“You have to be more flexible in adapting and adjusting to a changing context”: Mark Jordans of War Child on evidence-based practices supporting youth affected by armed conflict

Rollo Romig
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Rollo Romig: Could you introduce yourself and tell me about your work?

Mark Jordans: My name is Mark Jordans. I'm the director of the Research & Development Department at War Child. Affiliated to that, I'm a professor in global mental health at the University of Amsterdam. Independent of War Child, I'm a professor in global mental health at King's College London.

All of that focuses specifically around children, adolescents, and youth mental health in lower-middle-income countries, but specifically in conflict settings.

My research team functions as a research center, as a university would, but within an NGO. It bridges the divide between practice and academia — researching the answers to the questions that come from our practice, but equally having the research that we conduct translated back into practice.

Rollo Romig: Can you give me an example of how that interplay happens?

Mark Jordans: The bigger picture is what an organization such as War Child does to move towards evidence-based practice. The way we're doing that is by identifying the

gaps in the current offerings for youth affected by armed conflict, for which there's no service offer yet. For that, we enter into a long-term trajectory of development, co-designing, field testing, feasibility testing, adaptation, all the way up to effectiveness research, in order to then scale up those evidence-based services.

The research and development team is mandated within the organization to develop a suite of interventions, including psychological, and education and child protection interventions that form a system of care offered to youth and children as well as their caregivers, schools, and communities affected by armed conflict.

We don't have, at the moment, a good solution for youth between 15 and 25. All the mental health interventions that are out there are either targeting children and adolescents, up to 18, or as adults, as 18 and above. What we found out to be quite a gap is an intervention that improves and focuses on the mental health of the group that is specifically between 15 and 24, where we know there's a lot of social role transition, and a lot of biological changes happening. It's often a period where you see the highest onset of psychological problems and mental health conditions.

That gap was identified from our practice in the field. Then we go through a process of iterative stages of development and research, all the way towards evidence-based care.

Rollo Romig: You learned through your work in the field that this kind of categorizing—under 18 as a minor, and 18 and older as an adult—doesn't fit the problem helpfully.

Mark Jordans: Not for the group that is in that age group of 15 to 24. Sure, some of that gets captured in the adolescent work, and some of it gets captured in the adult work, but not distinctively in that age category of 15 to 24.

Rollo Romig: Tell me more about what makes that particular group distinct. What did you learn in the field? What are the interventions that you've started to find are most helpful for that age group?

Mark Jordans: First, we know now that neurological changes are happening all the way up to early 20s. It's called the second window of neurological development. Second of all, we have global data about when we see the highest prevalence of mental health conditions. That often falls in that age bracket.

The third thing that we see a lot, and especially in the countries where we're working, is that all of a sudden people are going through a lot of social role transitions. They're being asked to take on a lot of responsibilities — familial responsibilities, income-generating responsibilities, marriage responsibilities, and caretaking responsibilities.

The confluence of these factors make this quite a specific age group for mental health.

We start with a systematic review of the literature. What is known about this age group specifically and what gets done already? Then we go into formative research. We go

and work with people between 15 and 24 years old in conflict-affected settings, so in Ukraine, in Colombia, in Syria, in Jordan, and say, “What are your needs? What are your mental health issues? What are the main issues?”

Then, further down the line, we go into more formal evaluations. We’re going towards effectiveness evaluation so that we can demonstrate whether that intervention is effective in improving the mental health of this age group.

Rollo Romig: Is it challenging to get that information from young people about what their problems are? Does that differ from place to place — the challenges and willingness to talk about this stuff?

Mark Jordans: There are two answers to that. One is that we find a lot of youth are eager to talk about it, especially once they're into the conversation. They're motivated to share experiences and they have good ideas about how to address it.

We also see there is still a stigma attached to mental health and mental health conditions in the countries where we're working. That's something we need to be aware of in order to get people to commit and discuss. Once they do, there's definitely an eagerness to do so.

Rollo Romig: The Co-Lab defines three focus areas that it works in: building young people's resilience, giving young people agency, and helping them build a sense of community and belonging. How do you feel like your work fits into those categories, or do you even think of it in those ways?

Mark Jordans: The work that we're doing more broadly touches on these topics. Our theory of change outlines how the work we're doing ultimately leads to change in youth in the countries where we're working. An improved well-being and resilience is at the top of that theory of change.

We know from the literature that there's about five times as much risk of mental health conditions and mental health problems in conflict-affected areas versus the global average. To do anything possible to boost or to buffer against that risk and to increase their resilience is especially important in the context where we are working.

The way we go about it is by addressing mental health head-on by interventions that improve mental health. We do mental health promotion work as well as treatment work. It's not just focusing on those that are having mental health problems, but also on preventing youth from developing the problems and focusing on the positive aspects of their mental health.

