**Table S7**. *Summary of studies, samples and interventions reported.*

| Study | *N* | Study Design | Home Country | Country of study | Age range | Intervention Used | Measures Used | Additional Information | Findings | QualityAssessment(/20) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  *Cognitive Behaviour Therapy* |
| Unterhitzenbergeret al., (2015) | 6 | Case Series | AfghanistanSomalia | Germany | 16-18 | Trauma-Focused Cognitive Behaviour Therapy  | * Clinician Administered PTSD Scale for DSM-5 – Child/Adolescent Version (interview)
* The Posttraumatic Diagnostic Scale (interview)
 | * 12-28 treatment sessions
* Administered by 3 trained therapist
* Conducted within an outpatient clinic
* Caregiver sessions provided
 | TF-CBT was effective in reducing overall symptom severity for PTSD (*p* < .001; *Z* score not reported due to small sample size) | 17 |
| Doumit et al., (2020) | 31 | One group pre-post test | Syria | Lebanon | 13-17 | Cognitive-Behavioural Therapy (Creating Opportunities for Patient Empowerment [COPE] program) | * Patient Health Questionnaire-9 (PHQ-9)
* Generalized Anxiety Disorder-7 (GAD-7)
* Pediatric Quality of Life (PedsQL)

\* All self-report | * Program consisted of one weekly 60-minute sessions (7 weeks total)
* Group-based format
* Led by licensed instructor and therapist
 | Significant decreases in symptoms of depression (*p* = .025, *d* = .42) and anxiety (*p* = .049, *d* = .37) as well as improvements in overall quality of life (*p* = .05, *d* = .39) | 16 |
| Kazandjian et al., (2020; secondary analysis) | 31 | One group pre-post test | Syria | Lebanon  | 13-17 | Cognitive-Behavioural Therapy (Creating Opportunities for Patient Empowerment [COPE] program) | * Patient Health Questionnaire-9
* Generalized Anxiety Disorder-7
* Pediatric Quality of Life Inventory

\* All self-report  | * Secondary analysis of data collected by Doumit et al (2020 – detailed above)
 | Between males and females, males demonstrated a significant reduction in mean anxiety scores post-intervention (*p* = .04). Within sex differences identified significant reductions in mean anxiety (*t* (15) = 2.28, *p* = .04) and depression (*t* (15) = 1.83, *p* = .04) scores post-intervention, but only for males. Furthermore, males demonstrated significant increases in overall quality of life scores (*t* (15) = 1.89, *p* = .04), including significant increases in physical (*t* (15) = 1.93, *p* = .04) and psychosocial (*t* (15) = 1.76, *p* = .05) health | 16 |
| Fox et al., (2005) | 58 | One-group pretest-posttest | Vietnam Cambodia | America | 6-15 | Cognitive Behaviour Therapy | * Children’s Depression Inventory (screener delivered by bilingual teachers or nurses)
 | * School-based, group therapy program
* Eight weekly sessions, lasting approximately 1 hour
* Program was implemented by bilingual and bicultural teachers and nurses
* Children were divided into age-appropriate groups
 | Effective in reducing depressive symptoms (*p* = .003). One month following the intervention, participants continued to demonstrated improvements in depressive symptoms (*p* < .001) | 17 |
| Ehntholt et al., (2005) | 26 | Non-randomised controlled study | Countries across Europe, Africa, The Middle East | England | 11-15 | Cognitive Behaviour Therapy | * Revised Impact of Event Scale
* Depression Self-Rating Scale
* Revised Children’s Manifest Anxiety Scale
* Strengths and Difficulties Questionnaire
 | * Conducted across two schools
* Group-based therapy
* Weekly 1-hour sessions for 6 weeks
* Administered by a clinical psychology trainee
* Children were allocated into a treatment group, or a waitlist control group
 | Significant difference between groups with regards to PTSD symptom severity (*F* (1,23) = 10.96, *p* = .003) with results indicating that the intervention grouped demonstrated significant reductions in PTSD symptom severity (*t* (14) = 2.93, *p* = .01) including significant reductions in intrusion (*t* (14) = 3.83, *p* = .002). Results also indicated significant improvements in behavioural (*p=*.03, *Z* = -2.21), and emotional (*p*=.01, *Z* = -2.56) difficulties. Did not impact anxiety or depression | 17 |
| Pfeiffer & Goldbeck (2017) | 29 | One-group pretest-posttest | Countries across Africa and The Middle East | Germany | 14-18 | Mein Weg (Trauma-Focused Cognitive Behaviour Therapy) | * Child and Adolescent Trauma Screen
 | * Consisted of six 90-minute group sessions
* 2-6 participants per group
* Administered by 1-2 social workers
 | Effective in reducing self-reported PTSD symptom severity (*p* < .001, *d* = .97), including significant reductions in re-experiencing (*p* < .001, *d* = .84), avoidance (*p* = .04, *d* = .45), and negative altercations in cognitions and mood (*p* < .001, *d* = .87). No significant improvement in hyper arousal | 18 |
| El-Khani et al., (2018) | 16 | One-group pretest-posttest | Syria | Turkey | 6-12 | Teaching Recovery Techniques (Trauma-Focused Cognitive Behaviour Therapy) plus additional parent skill sessions | * Child Revised Impact of Events Scale (CRIES-13)
* The Depression Self-Rating Scale for Children
* The Screen for Childhood Anxiety Related Disorders
* The Strengths and Difficulties Questionnaire
* The Child Adjustment and Parenting Efficacy Scale
 | * Administered in a school for displaced children
* Consisted of five 2-hour child sessions
* Group-based intervention (up to 15 children per group)
* Parallel 2-hour parent sessions focusing on parenting skills
* Administered by four trained teachers
 | TF-CBT was effective in reducing symptoms of child reported intrusion (*p* = .02, Z = -2.27) and parent-reported behavioural difficulties (*p* = .04, Z = -2.05). Parents also reported significant improvements in child intensity (*p* = .02, Z = -2.36)CBT did not reduce symptoms of child or parent rated depression or anxiety. Parents did not report significant improvements in emotional maladjustment | 17 |
| El-Khani et al., (2021) | 119 | RCT | Syria | Lebanon | 9-12 | Teaching Recovery Techniques (Trauma-Focused Cognitive Behaviour Therapy) plus additional parent skill sessions (TRT + P) | * Child Revised Impact of Events Scale (CRIES-13)
* The Depression Self-Rating Scale for Children
* The Screen for Childhood Anxiety Related Disorders
* The Strengths and Difficulties Questionnaire
* The Parenting Scale
* The Impact of Events Scale Revised
 | * Consists of five 2hour child sessions delivered in a group format (15 children)
* Original protocol included two parallel caregiver sessions
* New protocol includes three additional caregiver sessions
* Randomly allocated into TRT+P (intervention), TRT (active control), or waitlist control
 | All three groups demonstrated significant reductions in PTSD symptom severity when compared to baseline. However, highest reduction found in TRT+P intervention group. TRT+P intervention group had significantly lower scores on PTSD symptom severity at T2 (*p* = .00) and T3 (*p* < .001) when compared to the waitlist control. Depression symptom severity decreased significantly in both the TRT-P (*p* < .001) and TRT group (*p* < .001) but not the waitlist control.Significant reductions in child reported anxiety were observed in both the TRT+P group (*p* < .001) as well as the TRT group (*p* < .001) but not the waitlist control. Similarly, significant decreases in parent-rated anxiety were seen in both the TRT+P group (*p* < .001) as well as the TRT group (*p* < .001) but not the waitlist control.No significant change found regarding emotional and behavioral difficulties.  | Low risk of bias |
| Schottelkorb et al., (2012) | 31 | RCT | Countries across Africa, Asia, Europe, The Middle East | America | 6-13 | Trauma-Focused Cognitive Behaviour Therapy  | * UCLA PTSD Reaction Index for DSM-IV (child report)
* Parent Report of Post-Traumatic Symptoms
 | TF-CBT* Therapists were 9 trained second- or third-year graduate students
* Consisted of nine 30-minute weekly sessions for children and parents, plus 3 x 90-minute conjoint parent-child sessions.
