes a range of life skills that help individuals recognize and manage emotions, build self-esteem and self-efficacy, create and maintain positive relationships, and achieve goals.

Social emotional learning refers to the approach and process of fostering social emotional skills in children. PSS programming targets contextually relevant social emotional skills, which can be identified and measured as outcomes under an overarching PSS approach. Many documents in this review examined programs that considered SEL skills outcomes in the short and medium term, and psychosocial well-being outcomes as longer-term or distal outcomes reached via the attainment of the SEL outcomes.

HOW PLAY IMPACTS THE PSYCHOSOCIAL WELL-BEING OF CHILDREN AND YOUTH

There are many forms of play that can positively impact children's well-being. From free play to guided play to play-based therapy, a significant evidence base underlines the potential in play-based approaches to facilitate psychosocial support (Blalock et al., 2019; Yogman et al., 2018). There is a strong evidence base documenting the impact of play on children's cognitive, social, and emotional development – though the majority of such research has been generated in non-crisis-affected contexts (Gaskill et al., 2014; Veiga et al., 2016). For children exposed to adversity, play provides a supportive, safe context through which children engage with others, express themselves, and learn coping skills. Importantly, children themselves describe their use of play and the social context it creates as a means to manage their own stress and cope with negative emotions (Solis et al., n.d.).

Methods

In order to answer the research questions, the team searched for academic and grey literature that was published in the last 10 years (2013–present) and that studied an intervention that (a) was implemented in complex or crisis-affected contexts or that targeted populations originating in such contexts; (b) targeted school-aged children from early childhood education to youth; [2] (c) incorporated psychosocial approaches and outcomes; and (d) was play-based or included play-based activities. We searched electronic academic databases for literature that met the search criteria, as well as websites of known humanitarian actors, networks, and resource hubs for relevant grey literature. Additionally, members of the team outreached to professional networks in order to acquire suggestions of additional studies, evaluations, and program documentation. Our search yielded 36 publications that met the inclusion criteria, covering interventions delivered in 33 different countries.[3]

Upon selecting studies for inclusion in this review, we extracted key programmatic details from them and input these into a tracking document that allowed us to analyze key characteristics of the studies for themes, patterns or trends, and learning related to the research questions.

Summary: Key Learning from the Literature Review

1	**EVIDENCE OF POSITIVE IMPACT**	There is a good quantity of evidence from complex and crisis-affected contexts indicating that play-based PSS interventions affect well-being outcomes, spanning a wide geographic area.
		The evidence shows a significant positive impact on outcomes related to well-being. In this review, it was not necessarily true that we learned more about what works from higher-rigour studies.

[2] The included age range for youth in projects in this review is 4–22, with only one intervention targeting young people over 18. We did not impose an age range in our search criteria and instead included any program that targeted "youth" as defined by the program.

[3] Of these 36, 26 were academic articles published in peer-reviewed journals and 10 were grey literature, largely program documents published by international organizations. Of these 10, 7 were program evaluations and 3 were case-study reports that described measurement and impact.

2	**PLAY AND PSS COMPONENTS OF AN INTERVENTION & DISCERNING "WHAT WORKS"**	There is a notable brevity of the description of PSS and play components included in interventions across the literature. This overall lack of detail of the program activities and approaches makes it exceedingly difficult, despite the reasonable amount of evidence, to identify the causal mechanisms or to determine "what works" in terms of these approaches or elements of the intervention.
	Play component	There is very little evidence linking certain or specific types or categories of play to PSS outcomes in crisis-affected contexts.
	PSS component	In the majority of reviewed studies, it is difficult to determine what, exactly, is included in the PSS component of the program.
3	**THEORY OF CHANGE IN THE INTERVENTIONS**	There was a notable lack of clarity in the documents reviewed regarding how an intervention was hypothesized to work, and how the different components of the intervention related to one another.
	The relationship between intervention activities and measured outcomes	It was rarely made explicitly clear how program activities or approaches were hypothesized or observed to relate to the measured outcomes, and in particular how those outcomes were selected.
	The relationship between shorter- and longer-term outcomes	SEL outcomes were often described as an intermediate, primary, or medium-term outcome, and broader PSS, well-being, and resilience outcomes were described as long-term or distal outcomes.
4	**OUTCOMES MEASURED**	Multiple studies noted the shift away from measuring mental health outcomes in a PSS/SEL-oriented program toward measuring social, emotional, and well-being outcomes.
	SEL outcomes	SEL outcomes were the most measured across documents in this review.
	Mental health outcomes	Mental health outcomes were still measured with high frequency, but this outcome category shows the lowest percentage of positively measured impact (calculated as the number of times an outcome in that category showed positive impact divided by the number of times that outcome category was measured).

	Composite well-being outcomes	General well-being outcomes were also frequently measured across studies. These outcomes were comprised of composite scores measuring well-being, psychosocial well-being, or resilience. Many of these outcomes incorporate several SEL outcomes, but most often the studies do not elaborate on the makeup of these composite scores nor which SEL skills or outcomes are included within them.
		When composite score measurement tools were used, it was often more challenging to understand exactly what positive impact means or how to interpret the results, due to the subjective nature of well-being or resilience and how such concepts differ across contexts and age groups.
5	**MEASUREMENT TOOLS**	It was challenging to ascertain whether or not the measurement tools used were the most appropriate or relevant in regard to the intervention's intended impact or identified outcomes.
		In crisis-affected contexts, a large number of MHPSS/SEL-related measures are used, such as those measuring general well-being, psychosocial well-being, and resilience.
6	**KEY INGREDIENTS FOR PLAY-BASED PSS PROGRAMMING**	Based on this review, six key factors (or key ingredients) emerged that are essential to program impact and understanding. Each key ingredient is essential for programs to acknowledge and understand in context; this means: Focusing on context and setting components of the intervention • Focusing on relational and social components of the intervention • Understanding play in context and the intentional play components of the intervention • Understanding mental health and psychosocial well-being in context, and assuring clarity in how a program delivers PSS • Identifying appropriate, relevant outcomes and measuring those in a way that will help the program understand its impact

This review is structured as follows:

- In **Part 1**, we summarize learning from the literature review, including descriptions of key elements of studied interventions and measured outcomes. We conclude with elaboration on the key learnings above.
- In **Part 2**, we offer greater description of the above key ingredients, informed by both the literature review and key informant interviews.
- In **Part 3,** we conclude with action points and future opportunities for a range of actors in the play and MHPSS space, based on learning from both the review and interviews and technical expertise.

PART 1: LITERATURE REVIEW

Summary of Program Elements in the Study Interventions

PLAY-BASED PROGRAMMING

Per search criteria, all interventions included play or play-based activities. Initially, the intention was to code interventions by categories or types of play; however, this posed a few key methodological challenges:

- There are many different typologies and categories of play in the relevant literature. While recent work in the humanitarian space has produced categories relevant to children in such contexts,[4] such categorization is new and has also emerged based on work originating within organizations (and thus reflect their own implementation);
- The studies reviewed only sometimes offered detailed enough descriptions to classify the types of play (for example, in terms of detailing the level of adult supervision, or the type of support and instructions offered);
- Most interventions included a number of activities that (when possible to distinguish) may be classified in multiple categories. Additionally, the categories themselves may overlap, as there is often no single, universal definition or defining characteristic of a particular play activity.

We created six categories, based on descriptions in the studies themselves, that reflected distinct descriptions of activities. These categories are sports, movement-based play, creative expression, drama and role play, games, and free play.[5] All activities described in the literature are presented in Table 1 below and are included in order to offer more descriptive elements of the play-based approaches as well as to underline how commonly such approaches utilize a range of activities.

