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PSYCHOSOCIAL SUPPORT AS THE MOST CROSS-CUTTING INTERVENTION: IMPACT ON MENTAL WELL-BEING AND SOCIAL INTEGRATION OF AFGHAN REFUGEES

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Abstract

Afghan refugees in Balochistan, Pakistan, suffer from long-term displacement, social, economic, legal, and service access issues that can have an impact on their psychological health and relationship with host communities. This article explores the potential for psychosocial support as a cross-cutting element of social protection, and its statistical association with reported mental health change and perceived social integration. It is based on the survey analysis, with 300 respondents and a hierarchical regression analysis to compare psychosocial support with other types of support. Both psychosocial support (β = .21, p = .002) and support frequency (β = .11, p = .03) were significant in the final mental-health model. Psychosocial support (β = .18, p = .006) and support frequency (β = .12, p = .04) were also important for perceived integration. The final models accounted for 9.9% of the variance in mental health change and 8.4% of the variance in integration feelings. These results suggest that psychosocial support is important for both emotional and relational outcomes and that the limited explanatory power suggests that more general structural factors are relevant. The research designates some parts of its qualitative NVivo output as simulated, and thereby simulated qualitative frequencies are not considered here as empirical findings. The article suggests that continuous culturally responsive supports are needed as part of regular services and are clearly assessed over time.

INTRODUCTION

The displacement of Afghans into Pakistan has been ongoing for decades and has been influenced by conflicts and political instability or shifts in the safety environment in Afghanistan. The refugees in Balochistan are especially vulnerable due to many communities that have limited infrastructure, poverty, and limited access to public services and competition over scarce resources. These factors affect not only material security but also emotional health, the capacity to build secure social connections in families and communities, and access to services. Studies of Afghan refugee mental health have identified pre-migration experiences

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and post-migration stressors as related to mental health problems, rather than as discrete individual issues, and have emphasized the need to view psychological issues in relation to the social environment (Andisha & Lueger-Schuster, 2024).

Social protection programs typically package together cash transfers, food, social protection services (such as healthcare and education), livelihood support, and other interventions designed to reduce vulnerability. While all types of assistance can serve a different need, providing material assistance does not necessarily alleviate trauma, distress, loneliness or diminished confidence in approaching host-community institutions. Psychosocial support can be particularly relevant as it can include counseling, emotional support, case management, peer activities and community involvement. Afghan mental health research and culturally adapted interventions highlight the need for culturally and linguistically appropriate approaches that consider social norms, trust, and local understandings of distress (Alemi et al., 2023; Hosseini et al., 2024). The focus isn't on whether psychosocial services are a substitute for economic aid, but whether they complement services that do not directly target economic outcomes.

Social integration is more complicated than access to a school, clinic, or cash-transfer scheme. It encompasses perceived belonging, day-to-day social relations, trust, and the degree to which host communities accept displaced individuals. For Afghan refugees in Pakistan, challenges can arise such as legal status insecurity, lack of access to formal opportunities, discrimination, and challenges in accessing services. Research on social integration and cultural adaptation highlights the interconnection between legal, social, and economic conditions, and how refugees build relationships and engage with their host communities (Humayun et al., 2023). Community-based social protection also indicates that social relations and social connection matter beyond service coverage and immediate material benefits when assessing refugee well-being (James, 2021). Therefore, the relationship between psychosocial support and perceived integration is a critical issue in Balochistan.

The second aim is to analyze the impact of social protection initiatives for Afghan refugees, which this article focuses on. It narrows this goal to two interrelated outcomes, reported mental health change and perceived social integration, and examines the relationship between psychosocial support and both outcomes after accounting for other types of support and selected demographic characteristics. The article presents statistical data from a survey of 300 respondents and situates the results within the existing literature. The interpretation is still conservative: the results of the regression analyses suggest predictive relationships but not evidence that the psychosocial support led to the results. This difference matters because the models explain only a small proportion of the variance, meaning legal, economic, social, and service-system context can influence refugees' experiences.

Research objectives

- To examine the relationship between psychosocial support, reported mental health change and perceived social integration among Afghan refugees in Balochistan, Pakistan.