* Administered in a school setting
 | Effective in significantly reducing both child (*p* > .01, η2 = .43) and parent reported *p* > .01, η2= .57) PTSD symptom severity in children who had met criteria for a PTSD diagnosis | Low risk of bias |
| Ooi et al., (2016) | 82 | Cluster RCT | Countries across Asia, Africa, and the Middle East | Australia | 10-17 | Teaching Recovery Techniques (Trauma-Focused Cognitive Behaviour Therapy) | * Parent-rated Strengths and Difficulties Questionnaire
* Children’s Revised Impact of Event Scale
* Birleson Depression Self-Rating Scale
* Hopkins Symptoms Checklist-37 for Adolescents
 | * Group-based intervention
* Administered within a school setting
* Groups were conducted 1 hour a week, for 8 weeks
* Group size ranged from 4-10 participants
* Administered by two trained facilitators, and four co-facilitators (masters and PhD level psychology students)
 | TF-CBT was found to be effective in reducing self-reported symptom severity for depression (*p*= .02, η2 = .07). Significant PTSD reductions were observed across both groups (TF-CBT vs. Waitlist). However, no significant intervention effect was found in terms of reducing overall PTSD symptom severity (*p*= .08, η2 = .04). Similarly, significant reductions in parent-rated behavioural difficulties were observed across both groups (*p*< .001, η2 = .18). Three month follow up (no control group) indicated significant improvements in self-reported PTSD symptoms (*p*< .001, η2 = .25) as well as internalizing (*p* = .02, η2 = .15) and externalising (*p* < .001, η2 = .06) difficulties. Significant improvements in parent rated social/emotional difficulties were maintained (*p*< .001, η2 = .17) | Low risk of bias |
| Gormez et al., (2017) | 32 | One-group pretest-posttest | Syria | Turkey | 10-15 | Cognitive Behaviour Therapy | * The Child Post-Traumatic Stress – Reaction Index
* Spence Children’s Anxiety Scale
* Strengths and Difficulties Questionnaire

\*Self-administered but teachers provided guidance where needed  | * Administered in a school setting (temporary education centre)
* Eight session (~70-90 mins) group-based program consisting of 8-10 children
* Delivered by trained Arabic speaking teachers
 | CBT was effective in reducing self-reported PTSD symptom severity (*p* = .01, *t* = 2.72), including significant reductions in intrusiveness (*p* = .01, *t* = 3.88) and arousal (*p* = .02, *t* = 2.60). Significant reductions in anxiety (*p* < .001, *t* = 3.73), emotional problems (*p* = .01, *t* = 2.85) were also found | 17 |
| Sarkadi et al., (2018) | 46 | One-group pretest-posttest | The Middle East  | Sweden | 14-18 | Teaching Recovery Techniques (Trauma-Focused Cognitive Behaviour Therapy) | * Children’s Revised Impact of Event Scale (CRIES-8)
* The Montgomery-Asberg Depression Rating Scale
 | * Five sessions lasting between 90-120 minutes
* Two sessions for caregivers
* Group-based intervention program, administered across various community settings (e.g., group homes, asylum health care center)
* Administered by practitioners trained in delivering TRT
 | TF-CBT was effective in reducing self-reported depression symptom severity (*p* < .001, *t* = -3.93) as well as overall PTSD symptom severity (*p* = .02, *t* = -2.49) | 17 |
| Baggerly & Corbin (2021) | 20 | One group pretest-posttest | Myanmar and Vietnam | United States of America | 8-14 | Cognitive Behavioral Intervention for Trauma in Schools (CBITS) | * The Child PTSD Symptom Scale
 | * Delivered within a school setting
* Aims to equip children with skills to help relax, challenge negative thoughts, solve social problems, and process traumatic memories
* Includes 10 group sessions and 3 individual sessions
 | Significant drop in PTSD symptom severity score from pre- to post-intervention (*p* = .00) | 17 |
| Elswick et al., (2022) | 88 | One group pretest-posttest | Countries across Africa | United States of America | 12-18 | Trauma Healing Club (Adaptation of Cognitive Behavioral Interventionfor Trauma in Schools (CBITS)) | * Child PTSD Symptom Scale
* Subjective Units of Distress Scale
 | * Utilises the CBITS framework
* Incorporated culturally responsive programming (e.g., African drumming) to adapt the intervention for African refugee populations
* 12-week, group-based program
 | Clinically significant improvement in PTSD symptom severity found post-intervention | 18 |
| Schuler & Raknes (2022) | 125 | One group pretest-posttest | Syria | Lebanon | 13-17 | The Helping Hand | * WHO-Five-Well-being Index
 | * Intervention is a cognitive behavioral digital game for adolescents
* Involves mastering emotional challenges, dealing with criticism, suicidal thoughts, and bad memories
* Group-based sessions delivered over 10 weeks (45-60 minutes)
 | Significant improvements in wellbeing from baseline to postintervention (*p* < .05) | 17 |
| Roger et al., (2021) | 6 | One group pretest-posttest | Syria | Canada | 7 - 11 | Family-Based storybook intervention (based on CBT principals)  | * Revised Children’s Anxiety and Depression Scale (self and parent-report)
 | * Consisted of an illustrative interactive storybook
* Caregivers and children provided with four different stories which are to be completed together
* Encourages discussions surrounding emotions and problem solving
 | Parent (*p* < .05) and child-reported (*p* < .05) anxiety scores significantly decreased post-intervention | 16 |
|  *Play Therapy* |
| Eruyar & Vostanis (2020) | 15  | One group pre-post test | Syria | Turkey | 8-14 | Group Theraplay  | * Children’s Revised Impact of Events Scale (child rated)
* The Security Scale (child rated)
* The Strengths and Difficulties Questionnaire (parent-rated)
* Relationship Problems Questionnaire (parent rated)
* Parent Perception Inventory (parent rated)
 | * Consisted of at least eight weekly sessions
* Sessions lasted 45 minutes and was delivered by a trained therapist
* Children were divided into groups based on gender
* Mothers attended for the first and final session
* Includes participation in various games and group activities
 | No comparison between intervention and control group could be done. However, results indicated significant difference in pre-post parent-rated attachment problems (*t* (14) =2.19, *p* = < .05, *r* = .40) in the intervention group. Significant reductions in pre-post symptoms of PTSD (*t* (13) = 2.65, *p* = .020, *r* = .59) and behavioural/emotional difficulties (*t* (13) = 3.40, *p* = .004, *r* = .62) were also found for the intervention group  | 16 |
| Schottelkorb et al., (2012) | 31 | RCT | Countries across Africa, Asia, Europe, The Middle East | America | 6-13 | Child- Centered Play Therapy | * UCLA PTSD Reaction Index for DSM-IV (child report)
* Parent Report of Post-Traumatic Symptoms
 | CCPT:* Administered by 9 trained child-centered play therapist
* Therapy session were held both in a school setting (30 mins) and a clinic setting (45 mins)
* Children attended therapy sessions twice a week for 12 weeks
