Review of the current evidence base for Mental Health and Psychosocial Support (MHPSS) in Emergencies

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Emergencies including armed conflict, disasters, and other crises have profound humanitarian consequences for individuals, families, and communities, disrupting essential services and amplifying psychological stress. Almost all people affected by emergencies experience psychological distress, though for many this improves over time. Particularly when people can use their personal coping strategies and access social, family, and community resources. However, a substantial proportion of people affected will develop diagnosable mental health conditions. An estimated one in five people (22%) affected by emergencies experience depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder, or schizophrenia at any given time[1].

This burden is compounded by disruptions to health systems and reduced access to quality care, leaving many people with severe mental health conditions particularly vulnerable. While not specific only to emergency settings, globally more than 720,000 people die by suicide each year, and suicide is a leading cause of death among adolescents and young adults[2]. Growing evidence indicates that humanitarian emergencies and fragile states

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1 Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis. The Lancet, 394(10194), 240–248.

2 World Health Organization. (2025). Key facts on suicide.

are associated with an elevated risk of suicide[3]. In emergencies, risk factors such as loss, violence, and isolation can elevate psychological distress and risk behaviours. In many contemporary crises, exposure to insecurity is often prolonged or recurrent, compounding distress over time and delaying recovery.

In this context, mental health and psychosocial support (MHPSS) is essential—not optional. Evidence-based MHPSS interventions are critical for reducing suffering, promoting recovery, and strengthening individual and community functioning across the phases of emergencies[4]. Moreover, implementing evidence-based practices is vital to "do no harm." Interventions that are not grounded in evidence or culturally appropriate principles can inadvertently disrupt local coping strategies, reinforce trauma responses or create dependency, thereby undermining well-being rather than supporting it. Affected populations present with diverse and evolving needs, requiring multi-layered responses ranging from basic psychosocial support to specialised mental health care. Over time, a range of MHPSS activities and interventions across this continuum have been designed and implemented in an effort to meet needs that arise as a result of emergencies. However, there is a need to better understand the scope of the evidence behind these responses to guide practice and inform future research.

This review was conducted to determine current MHPSS activities and interventions being implemented in emergencies (e.g., armed conflicts and disasters), and the status of evidence supporting these activities and interventions. The review offers guidance to MHPSS workers regarding up-to-date evidence in the field of MHPSS in emergency contexts, identifies existing gaps in research, offers practical recommendations and identifies opportunities for future research.

The review was commissioned by the International Committee of the Red Cross (ICRC), conducted by the British Red Cross and reviewed and prepared for publication by the Red Cross and Red Crescent Movement (RCRC) MHPSS Hub for use by partners from the RCRC Movement and broader humanitarian actors, and stakeholders.

Definitions

For the purposes of this review and to ensure a common understanding, several key terms are defined below. These terms informed data collection and analysis.

Emergency

An emergency is a life-threatening situation that suddenly and significantly deteriorates (in scale, urgency, or complexity), putting large segments of the population at acute risk of death, severe health deterioration, suffering, or loss of dignity. These situations exceed the normal coping capacity of individuals, families, communities, and state support systems, while simultaneously outstripping available humanitarian response capacity on the ground. Emergencies may affect people of different genders, and children differently, with varying impacts and coping mechanisms across different groups[5].

Mental health and psychosocial support (MHPSS)

The Interagency Standing Committee (IASC) defines MHPSS as 'any type of

3 Zemp, C., Vallières, F., Broecker, F., Haroz, E. E. E., Kakish, I., Sheaf, G., Lee, J. S. Y., Harrison, S., & Siersbaek, R. (2025). Self-harm and suicide prevention in humanitarian and fragile contexts: A systematic scoping review. Global Mental Health, 12, e145.

4 World Health Organization (2025). Mental Health in Emergencies.

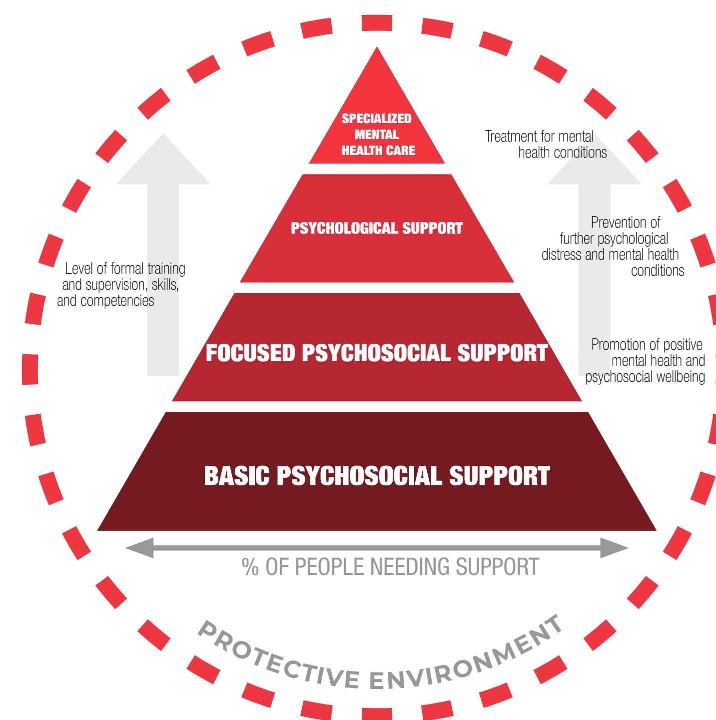
5 Definition informed by: International Committee of the Red Cross. (2020). Guidelines on mental health and psychosocial support. ICRC.; International Committee of the Red Cross. (1998). Eleventh General Assembly of the International Federation of Red Cross and Red Crescent Societies, Seville, Spain, 20–25 November 1997. International Review of the Red Cross, 322.; International Federation of Red Cross and Red Crescent Societies. (1997). Emergency response policy: 11th session of the General Assembly of the International Red Cross and Red Crescent Societies. IFRC.; IFRC Reference Centre for Psychosocial Support. (2023). Strategic operational framework. IFRC.; Inter-Agency Standing Committee. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. IASC.; International Red Cross and Red Crescent Movement. (2020). Movement policy on addressing mental health and psychosocial needs. IFRC.

local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'[6]. At a programmatic level, for the ICRC, the term MHPSS describes a wide range of activities carried out by the ICRC to address the psychological and psychosocial problems caused or exacerbated by armed conflict and other situations of violence. MHPSS support aims to protect and promote psychosocial well-being, prevent mental health conditions and treat such disorders when they occur[7].

Red Cross and Red Crescent Movement (RCRC) MHPSS Framework[8]
The RCRC MHPSS Framework is organised as a four-layer pyramid (shown in Figure 1) representing complementary layers of mental health and psychosocial support. At the base, **Basic psychosocial support** activities target the entire population to promote resilience and awareness of common psychological consequences of emergencies and violence and of available services. **Focused psychosocial support** provides more targeted interventions for at-risk individuals and groups through structured activities, peer support, and group work. **Psychological support** addresses individuals experiencing more severe psychological distress through individualised counselling and therapeutic group interventions. At the top, **Specialised mental health care** delivers advanced psychological and psychiatric services for those with chronic mental health conditions or severe, persistent distress that significantly impairs daily functioning.

This multi-layered approach ensures that different levels of need are met through appropriate interventions, with referral pathways connecting the layers to provide comprehensive care across all contexts where the Movement operates. It should be noted that the differentiation of interventions across layers is based on the type of intervention, rather than the profession or profile of the provider. However, the level of formal training, supervision, skills and competencies of MHPSS providers increases at higher layers of the Framework.

Figure 1
The Red Cross and Red Crescent Movement MHPSS Framework



Levels of evidence[9]
The studies gathered by this review were analysed using a hierarchical system of classifying evidence, known as the levels of evidence. These levels enable the rating of evidence on a scale related to the type of evidence, the design of the study, and quality of the data. For the purposes of this review, two levels

6 Inter-Agency Standing Committee. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. IASC.
7 International Committee of the Red Cross. (2020). Guidelines on mental health and psychosocial support. ICRC.
8 International Red Cross and Red Crescent Movement. (2021). The International Red Cross and Red Crescent Movement's mental health and psychosocial support framework. IFRC.
9 Burns, P. B., Rohrich, R. J., & Chung, K. C. (2011). The levels of evidence and their role in evidence-based medicine. Plastic and Reconstructive Surgery, 128(1), 305–310.

of evidence are described, these include 'low quality evidence' and 'high quality evidence' and are defined as follows:

- **Low quality evidence:** the study did not include comparison groups or control group measures but did include descriptive reviews.
- **High quality evidence:** the study used comparative groups where an experimental group was compared to a control group: The most robust being Randomized Control Trials (RCTs).