[4] See, for example, the categories of play in Save the Children's (2023) Let's Play! Save the Children and Play: Guidance Note, supported by The LEGO Foundation.

[5] In general, there may be some overlap between these categories (for example, movement-based play and sports, or creative and dramatic play). The distinction between the categories here is based on the specific description of activities offered in the articles reviewed. For movement-based play, for example, interventions often included many of the activities listed in small doses, as well as other categories of play. In the sports category, it was often the case that an intervention had a significant or longer-term focus on only one or two of the sports.

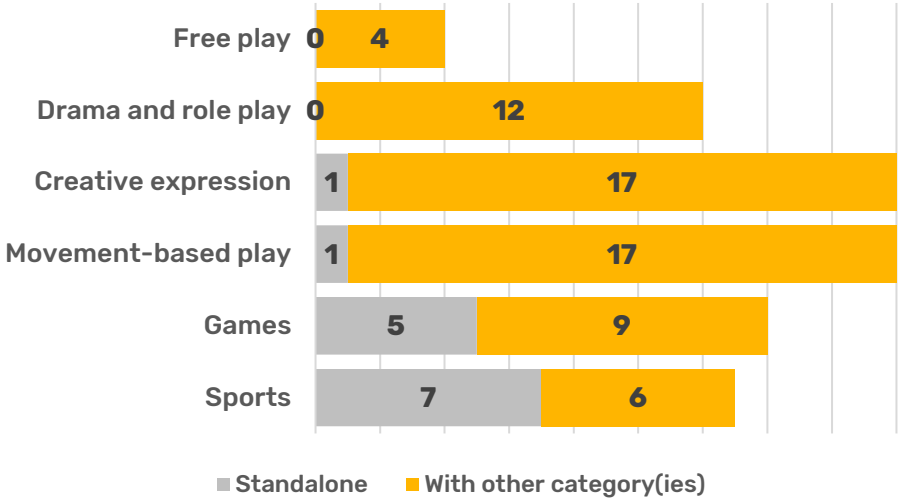
Table 1: *Categories of play and activities in studied interventions*

	Category of Play	Activities
1	**Sports**	Individual and team sports, football, cricket, volleyball, surfing, chinlone
2	**Movement-based play**	Structured movement, acrobatics, martial arts movement, body awareness practices, creative movement, yoga, circus activities, nature walks, skipping rope
3	**Creative expression**	Singing, music, dance, cultural dance, drawing, musical games, musical improvisation games, musical improvisation, crafting, sculpting, painting, collage, construction using wood and fabrics, photography, digital art, doll and mask making, group murals, songwriting, song parody, learning to play an instrument, listening and sharing songs, performing, sewing, graphic design, coding and robotics, poetry
4	**Drama and role play**	Drama, role play, puppetry, storytelling, reauthoring of folk tales and performing them, caring for a stuffed animal, folklore, theatre sessions
5	**Games**	Ladder game, blind fly, rubber bands, ludo, carrom, malpat, Magic Bag, solving puzzles, Brain Games, culturally adapted games, playful STEM sessions
6	**Free play**[6]	Free play

Ultimately, 23 of the 36 studies included activities across multiple categories, as shown in Figure 3, below. Only sports and games categories provided multiple studies linked to a standalone category; of the five games interventions, four were the same intervention (IRC's Brain Games as part of the Healing Classrooms program).

[6] We include the free play category because it was explicitly written in four studies, but it is possible (and likely) that free play was included in other interventions but not specified directly.

Figure 3: *Instances of each category of play in an intervention across all studies (standalone indicates the intervention included only that category of play, while other categories indicate that the intervention included multiple categories of play)*



We were not able to discern any linkages between type or category of play and impact in order to explore causal mechanisms. This was mainly due to most interventions incorporating multiple activities and/or categories of play with little specification of dose or time spent on a specific activity versus other components of an intervention. For studies that included a control group, there were no significant trends across these studies in relation to category of play.

While this poses challenges for establishing a detailed impact-oriented evidence base, it is also clear from the literature that implementers often intentionally offer options for play types and activities. This allows children choice and agency in how they participate (a key characteristic of play-based learning), and offers multiple avenues for the provision of psychosocial support.

Additionally, the diversity of play approaches represented in this review – from a surfing intervention in Sierra Leone to manualized play therapy in Bangladesh to narrative storytelling in Gaza – emphasize how the benefits of play can be facilitated in a myriad of ways that are relevant to context and social norms; to availability of support, materials, and space; and in settings that are challenging, dynamic, and with many interconnecting stressors.

PSYCHOSOCIAL SUPPORT PROGRAMMING

In order to understand the mechanisms of impact, the purpose of this review was to identify programming that combined play-based approaches with psychosocial support techniques or interventions to improve well-being outcomes. This meant that the included interventions were not solely "play" (e.g., the program is children participating in a football league) but also reported integrating a PSS component to support children's social-emotional learning and psychosocial well-being. What exactly this "PSS component" was comprised of was often unclear in the literature, which offered similar challenges in assessing causal mechanisms or even contributing factors as the play categories above.

Due to the lack of detailed information regarding a PSS approach or activities, it was rarely possible to determine how exactly an intervention worked. Even in literature that described positive impact on MHPSS outcomes of a play-based intervention, unpacking the causal mechanisms based on the level of detail included in the studies was challenging. In order to determine what we could learn from the literature, we instead reviewed whether a PSS component was described explicitly, implicitly, or not defined at all. The purpose of this exercise was to understand how programs were theorized to work when possible, and to examine any trends in the evidence base related to the stated PSS components.

Overall, 17 studies explicitly described the PSS component of program implementation and showed positive impact. In the remaining studies (n=19), the PSS component was either implicit or not defined.[7] While many of the latter interventions also showed positive impacts, there was still less information to draw from to understand exactly how the intervention worked. Table 2 provides an overview of a selection of the studies that fell into each category.

Many studies were significantly less explicit in their description of the PSS component. An implication of this is that fewer conclusions can be drawn regarding "what works" from these studies, as it is unclear how psychosocial support was integrated into the play-based intervention. Examples of each category – explicit, implicit, and undefined PSS component – are included in Table 2 below.

Table 2: *PSS component of select interventions in review*

[7] We note that published studies are often edited for length, and thus we are not inferring that a lack of description of the PSS component necessarily means it did not exist in the program implementation. However, for the purpose of this review, such studies were more challenging to learn from.

	Study	Approach	PSS component
Explicit	(Marshall et al., 2021) Sierra Leone Children and youth ages 7–22, affected by conflict	Community-based surf therapy program	The surf therapy intervention centred on the creation of a safe space, positive social support, effective transfer of coping skills, and respite from negative emotions while in the water. The sessions consisted of an initial meeting, with a safe space held so all participants could "check in" with how they were feeling. This was followed by a warm-up game and the learning activity for the day. Activities were based around surfing but were designed to support emotional regulation, goal-setting, mindfulness, positive socializing, and respite. The session finished with time allocated to unstructured but supervised surfing/swimming, followed by a debrief. It is important to note that these learning activities, the safe space, caring coaches, and positive socializing are identified as integral and integrated within surf therapy. The surfing component is viewed as the vehicle for the delivery of psychosocial support rather than the focus of the intervention. **Showed positive results.**
Implicit	(Zapata et al., 2018) Colombia Children ages 6–8, affected by conflict	Music intervention	The PSS component of making music was considered implicit by the program/researchers. They theorized that the very nature of making music in a group setting would positively affect children's self-esteem and did not describe a targeted PSS approach or additional activity in the study. **Showed mixed results.**
Absent	(Richards et al., 2014) Uganda Children ages 11–14, affected by conflict	Football program; sport for development intervention	While there was a training for coaches that included "peace-building" and "community-building" language, the study notes that coaches' focus in implementation was centred on football performance, without a PSS component integrated. The study specifically cautions against the assumption that physical activity and sports alone will have positive mental health outcomes for conflict-affected adolescents, and emphasized that participation in the football league in fact had negative impact on emotional outcomes for boys. **Showed no results and negative results.**

Outcomes measured in the reviewed studies

The included studies measured a wide range of outcomes, the majority of which are considered social emotional skills. From the included studies, we extracted all measured outcomes. These were then categorized through an iterative process of MHPSS/SEL framework review and team inputs.[8] A key priority of this categorization process was a deductive approach, which would allow us to learn from the evidence base versus coding or categorizing based on pre-existing assumptions, ideas, or frameworks.