 | Effective in significantly reducing both child (*p* > .01, η2 = .43) and parent reported *p* > .01, η2= .57) PTSD symptom severity in children who had met criteria for a PTSD diagnosis | 16 |
| Tucker et al., 2021 | 189 | RCT | Countries across Africa, Asia, Central America, The Middle East | America | 3-4 | Sunshine Circles: Attachment-based play group  | * Ages and Stages Questionnaire
* Ages and Stages Questionnaire: Social Emotional
* GOAL Assessment System
* The Devereux Early Childhood Assessment for Preschool Children (DECA)
* Preschool Behavior Questionnaire
 | * Group-based intervention and model for groups and classrooms
* Teacher-led classroom groups (20 – 30 minutes) once or more per week
* Aims to provide children with opportunities to develop up- and down- regulation, social connection, and attunement with a caregiver
* Children randomized to intervention or programming-as-usual
 | Participants in the intervention group demonstrated significantly higher problem solving (*p* < .001) and personal-social skills (*p* < .001) when compared to control groupNo significant change found in regard to emotional problems. On the DECA, Participants in the intervention group demonstrated significant improvements in the following subscales: initiative solving (*p* < .001), self-regulation (*p* < .001), attachment/ relationships (*p* < .001), behavior concerns (*p* = .02) when compared to the control group | Some concerns  |
|  *Narrative Exposure Therapy* |
| Catani et al., (2009) | 31 | RCT | Sri Lanka | Sri Lanka | 8-14 | Narrative Exposure Therapy (KIDNET) | * UCLA PTSD Index for DSM-IV (interview with child)
 | * Intervention consisted of six sessions (~60-90-mins each)
* Sessions completed over two-week span
* Administered by six female counselors to participants living in a refugee camp
* Participants were randomly assigned into treatment or control group (meditation-relaxation)
 | Significant reductions in PTSD symptom severity were reported across both groups (NET vs. Mediation-relaxation; *p* < .001) - the interaction effect was non-significant. Effect size (Cohen’s d) for the KIDNET group post-intervention was 1.76 and 1.96 at 6-month follow upSignificant reductions with regards to impairments in functioning were reported across both groups (*F* (2,54) = 19.54; *p* < 0.001)- The interaction effect was non-significant  | Low risk of bias |
| Onyut et al., (2005) | 6 | One-group pretest-posttest | Somalia | Uganda | 13-17 | Narrative Exposure Therapy (KIDNET) | * The Posttraumatic Diagnostic Scale
* Hopkins Symptom Checklist-25

\*Self-report instruments but delivered through interview format to provide assistance | * Individual intervention was delivered in Ugandan refugee settlement
* Treatment consisted of 4-6 sessions (of ~1-2 hours)
* Intervention administered by experienced clinicians Trained interpreters employed to facilitate treatment delivery
 | NET was effective in reducing overall PTSD symptom severity (*F* (2,5) = 15.45, *p* < .01) | 18 |
| Peltonen & Kangaslampi (2019) | 50  | RCT | Countries across Africa and The Middle East  | Finland  | 9-17 | Narrative Exposure Therapy(KIDNET) | * Children’s Revised Impact of Event scale
* Depression Self-Rating Scale for Children
* Strengths and Difficulties Questionnaire (parent and child report)
 | * Recruited 51 experienced mental health professionals who had been trained in the delivery of NET
* Intervention consisted of between 7 and 10 weekly sessions (90 mins)
* KIDNET was utilised with younger participants
* Conducted across several treatment centres in Finland
 | Reductions in overall PTSD symptom severity reported across both groups (NET vs. TAU; *F* (1,35) = 12.93, *p* < .001), but no NET- effects were found. Both groups demonstrated reductions in both child (*F*(1,18) = 4.97, *p* < .039) and parent (*F*(1,17) = 5.94, *p* < .026) reported psychological distress, as well as increases in resilience (*F*(1,23) = 5.14, *p* < .033) but the intervention effects were non significant. No significant reductions in depression symptoms severity found (*p* = .62) | Some concerns |
| Kangaslampi & Peltonen (2020; secondary analysis of Peltonen & Kangaslampi, 2019) | 40 | RCT | 75% of participants were from refugee background (Iraq, Afghanistan) | Finland  | 9-17 | Narrative Exposure Therapy | * Children’s Revised Impact of Events Scale
* Child Post-Traumatic Cognitions Inventory
* Trauma Memory Quality Questionnaire
* \*All self-report
 | * Clinicians (e.g., psychologists) were trained in delivering NET
* NET intervention consisted of 7-10 sessions of approximately 90 sessions (over 3 months)
* TAU group received whatever treatment they would normally receive at cooperating units (e.g., family therapy)
 | No significant intervention effect was found in terms of reducing traumatic memories (*F* (14, 315.37) = .84, *p* = .361), traumatic cognitions (*F* (1, 4498.45) = .95, *p* = .330), or post-traumatic stress symptoms (*F* (1, 15,347.50) = 1.69, *p* = .194)  | 19 |
| Ruf et al., (2010) | 26 | RCT  | Countries across Europe and The Middle East | Germany | 7-16 | Narrative Exposure Therapy (KIDNET) | * UCLA PTSD Index for DSM-IV (interview format)
* Mini International Neuropsychiatric Interview for Children
 | * The intervention was carried out by 8 clinical psychologists
* Interpreters employed where necessary
* Intervention consisted of eight weekly sessions (90-120 mins each)
* Depending on individual cases, participants were offered less or more sessions
 | NET was effective in reducing overall PTSD symptom severity (*p* = .001, *t* = 4.20) forparticipants in the treatment group. Significant reductions in intrusion (*p* < .001, *t* = 4.90), avoidance and numbing (*p* = .001, *t* = 4.21), hyper arousal (*p* < .05, *t* = 2.54), and functional impairment (*p* < .001, *t* = 5.61) | Low risk of bias |
| Said & King (2020) | 4 | One group pretest - posttest | Sudan, Vietnam, and Albania | United Kingdom  | 16-17 | Narrative Exposure Therapy | * Child Revised Impact of Events Scale
* Child PTSD Symptom Scale
 | * Delivered by trained clinical psychology doctoral trainees
* Therapy delivered in clients’ preferred language
* Clients received anywhere between 9 – 20 sessions
 | At the start of intervention, all participants were assessed as having severe PTSD. Following intervention, two clients’ scored below the clinical range for PTSD while three clients met criteria for reliable improvement.  | 17 |
|  *Expressive Art Therapies* |
| Lange-Neilsen et al., (2011) | 139 | RCT | Gaza | Gaza | 12-17 | Expressive Therapy (Writing for Recovery) | * Revised Child Impact of Event Scale 13 (CRIES-13)
* Revised Children’s Manifest Anxiety Scale
* Depression Self-Rating Scale for Children

\*All self-report | * Intervention was administered in a school setting
* Intervention was conducted across 3 consecutive days. Two sessions of 15 mins were conducted, with a break of 10 mins in between sessions
* Delivered by instructors trained in the delivery of the program