Methodology

Approach

This review used a rapid realist evaluation approach. This approach to knowledge synthesis is designed to provide time-sensitive, theory driven insights into how and why interventions work in specific contexts[10]. A rapid realist approach was considered appropriate for this review as the objective of the study was to understand what MHPSS activities work in emergency contexts and for whom. In addition, there was limited time and resourcing for the study, so a rapid approach was favoured. A systematic literature search was undertaken to gather evidence to be included in the review.

Inclusion and exclusion criteria

The inclusion criteria included articles that discussed psychosocial and psychological interventions conducted in emergency settings. Uncontrolled designs, experimental designs, controlled studies and reviews were included. Case studies or descriptive studies were excluded unless they were literature reviews. In addition, the search set out to cover MHPSS activities and interventions across all four layers of the RCRC MHPSS Framework.

Search terms

The search terms aimed to encapsulate all relevant treatments while being mindful of potential bias. Existing RCRC Movement[11] and ICRC guidelines[12] were reviewed which furthered informed the search terms. The terms used were variations of MHPSS, interventions, and types of emergencies. The search terms used included:

MHPSS or PFA or psychological first aid or mental health first aid or help the helper or self-help or problem management or single session therapy

and

Emergencies or Emergency response or Conflict settings or Armed conflict or Conflict situations or conflicts or Humanitarian crisis or Natural disasters

An additional hand search was conducted between June to September 2025 for common evidence-based interventions[13] to look for specific research that fit the inclusion criteria.

Study selection

Database searches (Ovid Medline, APA PsycInfo and Google scholar) and citation search (especially within systematic reviews; backward and forward search) were conducted to identify academic studies evaluating the interventions of interest. The primary search was conducted in June 2025. The studies included in this review were selected through a multitude of searches to try and include all high quality research.

Analysis

A scanning process, that involved reading each paper, ensured that the research literature was relevant to emergency settings, as interventions

10 Saul, J. E., Willis, C. D., Bitz, J., & Best, A. (2013). A time-responsive tool for informing policy making: Rapid realist review. Implementation Science, 8, Article 103.

11 Selection of publications from the RCRC MHPSS Hub

12 International Committee of the Red Cross. (2020). Guidelines on mental health and psychosocial support. ICRC.

13 Including Eye Movement Desensitization and Reprocessing (EMDR), Interpersonal Therapy (IPT), Cognitive Processing Therapy (CPT), Trauma-focused Cognitive Behavioural Therapy (TF-CBT), Narrative Exposure Therapy (NET).

for other settings can differ in response and capabilities. Each study was considered according to the relevant layer of the RCRC Movement Framework and were classified as high quality evidence or low quality evidence.

Results

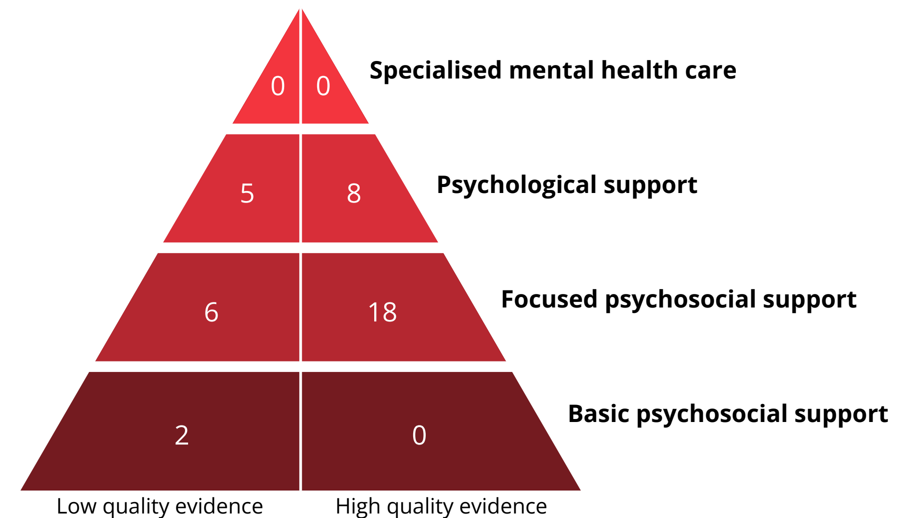
A total of 553 studies were screened from Ovid Medline (139) and APA PsycINFO (414) and 39 studies met criteria for inclusion in this review. A summary of the 39 studies included in the review can be found in Table 1.

This section provides a narrative account of the findings from this systematic literature search, with results categorised and summarised in Tables 2 and 3 in the appendix. Table 2 presents research classified as high quality evidence that met this review's rigorous inclusion criteria, while Table 3 includes low quality evidence that, despite methodological limitations, were deemed relevant and informative enough to warrant inclusion in this review. Tables 2 and 3 provide detailed information about the individual studies, including methodology, sample characteristics, and specific findings that informed the narrative synthesis below.

The information from these studies was collated and is presented according to the four layers of the RCRC Movement's MHPSS Framework. Figure 2 outlines the number of low and high quality studies found at each layer of the Framework. There were no low or high quality studies found at layer four of the Framework nor were any high quality studies for layer one. Two low quality studies were found for layer one. At the focused psychosocial support layer six low quality studies and 18 high quality studies were found. At the psychological support layer five low quality studies and eight high quality studies were found.

Figure 2

Results mapped to the RCRC Movement MHPSS Framework



Basic psychosocial support

No high quality evidence was identified for the foundational layer of the RCRC MHPSS Framework. The absence of high quality evidence at the basic psychosocial support layer may reflect several methodological and practical challenges inherent to studying foundational interventions. Basic psychosocial support typically targets entire populations and focuses on broad resilience-building activities that are difficult to isolate and measure using methods such as traditional RCT designs. The universal nature of these activities makes it challenging to establish appropriate control groups, as withholding basic support services from populations in crisis raises ethical concerns. Additionally, the outcomes of basic psychosocial support are often diffuse, long-term, and difficult to attribute directly to specific interventions. Furthermore, research funding and academic incentives tend to favour more targeted, measurable interventions at higher layers of the RCRC MHPSS Framework, potentially

contributing to the research gap at this foundational but critical level of support.

Commonly implemented MHPSS activities in this layer

Among the low quality evidence, **Psychological First Aid (PFA)** emerged as the primary intervention documented at the foundational layer of the RCRC MHPSS Framework. PFA was implemented across diverse settings including Gaza, Chile, USA, Kenya, Haiti, and Lebanon following various disasters and conflicts. The intervention was delivered by lay helpers and first responders, with field reports and quasi-experimental studies suggesting effectiveness in reducing initial post-trauma distress and increasing self-efficacy.

There have not been any randomised controlled trials (RCTs) based on our search evaluating the effectiveness of PFA in emergency settings. A systematic review of PFA in 2022 found one RCT but that was not implemented in emergencies. Authors have noted that there were inconsistent intervention components, insufficient evaluation methodologies and high risk of bias within the reviewed studies, where there was an imbalance between popular support for PFA and the evidence of outcome data.

Child-friendly spaces (CFS) are commonly implemented in emergencies, but no specific studies were found through the database search (as there were no RCTs). Through hand search, a systematic review from 2019 was found that included five field studies across five humanitarian settings (Ethiopia, Uganda, Iraq, Jordan and Nepal). The pooled results indicate that CFS can support psychosocial wellbeing for younger children but not reliably increase knowledge of community resources. Benefits for older children (12+ years) are weak and inconsistent. Longer term impacts are often not captured.

Focused psychosocial support

High quality evidence at this layer demonstrated strong evidence for multiple interventions, delivered primarily by trained lay or non-specialist providers, with 18 high quality studies found. **Problem Management Plus (PM+)**, supported by over 23 RCTs across diverse settings including Poland, Slovakia, Romania, Pakistan, Kenya, Netherlands, Ukraine and Jordan, showed small to moderate effects on depression and anxiety sustained up to six months, though effects diminished by 12 months. **Group Problem Management Plus (Group PM+)** demonstrated larger improvements across all five key outcomes (depression, daily functioning, general distress, PTSD) compared to enhanced usual care, with high retention and fidelity. **Self-Help Plus (SH+)**, implemented across Ukraine, various European countries, Turkey and Uganda, showed particular benefit for individuals with lower baseline wellbeing according to meta-analysis findings, with no adverse events reported.

