Conditions related to stress module - evidence profiles STR1 and STR2: Psychological interventions for adults with PTSD (STR1) and for children and adolescents with PTSD (STR2)

WHO mhGAP guideline update: Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders

2023

World Health Organization

Contents

Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, available at: https://www.who.int/publications/i/item/9789240084278

1. Background

The world faces an incredible number of emergencies. At the end of 2021, there were 274 million people in need of humanitarian assistance across the world[1] and 89.3 million people had been forcibly displaced from their homes due to warfare and conflict[2], the highest numbers since the Second World War. People surviving these situations are faced with incredible and often overwhelming adversity.

While it is true that the majority of people facing these circumstances can and will recover, particularly if they are able to reconnect with their social support systems and meet their basic needs and safety, some will continue to struggle. For example, a World Health Organization (WHO) meta-analysis indicated that one in five persons exposed to conflict in the last 10 years experiences some form of mental health condition (3), often conditions specifically related to stress,[3] including post-traumatic stress disorder (PTSD). PTSD demonstrates a lifetime prevalence ranging from 5% to 10% in community samples, with 12-month prevalence often closer to 5% (Koenen et al., 2017; Goldstein et al., 2016). Despite the prevalence, only half of those with severe cases of PTSD report receiving any treatment, and in many countries, there are large gaps in access to care (Koenen et al., 2017). These gaps in care are costly, given that PTSD can result in 3.6 days of productivity lost per month (Kessler et al., 2000) and estimates of total costs have been very high (Davis et al., 2022).

Many treatments for PTSD have been identified in the scientific literature. In 2013, WHO developed guidelines on the management of conditions specifically related to stress, including PTSD, as part of WHO's mental health Gap Action Programme (mhGAP) (WHO, 2013). These guidelines have not been updated since this time. In developing these guidelines, scoping questions focused on a select set of evidence-based psychological interventions (e.g. individual and group cognitive-behavioural therapy [CBT], including cognitive processing therapy and exposure therapies, eye movement desensitization and reprocessing [EMDR] and stress management) and psychoeducation for PTSD. CBT treatment for PTSD often involves skill-building to counteract maladaptive thoughts and behaviours, often through procedures that expose the person to recalling traumatic memories. Meanwhile, EMDR procedures focus on spontaneous associative processing of memories while also involving a bilateral stimulation (i.e. eye movements). Unlike CBT, EMDR does not involve direct targeting of thoughts or beliefs and does not typically use daily homework. Both treatment approaches differ from psychological debriefing, which is not recommended in WHO guidelines. Stress management refers to approaches that use cognitive or behavioural techniques to reduce stress but do not focus on recounting traumatic stressors (e.g. progressive relaxation training, stress inoculation training). Finally, in these guidelines, psychoeducation refers to "the provision of information about the nature of stress, post-traumatic and other symptoms, and what to do about them".

As part of the 2022 update to WHO's mhGAP Guidelines, recommendations on these interventions were also considered for updating based on new evidence since their initial publication. Therefore, the following sections describe the methodology for this update (WHO, 2013). The STR1 question relates to psychological treatments for adults with PTSD, while the STR2 question relates to psychological treatments for children and adolescents with PTSD.

[1] UNHCR global trends forced displacement report 2021. https://www.unhcr.org/us/media/global-trends-report-2021
The term conditions specifically related to stress refers here to problems such as PTSD, acute stress reaction and bereavement reactions that require an exposure to a defined stressor as a precursor. There are numerous other stress-related disorders and problems (e.g. depression, behavioural disorders, alcohol/substance use problems, self-harm/suicide, medically unexplained somatic complaints), but these are not specifically related to stress (i.e. they may also occur in the absence of identifiable stressful life events).

[2] UNHCR global trends forced displacement report 2021. https://www.unhcr.org/us/media/global-trends-report-2021

[3] The term conditions specifically related to stress refers here to problems such as PTSD, acute stress reaction and bereavement reactions that require an exposure to a defined stressor as a precursor. There are numerous other stress-related disorders and problems (e.g. depression, behavioural disorders, alcohol/substance use problems, self-harm/suicide, medically unexplained somatic complaints), but these are not specifically related to stress (i.e. they may also occur in the absence of identifiable stressful life events).

The STR1 and STR2 questions in the WHO Guidelines for the Management of Conditions Specifically Related to Stress will be developed based on an existing systematic review of randomized controlled trials (i.e. the Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Post-traumatic stress disorder and Complex PTSD[4] [Phoenix Australia, 2020]), which have been deemed sufficient to prepare the evidence summaries.