 | An *increase* in depressive symptoms was found following intervention (*p*< .001, *d* = 1.2). Reductions in PTSD were observed across both groups (Expressive therapy vs. Waitlist control) although no significant intervention effects on overall PTSD and anxiety symptom severity were found | High risk of bias |
| Feen-Calligan et al., (2020) | 15 | Non-randomised controlled study | Syria | The United States of America | 7-14 | Art Therapy  | * Screen for Child Anxiety Related Emotional Disorders
* UCLA Child/Adolescent PTSD Reaction Index
* \*All self-report
 | * No-treatment control participants included Syrian youths not currently engaged in any form of treatment
* Intervention was administered by a registered are therapist as well as graduate students
* 12 weekly sessions (90 minutes)
* Techniques used include deep breathing, mindfulness, collage, puppetry, and other media
 | Results indicated a significant and large effect in favour of art therapy for symptoms of self-reported separation anxiety (*p* = .002, *d* = 1.50). Non-significant changes found in the control group. However, no significant changes were found in favour of art therapy for symptoms of PTSD, overall anxiety, panic disorder, school avoidance, social anxiety as well as Generalised Anxiety Disorder (*p* > .05)  | 18 |
| Ugurlu et al., (2016) | 64 | One-group pretest-posttest | Syria | Istanbul | 7-12 | Art Therapy (including music, movement, and drawing).Skills for Psychological Recovery programmed was incorporated | * Child Depression Inventory
* State-Trait Anxiety Scale
* UCLA Post-Traumatic Stress Disorder INDEX for DSM-IV (parent version)
 | * Syrian volunteer translators helped facilitate the delivery of the program in Arabic
* Intervention was delivered by three licensed art therapists
* Children divided into groups depending on their ages (7-8; 9-10; 11-12)
* Implemented across 5-days
 | Intervention was effective in reducing overall symptom severity for depression (*p* < .05, *g* = .72), PTSD (*p* < .05, *g* = 1.00), and trait anxiety scores *(p* < .05, *g* = .80). No significant change in state anxiety (*p* >.05) | 18 |
| Grasser et al., (2019) | 16 | One group pre-post test | Syria | The United States of America  | 7-14 | Dance Movement Therapy  | * Posttraumatic Stress Disorder Reaction Index
* Screen for Child Anxiety-Related Emotional Disorders
* \* All self-report
 | * Facilitated by licensed therapists
* Integrates exposure, mindfulness, and somatic components to address trauma and stress
* Group based program
 | The intervention was associated with improvements in overall PTSD symptoms (*p* = .006, *d* = .81). Significant improvements in overall anxiety were also reported *(p* = .002, *d* = .91), including improvements in panic disorder (*p* = .005, *d* = .82), separation anxiety (*p* = .05, *d* = .54), social anxiety (*p* = .05, *d* = .53) and generalized anxiety (*p* = .002, *d* = 1.09) | 16 |
| DeMott et al., (2017) | 145 | Non-randomised controlled study | Countries across Africa and The Middle East | Norway | 15-18 | Expressive Arts In Transition (EXIT) program  | * Hopkins Symptom Checklist-25
* Harvard Trauma Questionnaire
* Cantril’s Ladder of Life Satisfaction

\*All self-report | * Participants assigned to intervention, or life as usual
* Intervention comprised of 10 sessions (~ 1.5 hours) delivered across 5 weeks
* Conducted across refugee facilities in Norway
* Up to 10 participants per group
* Intervention conducted by 2 expressive art therapists and a translator per session
 | EXIT was effective in reducing overall PTSD symptom severity (*p* = .04). Engagement in the intervention was associated with decreases in general psychological distress (*p* = .05) and increased life satisfaction (*p* =. 02) | 18 |
| Quinlan et al., (2016) | 42 | Non-randomised controlled study | Countries across Africa, The Middle East, and Asia | Australia | *M* = 15.5 years | Home of Expressive Arts and Learning (HEAL) - Uses an integrated arts/music and psychotherapy approach. Tree of Life program (narrative approach targeting self and cultural identity) | * Hopkins Symptoms Checklist-25 (read and translated to students)
* Strengths and Difficulties Questionnaire (teacher report)
 | * Treatment consisted of a minimum of 1 individual (~ 60 minutes) session per week, and engagement in group-based programs
* Conducted in a school setting
* Trained art psychotherapists as well as music therapists administered therapy
 | Improvements were noted across both groups - no intervention effect for depression (*p* = .75), anxiety (*p* = .60), somatic complaints (*p* = .67), or overall behavioural difficulties (*p* = .08). Significant improvements in emotional symptoms were noted (*p* = .04, *d* = .52) | 18 |
| Rousseau et al., (2009) | 105 | RCT | Countries across Asia, Europe and South America | Canada | 4-6 | Creative expression workshops (sandplay program) | * Strengths and Difficulties Questionnaire (teacher and parent versions)
 | * Intervention was delivered within a school-based setting
* Consist of 10 60-minute workshops that occur every second week
* Program was delivered across a period of four months
* The program was delivered by three trained art therapists with the help of classroom teachers
 | Workshops were effective in reducing parent-rated total SDQ scores (*p* = .003, *d* = .36), including significant reductions in emotional difficulties (*p* = .002, *d* = .43) and relational symptoms (*p* = .001, *d* = .48)No differences in teacher-rated scores for behavioural or emotional difficulties | Low risk of bias |
| Baker & Jones (2007) | 31 | Cross-over design | Sudan, Iran, Liberia, Rwanda, Ethiopia and Congo | Australia | 11-16 | Music therapy  | * Behaviour Assessment System for Children (teacher report)
 | * Participants received 2x5-week blocks of therapy, and 2x5-weeks blocks of no therapy
* Sessions were ~40 mins
* Therapy was delivered in a school setting
 | Music therapy was effective in reducing externalising behavioural difficulties (*p* < .01), but not internalising behavioural difficulties (*p* = .86), school problems (*p* = .49) or adaptive skills (*p* = .71) | 17 |
| Rousseau et al., (2005) | 138 | Non-randomised controlled study | Countries across Africa, Asia, Europe, South America | Canada | 7-13 | Creative Expression Workshop | * Teacher Report Form
* Dominic Child Self-report
* Piers-Harris Children’s Self-Concept Scale (interview form)
 | * Group-based sessions were delivered within two school settings
* Consisted of 12 weekly sessions of 2 hours
* Therapy was implemented by an art therapist and a psychologist
 | Overall, results indicated overall improvements in self-reported internalizing (*p* = .001) and externalizing (*p* < .000) behaviours, as well as improvements in popularity (*p* = .008) and satisfaction (*p* < .000). Teachers also indicated significant improvements in internalizing behaviours (*p* = .021) | 18 |
| Kalantari et al., (2012) | 88 | RCT | Afghanistan | Iran | 12-18 | Writing for Recovery | * The Traumatic Grief Inventory for Children (Farsi Version – self-report)
 | * Group-based program delivered over 3 days, (2 x 15-min session).