We do that by dealing with some of the social determinants of their mental health, so looking at their education setup or the future opportunities.

Rollo Romig: Tell me a little bit more about the promotion part of it. You mentioned education, employment. How does that work?

Mark Jordans: One thing that we have developed and tested is an educational technology intervention. It's essentially offering education on a tablet. This is for the younger children. It's game-based education focusing on foundational numeracy and literacy skills following the national curriculum, whether it's in South Sudan, Ukraine, or Uganda.

We make sure that children get the education that they need and deserve, even in a context where that is disrupted or of very poor quality because of conflict.

Another example is an intervention called TeamUp. It's a likable intervention because it's working with games, movements, and play-based activities in order to improve the psychosocial well-being of children from 6 to 16 or 17.

That's an intervention we're rolling out now in 26 countries, but started off with just developing from scratch and evaluating it. It's an intervention that focuses on the positive aspects of mental health.

Rollo Romig: You mentioned games in both of those examples. What have you learned about the use of games in this context, and why do you think games are effective?

Mark Jordans: Why it works and why it's so powerful is because starting off from the beginning, children like it. Whereas with other interventions, you need to first get them engaged.

The second element is that you're packing your content into the games. The game itself is not necessarily the key ingredient, but within the game is your medicine. It's a fantastic vehicle to bring intervention content to children.

Rollo Romig: If you're telling someone about the work that you do, what's an aspect of it that's most likely to be unexpected to people?

Mark Jordans: I often start off by saying that the majority of the work that the humanitarian sector is doing is not evidence-based. There's an enormous amount of goodwill, motivation, and hard work.

However, we owe it to children, in our case, but everywhere else, to make sure that humanitarian aid is as evidence-based as we expect it to be here in the Netherlands, in the UK, the US, or wherever.

When I talk about the work that we do, or the organization I work for, the immediate connotation is that everybody is traumatized in the context where we work. That's not the case.

In fact, a lot of children, a lot of adults, a lot of people, in the most difficult context, are able to be resilient with or without outside support. Sure, there are people that are heavily traumatized. There's people that are having severe difficulties in coping, but

there's also a very large group that does manage to do so even in the most difficult of contexts.

Rollo Romig: When it comes to collecting this important evidence, what are some of the biggest challenges, especially in these situations where you're working? Are there particular kinds of evidence that are especially difficult to get?

Mark Jordans: The most simple one is that these are all contexts of high volatility. You have to be more flexible in adapting and adjusting to a changing context.

The second challenge is to make sure that the way we do research fits and is respectful and adapted to the cultural context where we're doing the research. I'm calling in from Amsterdam, but I'm not doing the research in South Sudan; it's my colleagues in South Sudan that are doing that research. They're running the intervention and they're collecting data, so it's done by people in the countries where we work. A lot of preparatory work goes into making sure that the methods are adapted to the cultural context where we're working.

Rollo Romig: Can you give an example of a particular adjustment that you've made to help fit a particular cultural context?

Mark Jordans: We use quite a lot of surveys and survey questionnaires in order to test if there is a change before or after on things like wellbeing or hope or social connectedness or agency. Often, you use instruments that are already available, but they're in English and they use terminologies that are not relevant in a new cultural context.

For example, you could easily find an instrument that measures depression or depressive symptoms, and it will ask a question like, "How much have you been feeling blue in the last two weeks?" That does not make sense in any other context.

We go through a rigorous process of translating, back translating, interviewing, testing, practicing in order to get the language right or the terms right. Sometimes, even developing new tools specifically for that context in order to deal with that issue.

Rollo Romig: Is there an example of something that you tried, it didn't work, but you learned from it?

Mark Jordans: I'm happy to share that. When I started off the research work in War Child, there was a life skills intervention that was the flagship intervention of the organization, but it had never been evaluated scientifically.

I thought, "That's low-hanging fruit. I'm starting my research work in this new organization and this new department by evaluating this existing life skills intervention."

Only to find out, after doing a full study, that it had no effect at all compared to a control group. This was a big surprise. We did a replication, different context, same intervention. Again, no results, no improvement compared to the control group. Two

controlled studies showing no results compared to a control group of this flagship intervention.

Basically, we've been implementing an intervention that people like and people are excited about, but we cannot demonstrate its effectiveness. Then, you need to say, “We have to stop. We have to pull the plug on this intervention.”

That's a big lesson. That's a big change.

Rollo Romig: It sounds like one of the lessons from that is that just because people like something, that's not evidence that it works.

Mark Jordans: Exactly. That's it.

Rollo Romig: If you were talking to someone from another organization that wanted to do similar work, what's a key piece of advice that you would give them for how to approach it?