Doing What Matters in Times of Stress (DWM), adapted from SH+, demonstrated reduction in depression and anxiety symptoms across Ukraine and various European countries. **Classroom-Based Interventions (CBI)** using manualized **Cognitive Behaviour Therapy (CBT)** showed effectiveness in decreasing PTSD and anxiety among conflict-affected Syrian children and in Indonesia when delivered by trained teachers. **The Caregiver Support Intervention (CSI)** for Syrian refugee parents in Lebanon showed small to medium effects of reduction in harsh parenting and caregiver distress for those receiving the full intervention. Physical exercise interventions, including ballroom dancing in earthquake-affected China, showed significant anxiety reduction among adolescents.

Additional evidence-based approaches included **Critical Incident Stress Debriefing (CISD)** for earthquake rescuers in China, and the **Advancing Adolescent programme** in Jordan showing sustained impact up to 11 months. However, it is important to highlight that the evidence for CISD is contradictory. A recent systematic review indicated that CISD may not only fail to prevent PTSD but can also lead to mixed or even harmful outcomes, with some studies showing no benefit and others suggesting potential worsening of psychological distress. **Narrative Exposure Therapy (NET)** demonstrated effectiveness in reducing PTSD and aggression symptoms across multiple RCTs with former child soldiers and refugees in Democratic Republic of Congo (DRC), Uganda,

and other settings. **The Common Elements Treatment Approach (CETA)** showed that 50% of clients demonstrate improvement after 4-6 sessions, with large improvements after 7-10 sessions, across populations affected by torture, violence, and intimate partner violence.

Culturally Adapted CBT (CA-CBT) for Syrian refugee women in Turkey showed large effects on PTSD and near-medium effect sizes for anxious-depressive distress. **Group-based Trauma-focused CBT** in Congo demonstrated large reductions in PTSD, depression, anxiety, and conduct problems among girls exposed to sexual violence. Trauma healing and reconciliation workshops in rural Burundi showed greater PTSD symptom reduction, particularly for workshops without PTSD psychoeducation. Finally, trauma-focused cognitive behaviour therapy and problem-solving therapy delivered by lay counsellors in post-conflict Indonesia showed significant reductions in PTSD and anger among children with large effect sizes.

The six low quality research studies at this layer included various interventions with more limited methodological rigor but showing promising results. **Art therapy** in earthquake-affected China demonstrated better effectiveness in treating depression, anxiety, and general mental symptoms compared to psychological counselling. **CBT interventions for children and young people** across the Middle East, Africa, and Asia showed statistically significant but clinically marginal improvements for depression when delivered by trained teachers and lay community workers. The **Solution-Oriented Approach** implemented by the ICRC across DRC, Mali, and Nigeria showed that 65% of participants experienced reduced psychological distress and 80% showed improved daily functioning, though these findings lacked control groups and randomization. **Skills for Life Adjustment and Resilience (SOLAR)** interventions in Australia and Pacific Island communities showed potential benefits for PTSD and impairment reduction. The **Happy Helping Hand** online programme for Syrian refugee adolescents in Lebanon demonstrated significant improvements in anxiety, depression, and wellbeing when delivered by teachers, though through uncontrolled trials. **Hotline counselling** during SARS in China showed improved general mental health.

Psychological support

High quality evidence identified several effective interventions at this layer delivered by trained professionals and supervised non-clinical staff with specialised training. The **Skills for Life (SFL)** programme was implemented in Chile following earthquake and tsunami, drawn from a three-tiered WHO model providing non-trauma focused school-based mental health support (covering emotional regulation, social skills, problem-solving, and resilience) for students. It was delivered by trained psychologists or social workers through a quasi-experimental design and showed effectiveness in reducing internalizing problems and post-traumatic symptoms.

Teaching Recovery Techniques (TRT), a school-based intervention for PTSD symptoms implemented in Gaza, Palestine, showed promising results with corrected analyses indicating potentially large, clinically significant effects. **EMDR Group Intervention (EMDR G-TEP)** demonstrated significant PTSD symptom reduction among Syrian refugees in Turkish refugee camps, with effects maintained at 4-week follow-up when delivered by professionals with extensive EMDR training. Comparative studies of Group CBT and Group EMDR in internally displaced populations in Northern Iraq showed equivalent effectiveness for both approaches, with significant reductions in PTSD, depression, and anxiety when delivered by supervised psychosocial workers.

Trauma-Focused CBT (TF-CBT) showed substantial improvements when culturally adapted for post-conflict settings in Timor-Leste, with modifications including traditional Timorese elements and family involvement reflecting cultural values around collective care and recovery. **Group Interpersonal Therapy (IPT-G)** in Northern Uganda camps demonstrated significant depression reduction among adolescent female survivors of war compared to creative play and waitlist controls, though showed more limited effects for male participants. **Individual Interpersonal Therapy (IPT)** proved effective across multiple settings, including a pilot study in post-earthquake China

showing significant PTSD and depression reduction, and among Sudanese refugees in Cairo where community members with no previous mental health education were successfully trained to deliver treatment with significant improvements in PTSD and depression.

Cognitive Processing Therapy (CPT) demonstrated significant effectiveness among female survivors of sexual violence in DRC, with local community psychosocial assistants trained in 2-week programmes delivering group interventions that resulted in sustained PTSD and anxiety/depression improvements at 6-month follow-up. In Southern Iraq, both **CPT** and a transdiagnostic intervention **CETA** showed effectiveness when delivered by local community mental health workers to survivors of torture and militant attacks, with CETA demonstrating large effect sizes on trauma symptoms and dysfunction, while CPT showed moderate effect sizes for trauma and depression.

The five low quality evidence papers found at this layer encompass diverse interventions with varying methodological limitations but showing encouraging outcomes. **Multi-family approach (MFA)** in Poland, Slovakia, and Romania claimed feasibility for conflict-affected populations, though efficacy remained empirically unevaluated (the approach involved identifying stressors, family interactions, and exploring resources). In Gaza, Palestine, three interventions showed promise: **Family Therapy Programme (FTP)** emphasized cultural resilience aspects and promoted both symptom reduction and resilience building; **Community Wellness Focusing** used symbolic expression and culturally adapted methods showing significant PTSD symptom reduction; and **Psycho-Social Support Programme (SANID)** incorporated psychological debriefing and resilience-building over six sessions with significant symptom improvements.

Online EMDR delivery for forcibly displaced Syrian women demonstrated the potential for increased access and scalability, with reductions in PTSD, depression, and anxiety symptoms when delivered by trained Syrian women therapists, though challenges included poor internet connectivity and privacy concerns. **Trauma-Focused CBT** implementation in Puerto Rico following Hurricane Maria showed large effect sizes for PTSD, depression, and anxiety reduction among children and adolescents, demonstrating effectiveness within telehealth settings. Additional lower quality studies included various **narrative and EMDR-based protocols** in Central African Republic demonstrating significant PTSD symptom reduction with effects maintained at 5-month follow-up, though delivered in contexts of ongoing conflict with limited follow-up data collection.

Specialised mental health care

The absence of research at the specialised mental health care layer likely reflects several practical and methodological barriers unique to humanitarian settings. Specialised mental health services require highly trained clinical professionals such as psychiatrists, clinical psychologists, and psychiatric nurses, who are often scarce or unavailable in crisis-affected areas, making research implementation extremely challenging. Additionally, individuals requiring this level of care typically present with complex mental health conditions that may preclude participation in research studies due to capacity for consent for research participation within emergency settings.

The specialised nature of these interventions also means they serve a much smaller population compared to lower layers of the RCRC MHPSS Framework, making it difficult to achieve adequate sample sizes for robust research studies. Furthermore, ethical considerations around conducting research with severely mentally ill populations in humanitarian contexts, combined with the urgent need to provide immediate care rather than withhold treatment for control groups, create significant barriers to traditional research designs. However, there are significant issues with this lack of guidance from the evidence-base for the implementation of support to those that have need for specialised mental health care.

Summary table of key findings

Table 1

Summary of the intervention and level of evidence mapped to the RCRC MHPSS Framework

Legend: Hyperlink to study provided in Intervention column. Location of the MHPSS interventions if not given are cited in tables in the appendix.