* Participants express thoughts & feelings associated with trauma through writing
* Participants randomly allocated into a treatment or a no-intervention control group
 | The intervention was associated with significant decreases in traumatic grief symptoms for participants in the intervention group (*p* < .001, ηp2 = .19) | Low risk of bias |
| Gerami (2021) | 10 | One group pre-post | Iran | Canada | 8-12 | Art Therapy | * Symptom Checklist-90-Revised
* KINDL-R
* The Perceived Stress Scale
* Salivary Cortisol
 | * Intervention consisted of a 10-week art therapy group (2 hours)
* Expressive Therapies Continuum used as a theoretical model
* Individuals are guided to use art media and self-expression
 | Perceived stress scores significantly reduced following the intervention (*p* < .001). Participants continued to report lower perceived stress four weeks following the final session.Quality of life significantly increased following the intervention (*p* < .001). Participants continued to report improved quality of life four weeks following the final session.Psychological distress scores significantly reduced following the intervention (*p* < .001). Participants continued to report reduced psychological distress four weeks following the final session.Cortisol levels significantly reduced following the intervention (*p* = .01). | 17 |
| Burruss et al., (2021) | 28 | One group pretest-posttest | Burma, Somalia, Syria, Iran, Mexico, and the Democratic Republic of Congo | America | 4-14 | Art Therapy  | * Strengths and Difficulties Questionnaire (parent report)
 | * Structured art therapy sessions held weekly
* Participants were provided 4-10 sessions (1-2 hours)
* Engaged in art-based activities with trained volunteers
 | While there were improvements in overall total scores on the SDQ as well as on several subscales (emotional problems, conduct problems, peer problems, and prosocial behavior), post-intervention, these were not significant  | 16 |
| Kevers et al., (2022) | 120 | RCT | 32 countries represented | Belgium | 8-12 | Art-based expression program | * Strengths and Difficulties Questionnaire
* Youth Self-Report
 | * Classroom-based, creative arts program
* Children work with stories of forced migration in both verbal and nonverbal modalities
* Eight sessions spanning two hours each
* Randomly assigned to intervention or control
 | No significant improvements in all outcomes reported following the intervention when comparing experimental group with control groupPost hoc analysis looking at baseline severity indicated that students with higher baseline PTSD symptoms reported reduced symptoms post-intervention when compared to control group (*p* = .04). Refugee students reported significantly less difficulties when compared to non-refugee peers (*p* < .01) | Some concerns |
|  *Multimodal Interventions*  |
| Garoff et al., (2019) | 18  | One-group pretest-posttest | Afghanistan, Iraq  | Finland | 9-17 | * Stepped model of trauma care
* Group-based intervention
* Individual trauma-focused intervention
 | * Children’s Impact of Event Scale (self-rated)
* Self-rated original questionnaire measuring resilience
* The Strengths and Difficulties Questionnaire (staff rated)
 | * 10 weekly group sessions (~90 mins)
* Groups of 4-8 participants
* Interventions facilitated by mental health professionals, trained staff members of refugee accommodations, and interpreters
 | Intervention was not effective in reducing overall PTSD symptom severity (*t* (9) = 1.30, *p* = .23), behavioural difficulties (*t* (11) = 0.23, *p* = .82), or increasing resilience (*t* (10) = 0.31, *p* = .76)  | 19 |
| Möhlen et al., (2005) | 10 | One-group pretest-posttest | Kosovo | Germany | 10-18 | Multimodal program:* Individual, family, and group sessions
* Utilised a psycho-educational approach, alongside trauma and grief focused activities
 | * Semi structured diagnostic interview for the Schedule for Affective Disorders and Schizophrenia for School-Age Children
* Harvard Trauma Questionnaire (self-report)
* Diagnostic System for Psychological Disorders (parent version)
* Children’s Global Assessment Scale (rated by physician)
 | * Program delivered over 12 weeks
* Participants involved in two information sessions, two diagnostic sessions, six group sessions, two-to-four individual sessions, and a family session
* Sessions lasted ~three hours and conducted in refugee accommodation areas by a trained medical student
 | Multi-modal intervention was effective in reducing overall symptom severity for PTSD (*p* = .02), depression (*p* = .01), and anxiety (*p* = .01), and increasing overall levels of functioning (*p* < .001) | 18 |
| Ellis et al., (2013) | 30 | One-group pretest-posttest | Somalia | United States | 11-15 | Multi-Tier Mental Health ProgramSchool-based early intervention, trauma-focused direct intervention | * War Trauma Screening Scale (self-report)
* Adolescent post-Warn Adversities Scale – Somali version (self report)
* UCLA PTSD Reaction Index for DSM-IV (self-report)
* Depression Self-Rating Scale (self-report)
 | * Tier 2: of skill-based groups
* Tier 3: individual trauma systems therapy
* Tier 4 consisted of home-based trauma systems therapy
* Intervention across various settings (schools, homes)
* Participants placed in specific phase of treatment depending on an assessment of their ability to emotionally regulate
* Cultural broker utilised in order to provide in depth understanding of different cultural perspective
 | Symptoms of PTSD decreased over time for participants across all groups (*b* = -.21, *t* (74) = -2.45, *p* < .02) - no significant tier/ group by time interaction was found. Participants in all tiers demonstrated reductions in depression symptom severity (*b* = -.08, *t* (76) = -2.60, *p* = .01) - no significant tier/ group by time interaction was found | 19 |
| O’Shea et al., (2000) | 14 | One-group pretest-posttest | Countries across Africa, The Middle East, and Europe | England | 7-11 | Range of therapy options provided* Family therapy
* Cognitive Behaviour Therapy
 | * The Strengths and Difficulties Questionnaire (teacher version)
 | * Sessions were conducted in a school-based setting
* Therapy sessions provided by a child-mental health professional
* An interpreter provided to facilitate conversation and delivery of the intervention
 | Intervention was not effective in reducing behavioural difficulties  *(p* = .11) | 17 |
| Fazel et al., (2014) | 47 | Non-randomised controlled study | The Balkans, Asia, and Africa | England | 5-17 | Range of therapy options provided: * Family work
* Individual psychodynamic/ supportive therapy
* Group work
 | * The Strengths and Difficulties Questionnaire (teacher-report)
 | * Interventions were delivered by child psychiatrists
* Weekly consultations between mental health key worker and teacher
* Discussion of strategies that can be implemented in school settings by the teachers were provided
* Five work sessions per week were provided to teachers
* Where necessary, children were directly seen by the service if they presented with significant concerns
 | Intervention was effective in decreasing behavioural difficulties across participants in all groups (i.e., refugees, non-refugee ethnic minorities, indigenous white) *p* = .02. Refugees that had been seen (*n*=11) demonstrated significant decreases in overall behavioural difficulties (*F* (1,45) = 5.3, *p* = .03) as well as improvements in peer problems (*F* (1,45) = 10.9, *p* = .002) when compared to refugees that had not been seen | 18 |
| Dura –vila et al., (2012) | 102 | One-group pretest-posttest | Countries across The Middle East, African , and Europe | England | 3-17 | Range of therapy options provided:* Individual psychotherapy
* Supportive treatment
* Family therapy
* Cognitive therapy
 | * The Strengths and Difficulties Questionnaire (teachers, parents or adolescents)
 | * Teachers referred students to the metal health service
* Therapy was delivered by community-based child and adolescent mental health professionals
* Therapists included family therapists, child and adolescent psychiatric nurses, and a trainee in child psychiatry