2. Methodology

2.1. PICO questions

(STR1) For **adults** with PTSD, are psychological interventions effective, when compared to treatment as usual, waiting list/no treatment or other psychological treatment, in the reduction of PTSD symptoms?

Population (P):	Adults with PTSD, after the first month of a potentially traumatic event
Intervention (I):	CBT with a trauma focus Group CBT with a trauma focus EMDR Stress management – stress inoculation training, relaxation Delivered in person or online
Comparator (C):	Treatment as usual or no treatment/waitlist Comparison of different modalities (online vs face-to-face) Comparison of different types of interventions Watchful waiting
Outcomes (O):	List critical outcomes: PTSD symptom severity Functioning/quality of life Presence of mental disorder Adverse effects

(STR2) For **children and adolescents** with PTSD, are psychological interventions effective, when compared to treatment as usual, waiting list/no treatment or other psychological treatment, in the reduction of PTSD symptoms?

Population (P):	Children and adolescents with PTSD, after the first month of a potentially traumatic event
Intervention (I):	Individual CBT with a trauma focus Group CBT with a trauma focus EMDR Stress management – stress inoculation training, relaxation Delivered in person or online

[4] Phoenix Australia (2020). Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD.

Comparator (C):	Treatment as usual or no treatment/waitlist Comparison of different modalities (online vs face-to-face) Comparison of different types of interventions Watchful waiting
Outcomes (O):	List critical outcomes: PTSD symptom severity Functioning/quality of life Presence of mental disorder Adverse effects

2.2. Search strategy

Literature sources

Existing systematic reviews were used to source the trials for inclusion in the STR1 and STR2 questions of the WHO Guidelines for the Management of Conditions Specifically Related to Stress. The first source of trials was the systematic reviews that were used as the basis of the International Traumatic Stress Society (ISTSS) PTSD Guidelines. Given the limited resources available, it was not possible for the ISTSS Guideline developers to commission new comprehensive systematic reviews in every area.

High-quality systematic reviews developed through the Cochrane Collaboration, NICE (The National Institute for Health and Care Excellence), and the WHO were identified that addressed the questions of interest except those pertaining to non-psychological and non-pharmacological interventions. Randomized controlled trials (RCTs) from these reviews were used as the basis of the evidence to be considered and re-evaluated according to the criteria agreed for the ISTSS Treatment Guidelines. Existing reviews (Bisson, et al., 2013; Hoskins et al., 2015; Lewis, et al., 2015; NICE, 2018; Roberts, et al., 2009; Rose, et al., 2005; Sijbrandij, et al., 2015) were supplemented with additional systematic searches for more recent RCTs and by asking experts in the field and the ISTSS membership to determine if there were any missing studies.

New systematic reviews were undertaken for the non-psychological and non-pharmacological scoping questions. The Cochrane Collaboration Mental Health Disorders Group completed additional searches, using their comprehensive search strategies to identify RCTs of any intervention designed to prevent or treat PTSD.

The second source of trials was updates conducted by Phoenix Australia for the purpose of the Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD. First, Phoenix Australia updated the ISTSS searches for the period of May 2018 to June 2019 (see Appendix I, Figure 1). A second update was conducted by Phoenix Australia for the period of June 2019 to December 2020 (see Appendix I, Figure 2). All search updates were conducted in CENTRAL (Cochrane Central Register of Controlled Trials), MEDLINE (Medical Literature Analysis and Retrieval System Online), PsycInfo and the Published International Literature on Traumatic Stress (PILOTS) databases.

The search strategy was not restricted to individual research questions, but rather targeted all research questions (e.g. both children and adult populations; psychological, pharmacological, and alternative treatments). However, only trials relevant to the PICO framework outlined in section 2.2. have been considered for inclusion in the WHO Guidelines.

A scoping search was also conducted in December 2021, to identify any relevant systematic reviews focused on psychological treatments for adults and children with PTSD which were published in 2021 (see Appendix I, Figure 3).

Search strategy

The ISTSS systematic reviews, updates to these reviews and the scoping search each involved the same search strategy. The search terms 'PTSD', 'posttrauma*', 'post-trauma*', 'post trauma*', 'combat disorder*', 'stress disorder*' were used to be as broad as possible and ensure that all relevant RCTs were captured.

The scoping search was conducted in MEDLINE and PsycInfo and used the above search terms with the addition of the search term “review.mp”.