Research questions

- How is perceived psychosocial support associated with reported mental health change among Afghan refugees?
- What relationship exists between psychosocial support and perceived social integration?
- How does support frequency relate to the two outcomes after other measured factors are considered?

Literature Review

Psychosocial well-being among forcibly displaced people is influenced by traumatic experiences, present-day stressors, and access to supportive relationships. Afghan refugees can have distress related to conflict and loss and are also facing uncertainty regarding safety, housing, employment, documentation, and the future. Afghan refugee mental health is explored in relation to pre-migration differences and post-migration stressors by Andisha and Lueger-Schuster (2024). Additionally, long-term and multidimensional

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psychosocial needs have been highlighted in research on mental health in Afghanistan, necessitating interventions modified to local contexts and available resources (Alemi et al., 2023). In addition, there is evidence of common mental health issues among Syrian and Afghan refugees in Türkiye that indicates that distress and the factors associated with it are a concern in refugee-hosting settings (Kurt et al., 2022). Therefore, mental health needs to be measured as a valid social-protection indicator, not taken for granted as a result of food, cash, or physical health care.

Evidence related to refugee mental health issues also highlights the importance of acceptability and cultural adaptation. Hosseini et al. (2024) provide an overview of evidence-based mental health interventions for Afghan refugees and explore cultural adaptation. Rosenberg et al. (2024) discuss factors that influence implementation of a preventive mental-health and wellness intervention with Afghan refugee families, and Versteele et al. (2024) highlight collaborative strategies for enhancing access to and acceptability of mental healthcare for young Afghans. Together, these help focus attention on service design, trusted relationships, and the views of refugee communities. They are not meant to suggest that any one delivery model is applicable to all groups. Instead, when planning interventions, consider confidentiality, communication, gender-related issues, youth participation, and practical issues that affect access to and continued use of services.

Factors beyond clinical availability can limit access to mental health support. Reihani et al. (2021) highlight the practical and institutional experiences of recently resettled Afghan refugees and identify barriers and facilitators to their access to health services. Stigma can inhibit disclosures of distress, and travel expenses, language barriers, family responsibilities, lack of privacy, and fear of judgment can limit service uptake in refugee contexts. Gender norms and mobility constraints could also create additional challenges for women and young people. The following issues are pertinent in Balochistan: legal uncertainty and geographic and socioeconomic marginalization of Afghan refugee communities. A responsive psychosocial approach requires accessible places, confidential referral systems, appropriate communication and trust-building, and an awareness that some barriers may stem from policy or resource constraints beyond any individual service provider's control.

Social integration can be considered structural or relational. Access to education, healthcare, and livelihoods offers practical opportunities for participation, while perceived belonging depends on feeling accepted, having supportive relationships, and opportunities for mutual interaction. Humayun et al. (2023) examined the socio-legal and socio-economic aspects of Afghan refugees' social integration and cultural adaptation in Pakistan. Community-based social protection interventions for asylum seekers and refugees in the United Kingdom support well-being, as James (2021) notes. A systematic review by Villalonga-Olives et al. (2022) explores social-capital-based mental-health interventions for refugees, further supporting the importance of social connection for psychological support. These studies view integration as a process rather than a product and consider the link between psychosocial services and refugees' perceptions of inclusion.

There is also evidence in the literature that the effect of the intervention should be considered within the context of the type of outcome assessed. Material support can directly address immediate household needs, formal health care can address physical health needs, and educational support can help maintain learning. Psychosocial support, on the other hand, may relate more to emotional coping, supportive relationships, and confidence in community participation. This is important because a program can be beneficial but not necessarily show the same effect in all domains. It also warns against ordering interventions based on a single measure of overall effectiveness when services are modified to meet different needs and outcome measures reflect different dimensions of wellbeing.

The study's conceptual argument is that psychosocial support can affect two outcome domains: mental health and perceived social integration. Refugees may benefit from counseling and emotional support to help them deal with

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distress, and group or community-based contact can offer opportunities to feel connected and belong. Support frequency is considered alongside the effectiveness of psychosocial services, as repeated contact can support continuity, familiarity, and opportunities to build trust. Legal uncertainty, poverty, stigma and gender-related barriers are considered as contextual factors that can affect access to support and the effects of support services. This framework does not imply that all of the pathways proposed were measured directly. Rather, it identifies the relationships being tested through the regression models, and offers a modest lens of interpretation for the coefficients and their limited explanatory power.