* Interventions were delivered across multiple settings (e.g., schools, homeless family service
 | Teacher-rated data revealed reductions in behavioural difficulties (*t* (23) = 2.79, *p* = .01), hyperactivity (*t* (23) = 2.64, *p* = .02) and peer problems(*t* (25) = 2.55, *p* = .02). No significant improvements in emotional problems, conduct problems, or pro-social behaviour. Parent-rated data revealed reductions in behavioural difficulties (*t* (10) = 3.43, *p* = .01), hyperactivity (*t* (10) = 5.24, *p* < .001) and conduct problems(*t* (10) = 2.32, *p* = .04). No significant improvements in emotional problems, peer problems and pro-social behaviour | 17 |
|  *Eye Movement Desensitization and Reprocessing Therapy*  |
| Oras et al., (2004) | 31 | One-group pretest-posttest | Countries across Asia, Europe, and Africa | Sweden | 8-16 | Eye Movement Desensitization and Reprocessing  | * PTSD Symptom Scale for Children (clinician administered)
* Global Assessment of Functioning (GAF; clinician judgment)
 | * EMDR was paired with conversational therapy for adolescents and play therapy for younger children
* Participants received 5-25 psychotherapeutic sessions, and between 1-6 of those sessions utilised EMDR
* Administered by a trained psychologist
 | EMDR was effective in reducing overall symptoms of PTSD (Z = -3.1, *p* < .01) including reductions in re-experiencing (Z = -3.1, *p* < .01), avoidance (Z = -2.4, *p* < .05), and hyper arousal (Z = -2.8, *p* < .01). Significant reductions in depressive symptoms (*Z* = 3.0, *p* < .01) were found. GAF scores also significantly increased following intervention (*Z* = -2.7, *p* < .01) | 18 |
| Lempertz et al., (2020) | 10 | One group pre-post test | Syria, Afghanistan | Germany | 4-6 | EMDR | * Daily Life Test for Children (teacher report)
* Child Behavioural Checklist (parent and teacher report)
 | * Intervention delivered in 4 groups (2-5 children)
* Sessions ran for approximately 50-60 minutes daily for five days
* Delivered by a child and adolescent practitioner trained in EMDR
 | Teacher reports indicate significant reductions in PTSD symptom severity post-intervention (*p* = .018, *d* = 0.93) as well as 3-month follow-up (*p* = .034, *d* = 0.81). Parent reports indicate no significant decreases | 16 |
| Perilli et al., (2019) | 14 | One group pre-post test | Syria | Turkey | 8-17 | EMDR Integrative Group Treatment Protocol  | * Children’s Revised Impact of Event Scale (child rated)
* Depression Self Rating Scale
* Screen for Child Anxiety Related Disorders (child rated)
 | * Intervention delivered by three EMDR therapists, two Syrian mediators, and a Syrian psychiatrist
* Delivered in groups of 7-12 children
* Children assigned to three age groups (3-7; 9-12; 13-18)
* Each group received three sessions
 | The intervention was associated with significant reductions in PTSD symptom severity (*p* < .001) post-intervention | 18 |
| [Banoğlu](https://www.sciencedirect.com/science/article/pii/S2468749921000417%22%20%5Cl%20%22%21) & Korkmazlar (2022) | 61 | RCT | Syria | Turkey | 6-15 | EMDR- Group Protocol for Children | * Child Posttraumatic Stress Reaction Index
* World Health Organization – 5 Well-being Index
* Major Depression Inventory
 | * Participants allocated into intervention or control group
* Intervention consists of conventional EMDR with a particular focus on the group therapy model
* Approximately three – four sessions (90-120 minutes)
* Group sessions with 8 participants on average
 | Participants in the intervention group demonstrated significant reductions in PTSD (*p* = .03) and depression symptom severity (*p* = .01), as well as increases in wellbeing (*p* = .01) when compared to the control group post-intervention. The time-by-group interaction was significant for PTSD symptom severity (*p* = .04) but not for depression or wellbeing.  | Low risk of bias |
| Draper et al., (2020) | 20 | One group pretest-posttest |  | United Kingdom | 16-18 | Fast Feet Forward | * Validity of Cognition
* Subjective Units of Disturbance
 | * Intervention underpinned by the EMDR group approach
* Intervention consisted of nine sessions led by three therapist and interpreters
* Incorporated feet bilateral movement through running and tapping
 | Significant improvements in validity of cognition scores (*p* < .001) as well as significant decreases in subjective units of disturbance (*p* < .001) scores were found post-intervention.  | 16 |
|  *Psychosocial Interventions* |
| Mancini (2020) | 34 | One group pre-post test | Countries across Africa, Asia, North America, The Middle East (included immigrants) | The United States of America | 6-11 | Somatic Soothing and Emotional Regulation Skill Development (SSERSD; trauma-focused intervention) | * UCLA PTSD Reaction Index for DSM-IV (screener provided to children)
* Center for Epidemiological Studies Depression Scale for Children (self-report)
* Screen for Child Anxiety Related Disorders (parent and child report)
* Pediatric Symptom Checklist (parent and self-report)
 | * School-based and trauma informed intervention designed to reduce intensity of physiological and somatic symptoms of trauma
* Incorporates sensory diet activities, sensory motor arousal regulation, sensorimotor psychotherapy, mindfulness, yoga
* Eight sessions (two sessions a week for four weeks)
 | Post-intervention, results indicated that the intervention was associated with significant improvements anxiety (*p* < .001, *d* = .90), depression (*p* < .001, *d* = 0.71) and overall psychological functioning (*p* = .003, *d* = 0.46). Significant reductions in PTSD symptoms were also reported (*p* < .001, *d* = 1.08) including significant reductions in hyper-arousal (*p* < .001, *d* = 0.83), avoidance (*p* < .001, *d* = 1.06), and re-experiencing (*p* < .001, *d* = 0.84) | 17 |
| Van der Gucht et al., (2019) | 13 | One group pre-post test | Countries across Africa, The Middle East, and Europe | Belgium | 13-18 | Mindfulness-Based Intervention  | * The International Positive and negative Affect Schedule
* Depression Anxiety Stress Scales
* Children’s Impact of Events Scale

(All self-report)  | * Intervention adhered to a standardized protocol developed from the mindfulness-based stress reduction and mindfulness-based cognitive therapy manual
* Consisted of eight 90-minute sessions
* Held once a week for eight consecutive weeks
* Components included guided mindfulness, informal exercise, psycho-education
 | Post-intervention, results indicated that the intervention was associated with significant reductions in negative affect (*p* = .04, *g* = .79). No significant improvements in positive affect or symptoms of depression or PTSD were found | 18 |
| Thabet et al., (2005) | 111 | Non-randomised controlled study | Gaza | Gaza | 9-15 | Children allocated into a crisis intervention group, teacher education group, or a no intervention group  | * Child Post Traumatic Stress Reaction Index (self-report)
* Children’s Depression Inventory (self- report)
 | * *Crisis intervention group* weekly therapy for 7 weeks - engaged in activities such as drawing, writing, storytelling, role-playing, and discussions about their traumatic experiences
* Facilitated by a psychiatrist, psychologist, and social worker
* *Teacher education group* received information regarding the impact of trauma in order to normalise the children’s experience
 | Intervention was not effective in reducing symptom severity for both PTSD or depression | 18 |
| Panter-Brick et al., (2018)  | 817 | Experiment and randomised controlled study | Syria and Jordan  | Jordan  | 12-18 | Psychosocial Intervention using *The Advancing Adolescents* program Profound Stress Attunement (PSA) framework utilised to target mental health and social and emotional development | * Human Insecurity Scale,
* Human Distress Scale
* Arab Youth Mental Health
* Strengths and Difficulties Questionnaire
* Traumatic Event Checklist

(All self-report) | * Intervention was delivered by trained lay facilitators over five implementation cycles
* Intervention consisted of 16 sessions held across eight weeks
* Participants placed into groups of approximately 10-15 youth (age-matched)