Layer of RCRC MHPSS Framework	Intervention	Stage in emergencies (Acute/ Ongoing/ Protracted)/ can't tell	Level of evidence
Basic psychosocial support	Psychological first aid (PFA)	Acute	Low
	Child friendly spaces (CFS)	Refugee camps in Ethiopia, Uganda, Jordan, and Iraq and aftermath of earthquake in Nepal	Low
Focused psychosocial support	Problem management plus (PM+)	Refugee camps, Protracted (WHO's definition is for populations affected by adversity)	High
	Group Problem Management Plus	(WHO's definition is for populations affected by adversity)	High
	Self-help Plus (SH+)	Ongoing, post-conflict	High
	Doing What Matters in Times of Stress (DWM)	Post-conflict, can't tell	High
	Classroom Based Intervention (CBI)	Ongoing/ protracted	High (mixed results)
	Caregiver Support Intervention (CSI)	Ongoing stressor	High
	Physical exercise (including dancing)	Post emergency	High (mixed results)
	Critical Incident Stress Debriefing (CISD)	Acute/ ongoing	High (mixed results)
	Advancing Adolescents programme Profound Stress Attunement (PSA)	Syrian refugees in Jordan (relative safety)	High

Layer of RCRC MHPSS Framework	Intervention	Stage in emergencies (Acute/ Ongoing/ Protracted)/ can't tell	Level of evidence
Focused psychosocial support	Narrative exposure therapy (NET)	Ongoing stress	High
	Common Elements Treatment Approach (CETA)	Ongoing, protracted	High
	Culturally adapted CBT (CA-CBT) sessions in a group format	Syrian refugees in Türkiye (relative safety)	High
	Group-based Trauma-focused CBT	Potentially protracted	High
	Trauma healing and reconciliation workshop (with and without PTSD psychoeducation)	Post-conflict but conducted near IDP camp so there may be ongoing stressors	High
	Trauma-focused cognitive behaviour therapy or problem-solving therapy	Ongoing stressor	High
	Mind-Body skills schools-based group programme	Post-conflict	High (with only 1 study)
	Art therapy	Aftermath of the earthquake	Low
	CCC (Concerned Christian Community) – Trauma Counselling Intervention & WHDP (Women's Health and Development Program) – Support Groups and Skills Training	Post-conflict	Low
	Happy Helping Hand (Raising awareness of relationships between feelings, thoughts, behaviours, coping skills; online text, videos, games/interactive exercises)	Conflict and displacement	Low
	Skills Or Life Adjustment and Resilience (SOLAR)-Kids/Teens2; brief 5 session intervention, CBT-based	Natural hazards (bushfires), Cyclone affected communities. As the occurrence of these hazards might be high, it is difficult to determine if it is post-disaster as it is an ongoing risk	Low

Layer of RCRC MHPSS Framework	Intervention	Stage in emergencies (Acute/ Ongoing/ Protracted)/ can't tell	Level of evidence
Focused psychosocial support	Solution-oriented approach (group work with 10 sessions on psychoeducation and coping skills)	Post conflict related violence	Low
	Community Wellness Focusing (CWF)	Ongoing	Low
	Narrative protocol: Action contre la Faim (ACF)/ KONO and EMDR-based Group Trauma Episode Protocol (G-TEP)	Conflict, violence and insecurity	High
	Hotline counselling	Acute (During SARS – epidemic)	Low
Psychological support	Teaching Recovery Techniques (TRT) School-based intervention for PTSD symptoms	Ongoing	High
	Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention (EMDR G-TEP)	Post conflict with ongoing stressor (Syrian refugee in Türkiye)	High
	Comparing Group CBT and group EMDR	Ongoing (IDP in Iraq)	High
	Multi-family approach (MFA); Six sessions, 2.5 hours each; focuses on identifying stressors, family interactions, and exploring resources	Ongoing conflict	Low
	Family Therapy Programme (FTP)	Ongoing conflict	Low
	Psycho-Social Support Programme (SANID	Ongoing conflict	Low
	Online Eye Movement Desensitisation and Reprocessing (EMDR) (Standard EMDR protocol, adapted for language)	Syrian conflict (since 2011). Needs compounded by the 2023 earthquake.	Low

Layer of RCRC MHPSS Framework	Intervention	Stage in emergencies (Acute/ Ongoing/ Protracted)/ can't tell	Level of evidence
Psychological support	Trauma focused Cognitive Behavioural Therapy (TFCBT)	Protracted effects of category 4 Hurricane Maria; post-conflict in Timor Este	Low for the hurricane study, High for post-conflict in Timor Leste
	Interpersonal Psychotherapy and Group Interpersonal Psychotherapy (IPT and IPT-G)	Likely protracted	High
	Cognitive processing therapy (CPT) Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence | New England Journal of Medicine	Likely protracted	High
	Cognitive processing therapy (CPT) Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial	Likely protracted	High

Discussion

A notable gap exists between field practices and evidence-based interventions. This is particularly evident at the basic psychosocial support and specialised mental health care layers of the RCRC MHPSS Framework. No evidence was found at the specialised mental health care layer specific to emergency response. This is likely due to the difficulty and ethical concerns, in conducting research on these interventions in emergency situations. Basic psychosocial activities, such as CFSs and universal sport activities, are widely implemented but the evidence base remains limited. This is also true of the proliferation of Psychological First Aid training to build basic psychosocial skills as its evidence base also remains limited. The current search also revealed less evidence than expected for psychological support interventions such as cognitive processing therapy, interpersonal therapy, EMDR and teaching recovery techniques, possibly due to search terminology or publication indexing.

It would not be ethical to do an RCT with a placebo or non- interventional arm in emergencies. Even a suitable control arm might be hard to include. Therefore, no high quality papers that fit the inclusion criteria were found for some common MHPSS interventions (especially for basic psychosocial support such as CFSs). There might be a concern that an element of unconscious coercion to agree to take part could exist. It is not ethical to invite participants to take part in any research where there is no possibility of any valid or reliable outcome, and this is also true for research in emergency settings. In addition, though this is obviously an area where long term follow- up studies would allow for good evaluation of interventions, with movement and displacement after an emergency, this would be hard to carry out. Qualitative research might be of use, but selection of a small group and how this might be done without suggestion of favourable intervention could be difficult.

Cultural adaptations and locally developed approaches are rarely discussed in the papers in sufficient detail, highlighting the need for greater transparency regarding how interventions are shaped by, or rooted in, specific cultural and contextual settings. However, there was an emphasis on the importance of cultural adaptation and age-appropriate delivery in the review of PFA, which highlighted that effective implementation requires sensitivity to local cultural and religious contexts. Specifically, the research noted that PFA should incorporate culturally appropriate practices that align with the affected population's beliefs and traditions. This suggests that generic PFA protocols need modification to include religious or spiritual elements meaningful to the specific community. The context-specific modifications likely encompassed adapting communication styles, incorporating local understanding of distress and coping, using culturally relevant metaphors and examples, and ensuring that the eight core PFA[14] actions are delivered in ways that respect local customs and social norms. Age-appropriate delivery would involve adjusting language complexity, using developmentally suitable explanations for children versus adults, and recognising different cultural expectations for how various age groups should receive support and express distress.

Differences in intervention effectiveness across settings may not only reflect contextual factors, but also variations in practitioner training and supervision, which remain significant gaps in many humanitarian contexts. As the differentiation of intervention across layers of the MHPSS Framework is related in part to the type of intervention and not the profile of the provider, there exists a range of skills and competencies required to implement MHPSS services. Many MHPSS interventions and activities implemented across the bottom three layers of the MHPSS Framework may be delivered by trained lay or non-specialist providers. It was not always clear across the reviewed studies what training and support was given to these providers. Particularly at the focused psychosocial support and psychological support layers substantial, structured training and ongoing supervision is required to ensure providers have the skills and competencies required to deliver and maintain their knowledge and skills in MHPSS interventions. This implies that these

14 These are: contact and engagement, safety and comfort, stabilisation, information gathering, practical assistance, connection with social support, coping support, and linkage to services.

approaches need to be implemented within broader MHPSS programming or services to ensure providers receive appropriate preparation, clinical supervision and coaching and to avoid ad hoc or improvised use of MHPSS interventions and techniques.