Evidence syntheses will be used to situate the Balochistan evidence in broader evidence on psychosocial interventions for displaced populations. Turrini et al. (2025) conducted a comparative study on the efficacy and acceptability of psychosocial interventions for post-traumatic stress disorder (PTSD), depression and anxiety among asylum seekers, refugees and other migrant groups. This is relevant because this work assesses interventions for specific psychological outcomes, not the service contact itself as an indicator of recovery. Nevertheless, results from other populations and intervention models should not be blindly applied to Afghan refugees in Balochistan without considering the local context, service availability, and cultural meaning. This article does not attempt to prove results, but to justify its focus on mental well-being. It also emphasizes the importance of distinguishing between changes perceived in surveys and clinical diagnosis or experimentally proven treatment effects.

Social support accounts for the fact that psychosocial services could be relevant to mental health and integration at the same time. Wachter et al. (2022) reviewed the social-support literature among refugees in resettlement and noted the need to clearly define and measure social support. Support may be emotional reassurance, information, practical support, and reliable relationships with people or institutions. Villalonga-Olives et al. (2022) reviewed mental-health interventions based on social capital for refugees, highlighting community connections as a component of psychosocial responses. Psychosocial support should not be seen as a one-on-one, formal counseling service. When safe and acceptable to the participants, peer groups, community activities, and ongoing case-worker relationships may also be relevant. The Balochistan results on support frequency support considering access and continuity, as well as perceived effectiveness, in service planning.

Displacement can also bring specific difficulties for young refugees, such as the disruption of education, peer relationships, and family routines and expectations about the future. Consistent with the idea that youth should be active in programs, not just vulnerable recipients, Abdi et al. (2023) discussed strategies to encourage positive development among refugee adolescents. In the Afghan context, Versteele et al. (2024) examined a joint effort to improve access to and acceptance of mental-health care among refugee youth. These research studies highlight the link between program design and youth receptivity to services. Adolescents' perceptions of psychosocial support as safe and useful may be shaped by confidentiality, respectful communication, participation, and connections to trusted community settings. Support for youth in Balochistan should be part of a comprehensive mental health and social engagement strategy.

Gender is important for access, acceptability, and outcomes of programs. The needs of asylum-seeking and refugee women may be influenced by pregnancy, family responsibilities, isolation, and challenges accessing services, and Balaam et al. (2022) conducted a review of perinatal social-support interventions. The research also cites studies on the social and economic constraints of Afghan refugee female-headed households in Balochistan (Kakar et al., 2022) and gender dynamics in refugee communities in Pakistan (Ismail et al., 2025). This literature indicates that, in theory, a service can be offered but may not be available in practice if transport, mobility, childcare, language, or social expectations create unmet needs. Practical arrangements are needed to ensure that women can participate without violating

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confidentiality and safety, and that their psychosocial support needs are addressed. Outreach, referral, scheduling, and monitoring should be gender-responsive from the start.

The context in which distress is experienced also matters. Lavdas et al. (2023) examined Afghan refugees' understanding of depression in camps in Northern Greece under challenging living conditions. Their work suggests that emotional distress is read in a specific social and material context. Similarly, Andisha and Lueger-Schuster (2024) separate pre-migration differences and post-migration stressors in their study of mental health among Afghan refugees. These views warn against simplifying the distress to one trigger and suggest that counseling cannot solve distress if the uncertainty, poverty, insecurity, or discrimination persists. They also recommend that providers seek to understand the challenges participants face and what they are looking for in terms of support. Psycho-social support should not be viewed as a clinical response, but as a response to living conditions and institutional constraints, since this is a situation in Balochistan that is not unique.