* Participants allocated into a treatment group, or a waitlist control group
 | Intervention was effective in reducing perceived levels of insecurity (*p* < .01, *d* = -0.4), distress (*p* < .01, *d* = -0.3), stress ( *p*<.001, *d* = -0.3), behavioural difficulties (*p*<.01, *d* = -0.2), and perceived mental health difficulties (*p*<.001, *d* = -0.4). Intervention was not effective in reducing PTSD symptoms (*p* = .39, *d* = -0.13)  | Low risk of bias |
| Metzler et al., (2019) | 591 | Randomized Cluster Sampling | Congo  | Uganda  | 6-12 | Child Friendly Space Intervention  | * The Child Protection Rapid Assessment (caregiver report)
* Locally derived measure of psychosocial wellbeing (caregiver report)
* Caregiver Rating of Developmental Assets
 | * Delivered across a refugee settlement
* Intervention aimed to provide children with safe spaces in order to promote mental health and psychosocial wellbeing
* Consisted of a range of psychosocial activities, such as traditional song and dance, art, sports, unstructured free play, and educational components
* Five days a week, 4-hour blocks
 | Overall, participation in the intervention was associated with significant improvements in caregiver reported developmental assets (*p* < .001, *d* = 0.23) as well as psychosocial wellbeing (*p* < .001, *d* = 0.35). Subgroup analyses reveal that both boys and girls demonstrated significant improvements. However, no significant improvements were found during the 18 month follow up | 18 |
| Akhtar et al., (2021) | 59 | RCT | Syria | Jordan | 10-14 | Early Adolescent Skills for Emotions EASE | * Pediatric Symptom Checklist
* Patient Health Questionnaire – Adolescent version
* Children’s Revised Impact of Events Scale
* Warwick Edinburgh Mental Wellbeing Scale
* Psychological Sense of School Membership
* Items measuring daily functioning
* Kessler Distress Scale (parent report)
* Traumatic Events checklist (parent report)
 | * Participants randomized into intervention or control (treatment as usual)
* Children in intervention group receive seven 90-minute group sessions
* Sessions focus on psychoeducation, problem-solving, stress management, behavioral activation, and relapse prevention
* Caregivers received three 120-minute group sessions – psychoeducation, active listening, self-care, relapse prevention
 | There were significant improvements in both groups from pre- to post- treatment on child reported internalizing symptoms (*p* = .02), depression (*p* = .01), as well as sense of school membership (*p* = .02).There was a significant between-group main effect in regard to caregiver reported attention (*p* = .05) and externalizing scores (*p* = .05). | Low risk of bias |
| Bryant et al., (2022) | 471 | RCT  | Syria | Jordan | 10-14 | Early Adolescent Skills for Emotions (EASE) | * Pediatric Symptom Checklist
* Patient Health Questionnaire
* The Children’s Revised Impact of Event Scale
* Warwick Edinburgh Mental Wellbeing Scale
* Psychological Sense of School Membership Scale
* Items measuring daily functioning
* Kessler Distress Scale (parent report)
* Traumatic Events checklist (parent report)
 | * Participants randomized into intervention group or enhanced usual care (EUC)
* Intervention consisted of 7-weekly group sessions (gender specific; 1.5 hours)
* Sessions focus on psychoeducation, problem-solving, stress management, behavioral activation, and relapse prevention
* Caregivers received three 120-minute group sessions – psychoeducation, active listening, self-care, relapse prevention
 | At 3-month follow up, intervention group demonstrated significant reductions in internalizing scores when compared to control group (*p* = .01). No significant differences found with regards to other outcomes.  | Low risk of bias |
| Fine et al., (2021) |  | RCT | Burundi | Tanzania | 10-14 | Early Adolescent Skills for Emotions (EASE) | * African Youth Psychosocial Assessment
* Child PTSD Symptom Scale
* Short Warwick-Edinburgh Mental Well-being Scale
* Child Trauma Questionnaire
* Items measuring functional impairment
 | * Randomized into intervention group or control group (enhanced treatment as usual)
* Intervention developed by World Health Organization
* Manualized intervention consisting of seven weekly group sessions
 | Statistically significant decrease in psychological distress in both intervention (*p* < .001) and control group (*p* = .02). Significant decreases in internalizing symptoms (*p* = .00) as well as somatic complaints (*p* < .001) observed in both groups. Males in the intervention group demonstrated a significant decrease in psychological distress (*p* = .02) when compared to the control group. Females demonstrated no significant decreases when compared to the control group | Some concern |
| Miller et al., (2022) | 325 | RCT | Syria, Palestine | Lebanon | 10-15 | I-Deal Life Skills Intervention | * Strengths and Difficulties Questionnaire
* Warwick-Edinburgh mental Wellbeing Scale
* Children’s Hope Scale
* Rosenberg Self-esteem Scale
* Social Connectedness Scale - Revised
 | * Intervention consisted of 16 group-based sessions (90 minutes, once or twice weekly)
* Utilizes activities such as role playing, drawing, games, and discussions to encourage relaxation and fun while strengthening key life skills
* Randomly assigned to intervention or structured recreational activity group
 | No significant changes over time, no significant differences between the intervention groups as well as no significant interaction between group and time was found on all outcomes  | Some concern  |
|  |  |  |  |  |  |  |  |  |  |  |
| Simonds et al., (2022) | 16,768 | One group pretest-posttest | Countries across Asia | Philippines, Mongolia, and Nepal  | 6-12 | OperationSAFE | * Original items related to trauma-related functioning and well-being
 | * Aims to promote safety, calm, a sense of self-efficacy, connectedness, and instill hope
* Employed within camp settings
* Includes identification and understanding of PTSD, preventative early intervention, skills for self-care
* Sessions held over five days (four hours)
 | Significant improvements in post-trauma functioning and wellbeing were found post-intervention (*p* < .001)Intervention was significantly more beneficial for older children (*p* < .001)Refugee children/ those exposed to war responded better compared to children exposed to natural disaster (*p* < .001) | 16 |
| Michalek et al., 2021 | 94 | Non-randomised controlled study | Syria and Jordan | Jordan | 7-12 | We Love Reading intervention | * Traumatic Events Checklist
* Child Revised Impact of Events Scale
* Arab Youth mental Health Scale
* Human Insecurity and Distress Scale
* Youth Life Orientation Test
 | * Reading-based intervention
* Delivered over a five-week period across various settings (e.g., schools)
 | No significant changes in all outcomes relating to mental health and wellbeing from baseline to post-intervention.  | 18 |
| Erdemir (2022) | 711 | Non-randomised controlled study | Syria | Turkey | 5-6 | Summer Preschool Program | * Emotion Regulation Checklist
* Social Competence and Behavioral Assessment Scale
 | * Multilayered fidelity system run by teachers, supervisors, field experts, and project officers
* Aims to promote child development, wellbeing, and school readiness
* Structured and semi-structured activities incorporated within classrooms throughout daily routine
 | Significant improvements in emotional regulation, social competence, and internalizing/externalizing behavioral problems found post-intervention in both samples of refugees and local children (*p* < .001) | 19 |
| Peltonen et al., 2022 | I974 | RCT |  | Finland  | 12-17 | In-service teacher training (INSETT\_ and Peer Integration and Enhance Resource (PIER) | * Strengths and Difficulties Questionnaire
* Child and Youth Resilience Measure
* Items measuring perceived discrimination
* Daily Stressor Scale for Young Refugees
 | * Allocated into INSETT, PIER, or control group
* INSETT: aims to strengthen teacher’s competence and self-efficacy
* PIER: aims at supportive safe and positive peer interactions and social relationships.