It is vital to recognize the contraindications raised by some studies; for example, whilst Critical Incident Stress Debriefing (CISD) has shown efficacy in an RCT, psychological debriefing methods have been generally discouraged due to potential adverse effects. Results from a pooled meta-analysis of psychosocial interventions in conflict settings have shown small worsening of internalising symptoms among children. However, it was not clear which interventions might cause worsening symptoms as it was a pooled estimate.

Attention must also be paid to the type of outcome variables of interest. For example, for classroom-based interventions, whilst positive results were found for pro-social behaviour or increased hope, the findings regarding their effectiveness on psychiatric/ mental health symptoms were mixed. Future research needs to clarify how best to deliver basic psychosocial interventions and document the adverse effects of the difficulties of carrying out research in these circumstances.

Limitations of findings

Fundamental limitations of this review are the difficulties, and ethical concerns, related to conducting research in emergency settings.

The use of the MHPSS Framework to classify the evidence found in this review presented challenges. While the MHPSS Framework provides a useful structure for organizing interventions according to different levels of support, the categorization of interventions within these layers is not always straightforward. Some interventions can be clearly positioned within a specific layer; however, others may be more difficult to classify. This is largely due to ambiguity in the definition of the layers of the Framework and how they are applied. In practice, interventions may be categorized based on different criteria, including the nature and content of the intervention protocol, the level of specialization required, the qualifications or role of the provider delivering the intervention, or the broader service context in which it is implemented. Consequently, assigning interventions to a single layer of the Framework may not fully capture their complexity, and some interventions may overlap across levels depending on the implementation approach and contextual factors.

Additional limitations were methodological and related to the content of the evidence reviewed. It should also be highlighted that the evidence presented in this review represents a snapshot of interventions up to September 2025. The field is rapidly changing and evolving.

Limitations related to the evidence

A number of papers did not specify or differentiate the stage of emergency in which the psychosocial and psychological interventions were implemented. It was difficult to determine specifically which interventions were effective/ useful in an acute phase of emergencies. Therefore, some results may not fully fit within the timeframe of an emergency. It might also be difficult to infer when the situation was acute as a protracted conflict may also re-intensify. As a result, most evidence for trauma-focused interventions derives from protracted or post-conflict settings, while evidence from acute phases remains limited and largely confined to basic or focused psychosocial support.

Descriptions of intervention content were often insufficiently detailed, with broad labels encompassing heterogeneous practices with differing levels of structure, intensity, and provider expertise. For example, the term “art therapy” is used widely but the actual activity can differ significantly from a recreational to a more structured, therapist-led therapeutic approach. In addition, it was not always clear from papers how protocolised or manualised the interventions included in the studies were.

Capacity strengthening is critical in the delivery of quality of MHPSS activities and interventions. Variability in practitioner training, supervision, and implementation fidelity is often constrained in emergencies was inconsistently

reported and may have influenced observed outcomes.

Whilst some interventions are ‘scalable’ interventions (e.g. Self-Help Plus) with multiple RCTs and evidence-base, others might be a standalone intervention developed in a country and the findings may not be directly generalisable to other countries/settings/cultures. Equally, whilst one study was found using a RCT to evaluate physical exercise (dancing) post-earthquake, it does not directly imply that the same intervention would show the same benefit in another emergency setting.

Methodological limitations
Related to the lack of clarity in defining the emergency phase in which the study took place, is the definition of emergency used by this review. It did not define emergency phases nor give any clarity on related timelines. Emergency definitions are operational in nature and often differ between different organisations. Differences often relate to what and when constitutes the ‘acute’ phase and so on. These differences in emergency definitions, phases and timelines are likely to have affected the papers included, or not, in this review.

Despite attempts in doing systematic search, due to time constraints, a rapid realist evaluation approach was used to balance systematic search with realism. There might be articles that were omitted since they did not fit the search terms used. The a priori database search was complemented with pre-determined search terms by doing targeted hand search on evidence-based interventions. However, that was not systematic. In addition, no search terms on psychological/psychiatric care in emergencies were used. This may have limited findings at the specialised mental health care layer of the Framework.

This review was conducted in English and therefore may be subject to publication and language bias, as interventions developed and documented in languages other than English are less likely to be represented in peer-reviewed journals.

Recommendations

There are several priorities for consideration in advancing the evidence base on MHPSS in emergency settings. These include both practical recommendations and recommendations for future research.

Practical recommendations
Strengthening the evidence base for MHPSS in emergencies requires greater investment in monitoring and evaluation systems both during emergencies and across the longer-term recovery phase. Collecting timely, context specific data in emergencies enables practitioners to make informed decisions and adapt programming but could also contribute closing the research gap, particularly at the foundational layer of the MHPSS Framework.

This could also include considerations regarding research preparedness measures in advance of crises, including developing logistical plans, considering consent, ensuring the availability of trained personnel, and investing in the training of local paraprofessionals and community workers. Research planning must consider not only feasibility and rigour but also the wellbeing and capacity of those involved in both delivering and researching interventions in emergencies.

Longer term evaluation of MHPSS activities is essential to understanding their outcomes and impact and could contribute to furthering understanding of the effectiveness of different MHPSS activities and interventions.

In addition, it is recommended that the RCRC MHPSS Framework be reviewed to clearly articulate its definitions and operational use with a focus on strengthening coherence in programme design and outcome measurement. Standardising how the Framework’s layers are interpreted and applied would reduce current inconsistencies across the RCRC Movement and enable more meaningful comparison of interventions and synthesis of evidence across contexts.

Future research
The limited research on the feasibility and effectiveness of interventions in emergency settings creates a gap between evidence and practice. Even well-established trauma-focused treatments are seldom evaluated or published in such contexts due to operational challenges. Where these are implemented, cultural adaptations are often made, yet the specifics are rarely well documented. Across studies, adaptations most often focus on language, the use of locally meaningful metaphors, and practical adjustments to how interventions are delivered (for example, group composition or session structure). Much less attention is given to adapting underlying concepts of distress, mechanisms of change, or involving communities in intervention design. This makes replication and cross-context learning more difficult. Future studies should explicitly describe any adaptations to enhance replicability and contextual relevance.

Underrepresentation of geographical regions and marginalised groups also undermines the generalisability of findings. There is a notable lack of research from parts of Asia and of marginalised populations globally. Where appropriate and safe, future studies should aim to include and identify underrepresented groups to ensure equitable evidence generation.

Mental health outcomes in emergency settings are shaped not only by exposure to acute traumatic events, but also by ongoing stressors following crises, such as displacement, insecurity, poverty, family disruption and uncertainty. Longitudinal studies are also needed to assess sustained impact and cost-effectiveness beyond the immediate crisis phase. To support practical application, research should clearly specify the phase of the emergency (acute, protracted, recovery, post-conflict) during which interventions were tested. Given the challenges of conducting RCTs in emergency settings, robust qualitative methodologies and mixed-methods approaches could also be further explored.

Ultimately, future research should prioritise specificity, transparency, and replicability to support evidence-informed practice in diverse emergency contexts.

Acknowledgments

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Appendix

Table 2:

High quality evidence

Legend: Interventions in red indicate a hyperlink to the original Paper.

Layer of RCRC MHPSS Framework	Intervention	Country Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Focused psychosocial support	Problem management plus (PM+) eg2,11. Five weekly 90 min sessions, stress management, problem-solving, behavioural activation, social support	Poland, Slovakia, Romania (FDPs from Ukraine); Pakistan, Kenya, Netherlands (Syrian refugees); Ukraine, Jordan, refugee camps	Adversity, post-conflict/ displacement, earthquakes, HIV	Trained lay/local non-specialists	23+ RCTs (across settings)	Adults and young people	Culturally adapted for certain contexts e.g. for Ukrainians or Afghan refugees	Scalable	Small to moderate effects on distress such as depression and anxiety, sustained till 6 months. At 12 months, the effects diminished and was comparable to care as usual. Effect for PTSD was smaller when compared to common mental health disorders.	Protocol available online	n/a
	Group Problem Management Plus (Group PM+) - 5 sessions, 2.5-3 hours each (gPM+) Sessions include managing stress, behavioural activation, managing problems. strengthening social support, review of techniques	Nepal (Earthquake-affected), Syrian, Turkey	Syrian civil war, ongoing stressors (poverty, overcrowding, violence, COVID-19 pandemic impacts)	Trained lay/local non-specialists – received 8 days of training and supervision RCT	RCT	Adults	Adapting to local idioms of distress; gender-matched facilitators	High retention and fidelity	a meta-analysis of nine studies showed that there was improvement in physical functioning and reduction in negative emotions, but there was no statistically significant improvement in social-interpersonal level or reduction in PTSD	Protocol available online	n/a
	Self-help Plus (SH+); 5 session, group-based, WHO-developed; strategies from Acceptance and Commitment Therapy (grounding, unhooking, accepting negative feelings); uses pre-recorded audio.	Ukraine, various European countries, Turkey (refugees); Uganda (camp for South Sudanese)	Displacement, adversity	Trained lay/local non-specialists	Multiple RCTs	Adults	Adapted into different language, colloquial language, culturally adapting illustration	Scalable	Meta-analysis favoured SH+ at follow-up, particularly beneficial to people with lower wellbeing level.	Protocol available online	No adverse events reported. However, some evidence in preventing the development of mental health disorder post intervention but not at 6-month follow-up from a prevention RCT. No difference between SH+ and enhanced care as usual at post-intervention