Databases: CENTRAL, MEDLINE, Embase, PsycInfo, PILOTS

#1	PTSD.mp. or posttrauma*.mp. or post-trauma*.mp. or "post trauma*".mp. or "combat disorder*".mp. or "stress disorder*".mp.
#2	Limit #1 (publication date May 2018-June 2019 and english language)

Selection criteria

The selection criteria described below was used for the question STR1 (i.e. for **adults** with PTSD, are psychological interventions effective, when compared to treatment as usual, waiting list/no treatment or other psychological treatment, in the reduction of PTSD symptoms?).

Types of studies	Any RCT (including cluster and cross-over trials). Not solely a dismantling study. No minimum sample size. unpublished studies eligible. From any country. Exclusions: Editorials, letters to the editor, reviews, dissertations, and protocol papers.
Types of participants	At least 70% of participants required to be diagnosed with full PTSD according to Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) criteria by means of a structured interview or diagnosis by a clinician. Excluded participants with partial/subthreshold PTSD. No restrictions on the basis of comorbidity, but PTSD required to be the primary diagnosis. No restriction on the basis of severity of PTSD symptoms. Traumatic event was defined as Criterion A event but no restriction on the type of traumatic event.
Types of interventions	Psychological interventions aimed at reducing symptoms of PTSD, including: Individual CBT with a trauma focus, Group CBT with a trauma focus, EMDR, Stress management (i.e., stress inoculation training, relaxation). Delivered by any mode or modality, including to individuals, groups or couples, telehealth.
Types of comparators	Waitlist, treatment as usual, symptom monitoring, repeated assessment, other minimal attention control group. Comparison of different modalities (online vs face-to-face). Comparison of different types of interventions. Watchful waiting

Types of outcomes	Post-treatment PTSD symptom severity, as measured on any validated PTSD outcome measure. Excluded: does not report data on PTSD symptoms.
Additional eligibility criteria	All studies included in these guidelines were published within the dates of the search, that is, inception to December 2021. All included studies were published in English.

The selection criteria described below was used for the question STR2 (i.e. for **children and adolescents** with PTSD, are psychological interventions effective, when compared to treatment as usual, waiting list/no treatment or other psychological treatment, in the reduction of PTSD symptoms).

Types of studies	Any randomized controlled trial (including cluster and cross-over trials). Not solely a dismantling study. No minimum sample size. Unpublished studies eligible. From any country. Exclusions: Editorials, letters to the editor, reviews, dissertations, and protocol papers.
Types of participants	At least 70% diagnosed with partial or full DSM or ICD PTSD by means of a structured interview or diagnosis by a clinician. Partial PTSD is defined as at least one symptom per cluster and presence of impairment. No restrictions on the basis of comorbidity, but PTSD required to be the primary diagnosis. No restriction on the basis of severity of PTSD symptoms. Traumatic event was defined as Criterion A event but no restriction on the type of traumatic event.
Types of interventions	Psychological interventions aimed at reducing symptoms of PTSD, including: Individual CBT with a trauma focus, Group CBT with a trauma focus, EMDR, Stress management (i.e., stress inoculation training, relaxation). Delivered by any mode or modality, including to individuals, groups or couples, telehealth.
Types of comparators	Waitlist, treatment as usual, symptom monitoring, repeated assessment, other minimal attention control group. comparison of different modalities (online vs face-to-face). comparison of different types of interventions. watchful waiting.
Types of outcomes	Post-treatment PTSD symptom severity, as measured on any validated PTSD outcome measure. Excluded: does not report data on PTSD symptoms.
Additional eligibility criteria	All studies included in these guidelines were published within the dates of the search, that is, inception to December 2021. All included studies were published in English.

Systematic reviews were eligible for inclusion in the December 2021 scoping search if:

- the database search within the review was conducted during or after January 2021,
- they included meta-analysis,
- included eligible interventions/comparators, and
- identified additional studies not already identified in the Phoenix Australia 2020 update search.

2.3. Data collection and analysis

Pre-defined evidence tables were used to guide the extraction of data from the individual studies and summarize results. Two researchers independently extracted data from included studies. Studies that fulfilled the inclusion criteria were further scrutinized to determine if data were available to use in the meta-analyses. If sufficient data were not available, requests were made to authors for data that could be used.

All available data addressing specific scoping questions were meta-analysed using Revman (Version 5.3) software (The Nordic Cochrane Centre, 2014) using a fixed-effects model where statistical heterogeneity, as indicated by I^2, was less than 30% and a random effects model where heterogeneity was > 30%.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram for the searches undertaken by Phoenix Australia is presented in Appendix I.