Driven by the literature, we grouped the outcomes into six distinct categories: social outcomes, self-perception outcomes, emotional outcomes, cognitive outcomes, behavioural (or externalizing) outcomes, mental health outcomes, and a composite well-being outcome category. This final category represented studies that measured well-being broadly through the use of composite scoring measurements. Often these tools are a composite of many of the above SEL outcomes, but it was not possible to discern specific breakdown into those categories.

Table 3, below, outlines all outcomes measured across all studies in the review, categorized per descriptions above. We note how often such outcomes were measured across all studies in Column C, and how many times an individual outcome showed positive impact across all studies in Column D. Most studies include outcomes from two or more of the categories, shown in Figure 4. Table 4 offers examples of interventions that demonstrate positive impact by category of outcome.

Table 3: *Outcomes, categories, and frequency of measurement*

[8] Review of MHPSS/SEL frameworks included extensive use of the Explore SEL tool via the EASEL Lab (http://exploresel.gse.harvard.edu/) and the IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency).

(A) Outcome Categories	(B) Individual Outcomes	(C) Total # of times an individual outcome (from Column B) appears across all studies	(D) Total number of times an individual outcome shows positive impact
Social outcomes	Attachment security, social inclusion, peer relationships, social connectedness, social bonding, sense of connection to others, social agency, pro-social behaviours, conflict resolution, reduced anti-social behaviours	27	24
Self-perception outcomes	Agency, personal goals, self-efficacy, sense of connection to self, coping skills, insecurity, reduced victimization, positive mindset, self-esteem, self-confidence, perseverance	15	14
Emotional outcomes	Stress reduction, hope, affective state, internalizing symptoms, emotional regulation	18	11
Behavioural outcomes	Hyperactivity, inhibitory control, disruptive behaviour, conduct problems	11	9
Mental health outcomes	Reduction in post-traumatic stress (PTS) and post-traumatic stress disorder (PTSD) symptoms, general mental health, depression, anxiety, generalized anxiety	21	12
Cognitive outcomes	Executive functioning, skills, academic performance, academic learning, functional impairment, literacy and numeracy, concentration	11	7
Composite well-being outcomes	Well-being, resilience, holistic learning, social-emotional learning	13	13

Figure 4: *Number of outcome categories examined in each study*

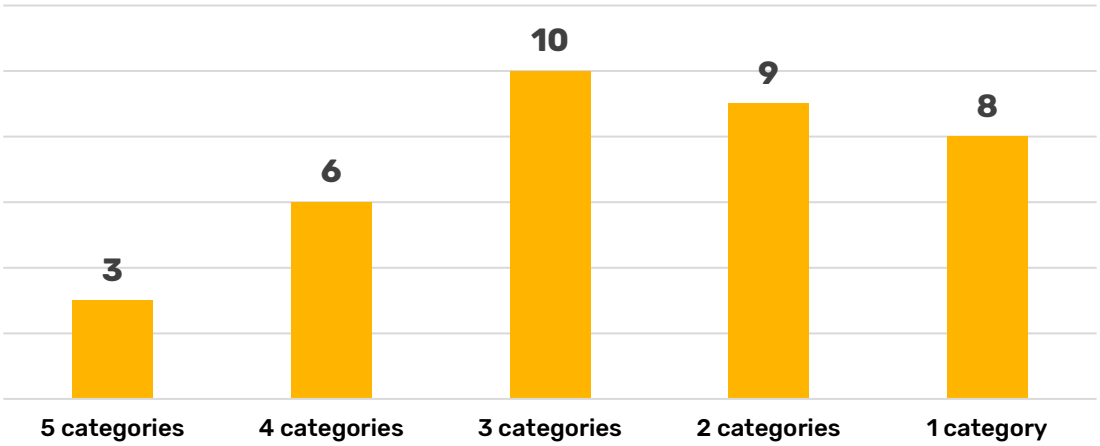
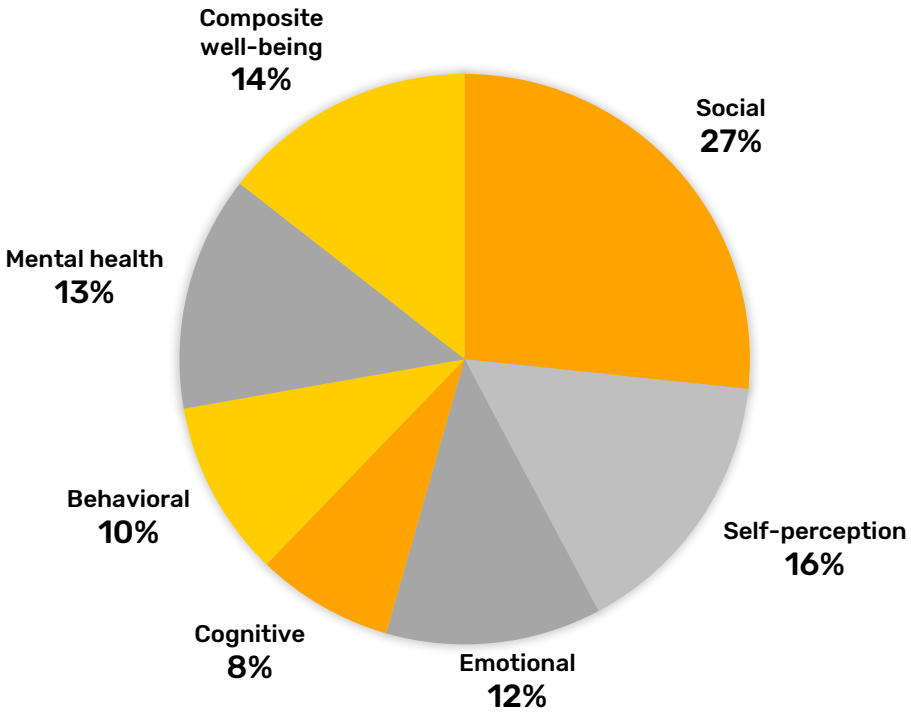


Figure 5: *Total number of instances where a positive impact was found on an individual outcome within the categories (studies include multiple outcomes)*