Research on integration indicates that outcomes are shaped by opportunities in the host environment and refugees' abilities. Phillimore (2021) recommends exploring the opportunity structures that influence refugee integration, rather than focusing solely on refugees, and instead focusing on the institutions and social contexts that surround them. Phillimore et al. (2021) examine the relationship between economic autonomy and social relations in integration programs. This matters because belonging can be shaped by community acceptance, access to services, meaningful relationship-building opportunities, and participation. Burchi et al. (2022) explore the link between social protection and social cohesion, highlighting the importance of considering how social protection programs affect broader community dynamics. While psychosocial services can help connect people to the social world, they cannot remove legal restrictions, discrimination, or material scarcity. They should be apparent in analysis and policy recommendations as external conditions.

Finally, the organization and measurement of social protection remain issues. Boenigk et al. (2021) suggest a transformative refugee service-experience framework that accounts for the dynamics among people, service systems, and public policy. Zaman et al. (2023) call for a more comprehensive understanding of refugee social protection beyond a rights-based approach, focusing on how systems function. These views reflect a theory-of-change approach: an intervention should include the services provided, mechanisms of change, measured outcomes, and contextual assumptions that can facilitate or impede outcomes. For psychosocial support, counseling, or group activities, it is relevant to link to objectives such as improved perceived mental health, continuity of care, or an increased sense of belonging. Evaluation should consider not just the number of activities, but also implementation, accessibility, and quality. This is especially relevant to the broader framework.

Research Methodology

The research used a mixed-methods approach, including a quantitative survey of 300 Afghan refugee respondents in Balochistan and a qualitative component described as interviews and focus-group discussions. The quantitative regression results then serve as the main empirical evidence for this focused article, including the sample size, model statistics, and coefficients for mental health change and integration feelings. Therefore, the frequencies of those qualitative codes cannot be interpreted as confirmed observations or as a confirmation of the statistical results reported in this article. The article does not present simulated coding as field evidence, but instead reports contextual issues. The underlying qualitative transcripts and analysis records should be verified before being published.

The survey analysis used 300 valid responses, and we analyzed social-protection effectiveness variables across cash, healthcare, education, vocational, food, and psychosocial support. Mental health change and perceived integration were analyzed as independent variables. Demographic controls (gender, age and employment status) were entered first in the hierarchical regression procedure, followed by the six variables of social protection,

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and finally support frequency and overall perceived impact. This sequence tested whether psychosocial support was statistically associated with each outcome after accounting for the other predictors. The final and intermediate values provided include standardized coefficients, p-values, model F statistics, and variance explained. It does not provide new estimates or make inferences about unreported confidence intervals, effect sizes, or individual-level outcomes.

The statistical results were read as associations in the sample observed and not as estimates of causality. The researcher screened regression assumptions, including residual normality, homoscedasticity, independence of errors, multicollinearity, and influential cases, and dropped no cases from the quantitative regression analysis. The article reports on the model statistics presented and acknowledges that the R-squared values of the models are relatively low. The article does not state random assignment, longitudinal follow-up, or experimental intervention. The limits are relevant when discussing the language of 'impact': the available results support language of prediction and association but cannot confirm that psychosocial support alone caused the observed changes.

The study was conducted in the Afghan refugee communities in Balochistan in both camp and urban-settlement settings. The methodology highlighted random sampling for the quantitative survey and purposive sampling for qualitative survey participants, focusing on individuals with personal experience with social-protection programs and stakeholders in service delivery. The article has used the quantitative sample reported in the results (300 valid responses) instead of the wider sample ranges reported in the prospective methodology narrative. This separation helps avoid mixing up the sample estimates with the actual data being analyzed.

The survey instruments included ratings of the perceived effectiveness of cash, healthcare, educational, vocational, food, and psychosocial support; demographic data; and the frequency of support received. The outcome variables were mental health change (as reported by the respondents) and perceived social integration. These outcomes were not measured using clinical diagnostic interviews or validated symptom scales and were self-reported or perceived. The regression strategy was hierarchical, with demographic variables entered first, followed by the six intervention variables and then support frequency and overall perceived impact. This sequence allowed us to test whether psychosocial support remained statistically correlated with each outcome. There is no predictor, confidence interval, or model estimate added for this article.