Mark Jordans: I would say make sure that your programs or interventions are evidence-based. The second piece is the quality of services. Even if something is evidence-based, the true impact that we have on the lives of youth only is determined by how well a particular service is offered. There's not a lot of focus on quality in our sector.

If the interventions are out there because they're evidence-based and they're good interventions, they're only as good as they're being implemented at scale.

For example, if we have an intervention that has seven sessions for children that have depression and anxiety problems, and we have this solution called EASE that we worked on with the World Health Organization. It's evidence-based. We've proven that it works. However, if children only come to, on average, two out of those seven sessions, we're never going to have the effect. It's as simple as that. Attendance becomes a very important tracker. Second of all, if the service provider is not doing what is in the protocol, we're not quite sure if quality is sufficient. The third issue is what are the basic foundational helping skills and competencies that a service provider has? They might be doing harm by just not being good at those foundational helping skills.

Those are three ways by which we have developed tools to track whether the quality of any intervention is good, even if implemented at scale.

Rollo Romig: Are there frameworks that you've developed that could be shared and applied so that other organizations could profitably apply them to their work?

Mark Jordans: Because we invested so much in the last 10 years in developing these new interventions and solutions, we want to make them available to other organizations. A number of our interventions have been taken up by organizations that are much larger than us — Save the Children, SOS Children's Village, UNICEF, but also many smaller

organizations are adopting some of the interventions that we've developed, and thereby, are reaching many more children.

We've also worked with the World Health Organization to get a number of our products into their normative work.

There's also a translation back from low-income countries or lower-middle-income countries to high-income countries. There's solutions and interventions that have been developed in low-resource settings that are quite scalable to use in high-income settings where there's high levels of waiting lists, there's high levels of asylum seekers and refugees for whom it might be equally relevant.

Rollo Romig: What are some other ways that you find it fruitful to collaborate or connect with other organizations?

Mark Jordans: I love collaboration. Almost all of the work that we do is in collaboration with other organizations. What stands out for me is partnerships with other large humanitarian organizations.

Academia is good at collaborating, at least in global mental health. There's a number of research institutes all over the world focusing on global mental health that collaborate well together in developing interventions, testing interventions, implementation, and science questions.

It's commonly accepted by everybody that a treatment approach alone is not enough. We need to also be in the more preventive aspects of the work. How do we prevent people from getting depressed, rather than just treating depression when it occurs?

One of those ways of doing that is a collaboration that we have between King's College London, and a collective of partners to tackle this problem.

By combining poverty reduction interventions with a mental health intervention, we're designing a way to see whether a combined economic and mental health intervention is more powerful in preventing depression.

That's tackling a big problem because we're talking about trying to see if we can prevent depression, especially in areas of high poverty, where we know depression is very high. We're doing that by a large group of interdisciplinary collaborators. We've got economists, anthropologists, and psychologists coming to try to tackle that big issue.

Rollo Romig: You mentioned there are some misconceptions around the mental health problems that young people might be experiencing in conflict areas, the assumption that everyone's traumatized. Do you think that attitudes or understandings of mental health problems in these contexts have improved over time?

Mark Jordans: It's definitely much more part of the discourse at the moment than it was many years ago.

Rollo Romig: What do you think prompted the change that has happened? What do you think is needed to keep moving forward that change that needs to happen?

Mark Jordans: It is up to governments to start adopting more, not just mental health policies, but also putting the resources to address it. That also means addressing some of the determinants of mental health.

It's again, not just treatments or psychiatric services, but also prevention and mental health promotion work.

Rollo Romig: Why do you think mental health is so under-resourced? When you know the data, you know its impacts on livelihood, that it's a great investment — why do you think that investment is not happening?

Mark Jordans: It's a number of factors. The data is there, but we know that it takes a long time for research and data to translate into policy. In countries like Nepal, Syria, Columbia, there are very tight budgets, so it's also a competition of resources.

And there is still a stigma attached to addressing mental health, more so than maybe other areas of investment or health in general.

Finally, there's still a large amount of unawareness. Even though I'm saying there's an increase in awareness on the importance of mental health, we're not even close to having enough awareness amongst policymakers about the importance of mental health and mental health at the population level.

Rollo Romig: Is there anything that you'd like to add that we haven't mentioned?

Mark Jordans: Part of our Co-Lab work is stretching the boundaries of what is needed to improve the mental health of youth. That includes looking at reducing the risk of child maltreatment and child neglect, and looking at more child protection services as part of an avenue to improve mental health.

Rollo Romig: Thank you so much for your time.

Rollo Romig is the manager of Solutions Insights Lab. He is the author of I Am on the Hit List: A Journalist's Murder and the Rise of Autocracy in India, which was named a finalist for the Pulitzer Prize.

** This interview has been edited and condensed.*