SUMMARY OF MEASURED OUTCOMES

- **Social outcomes** were the most observed across these studies, measured 27 times over 19 studies. Fifteen studies show positive impact of the play-based PSS interventions on at least one social outcome.
- **Self-perception outcomes**, characterized by concepts of identity and agency, were measured 15 times over 13 studies. Outcomes included self-esteem, personal goal-setting, self-efficacy, self-confidence, increased sense of connection to self, coping skills, reduced feelings of insecurity, reduced victimization, resilience, and perseverance. Twelve studies show positive impact of the play-based PSS interventions on at least one self-perception outcome.
- **Emotional outcomes**, characterized often by reduction in emotional problems (and measured via the Strengths and Difficulties Questionnaire (SDQ)), were measured 18 times over 15 studies. Eleven studies show positive impact of the play-based PSS interventions on at least one emotional outcome.
- **Cognitive outcomes** were measured 14 times over 12 studies. Seven studies show positive impact of the play-based PSS intervention on cognitive outcomes, such as executive functioning, concentration, functional impairment, academic learning, and literacy and numeracy outcomes.
- **Behavioural outcomes**, characterized by externalizing symptoms, including disruptive behaviours, hyperactivity, inattention, and other conduct problems, were measured 11 times over 10 studies. Nine studies show positive impact of the play-based PSS interventions on at least one behavioural outcome. Behavioural outcomes were the least-assessed outcome category across studies, and these were measured via the SDQ only. Thus, there were no studies measuring only behavioural outcomes since these were always paired with emotional outcomes via the SDQ.
- **Mental health outcomes** were measured 21 times over 14 studies. Nine studies show positive impact of the play-based PSS interventions on at least one mental health outcome. Notably, this outcome had the most mixed results, with 7 studies showing no impact of intervention on this category of outcome (one study showed mixed results and is counted in both categories).

MOVING AWAY FROM MENTAL HEALTH OUTCOMES AS THE PRIMARY MEASURE OF IMPACT

The reason for the varying findings in this category of mental health outcomes is likely that the change the intervention aimed to bring about was not aligned with the measurement of mental health conditions (such as PTS/D, depression, and anxiety) used to evaluate change or impact. The majority of the examined interventions in this review were implemented universally; children were not evaluated for suitability for the intervention based on internalizing symptoms or mental health conditions. This indicates that the intervention was not designed with children living with mental health conditions in mind, which explains why the lack of a meaningful impact on these metrics is not significant.

It is essential to recognize that many psychosocial interventions in humanitarian contexts are designed as preventive or promotive measures, aimed at fostering healthy development, strengthening coping mechanisms, and promoting overall well-being rather than directly addressing clinical mental health conditions. In such cases, relying solely on symptom-based measures of mental health disorders may fail to capture the broader impacts of the intervention on psychosocial functioning, social connectedness, and future growth trajectories. As is elaborated on in the subsequent section, an explicit connection between intervention activities and appropriate outcomes is essential to understanding whether or not the intervention achieved its intended impact.

- **Composite well-being outcomes** were measured in several studies, offering perceptions of holistic well-being or social-emotional learning outcomes as "composite" measures made up of a variety of constructs that define well-being broadly. These are often measured using a well-being or SEL composite tool, though we note that we only categorize outcomes as "composite well-being outcomes" if it was not possible to break down the measurement/tool into the other outcome categories (social, self-perception, emotional, behavioural, mental health, and cognitive outcomes). In addition, this category of outcomes also represents studies that utilize mainly qualitative measures or studies where the measurements or tools used were slightly less clear. Broad well-being outcomes were measured 13 times over 11 studies. All 11 studies show positive impact of the play-based PSS interventions on a broad well-being outcome.

Table 4: *Examples of outcomes by category in the literature review*

Outcome category	Study	Approach	Description of impact
Social outcomes	(Talbot et al., 2017) Ukraine Children ages 9–16, affected by conflict Mixed methods evaluation	Life skills education and psychosocial support Delivered in schools Activities/approach include using games as learning experiences via life skills and PSS lessons	Positive impacts on peer relationships, social cohesion, social inclusion, pro-social behaviour, and behavioural problems.
	(Metzler et al., 2021) Ethiopia Somali refugee children ages 6–11 Quasi-experimental	Activities in Child and Youth Learning Centres (CYLCs) Delivered in a community setting Activities/approach include cultural dance, drawing, recreational play, and singing	Positive impacts on **pro-social behaviours, social adjustment**, internal coping resources, emotional adjustment, and literacy and numeracy.
Self-perception outcomes	(Save the Children and MHPSS Collaborative, 2021) Jordan Refugee children and youth Mixed methods evaluation	Coaching for Life (football intervention) Delivered in a community setting Activities/approach include football, coaches from the community teach six resilience-building modules designed by Arsenal and Save, using football as a vehicle for communicating and developing skills	Positive impacts on **agency and identity outcomes, with children describing enhanced self-worth, self-esteem, confidence, coping skills**, and resilience.

	(Cohen et al., 2013) Israel Children ages 2–6, affected by conflict Qualitative study	Let's Make Room for Play ("NAMAL") intervention Delivered in community-based setting Activities/approach include crafting, playful interactions with body movement and songs, puppetry, imitations of child by mother, dance; sessions focus on encouraging creative expression in a playful context between mother and child to support resilience-building and self-expression in children	Positive impacts on **increased self-reliance, autonomy, coping skills**, mood and expressions of excitement, increased listening, and cooperation.
Emotional outcomes	(Quinlen et al., 2016) Australia Refugee children ages 11–14 Mixed methods evaluation	Home of Expressive Arts and Learning (HEAL) Delivered in schools Activities/approach include expressive and creative activities including crafts and music, drama, and role playing activities	Positive impact on **emotional symptoms, ability to cope/self-soothe**, behavioural challenges, and peer problems.
	(AbuKishk et al., 2015) Jordan Syrian refugee children and youth ages 4–18 Mixed methods evaluation	UNICEF PSS programming delivered in Child Friendly Spaces (CFS) and via Healing and Education through the Arts (HEART) Delivered in community-based child-friendly spaces Activities include music, arts and crafts, sports, role plays, puppet shows, puzzles	Positive impacts on **emotional well-being, happiness, reduction in anger**, social well-being, improved sleep, improved ability to acquire new skills and knowledge.

Behavioural outcomes	(Wu et al., 2023) Sierra Leone Children ages 5–9, affected by conflict Dosage study	IRC Healing Classrooms, including mindfulness and Brain Games Delivered in schools Activities/approach include Brain Games, which are simple, play-based games to help children practise executive function skills	**Positive impacts on disruptive behaviour, attention**, and pro-social behaviours. *[Dosage study of SEL activities – Mindfulness and Brain Games – within an adapted version of its Healing Classrooms program. The results showed that increased variety of games and activity duration led to positive impacts on above outcomes.]*
Cognitive outcomes	(Zapata & Hargreaves, 2018) Colombia Children ages 6–8, affected by conflict Quasi-experimental	Music and singing program Delivered in schools Activities/approach include singing, musical games, musical improvisation games, musical improvisation	**Positive impact on cognitive self-esteem.** No impact on social, physical, behavioural self-esteem.
Mental health outcomes	(Decosimo et al., 2019) Liberia Children and youth ages 4–18, affected by Ebola epidemic Evaluation, qualitative data	Playing to Live expressive arts program Delivered in a community-based setting Activities/approach include art, play, and yoga therapies	Positive impacts on psychological stress symptoms, via caregiver interviews.

	(Deeba et al., 2015) Bangladesh Children ages 5–9, affected by crisis Quasi-experimental	Huggy Puppy caretaking stuffed-puppy program Delivered in a community-based setting Activities/approach include caring for a stuffed animal, reciting positive statements to the stuffed animal	Positive impacts on perceptions of self, **post-traumatic stress, depression, and anxiety symptoms.**
	(Tol et al., 2012/2014) Burundi/Sri Lanka Children ages 8–17, affected by conflict Randomised Control Trials (RCTs)	Classroom-based MHPSS intervention Delivered in schools Activities/approach include manualized intervention with creative/expressive elements – cooperative games, structured movement, music, drama, dance	In Burundi: **No impact on mental health outcomes (PTSD symptoms, depression symptoms, and anxiety symptoms).** In Sri Lanka: **Mixed results on PTSD symptoms and anxiety symptoms (there was positive impact on boys but not girls for both outcomes) and no impact on depression.**
	(Ho et al., 2017) China Children, Grade 4, impacted by earthquake Quasi-experimental	Strength-based arts and play support program Delivered in schools Activities/approach include movement games, dancing, movement improvisation, painting, art, singing, play	**No impact on PTSD or traumatic symptoms.** Positive impacts on peer support and self-efficacy.