We prepared and analyzed the quantitative data using SPSS, including screening for missing data, coding consistency, normality, multicollinearity, and regression assumptions. The results chapter reports 300 valid responses, and no cases were dropped from the quantitative regression analysis. This article interprets the models based on the reported coefficients, p-values, F statistics, and R-squared values, and avoids causal statements the design does not support. The research also outlines informed consent, voluntary participation, anonymity and confidentiality as ethical issues in research with refugees, a population where disclosure might be problematic due to legal uncertainty. No ethics-approval identifier could be found on the source material for this article, and an ethics-approval identifier is not asserted.

Results

The analysis is focused on two outcomes in the broader social-protection evaluation: reported changes in mental health and perceived social integration. The quantitative data included 300 valid survey responses, and regression models were used to determine whether perceived effectiveness of psychosocial support was related to these outcomes, after accounting for other intervention types and demographic factors. Gender, age, and employment status were included in the first step of both model series, followed by the social-protection variables in the second step, and support frequency and overall perceived impact in the third step. This structure is used to see if the psychosocial-support coefficient remains after controlling for the measured covariates.

The model with only demographic controls was not significant for mental health change, $F(3, 296) =$

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0.84, p = .47, and accounted for 0.8% of the variance (R^2 = .008). Following the inclusion of six social-protection variables, the model was statistically significant, F (9, 290) = 3.22, p = .001, R^2 = .091. In that model, psychosocial support was positively and significantly related to mental health change (β = .22, p = .001), while cash assistance, educational support, vocational support, and food support did not have significant independent relationships with mental health change. In the reported model, healthcare support was positively associated but did not reach statistical significance. The measured intervention variables showed a clear association with reported mental-health improvement, with perceived effectiveness of psychosocial support showing the strongest association.

The final mental health model included support frequency and overall perceived impact. It remained statistically significant, F (11, 288) = 3.38, p < .001, and explained 9.9% of the variance (R^2 = .099). Among the intervention variables reported, psychosocial support was the most significant predictor (β = .21, p = .002). Support frequency also had a positive, significant coefficient (β = .11, p = .03), indicating that, after controlling for the included variables, those who reported receiving more frequent support were more likely to report mental-health improvement. The other support-type coefficients were not significant in the final model, and overall perceived impact was not significant. The results are different from an overall evaluation of social-protection programs by a respondent. However, they do not specify which counseling or community activities drive the individual changes.

Table 1. Regression results for mental health change and perceived social integration

Outcome / model	Predictor	Standardized β	p-value
Mental health M2	Psychosocial support	.22	.001
Mental health M3	Psychosocial support	.21	.002
Mental health M3	Support frequency	.11	.030
Integration, Model 2	Psychosocial support	.19	.004
Integration, Model 3	Psychosocial support	.18	.006
Integration, Model 3	Support frequency	.12	.040

The values of the coefficients are summarized in Table 1 and Figure 1. In both outcomes, psychosocial support remained positively associated and statistically significant after including support frequency and overall perceived impact. The coefficient for mental health remained relatively unchanged from β = .22 in Model 2 to β = .21 in Model 3. The integration coefficient for the corresponding process decreased from β = .19 to β = .18. For the mental health change, the final models included support frequency (β = .11, p = .03); for the integration feeling, support frequency (β = .12, p = .04) was significant. The stability of these coefficients supports the interpretation that the psychosocial-support association was not driven away by the inclusion of those last predictors.