Layer of RCRC MHPSS Framework	Intervention	Country Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Focused psychosocial support	Doing What Matters in Times of Stress (DWM)	Ukraine, various European countries, Turkey, Kenya	COVID 19, Adversity (e.g., conflict, displacement)	Self-help guide; lay-providers (e.g. Barber)	It was adapted from SH+ which was RCT-backed	Adults and youth	Available in many language	Scalable	Reduction in depression and anxiety symptoms, coping with adversity. A review of this has not been found so far	Freely available online	Self-help interventions using re-recorded video
	Classroom Based Intervention (CBI) 8,15; Manualised CBT (5-7 weeks): cognitive restructuring, relaxation, psychoeducation, trauma narrative and problem solving.	Conflict-affected children (Syrian Children and Turkey), Indonesia, Nepal	Violence and displacement	Teachers, lay person, trained and supervised by specialists	Cluster RCT and uncontrolled studies	Conflict-affected children	n/a	School-based delivery implies feasibility	Results were mixed, some studies mentioning improved resilience and hope, but inconsistent evidence on improving psychiatric symptoms	n/a	n/a
	Caregiver Support Intervention (CSI)9; nine-session group intervention for parents of children aged 3-13. Family interactive sessions, relaxation, stress management, positive parenting skills	Syrian Refugees in Lebanon	Conflict/ adversity	Lay non-specialists	RCT	Caregivers (parents	Changing mindfulness to relaxation activities; culturally specific expressions	Pandemic disrupted the research trial	No significant change on overall parenting skills, but significant effect for those who received the full intervention uninterrupted by COVID-19. Small to medium effect on harsh parenting and caregiver distress.	n/a	n/a
	Physical exercise (including dancing) (Chen et al 2010). 10 week ballroom dance and physical exercise. (original paper in Chinese)	China	Earthquake	n/a	RCT	Adolescents	n/a	n/a	Significant reduction in anxiety level	n/a	Potentially contradictory evidence for children regarding the internalising concerns in another review where we described.
	Critical Incident Stress Debriefing (CISD); group delivery	China	Earthquake	n/a	RCT	Rescuers	n/a	n/a	Significantly lower PTSD scores and positive efficacy in improving symptoms of re-experiencing, avoidance, and hyperarousal	n/a	Contradictory findings regarding the effectiveness of CISD
	Huggy Puppy (Plush dog and encouraging them to care for the plushie)	Israel	Conflict and displacement	Caregivers in semi-structured format	Two studies, one randomised, one nonrandomised controlled study	Children	Developed in Israel and not further adapted	Feasible in small scale but no evidence for scalability. Delivered in home or daycare settings	Reducing sleep problems, anxiety and distress. Long-term outcomes are unknown	n/a	Small sample sizes and limited replication across different cultural or conflict settings.

Layer of RCRC MHPSS Framework	Intervention	Country Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Focused psychosocial support	Advancing Adolescents programme Profound stress attunement (PSA)	Jordan	Displacement	Trained adult community workers	RCT	Children age 12-18	Locally Relevant Content and Delivery, Facilitators from Local Communities. Gender-Specific Groups. Use of Culturally Validated Tools, Stress-Attunement Framework Tailored to Conflict Settings	Low-cost in community centres	Effective in reducing distress and insecurity and sustained impact up to 11 months		
	Narrative exposure therapy (NET)	DRC (conflict); Sudanese refugees in Ugandan camps (camps, Somalian/ Rwandan refugees), adults after earthquake	Conflict, trauma	Refugees, volunteers, lay non-specialists	Refugees, volunteers, lay non-specialists	Multiple RCTs	Former child soldiers; Somalian/ Rwandan/ Refugees (mean age 33 years)	Adapting to local language and context	Reduce PTSD, aggression symptoms	n/a	n/a
	Common Elements Treatment Approach (CETA) - CBT, modular interventions	Torture and violence affected populations in Thailand (displaced people from Myanmar), IPV in Zambia	Conflict/trauma, intimate partner violence, unhealthy alcohol use	Lay providers with supervision	Multiple RCTs	Adults and children with diagnosed mental health problems	Linguistic adaptation described; 'culturally acceptable and feasible for sensitive topics'	No adverse events	Outcomes include post-traumatic stress, depression, anxiety. Analysis of two RCTs that overall, 50% of CETA clients show some improvement after 4–6 sessions (1 SD) and large improvement (2 SD) after 7–10 sessions.	n/a	No adverse event
	Culturally adapted CBT (CA-CBT); 7 sessions in a group format	Syrian Refugee Women, Turkey	Displacement	University students trained for 1-week, weekly supervision by clinical psychologists	RCT	Adults	Changing of length, session number, adapting exposure work with vulnerable populations. Incorporates local idioms, proverbs, analogies, and metaphors Involved preparatory focus groups and consultation of cultural experts.	Low drop-out rates. Community centre settings, group settings	Large effect on PTSD, near medium effect sizes for anxious-depressive distress	n/a.	No adverse event Small sample size (n=12)
	Group-based Trauma-focused CBT	Congo	Armed conflict and sexual violence	Nonclinically trained Congolese facilitators	Single blind RCT	12-17 years old girls exposed to sexual violence	Nonclinical workers under supervision	Language, local metaphor and examples	Large reduction in PTSD, depression, anxiety, conduct problems, increase in prosocial behaviour	n/a	

Layer of RCRC MHPSS Framework	Intervention	Country Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Focused psychosocial support	Trauma healing and reconciliation workshop (with and without PTSD psychoeducation)	Rural Burundi, near Internally Displaced Persons (IDP) camps.	Post-civil war; lived under persistent threat of renewed periodic violence.	Burundian facilitators, chosen by a nonprofit based on their extensive experience and comparable demographics to participants. Facilitators received a full day of training.	RCT	Adult	There was a Burundian advisory team. Acknowledges local trauma response "Ihahamuka."	Sample size constrained. Most participants not fully literate, so measures administered orally with visual aids.	Both active treatment interventions (with and without psychoeducation) reduced traumatic stress symptoms more than the waitlist control. Workshop without PTSD psychoeducation showed a greater reduction in PTSD symptoms. No significant effect on general symptoms (anxiety, depression, somatization).	n/a	Workshop phases: 3-day group sessions, followed by a 1-day follow-up session 1 month later. Explored themes of trauma, loss, anger, trust, and roots of violence using discussion, experiential exercises, and games. Emphasized recovery through restoring community relations. Psychoeducation involved a 90-minute presentation on 17 specific PTSD symptoms and Criterion A events, followed by discussion. "No psychoeducation" group used additional time for interpersonal sharing on trust, security, interethnic relations.
	Trauma-focused cognitive behaviour therapy or problem-solving therapy	Protracted. Young people meeting criteria for PTSD. Region greatly impacted by civil conflict in Aceh, Indonesia	Post conflict. civil conflict in Aceh, Indonesia	Lay counsellors after brief training.	High. RCT.	Children aged (7 and 14 years), probable PTSD.	Delivered by lay counsellors	Yes, due to lay counsellors and students all from an after-school club.	Significant reductions in post-traumatic stress disorder and anger. Across both conditions, there was a large effect size for self-reported post-traumatic stress disorder		
Psychological support	Mind-Body skills group programme. Written word, spoken word, drawings, movement. Small groups in school. Two hours twice a week for 6 weeks.	Schools in Kosovo	Conflict between Serbian Military and Albanian resistance in Kosovo.	4 trained schoolteachers. Trained by Washington DC based faculty of Centre of Mind-Body Medicine. 2 parts 10-day intensive training in Kosovo. The teachers were supervised by psychiatrists and psychologist from the faculty CMBMschoolteachers. Trained by Washington DC based faculty of Centre of Mind-Body Medicine. 2 parts 10-day intensive training in Kosovo. The teachers were supervised by psychiatrists and psychologist from the faculty CMBM	RCT	82 Students aged 14-18 with symptoms of PTSD	Yes. Delivered in Albanian by schoolteachers. Universal techniques applied for low risk of cultural or religious conflict. It was framed as skills training to reduce stigma around pathologising. Received support from ministry of education	High recruitment. High retention. non-specialist delivery	Good. Statistically significant decrease in PTSD symptoms: Mean HTQ score dropped from 2.29 to 1.66. Effects were sustained after 3 months. majority of participants no longer met PTSD criteria at follow-up.		