	(Panter-Brick et al., 2018) Jordan Syrian refugee children and youth ages 12–18 RCT	Advancing Adolescents PSS program Delivered in a community setting Activities/approach include nature walks, football, sewing, graphic design, photography, singing and folklore, drama, theatre sessions	**Positive impacts on mental health difficulties (anxiety, depression),** insecurity, and distress. **No impacts on post-traumatic stress symptoms** and pro-social behaviour.
Composite well-being outcomes	(Marshall et al., 2021) Sierra Leone Children and youth ages 7–22, affected by conflict Mixed methods	Surf therapy program Delivered in a community setting Activities/approach include a targeted PSS session supporting emotional regulation, goal-setting, mindfulness, positive socializing, and respite followed by unstructured surfing and swimming	**Positive impacts on generalized well-being,** socializing, mindset, effort, behavioural improvements, generalized well-being, and academic performance. *[Well-being measured via the Stirling Children's Wellbeing Scale, which includes measures of optimism, cheerfulness, and relaxation; satisfying interpersonal relationships; positive functioning, including clear thinking and competence (Liddle & Carter, 2010).]*

Key learning from the literature review

Data extracted from the reviewed literature was synthesized in order to generate key findings that summarize the current evidence base for play-based MHPSS programming in crisis-affected contexts. These learnings have programmatic, research, and measurement implications and are relevant to actors designing, implementing, evaluating, and researching play-based PSS programming in crisis-affected contexts.

EVIDENCE OF POSITIVE IMPACT

- **There is a good quantity of evidence from complex and crisis-affected contexts indicating that play-based PSS interventions affect well-being outcomes, spanning a wide geographic area.** Impact on SEL-focused outcomes as well as more general composite well-being outcomes is demonstrated through the evidence. In addition, a wide range of methods were utilized to conduct the studies, from RCTs to qualitative studies.
- **The evidence shows a significant positive impact on outcomes related to well-being.** The majority of studies (94%) show positive impact on at least one PSS-related outcome. Twenty-five studies show entirely positive impacts, seven studies show mixed impact (both positive and no impact), and two studies showed no impact.
- **There was a range of study rigour in the documents included in this review, but it was not necessarily true that we learned more about what works from higher-rigour studies.** Limitations of understanding the mechanisms of change (described below) apply as well to RCTs/quasi-experimentally designed studies. Many of these studies emphasize the complexity of the interventions in context, coupled with the complexity of outcomes. There is notable intricacy required for a study design necessary to, for example, parse out proximate/distal outcomes or to identify which variables or context-specific factors may act as mediators/moderators. It is unclear that investment in such study design would result in more usable, contextually transferable knowledge.

  Many studies and evaluations included in this review emphasize the in-depth, detailed, and context-specific learning that occurred based on the qualitative data collected, especially when such data could be collected with children. The more flexible nature of qualitative data collection (versus, for example, an RCT) can allow for more nuance, as well as more space for participants to emphasize what is most important and relevant to them in regard to their experience with an intervention.

PLAY AND PSS COMPONENTS OF AN INTERVENTION AND DISCERNING "WHAT WORKS"

- There is a notable brevity of the description of PSS and play components included in interventions across the literature. This overall lack of detail of the program activities and approaches makes it exceedingly difficult, despite the reasonable amount of evidence, to identify the causal mechanisms or to determine "what works" in terms of these approaches or elements of the intervention.
- **There is very little evidence linking certain types or categories of play to PSS outcomes in crisis-affected contexts.** Across the reviewed literature, there is rarely in-depth description of the play components in an intervention, beyond a list of included play activities. It is challenging to classify or categorize this play for a number of reasons – including that many interventions involve multiple activities or that there is a lack of description of adult involvement, guidance, or structure. This makes it infeasible to determine what works, why, and for whom in terms of the details of the play itself.
- **In the majority of reviewed studies, it is difficult to determine what, exactly, is included in the PSS component of the program.** This includes description of the activities themselves (such as reflection, engaging with emotions and emotional responses, talking about stress and coping mechanisms) or the interpersonal aspects that the intervention sought to improve. Of the 36 reviewed studies, we note that 47% *explicitly* describe the PSS component; 27% *implicitly* refer to its inclusion but do not elaborate in detail; and in 25% of studies, reference to any PSS component is not defined. In studies where the PSS component is more explicit, the discussion often reflects more useful information on what was effective and how the intervention components lead to impact.

THEORY OF CHANGE IN THE INTERVENTIONS

- **There was a notable lack of clarity in the documents reviewed regarding how an intervention was hypothesized to work, and how the different components of the intervention related to one another.** As noted above, this was true in regard to description of the play and PSS components of an intervention; it was further true of additional inputs and program assumptions, as well as outcomes. While the review shows overwhelmingly positive impact of play-based MHPSS programming, without level of detail or explicit theory of change of a program, it is not possible to draw conclusions about causal mechanisms or relationships amongst the many moving parts of an intervention.
- **It was rarely made explicitly clear how program activities or approaches were hypothesized or observed to relate to the measured outcomes, and in particular how those outcomes were selected.** It is essential that interventions select and measure appropriate and relevant outcomes in relation to their program activities, and this is particularly important for so-called MHPSS interventions, which indicates an umbrella term that can be applied to many diverse approaches to well-being.
- **SEL outcomes were often described as an intermediate, primary, or medium-term outcome, and broader PSS, well-being, and resilience outcomes were described as long-term or distal outcomes.** While this may suggest a more

detailed Theory of Change than is described in the articles, such information is essential to more in-depth learning about program impact. There were only two interventions studied in this review that explicitly presented or linked to a Theory of Change; these were the articles studying IRC's Healing Classrooms and Brain Games, and the Marshall et al. (2021) study of a surfing intervention in Sierra Leone, which was explored in a separate article (Marshall et al., 2019).

Overall, while the reviewed studies often noted SEL outcomes in the intermediate term and resilience or well-being in the long term, these studies did not explain the hypothesized connection or mechanism of change between these outcomes. It appears to be an assumption in the literature of crisis-affected contexts that improvement in shorter-term SEL outcomes can lead to improvement in longer-term well-being outcomes (such as, for example, resilience).

ALIGNING PROGRAM ACTIVITIES TO APPROPRIATE OUTCOMES

Past reviews of MHPSS programming have emphasized that mismatch between intervention activities and outcomes may lead to inaccurate descriptions of impact (Haroz et al., 2020; Lasater et al., 2022; Nemiro et al., 2022). For MHPSS programs in crisis-affected settings, this mismatch has been often observed when non-specialized psychosocial interventions are evaluated via clinical symptoms of psychological distress, i.e., the mental health outcomes described in this review.

However, with the frequent use of SEL outcomes in the studies here, these connections were often straightforward to infer. For example, the social, collaborative, and relationship-centred activities of an intervention could be clearly connected to the measurement of specific social outcomes. Overall, intermediate SEL outcomes were the easiest to identify as well-connected to intervention activities.