 | No significant direct intervention effect found for students in the INSETT intervention group No significant direct intervention effect found for students in the PIER intervention group.   | High risk of bias  |
|  *Family and Parent-Based Interventions* |
| Sim et al., (2020) | 380 | One group pre-post test | Syria | Lebanon | 8-12 | Families Make the Difference Group Intervention | * Multiple Indicator Cluster Survey (parent and child report)
* Parental Acceptance Rejection Questionnaire (parent and child report)
* Strengths and Difficulties Questionnaire (parent report)
* Screen for Child Anxiety-Related Emotional Disorders (child report)
* Short Mood and Feelings Questionnaire (child report)
 | * Group-based, parenting program (10 sessions)
* Incorporated components from teaching recovery techniques (trauma-focused CBT)
* Aims included targeting parental stress and addressing children’s psychosocial needs
 | Results indicated significant reductions in parent reported behavioural and emotional difficulties (*p* > .001, *d* = 0.55). Furthermore, significant reductions in child reported anxiety (*p* > .001, *d* = 0.67) and depressive (*p* > .001, *d* = 0.69) symptoms were found  | 17 |
| Lakkis et al., 2020 | 125 parents | One group pre-post test | Syria | Lebanon and Jordan | 3-6 | Positive Parenting Intervention  | * Strengths and Difficulties Questionnaire (parent report)
 | * Intervention aimed to positively influence parenting behaviours through interactive parenting sessions and psychosocial support
* Implemented by a psychologist
 | Results indicated significant improvements in overall behavioural/emotional difficulties (*p* = .03, *d* = 0.40), with significant improvements in hyperactivity noted (*p* = .01, *d* = 0.42) | 16 |
| Ponguta et al., 2020 | 106 pairs | RCT | Libya, Jordan, Syria, Saudi Arabia, United Arab Emirates  | Lebanon  | 2-7 | Mother Child Education Program  | * Disciplinary Style Questionnaire (parent report)
* Better Parenting Program Questionnaire (parent report)
* Strengths and Difficulties Questionnaire (parent report)
* Bear/Dragon task
* Shape Stroop
 | * 25 sessions, group-based program designed to foster positive parenting practices as well as to promote early childhood development
* Delivered to three marginalized communities in Lebanon, including two refugee communities
* Mother-child dyads were randomly assigned into the intervention group, or waitlist control
 | No significant improvements in child emotional and behavioural difficulties were found post-intervention (*p* = .790) | Some concerns |
| Miller et al., 2020 | 151 | RCT | Syria | Lebanon  | 3-12 | Caregiver Support Intervention  | * Kid-KINDL
* Kiddy-KINDL
 | * Nine-session weekly group intervention
* Groups offered separately to mothers and fathers
* Sessions focus on targeting parental wellbeing, and increasing positive parenting practices
* Families were randomly assigned into the intervention group or waitlist control
 | Parents in the intervention group reported significant improvements in child psychosocial wellbeing (*p* < .01). However, child reports indicate no significant improvement in psychosocial wellbeing following engagement in the intervention (*p* = .27) | Low risk of bias |
| Shaw et al., 2020 | 79 | RCT | Afghanistan, Myanmar | Malaysia | < 18 | Parenting Intervention  | * Child Adjustment and Parent Efficacy Scale
 | * Eight-week, group-based manualised program
* Weekly one-hour sessions include: check ins, psycho-education, skill building, role-play
* Randomised into the treatment group or waitlist group
 | Results indicate that the treatment group was associated with significant reductions in child intensity (*p* < .001; between group effect size – *d* = 1.02) post-intervention as well as at the three-month follow up (*p* = .25). Waitlist group also demonstrated improvements following engagement in the intervention (*p* < .001) as well as during the follow up (*p* = .17) | Low risk of bias |
| Betancourt et al., (2020) | 257 | RCT | Somalia and Bhutan | The United States of America  | 7-17 | Family Strengthening Intervention for Refugees  | * Center for Epidemiologic Studies Depression Scale for Children
* WHO Disability Assessment Schedule for Children
* PTSD Reaction Index
* Child Behaviour Checklist
 | * The intervention was targeted towards families – both caregivers and children were involved
* Participants were randomised into the treatment group or care as usual (CAU)
* Delivered in 10, 90-minute weekly blocks at the family home
* Delivered by a trained interventionist
* Participants referred for more intensive mental/ physical health services where needed
 | Results indicated that the children demonstrated lower levels of traumatic stress (β = -.42, *p* = .03) as well as depressive symptoms (β = -.34, *p* < .001). When compared to Bhutanese CAU, Bhutanese children demonstrated significant improvements in depression (β = -9.20, *p* = .04) and conduct problems (β = -.02, *p* = .01). When compared to Somali CAU, Somali children demonstrated significant improvements in conduct problems (β = 1.48, *p* < .001) | Low risk of bias |
|  |  |  |  |  |  |  |  |  |  |  |
| Gotseva-Balgaranova et al., (2020) | 15 | One group pretest-posttest | Iraq, Afghanistan, and Syria | Bulgaria and Germany | 6-11 | Evidence-Based Trauma Stabilisation Programme | * Trauma Symptoms Checklist for Young Children
* Children Stress Checklist
 | * Intervention for parent-child pairs
* Aim is to improve attachment between parents and children as well as provide stabilizing techniques and psychoeducation
* Incorporates play-based stabilization techniques
* Short-term intervention (3-8 weeks) conducted in groups of 2-5 pairs
 | Post-intervention, children demonstrated significant reduction in reported intrusive episodes (*p* = .05). \*Authors report significant reductions in depression, arousal, and dissociation at *p* < .10  | 15 |
| El-Khani et al., (2021) | 25 | One group pretest-posttest | Afghanistan | Serbia | 8-15 | “Strong Families” Family Skills Intervention | * Strengths and Difficulties Questionnaire
 | * Evidence-informed prevention intervention that fosters parenting skills, child wellbeing and family mental health
* Delivered to families in groups of not more than 7 families across three sessions (5 hours in total)
 | Significant reductions in SDQ total scores following intervention (*p* = .00). Significant decreases also observed across emotional problems (*p* < .001) and conduct problems (*p* < .01) subscale | 18 |
|  *Positive Psychology Intervention* |
| Foka et al., (2020) | 72 | Quasi-randomised pilot study | Syria, Lebanon, Afghanistan, Kurdistan | Greece | 7-14 | Strengths for the Journey program (positive psychology intervention) | * World Health Organisation Well-Being Index
* Youth Life Orientation Test
* Lifespan Self-Esteem Scale
* Center for Epidemiological Studies Depression Scale for Children

\* All self-report  | * Brief group-based intervention based on the principals of positive psychology
* Designed particularly for forcibly displaced, late childhood and adolescent populations
* Participants were allocated to either the intervention group or a waitlist control group
* Intervention consisted of daily two-hour group sessions over six days
* Delivered by a trained facilitator and a refugee interpreter
* Participants grouped by age and language
 | When compared to the waitlist group, results indicated that the intervention was associated with significant improvements in participant wellbeing (*F* (1, 46) = 42.99,*p* < .001, ηp2= .48), optimism (*F* (1, 53) = 27.16, *p* < .001, ηp2= .34), self-esteem (*F* (1, 56) = 29.11, *p* < .001, ηp2= .40) and symptoms of depression (F (1, 31) = 62.14, p < .001, ηp2 = .67) | 18 |
|  *Trauma Systems Therapy* |
| Cardeli et al., (2020) | 34 | One group pre-post test | Bhutan | The United States of America | 11-15 | Trauma Systems Therapy for Refugees (TST-R) | * The War Trauma Screening Scale
* UCLA PTSD Reaction Index
* Depression Self-Rating Scale for Children
* The Psychological Sense of School membership Scale
* The Language, identity, and Behaviour Scale

(All self-report) | * Tier 2 curriculum of the TST-R program was delivered
* Group-based program delivered by a mental health clinician and a Bhutanese cultural broker
* Groups ran on a weekly basis for 12 weeks (approximately 1 hour)
* Groups consisted of 6-8 children, with boys/girls in separate groups
 | Post-intervention, results indicated that the intervention was associated with non-significant reductions in symptoms of depression (*p* = .92, *d* = 0.02) as well as non-significant increases with regards to sense of belonging (*p* = .04, *g* = .79). While no significant reductions in overall PTSD symptoms were found (*p* = .32, *d* = 0.18), there was a significant reduction in avoidance symptoms (*p* = .02, *d* = 0.36) | 17 |