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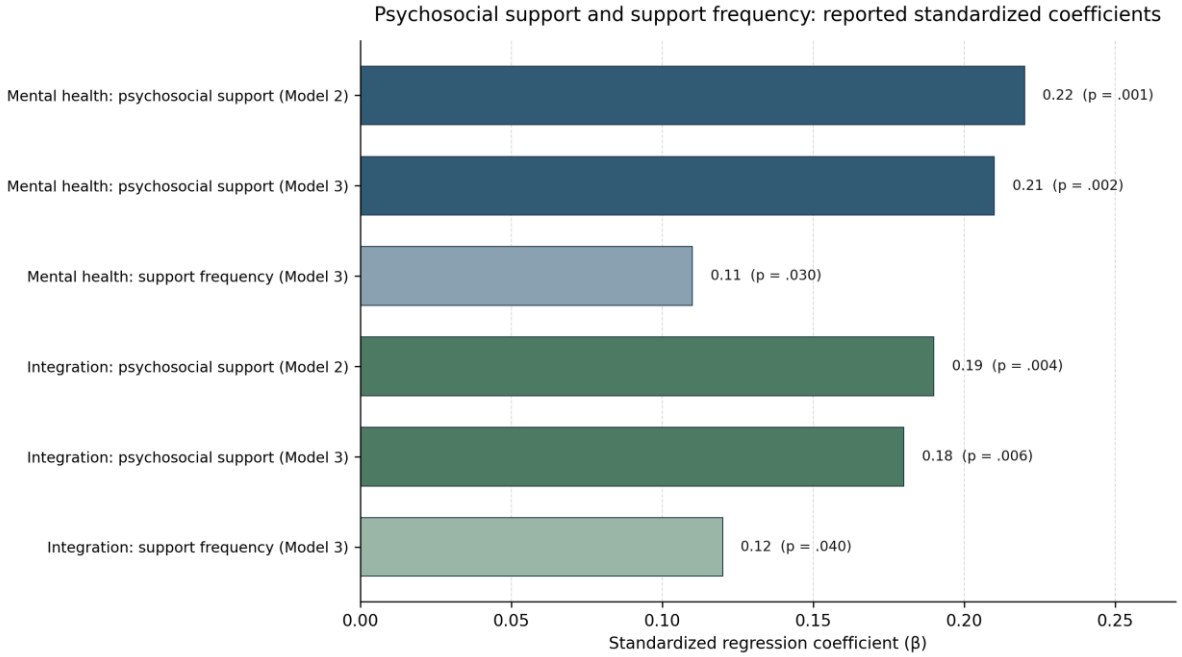

Figure 1. Reported standardized regression coefficients for psychosocial support and support frequency.

The demographic-only model was not statistically significant when it came to perceived social integration, $F(3, 296) = 1.01$, $p = .39$, $R^2 = .010$. When the six social-protection variables were added to the model, the model was significant, $F(9, 290) = 2.74$, $p = .005$, and explained 7.6% of the variance ($R^2 = .076$). In this model, psychosocial support was the only intervention type that was significantly associated with the outcome ($\beta = .19$, $p = .004$). The reported analysis did not reveal significant independent coefficients for cash, healthcare, education, vocational, and food assistance with regard to perceived integration. The findings suggest that respondents' evaluation of psychosocial support was more statistically significant for perceived belonging than for the other types of support measured. This does not mean that support for integration in a broader social and economic sense is not significant or unimportant for material and services.

When support frequency and overall perceived impact were added to the final integration model, they were statistically significant, $F(11, 288) = 2.91$, $p = .002$, $R^2 = .084$. Support frequency also had a positive significant association ($\beta = .12$, $p = .04$); psychosocial support remained significant ($\beta = .18$, $p = .006$). The overall perceived impact did not have a significant independent association. The mental health model remained important, as did psychosocial support and the regularity of assistance. According to the study's operational definition, integration feeling refers to respondents' sense of belonging and emotional connection with the host community. It is not the same as legal integration, equal rights, or the objective size of social networks, which the reported coefficient cannot determine, nor is it the same as measured discrimination.

The variance explained for each modelling step is compared in Figure 2. The R^2 values for mental health changes were 0.8% in the demographic model, 9.1% in the model with intervention variables, and 9.9% in the model with all variables. The respective values for perceived integration rose to 1.0%, then to 7.6%, and finally to 8.4%. The addition of social-protection variables accounted for more variance than the addition of support frequency and overall impact in the final step. However, the final models only accounted for less than 10% of the variance in each outcome. This means that only a portion of the factors of reported mental health and integration are captured by the

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measured predictors. Other factors, such as social acceptance, legal insecurity, economic conditions, past trauma, community networks, and service availability, may also play a role, but these models can estimate them only if they are measured directly and included.