An explicit explanation of the link between activities or intervention components and intentionally selected outcomes (both shorter and longer term) is critical and still largely missing in this literature review. However, overall this review indicates a positive shift in the implementation and study of non-specialized MHPSS programming, wherein a more holistic range of outcomes is available and used to assess impact.

OUTCOMES MEASURED

- As described in the above text box, multiple studies noted the shift away from measuring mental health outcomes in a PSS/SEL-oriented program and toward measuring social, emotional, and well-being outcomes.
- **SEL outcomes were the most measured across documents in this review.** Eighty-nine per cent of studies measured at least one SEL outcome. The outcome category with the overall highest count was social outcomes (n=27); in addition, studies measured self-perception outcomes (n=15), emotional outcomes (n=18), and cognitive outcomes (n=11).
- **Mental health outcomes were still measured with high frequency, second only to social outcomes.** Mental health outcomes (inclusive of PTSD symptoms, anxiety symptoms, and depression symptoms) were measured 21 times across all studies. This category of outcome shows the lowest percentage of positively measured impact (calculated as the number of times an outcome in that category showed positive impact, divided by the number of times that outcome category was measured). *See the text-box description of this shift on page 21.*
- **General well-being outcomes were also frequently measured (as composite outcomes) across studies.** These outcomes were comprised of composite scores measuring well-being, psychosocial well-being, or resilience and were measured 13 times across the studies. Many of these outcomes incorporate several SEL outcomes, but most often the studies do not elaborate on the makeup of these composite scores, nor which SEL skills or outcomes are included within them.
- **When composite score measurement tools were used, it was often more challenging to understand exactly what positive impact means or how to interpret the results, due to the subjective nature of well-being or resilience and how such concepts differ across contexts and age groups.**
- Assuring that the program activities can be clearly linked to aspects of any composite measurement is essential in order for results to be meaningful. It is essential for the success of programs that implementers understand how such composite tools break down, and to assure that the component parts of the tool match the program activities. In order to gain an in-depth understanding of impact (and how/why a program has accomplished such impact), more information needs to be present than a general indication of improved well-being. An example of such a broad concept – resilience – is expounded on in the text box below.

USING RESILIENCE AS A MEASURE OF IMPACT

Resilience, generally defined as the ability to adapt positively to adversity or significant sources of stress, has emerged as a popular construct in assessing the well-being of children in humanitarian contexts. Measuring resilience may offer insight into a child's capacity to cope with and bounce back from the myriad challenges inherent in such environments, which can include displacement, conflict, poverty, and lack of access to essential services. By examining resilience, implementers can better understand the factors that enable some children to thrive despite adverse circumstances, informing targeted interventions and support mechanisms. **Resilience is thus both a strengths-based concept and also one framed by a social-ecological model** – for both of these reasons it is notably appealing to organizations as a way to understand potential impacts of well-being-related programming.

However, operationalizing resilience as an assessment tool to measure impact over a short period of time (i.e., a pre-assessment, post-assessment, and six month follow-up assessment) presents significant challenges, as has been noted in resilience research and by those who have contributed to the development of key measurement tools, such as the Child and Youth Resilience Measure (Ungar & Liebenberg, 2011; 2013). The CYRM was designed as a screening tool to explore the resources (individual, relational, communal, and cultural) available to youth aged 12 to 23 that may bolster their resilience (Resilience Research Centre, n.d.).

MEASUREMENT TOOLS

- **It was challenging to ascertain whether or not the measurement tools used were the most appropriate or relevant in regard to the intervention's intended impact or identified outcomes.** It was extremely rare for a study to offer explanation for how or why a particular tool was selected; this was true for both academic articles and program evaluation or other documentation.
- **In crisis-affected contexts, a large number of MHPSS/SEL-related measures are used, such as those measuring general well-being, psychosocial well-being, and resilience.** Over 90 assessment tools that evaluated MHPSS and/or SEL utilized in conflict-affected situations were discovered in an unpublished analysis conducted by Save the Children, underscoring the wide range of tools accessible and employed by various actors. Measurement instruments like the SDQ and the International Social and Emotional Learning Assessment (ISELA) are widely utilized and have shown to be effective in a variety of crisis situations. A large number of these produce composite scores that incorporate several SEL outcomes. Some are very short, while several are long and thus take considerable time to use. Unfortunately, due to the many different ways one can measure the constructs of MHPSS/SEL, it will continue to be challenging to discern conclusions across studies.

KEY INGREDIENTS FOR PLAY-BASED PSS PROGRAMMING

- **Based on this review, five key ingredients emerged that are essential to program impact and understanding.** By referring to these considerations as "ingredients" we emphasize that the relationships amongst parts of an intervention are not necessarily linear, but instead represent pieces that are all part of an overall "recipe" that may lead to positive results. These key ingredients summarize many of the above findings, and also represent learning from RTP program document review and the expert interviews.
- **The key ingredients are elaborated on in Part 2 of this report.** Each key ingredient is essential for programs to acknowledge and understand in context; this is an important step and one that aligns with the evidence base. This means:

- Focusing on context and setting components of the intervention
- Focusing on relational and social components of the intervention
- Understanding play in context and the intentional play components of the intervention
- Understanding mental health and psychosocial well-being in context, and assuring clarity in how a program delivers PSS
- Identifying appropriate, relevant outcomes and measuring those in a way that will help the program understand its impact

PART 2:

KEY INGREDIENTS FOR PLAY-BASED MHPSS PROGRAMMING

Process for identifying the key ingredients

Drawing from initial review of the literature, we quickly observed that it was not possible to establish causal relationships, or even mechanisms that could result in impact, between play-based interventions and PSS outcomes. After conducting a thorough analysis and classification of the data, we combined our findings to create a learning matrix that outlined the key ingredients of the comprehensive body of literature. The key ingredients were developed through an iterative process by the research team, by first outlining all the characteristics of each study, including the setting and facilitation details, the social/relational and psychological components, the play-based activities, the outcomes measures, and, lastly, the results. We were then able to distill overarching key ingredient categories present across the literature base.

The purpose of this learning matrix is to serve as a list of fundamental, evidence-based components that should be considered in play-based psychosocial support programs in complex and conflict-affected settings. The learning matrix may be applied to the entire process of designing and implementing programs and can be used to not only evaluate existing programs but also as a guide to program design. The essential components for each of the five main categories are shown visually below and are then elaborated on in the subsequent sections.

Figure 6: *Key ingredient learning matrix*

The Key Ingredients

CONTEXT AND SETTING

The studied interventions were implemented in a variety of contexts and settings, from classroom delivery in school settings to community-based programming, or a combination of the two. The environment and context in which the intervention is conducted should be appropriate for the situation and should be planned to meet children, families, and other participants where they are, much like the play and PSS components of the intervention. In line with the guidelines outlined in the play section below, it is important to maintain flexibility and openness while collaborating with the community to identify the most appropriate location for the intervention that fosters psychological and emotional safety. Making the locations available, reachable, and accessible is crucial to fostering caregiver collaboration within interventions, as some interventions have indicated that caregiver engagement presents a barrier. It is additionally critical to map and be aware of the available MHPSS services in a given context and establish appropriate referral pathways to available MHPSS services.

Context and setting of delivery for the play-based mental health and psychosocial support intervention
The intervention is designed to be context-sensitive, particularly in terms of the nature and state of the crisis, and its impact on children, youth, and their families.[9]
The intervention has considered and is relevant and appropriate to the social and cultural context.
The setting of the intervention is in a safe, accessible, and relevant physical space, including for both the physical and emotional safety of children.
The physical setting of the intervention is appropriate, safe, and encouraging for play-based activities.
Appropriate referral pathways to specialized MHPSS services have been established.