Layer of RCRC MHPSS Framework	Intervention	Country Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Psychological support	SFL programme drawn on a three-tiered model recommended by WHO. Non trauma focused school-based mental health (emotional regulation, social skills, problem-solving, and resilience)	Chile	Earthquake and tsunami	Trained psychologists or social workers	Quasi-experimental, not randomized	Grade 2 students	n/a	Rural areas made it difficult to access	Reduced internalising problems and post-traumatic symptoms	n/a	
	Teaching Recovery Techniques (TRT) School-based intervention for PTSD symptoms	Gaza, Palestine, in school classes. Aftermath of 2008/2009 war, and context of ongoing military siege.	Post-war (major war in 2008/2009). Also considered ongoing conflict/siege that impacts daily life.	Four counsellors (master's degree in psychology, trained in TRT) ran sessions as extra-curricular activities on school premises. Weekly supervision provided.	Cluster Randomized Controlled Trial (RCT).	10–13 years old.	Arab-language manual with modifications, including culturally apt dream work and affect regulation elements.	Implemented as extra-curricular activities. Dropout of 16% between T2 and T3, with boys over-represented.	Nonsignificant effect on resilience, PTSD etc after adjusting for multiple comparisons in the erratum. Corrected confidence intervals indicated potentially large, clinically significant effects.	n/a	Other studies show positive results of TRT in the West Bank.
	Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention (EMDR G-TEP)	Kilis Refugee camp in southeast Turkey on the Syrian border	Conflict/ violence	Four professionals with EMDR Level 1 and Level 2 training and 3-15 years of EMDR experience. They received EMDR G-TEP training from the originator of the protocol.	RCT	Adults, 18 and older	Delivered with translation.	Practical and logistic difficulties, leading to a small sample size. Bureaucratic/security circumstances prevented continuing treatment for the control group. Literacy issues with worksheets for some participants were noted.	PTSD symptoms significantly lower in EMDR G-TEP group after intervention maintained at 4-week follow-up.	N/a	Delivered in 2 sessions over 3 days. Considered an early intervention. Ongoing stress in the camp may have triggered new traumas.
	Comparing Group CBT and group EMDR	Internally displaced people in Northern Iraq	Protracted. conducted in northern Iraq, in on-going emergency setting.	Psychosocial workers working for Action contre la Faim (ACF) supervised by psychologist. Trainings were provided by two authors of this article for four days.	RCT	Adults	n/a	Protocol used in this research was developed and has been used for several years by paraprofessional teams of Action contre la Faim. Aim was to be scalable. Delivered by paraprofessionals. Group based.	Results in the TF-CBT group and EMDR group showed a significant reduction in IES-R (PTSD) HAD-Depression and HAD-Anxiety.		

Layer of RCRC MHPSS Framework	Intervention	Country Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Psychological support	TF-CBT. Two sessions were reserved at the end of therapy to include a family member selected by the participant in keeping with the cultural salience given to the family as the unit of care and recovery.	Post-conflict Timor-Leste	Post conflict Timor-Leste	Clinical psychologist with 20 years of experience	High. Randomised into waitlist control and experimental group.	Adults	Content and style of delivered was adapted to fit setting of Timor-Leste	N/a	Psychological distress and PTSD showed substantial reductions in the TG but not the WL group	n/a	Modification of conventional TF-CBT to suit the Timor-Leste context, including the use of the Timor "lifeline," traditional Timorese dolls, and the provision of a fictional story of a Timorese man who overcame anger attacks.
	Group IPT (ITP-G) vs Creative play (CP) weekly for 16 weeks	Northern Uganda IDP camps adolescent survivors of war	Post conflict Uganda	Locally trained facilitators with 2-week training and weekly supervision	Randomised into waitlist control group or IPT-G or CP	Adolescents 14-17yrs single sex groups	Previous qualitative work by authors in Northern Uganda to ensure ITP-G compatible with Acholi culture	Yes	Girls significantly reduced depression scores compared to CP and w/l, and sig but smaller impact on anxiety. Boys –no sig difference in impact on anxiety, conduct disorder or functioning.		
	Interpersonal therapy (IPT) (Jiang, R et al 2014) 12 weekly sessions	China 3 years after Sichuan earthquake	Earthquake	Two-week intensive IPT training for local health personnel. Mainly psychologists and psychiatrists	RCT: IPT & TAU versus TAU, TAU group also then received IPT.	Adults- 18yrs+	n/a		Small scale pilot study. Significant reduction in PTSD and major depressive disorder symptoms for both IPT +TAU group and IPT participants following TAU		Feasibility & scalability aided by brief initial training and remote supervision effective.
	CPT Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence | New England Journal of Medicine	DRC female survivors of conflict and sexual violence	Ongoing conflict and violence	12 session CPT	RCT CPT (gp) versus individual support	Women	Local community psychosocial assistants trained for 2/52 in CPT	Scalable	Significant decrease for CPT participants in symptoms of PTSD and anxiety/depression at 6/12 f/up		
	Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial	Southern Iraq	Systematic violence and conflict	Local community mental health workers	RCT CPT vs w/ list and CETA vs w/list	Unclear	Local CMHWs used		CETA – large effect size on trauma symptoms & dysfunction CPT-moderate effect sizes for trauma & depression but no effect on anxiety or depression		

Table 3:

Lower quality evidence

Legend: Interventions in red indicate a hyperlink to the original Paper.

Layer of RCRC MHPSS Framework	Intervention	Country/Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Basic psychosocial support	Psychological first aid (PFA)	Gaza Strip, Chile. USA (natural hazard), Kenya (post-election violence), Haiti (earthquake), Lebanon (critical incident)	Immediate aftermath of disaster or conflict	Lay helpers/ first responders	Field reports (n=8), quantitative quasi-experimental studies, literature reviews. No RCT. There was also a study on assessing people's knowledge and readiness of delivering PFA but not effectiveness itself.	Adults and children	PFA should be age-appropriate and context-specific. It also highlights the importance of sensitively considering cultural and religious aspects, such as adding culturally appropriate prayers.	n/a	Reducing initial post-trauma distress; increasing self-efficacy and knowledge	n/a	Eight core actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social support, coping support, and linkage to collaborative services.
Focussed Psychosocial support	Art therapy (original article in Chinese hence the review paper is linked here)	China	Earthquake	n/a	Quasi-experimental	Caregivers	n/a	n/a	Better effectiveness in treating depression, anxiety, and general mental symptoms compared to psychological counselling	n/a	n/a
	CCC (Concerned Christian Community) – Trauma Counselling Intervention & WHDP (Women's Health and Development Program) – Support Groups and Skills Training	different locations in Liberia, primarily rural communities where people had returned after displacement due to war.	Women affected by war and sexual violence in Liberia	Lay counsellors (CCC); WHDP (trained midwives)	Quasi-experimental	Adults	n/a	limited training, stigma around sexual violence, and resource constraints posed significant challenges to consistent delivery and sustainability	CCC showed some improvement for Trauma symptom reduction and mental health distress. WHDP had limited improvement for trauma symptom reduction and mixed for mental health distress. More research needed.	n/a	Counsellors lacked training and some were experiencing trauma themselves.
	Happy Helping Hand (Raising awareness of relationships between feelings, thoughts, behaviours, coping skills; online text, videos, games/interactive exercises)	Norway (development), Lebanon (implementation with Syrian refugees)	Conflict and displacement	Teachers	Uncontrolled trial/ Master's dissertation	Adolescents	Language adaptation	Free protocol	Significant improvement in anxiety and depression symptoms and wellbeing	Free manual	