Table 2. Variance explained across hierarchical regression models

Outcome	Model 1 (R^2)	Model 2 (R^2)	Model 3 (R^2)
Mental health change	.008 (0.8%)	.091 (9.1%)	.099 (9.9%)
Perceived integration	.010 (1.0%)	.076 (7.6%)	.084 (8.4%)

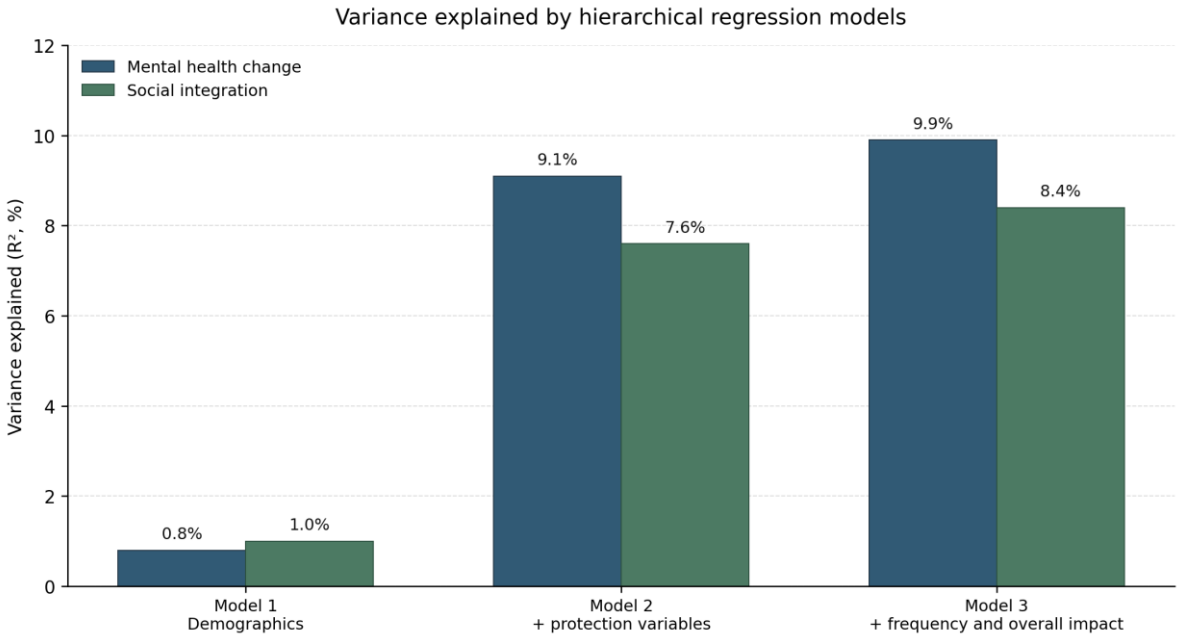

Figure 2. Proportion of variance explained by the hierarchical regression models for mental health change and perceived integration.

Discussion

The primary results show that psychosocial support was positively related to reported mental health change and perceived social integration and remained statistically significant after accounting for other social-protection indicators and frequency of support. This common connection helps frame psychosocial support as a cross-cutting intervention across the outcomes addressed in this article. It should be used with precision, but it does not mean that the measured psychosocial-support variable was most effective in comparison with all other interventions in all aspects of refugee welfare. Cash assistance, healthcare, and education may impact more directly on economic security, physical health, or education. The results indicate that emotional and relational outcomes must be assessed independently, and that improvements in material needs do not necessarily lead to improvements in emotional and relational outcomes.

The direction of the findings is in line with literature that highlights the complexity of Afghan refugee mental health and the need to respond to mental health in an in-depth way that takes into account the social context of distress. Alemi et al. (2023) review decades of research and interventions on the mental health and psychosocial well-being of Afghan people, while Hosseini et al. (2024) focus on cultural adaptation in evidence-based mental health interventions. Rosenberg et al. (2024) and Versteele et al. (2024) also highlight implementation and acceptability, especially for

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Afghan refugee families and youth. These sources help establish the feasibility of culturally responsive, accessible support as a key program element. While the present statistical results show a context-specific association in Balochistan, they do not imply that an intervention model will be uniformly effective across locations and/or demographic groups. Local feedback and systematic evaluation should remain as key influences on service design.