2.4. Selection and coding of identified records

At the first stage in selecting relevant studies, records retrieved from the bibliographic databases were collated in Endnote. All records were then imported into Covidence for removal of duplicate articles. Study titles and abstracts were first read independently by two of the reviewers and assessed for eligibility. This assessment was performed in accordance with the inclusion and exclusion criteria developed a priori. The full manuscripts of all studies that either reviewer felt potentially met the criteria were obtained and read independently by two reviewers to determine if the inclusion criteria were met.

Please see Endnote Libraries 'WHO PTSD GL psych tx – adults' and 'WHO PTSD GL psych tx – children' for a copy of the reference library in electronic format.

2.5. Quality assessment

Appraisal of the Phoenix Australia Guidelines

The systematic review underpinning the Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD (Phoenix Australia 2020) was rated using the Appraisal of Guidelines for Research & Evaluation Instrument (AGREE II). The AGREE II is a validated tool for the appraisal of health-related guidelines. It is a checklist that covers six domains: scope and purpose; stakeholder involvement; rigour of development; clarity and presentation; applicability; and editorial independence.

In order to be able to achieve endorsement by the Australian National Health and Medical Research Council, the Australian Guidelines were rated by two independent reviewers using the AGREE II tool and were found to score consistently well across the domains of the tool. The Australian Guidelines were also rated using the AGREE II tool by the authors of a recent systematic review examining PTSD Guidelines, and again were found to score highly across the domains (Martinet al., 2021). Both of these ratings are presented in Appendix II.

Appraisal of individual studies: risk of bias assessment

Individual studies were summarized and appraised independently by two people using version one of the Cochrane Collaboration's risk-of-bias tool (Higgins & Green, 2011). Inter-rater reliability was calculated, and disagreements were resolved by discussion.

Assessment involved judging whether there was a low, uncertain, or high risk of bias for each of the following domains:

- random sequence generation (selection bias),
- allocation concealment (selection bias),
- blinding of participants and personnel (performance bias),
- blinding of outcome assessment (detection bias),
- incomplete outcome data (attrition bias),
- selective reporting (reporting bias), and
- other bias Assessment of the certainty of the body of evidence.

Assessment of the certainty of the body of evidence

The Grading of Recommendations, Assessment, Development and Evaluations (GRADE) system was used to assess the certainty of the evidence base (Guyatt, et al., 2008). The GRADE rating provides an indication of confidence in the estimates of the effect of an intervention (Hultcrantz, et al., 2017).

Evidence from RCTs starts at high certainty and may be downgraded for serious or very serious concerns relating to each of the following domains:

- Risk of bias: based on the overall risk of bias (methodological limitations) of the trials contributing to each result. For the purpose of grading the evidence, an overall judgement of risk of bias was first made across studies for each risk bias domain, and then across domains. This judgment considered the extent to which studies at high or unclear risk of bias influenced the meta-analysis (i.e. weight).
- Indirectness: the extent to which the PICO characteristics of the body of evidence adequately address the clinical questions (PICO) for the guideline.
- Imprecision: whether the confidence interval includes both appreciable benefit and harm (or vice versa) and whether the optimal information size was met (based on a rule of thumb of >400 participants for continuous outcomes; > 300 events for binary). Judgments of appreciable benefit (or harm) were based on the thresholds below.
- Inconsistency: the extent to which there is unexplained inconsistency in results across studies. Judgements were based on visual inspection of data (overlap in confidence intervals, the direction and magnitude of effect) and statistical measures and tests of heterogeneity.
- Publication bias: The likelihood of small study effect or other evidence of publication bias.

A body of evidence is rated as being of **high quality** (i.e. further research is very unlikely to change our confidence in the estimate of effect), **moderate quality** (i.e. further research is likely to have an important impact on our confidence in the estimate effect and may change the estimate), **low quality** (i.e. further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate) or **very low quality** (i.e. we are very uncertain about the estimate).

Assessment of 2021 systematic reviews identified in scoping search

A scoping search was conducted in December 2021 to identify any major relevant systematic reviews with meta-analyses that were published in 2021.
A single systematic review was identified (Xiang et al., 2021) and rated using the AMSTAR (A Measurement Tool to Assess Systematic Reviews or Assessing the Methodological quality of SysTemAtic Reviews) instrument (Shea et al., 2007) to assess the methodological quality. In almost all respects, the quality of the review was high. However, using the AMSTAR rating tool, the review received a rating of 'low quality' due to the authors not providing a list of all potentially relevant studies that were read in full-text form but excluded from the review. The authors were contacted to request this information but unfortunately no response was forthcoming.

2.6. Analysis of subgroups or subsets

No subgroup analyses were conducted.

3. Results

3.1. PRISMA flowcharts

The PRISMA flow diagrams below depict the flow of information through the different phases of a systematic review. These diagrams map out the number of records identified, included, and excluded, and the reasons for exclusions, across various searches and updates of study records included for quantitative synthesis.