Layer of RCRC MHPSS Framework	Intervention	Country/ Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Focussed Psychosocial support	Skills Or Life Adjustment and Resilience (SOLAR)-Kids/ Teens2; brief 5 session intervention, CBT-based	Australia (uncontrolled), Pacific Island Tuvalu (controlled study)	Natural disasters (bushfires), Cyclone affected communities	Non-mental health professionals supervised by psychologists.	Pilot study (pre-post mixed methods design); Quasi-experimental (n = 49)	Children and adults	Cultural adaptation of materials following focus group discussion.	High programme fidelity 0% dropout rate.	Potentially useful/beneficial. Reduction in PTSD and impairment.	n/a	
	Solution-oriented approach (group work with 10 sessions on psychoeducation and coping skills)	DRC, Mali and Nigeria	Conflict and violence	ICRC-trainee lay counsellors	Retrospective cohort study and a mixture of cohort studies	Children and adults	Yes (delivered by local)	Seems feasible for task-sharing	65% of participants showed reduced psychological distress. Measured through use of tools - DASS21 (Depression Anxiety Stress Scales) and IES-R (Impact of Event Scale-Revised). 80% of participants showed improvement in daily functioning. re/post comparisons showed statistically significant reductions in symptoms of anxiety, depression, and trauma-related distress across countries. Effectiveness was noted in all three countries. However, no control group, no randomization, self-report, no long-term effects measured.	n/a	
	Community Wellness Focusing (CWF)	Gaza Strip, Palestine.	Ongoing conflict	Local NGOs train people to facilitate. Focusing trainers developed CWF. Trained by PTC. Weekly supervision from PTC-UK.	Experimental design comparing three therapies; no control group. Quantitative pre- and post-assessment using PTSD-SRII.	12 to 75 years.	Palestinians involved in adapting CWF. Uses symbolic expression (objects, movement, drawing, mood cards) to help people talk about feelings indirectly.	n/a	Significant reduction in PTSD symptoms.	Funded by Palestine Trauma Centre (UK), International Focusing Institute, and Irish Quakers.	Based on Professor Eugene Gendlin's Focusing method and psycho-social approaches to resilience. Twelve sessions (e.g., listening skills, safe place, drawing feelings, psychological resilience, proverbs/Quran verses, teddy bear exercise). Client-centred approach.

Layer of RCRC MHPSS Framework	Intervention	Country/Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Psychological Support	Narrative protocol: Action contre la Faim (ACF)/KONO and EMDR-based Group Trauma Episode Protocol (G-TEP)	Central African Republic (CAR), Context of ongoing conflict and insecurity	Conflict, violence and insecurity	Paraprofessionals (10 psychosocial workers) supervised by clinical psychologists. Paraprofessionals had varied educational backgrounds and 1.5-3+ years' experience, trained in psycho-trauma and protocols.	Retrospective study comparing two interventions. Data collected as part of routine monitoring and evaluation.	Children aged 6–17 years.	n/a	Task-sharing, scalable. High participation despite danger. G-TEP offers greater flexibility as each session is identical. Challenges: ongoing conflict limited access and follow-up data collection.	PTSD symptoms (CRIES-8): significant reduction. No significant difference between protocols in pre- and post-treatment scores. Maintenance: Effects of both protocols were maintained 5 months after treatment, Children >= 12 years showed larger improvement with G-TEP; children < 12 years with ACF/KONO.	Not explicitly stated, but use of paraprofessionals and group settings implies cost-effectiveness for scalability.	Both protocols involved five bi-weekly sessions. ACF/KONO involves narrative sharing and drawing; G-TEP involves individual work on a sheet with drawing, with less verbal sharing of trauma. G-TEP may be more protective against vicarious trauma for psychosocial workers as children do not share traumatic experiences verbally.
	Hotline counselling (original article in Chinese)	China	SARS	Psychotherapists and medical staff after training	Quasi- experimental (with control group)	SARS inpatients in a hospital	n/a	Active telephone consultation had the highest response (when compared to passive, or counselling through paper and pencil or face to face crisis intervention)	Improved general mental health except for phobia, paranoia and psychosis	n/a	
	Multi-family approach (MFA); Six sessions, 2.5 hours each; focuses on identifying stressors, family interactions, and exploring resources	Poland, Slovakia, Romania (conflict-affected populations)	Conflict	Professionals	not properly evaluated	Families	n/a	Claimed to be feasible	Efficacy not yet empirically evaluated; feasible and safe across populations; Aims to improve parenting skills, attachment, inter- and intra-family support, and prevent generational consequences of stressors	n/a	

Layer of RCRC MHPSS Framework	Intervention	Country/ Setting	Type of emergency	Who's delivering	Level of evidence	Age range	Cultural adaptation	Feasibility	Effectiveness	Cost	Any other indicators of interest
Psychological support	Family Therapy Programme (FTP)	Gaza Strip, Palestine.	Ongoing conflict	Psychologists and therapists trained by Palestine Trauma Centre (PTC). Local FTP intervention team. Weekly supervision from PTC-UK via Skype.	Experimental design comparing three therapies; no control group. Quantitative pre- and post-assessment using PTSD-SRII.	12 to 75 years.	Yes. Developed by PTC-Gaza to meet cultural needs since 2007, pilot tested among Arab speakers in UK. Emphasizes cultural aspects like resilience as part of Palestinian culture.	Challenged by constant bombardments.	Significant reduction in PTSD symptoms. Promoted resilience.	Funded by Palestine Trauma Centre (UK), Interpal, and Muslim Aid.	Aims to maintain good relationships, cope with emotions, and enhance resilience/steadfastness through practical skills and better communication. Includes psychoeducation to build community solidarity. 12 sessions over three months (e.g., building trust, hope/fear, cultural family genogram, resilient narrative, stress management, coping strategies).
	Psycho-Social Support Programme (SANID)	Gaza Strip, Palestine	Ongoing conflict.	Multidisciplinary project team. Unsure who delivered the programme. Psychologists, social workers, a psychiatrist, and activity facilitators. Trained by PTC. Weekly supervision from PTC-UK.	Experimental design comparing three therapies; no control group. Quantitative pre- and post-assessment using PTSD-SRII.	12 to 75 years.	Yes. Developed by PTC-Gaza to meet cultural needs since 2007, pilot tested among Arab speakers in UK.	Same as above.	Significant reduction in PTSD symptoms.	Funded by Palestine Trauma Centre (UK), Interpal, and Muslim Aid.	SANID has six sessions (1): Building trust and psychological debriefing; (2): Expressing feelings; (3): Safe space and colouring; (4): Stress and resilience; (5): Pain and hope. (6): Building a resilient narrative story.
	Online Eye Movement Desensitisation and Reprocessing (EMDR) (Standard EMDR protocol, adapted for language)	Forcibly displaced Syrian women living in Türkiye or inside Syria.	Syrian conflict (since 2011). Needs compounded by the 2023 earthquake.	Trained forcibly displaced Syrian women therapists (three female Syrian psychologists). They had a mental health background and received extensive EMDR training and supervision.	Observational pilot study.	Adult women	Delivered by forcibly displaced Syrian women therapists to Syrian women, using Arabic versions of measures. Shared experiences.	Online delivery increased access and availability, and privacy concerns in clinics. Training local community workers is seen as scalable, sustainable Challenges: poor internet connection, privacy issues (being overheard), caring responsibilities, other commitments	Reduction in PTSD, depression and anxiety symptoms. Maintenance: Not assessed		Up to 12 sessions over 3 months
	TFCBT	Puerto Rico post financial crisis and hurricane.	Protracted effects. Category 4 Hurricane Maria	Fifteen Puerto Rican psychologists were trained in TF-CBT. Sessions were delivered in mental health clinics and a primary care clinic.	Pre-post study without control group	56 children and adolescents. Age 5-18.	Community based and delivered by Puerto Rican psychologists.	Reasonable ease of implementation in local setting and reasonable effectiveness.	Thirty-six out of 56 children enrolled in the project (64.3%) successfully completed all components of TF-CBT. Results demonstrated large effect sizes for reduction in youth-reported posttraumatic stress symptoms, depressive symptoms, and anxiety symptoms		Study also reports it is effective within the setting of telehealth (due to the COVID-19 pandemic)