The second is the positive relationship between the support frequency and both outcomes in the final models. Ongoing, consistent contact can create opportunities for follow-up, continuity, and trust, while sporadic assistance can leave unmet needs unnoticed. Nevertheless, the regression models do not explain why frequency is important, or whether increased contact frequency is beneficial to outcomes. Perhaps those who have easier access to services are more likely to report improvement, or perhaps program quality and continuity are intertwined. The term is useful because it captures both the regularity of measurement and the perceived effectiveness of the intervention, rather than simply whether the intervention was available. Monitoring should distinguish between meaningful ongoing engagement and the number of contact events, as frequency alone may not address complex psychosocial needs if engagement is not appropriate, confidential, or includes referral options.

The results on social integration are particularly relevant, as integration is not an automatic consequence of receiving aid. Humayun et al. (2023) discuss the socio-legal and economic dimensions of Afghan refugees' integration and cultural adaptation in Pakistan, while Villalonga-Olives et al. (2022) review interventions based on social capital and refugee mental health. This literature suggests that emotional support and community connection are interrelated. Counseling, peer activities, trusted case-worker relationships, and community-based initiatives may offer opportunities to manage distress and build social connections, but they do not automatically resolve discrimination, legal insecurity, or limits on formal participation. Therefore, the statistically significant psychosocial-support coefficient should be interpreted as a relationship with perceived integration, not as evidence of integration or as an objective change in the host community's attitudes.

The relatively low R^2 values call for a balanced interpretation. The final models accounted for 9.9% of the variance in mental health change and 8.4% in integration feelings. Both models were statistically significant, but a large proportion of the variation in the results was not accounted for. Displacement history, household situation, current insecurity, access to services, stigma, social networks, language, legal status, and community acceptance can influence mental well-being and integration. Therefore, the study suggests a possible important intervention relationship but does not fully explain refugees' well-being. Future analyses could include additional measured contextual variables, validated outcome scales, and, if possible, changes over time to see whether reported associations are maintained.

As a consequence, the qualitative aspect of the source is limited. These outputs are not suitable for presentation as the number of interviews conducted or as independent empirical evidence without the original interview transcripts, coding framework, and audit trail. In this context, this concentrated article treats the quantitative regression results as evidence and does not treat the simulated qualitative frequencies as observed data. Prior to any submission to a journal with a mixed-methods design, the researcher should verify that the transcripts are true and accurate, record the coding process, and re-code or validate the analysis.

Policy and practice should be based on the positive relationships and the constraints in the evidence. Where appropriate, psychosocial services should connect with primary healthcare, educational environments, and community-based organizations to improve access to services and referral systems. The delivery should be culturally appropriate, confidential, and sensitive to the practical challenges faced by women and young people. Treat follow-up and continuity as service quality, not just administrative measures. Programs should not be seen as a replacement for cash assistance, health and education, or livelihood support, but should instead coordinate interventions based on people's needs.

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Monitoring systems could include perceived change in mental health, sense of belonging, continuity of support, referral completion, and barriers to referral. Over time, better outcome measures and clearer assessments would help determine which combinations of support are acceptable, effective, and sustainable in Balochistan.

The study has some limitations. It is geographically specific to Balochistan, and findings should not be automatically generalized to other Afghan refugee contexts in Pakistan or other displacement contexts. The outcomes are based on respondents' reported or perceived change rather than clinical assessment or longitudinal measures, as shown in the available results. The regression associations cannot show causation, and the small R^2 values indicate that other factors not included in the models explain the remaining variance. These limitations do not negate the usefulness of the reported regression patterns, but they underscore the need for careful wording, clear reporting, and further research before drawing strong conclusions about intervention effectiveness.

Finally, psychosocial support was the intervention variable that was most frequently included in the reported survey models and was related to both mental health change and perceived social integration. The model coefficients remained significant when support frequency and overall perceived impact were included, and support frequency was also positively associated with both outcomes. This trend indicates that refugee social-protection systems need to explicitly include emotional and relational well-being as targets and provide culturally appropriate, easily accessible, and ongoing services to address them. Psychosocial support should be in addition to material and public service support, since refugees' mental health and integration are also influenced by economic, legal, and social issues. Stronger qualitative analysis, measurement, and follow-up designs are needed to establish more robust evidence.

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