RELATIONAL AND SOCIAL COMPONENTS

While all studied interventions provided some degree of focus on relational and social components amongst peers, not all of them adopted a "whole family" or "whole school" approach. A whole family or whole school approach utilizes interventions or programs that not only address the mental health and well-being of the child but also build a holistic intervention that supports and strengthens the system surrounding the child, e.g., the Garfin et al. (2014) intervention that included 15 sessions for each at-risk student (2 groups for teachers, 3 sessions for parents, and 10 for students).

In order for family-based interventions to be effective, they need to focus not only on the mental health and well-being of the child, but also on the support system surrounding the child. Family-based interventions can improve the mental health and well-being of children and caregivers as well as improving a range of family processes (Bunn et al., 2022). Adopting a whole family or whole school approach when developing and implementing play-based PSS interventions has the potential to lead to better outcomes and improve the mental health and well-being of children, but also to enhance family dynamics, communication, and overall familial relationships or teacher-and-child relationships.

Beginning at the individual level, the intervention focuses on the relational skills children must learn to keep safe and healthy relationships with trusted adults and their peers. The aim of interventions should also be to support the trusted adults who are in the child's environment in order to strengthen the systems surrounding the child, rather than to target specific populations only.

[9] Sensitivity and appropriateness to context in terms of the PSS and play components are emphasized in the subsequent, respective sections.

Relational and social component of the intervention following the socio-ecological model with the child at the centre
The intervention focuses on children building trusting, supportive relationships with adults (such as caregivers, teachers, and coaches) as a key priority.
The intervention focuses on children building supportive, positive relationships with their peers as a key priority.
Parents/caregivers are specifically engaged and involved in the intervention and are supported to strengthen attachment bonds with their children through play and nurturing care, provide positive encouragement and support to their children, teach emotion-regulation techniques, and provide psychoeducation on signs of distress.
Interventions are designed as whole family or whole school approaches to strengthen the systems surrounding the child.

PLAY

Several play categories were described in both programmatic and academic literature. Overall, there was a limited evidence base that directly connects any particular type or category of play to the range of PSS outcomes assessed in crisis-affected contexts. These findings, along with the expert interviews, support the conclusion that, in fact, the most crucial factor to take into account when determining the play component of any intervention is to **gain insight into how play naturally occurs in the context or how children with trusted adults or peers engaged in play prior to the crisis.** This necessitates working with the affected populations, remaining flexible in determining which play category – or categories – should be used in interventions and avoiding overly prescribing play. It will become more evident why a category or categories of play were selected by going through this open and flexible discovery process to create the play-based component of the intervention. In addition, it will ultimately make it easier to create a clear theory of change and assess the intervention for impact.

All categories of play can act as **an accelerator** for the delivery of psychosocial support when PSS programming is well-defined and directly linked to the program's desired results, as demonstrated by this review. Using activities and interventions that support the enhancement of psychological and social functioning through play has the potential to enhance well-being, as play is the language that children use and how they interact with the world around them.

Play components of the intervention as an accelerator for the delivery of psychosocial support
The intervention has explored and considered what play means in context, and the ways in which play is locally understood and carried out.
The intervention has specifically identified the key, priority types of play that will be included (e.g., free play, guided play, structured play, games).
The intervention has specifically identified the skills or child-level elements of play (e.g., agency, social connectedness, movement, joy/fun), with considerations for age, disability, and gender, that are prioritized for the context and the overarching intervention goals.
There is support and training to play-based approaches and play-based learning for teachers, coaches, or facilitators, including how to integrate play into other programs (including PSS) or their classrooms.
There are resources, tools, and materials to support the use of play and play-based learning for teachers, coaches, or facilitators.

PSYCHOSOCIAL SUPPORT

The humanitarian community and beyond frequently use the term "psychosocial support" to describe programming that seeks to meet the psychological and social needs of individuals, families, and communities (IFRC, 2023). Psychosocial support is a term that has multiple definitions and encompasses a wide range of components. While terminology can change based on the context and the organization, it is critical that the PSS component of an intervention is explicit, clearly defined, and elaborated on throughout the program cycle. There should be little to no difference between what is stated and what actually happens in practice by having an operational definition of PSS that is shared globally and then contextualized at the national and local levels.

Only 47% of the publications in the literature *explicitly* defined and described the PSS component when it was clearly stated that the intervention was psychosocial. There are risks to program quality and learning when an organization simply states that the program includes psychosocial support components to enhance well-being, without defining and describing the specific activities and mechanisms that make an intervention psychosocial. One notable risk is that the intervention's lack of clarity could result in programming of low quality due to lack of understanding of concepts and objectives, as well as intervention activities that are appropriately linked to them. Other concerns include the inability to both identify and measure outcomes, which can lead to the subsequent inability to use assessment data to learn from and guide future programming. Having a clear operational definition of PSS, and ensuring that all programs that include PSS are articulated and directly linked to the well-being outcomes that the program seeks, will support the ability to determine and evaluate the relationship between play-based PSS and well-being. In addition, this level of clarity will support the replication of

interventions across various contexts and settings.

Achieving buy-in and sufficient understanding from all stakeholders is crucial to the effective implementation of PSS interventions once they have been clearly established. In addition, sufficient time and funds should be allocated to professional development and capacity-building, as well as resources to support the delivery of interventions and the people providing them.

PSS components of the intervention to promote healthy development and well-being
The intervention has explored and considered what psychosocial well-being means in context, and the ways in which mental health and psychosocial support is locally understood and carried out.
There is clarity and understanding of the definitions and meaning (in context) of key terms related to PSS. This includes psychosocial well-being, psychosocial support, social emotional learning, life skills, etc.
There is clarity and understanding around what activities and components of the project are considered psychosocial support and why.
Support, training, and resources on PSS – and how it is integrated into the intervention – are provided to staff and implementers of PSS activities.
There is adequate time and investment in professional development and the resources, tools, and materials to support the implementation of PSS activities and approaches by teachers, coaches, and facilitators. Administrators encourage the delivery of PSS interventions in learning environments as part of the curriculum.
Every intervention or program incorporates considerations and resources to promote and protect the mental health and well-being of teachers, coaches, and facilitators.

PSS OUTCOMES

By explicitly outlining both the PSS and play components – via a clear theory of change for the intervention – the decision-making process around what is being measured and why can be more clearly defined and understood. It is essential that this includes details about the relationships between different outcomes and emphasizes intermediate and longer-term outcomes (as well as how and which intermediate outcomes may lead to impact on longer-term outcomes).

There is a diversity of PSS outcomes measured across the literature – as well as ways to measure them – and it is thus critical to choose outcomes that are in alignment with program activities.

In this review, it was challenging to ascertain whether or not the measurement tools used were the most appropriate or relevant in regard to the intervention's intended impact or identified outcomes. There were also a large number of measurement tools used (n=46),

with very few tools being used across multiple studies. In recent years, there has been a boom in the development and sharing of MHPSS tools.[10] While such a resource has encouraged the sharing and explanation of tools used across the program cycle, from rapid needs assessments to psychometric testing data, it remains unclear in much of the documentation how and why tools are selected. Importantly, it was noted in interviews that often the selection of indicators, outcomes, and the tools to measure them are dictated by donors. This is an important acknowledgement for all stakeholders; donor-level desire for program-level measures to be evidence-based must coexist with adaptability and flexibility for implementers to make contextually relevant choices on the ground.

PSS outcomes to measure impact and intervention effectiveness
The intervention has explored and identified the relevant psychosocial outcomes for the context and program, and assures that such outcomes are related and relevant to the activities.
There is clarity of short-term, medium-term, and long-term outcomes and how these relate to and/or impact each other.
The measurement tools used to monitor project outcomes are appropriate and relevant to the intended outcomes and impact desired, as well as to the context. The justification for determining which measurement tool to use is clearly outlined and aligned with the theory of change.
The measurement tools used to monitor project outcomes are child-friendly and utilize playful and participatory approaches.
The processes for monitoring impact employ multiple methods in order to assure that in-depth understanding of impact from multiple actors can be assessed (i.e., the intervention values both quantitative and qualitative methods of data collection in order to contribute to learning).
Children's inputs and perceptions of the program should be prioritized and centred in assessing the relevance of outcomes and the project impacts overall.

[10] See, for example, the INEE Measurement Library: https://inee.org/measurement-library.

PART 3:
KEY ACTIONS AND FUTURE OPPORTUNITIES

PROGRAM COMPONENTS AND THEORY OF CHANGE

1. **Implementing organizations should be intentional in investing in context-specific understanding of play in the locations of interventions.** This includes increased emphasis on defining local approaches and understandings of play and its perceived benefits. A potential pathway to such understanding could be a "play in context assessment" prior to the design of an intervention. The purpose of such an assessment is to learn what play happens naturally and how that can be built upon to accelerate PSS impacts.
2. Implementing organizations should be explicit in **defining the PSS components of an intervention and developing resources, materials, trainings, and other avenues of support so that implementing team members are fully capacitated to deliver programming.** Like play, PSS components should be fully explored and understood for the context of the intervention.
3. **Projects should produce an explicit, context-relevant theory of change for all play- based PSS programs.** The theory of change should define the linkages between both play and PSS components vis-à-vis achieving intended outcomes, including by clarifying which core components are theorized to directly contribute to which set of outcomes.
4. **Theory of change – at both the global and the program level – should be tested and iterated in order to improve programming and understand what works.** The best TOCs are dynamic and are designed to incorporate organizational learning via feedback. This process of iterating and adapting a theory of change should be built into the implementation strategy, with specific avenues for feedback specified.

For guidance on building theory of change, especially in the case of complex programming, see the following resources:

- Guiding your program to build a theory of change
- Theory of change for complex mental health interventions: 10 lessons from the programme for improving mental healthcare
- Complexity (as related to theory of change)

5. **Global-level organizations (and specifically those that implement programs in multiple countries) should develop guidance materials** for the

contextualization of all global-level generated materials (such as an overarching MHPSS strategy) and provide facilitated support to implementation teams in order to assure PSS strategy, theory of change, and resources/materials can be effectively contextualized.

For a collection or resources related to contextualization of MHPSS and SEL approaches, see the following: https://inee.org/pss-sel-toolbox.

MHPSS OUTCOMES AND TOOLS

6. **At the implementation level, programs should identify appropriate MHPSS outcomes for the intervention, and assure that these outcomes are aligned to program activities.** The relationship between activities/approach and outcomes should be understood via the IASC intervention pyramid for MHPSS. For example, programs that do not provide targeted, specialized mental health support should not solely measure mental health outcomes.

7. In this review, it was common for longer-term or composite outcomes such as psychosocial wellbeing or resilience to have several SEL outcomes or concepts integrated within them**. It is necessary to better define (or at least theorize) the linkages between SEL outcomes that an intervention aims to achieve and the higher-level, longer-term impacts.** Appropriate tools should be selected to measure both short- and long-term outcomes.

8. **Programs should adapt measurement approaches and, with it, measurement tools to support the measurement of contextually defined outcomes.** While tested and validated tools can be supportive, they might not always present the most accurate measures for particular outcomes in specific contexts. The selection of tools should match the clear and elaborate definition of outcomes to be measured.

9. **There is a need for streamlined guidance on selection and use of measurement tools for MHPSS outcomes.** This is specifically true for both organizations and programs as well as for stakeholders working in this space more broadly. Organizations and researchers should provide explanation and rationale for use of certain measurement tools; this should apply to both evaluations and research broadly.

RESEARCH AND EVIDENCE

10. **There should be continued investment in research and rigorous evaluation that will contribute to a growing evidence base on play-based MHPSS programming.** While there is notable evidence of positive impact, there is still considerable need to grow this evidence base in terms of better understanding what works, why, and for who. All actors in this space—implementers, researchers, donors—should acknowledge that evidence production is a long-term commitment and this is still a nascent field of research in conflict affected settings.

11. Stakeholders should commit to investing in understanding the impacts of play and PSS programming in the long term. This means **designing and committing longer term funding to longitudinal studies.** Despite the resource-heaviness of such studies, they can provide essential insights into the true long-term effects of interventions on children's lives, a key limitation that reviewed studies

could not conclusively determine due to their short implementation duration.

12. Mixed methods should be prioritized and, in particular, investment should be made in qualitative studies that can contribute to more in-depth and contextually-aware understanding of the perspectives of children, caregivers, teachers, community members, and other stakeholders. **Organizations and researchers should ensure stronger focus on child-centered, locally-led, and participatory approaches to data collection.**

13. Disseminate organizational knowledge and insights by making learning initiatives and research open source and accessible to both global and country level researchers and practitioners, to contribute to the sharing of knowledge and creation of global goods. **We encourage the continued and increased publishing and sharing of such learnings with the wider community via existing fora and platforms.**

CROSS-SECTORAL COLLABORATION AND CONVENING ACTORS

14. **There is notable need for cross-sectoral collaboration to better understand how play-based MHPSS interventions can be most impactful and effective in context.** The evidence base described here is still nascent, and thus terms, concepts, and approaches are diverse and often difficult to compare. Due to this, it is challenging to effectively learn from findings from programming that has been siloed in, for example, education, health, and protection sectors. As has been noted throughout this report, MHPSS programming across sectors will benefit hugely from more explicitly defined components, as well as organizational commitment to examining, testing, and refining how they hypothesize those components to create positive impact.

15. **Increased collaboration across organizations in order to share learning, evidence and global goods is critical.** While calls for such collaboration have existed for years—and are in some ways exemplified via various networks, working groups, and communities of practice—there is still notable lack of open-source approaches, manuals, evaluations, and research conducted by organizations. This was underlined in our own efforts to acquire evaluations and other grey literature for review; we were ultimately reliant on personal networks and relationships to acquire material. There continues to exist a culture of proprietary knowledge in the humanitarian space, which ultimately stimies or significantly slows efforts to learn from practice and improve programming.

16. **Convene organizations and actors that share common objectives in order to galvanize increased support to play-based MHPSS programming.** This can foster greater sense of collaboration versus competition; offer opportunities to share and learn from experiences and organization-based evidence; and ultimately hone in on common messaging and calls to action relevant to implementation, funding, and advocacy and policy making.

17. **Growing participation in such spaces should prioritize inclusion of actors from all levels of humanitarian-development ecosystem, including those closest to implementation such as teachers, caregivers, and young**

people. Efforts should be made to adopt more participatory and action-oriented approach to data collection and research, but additionally these actors should be further included in dissemination of learning, as well as development and iteration of program design and approaches both in context and at the global level.

18. The language used by those in the fields of health, education, child protection, etc. has changed over the past several years. The language used no longer equates mental health solely with the health sector and psychosocial support with child protection, education, etc. Historically, these disciplines were separate fields of work, lacking in collaboration and coordination. Instead of using merely PSS when describing programs, i**t is advised to use the composite term mental health and psychosocial support and indicate which layer(s) of IASC MHPSS pyramid the intervention covers and how it fits into the larger MHPSS system.** This will help to provide clarity and be more precise about what PSS entails in practice and denote the multi-sectoral nature of interventions.

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