Figure 1 illustrates the flow of information resulting from an update of the ISTSS systematic review where relevant studies published between May of 2018 to June of 2019 were identified.

Figure 1: PRISMA for the ISTSS systematic review update (May 2018 to 6 June 2019), conducted by Phoenix Australia

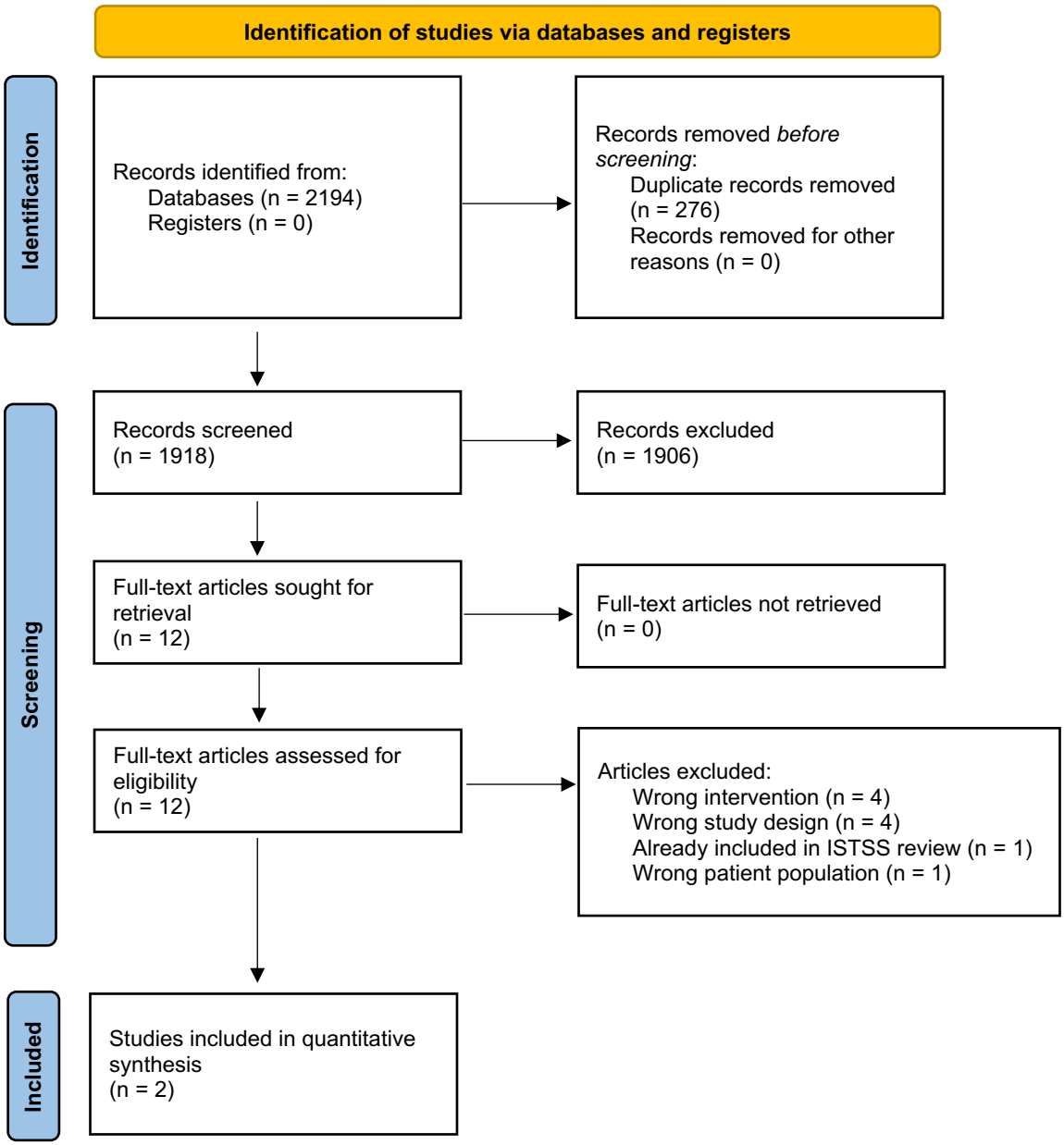


Figure 2 illustrates the flow of information resulting from a more recent search of the literature, where relevant studies published between June of 2019 to December of 2020 were identified.

Figure 2: PRISMA flow diagram for the 2020 update (June 2019 to December 2020) conducted by Phoenix Australia

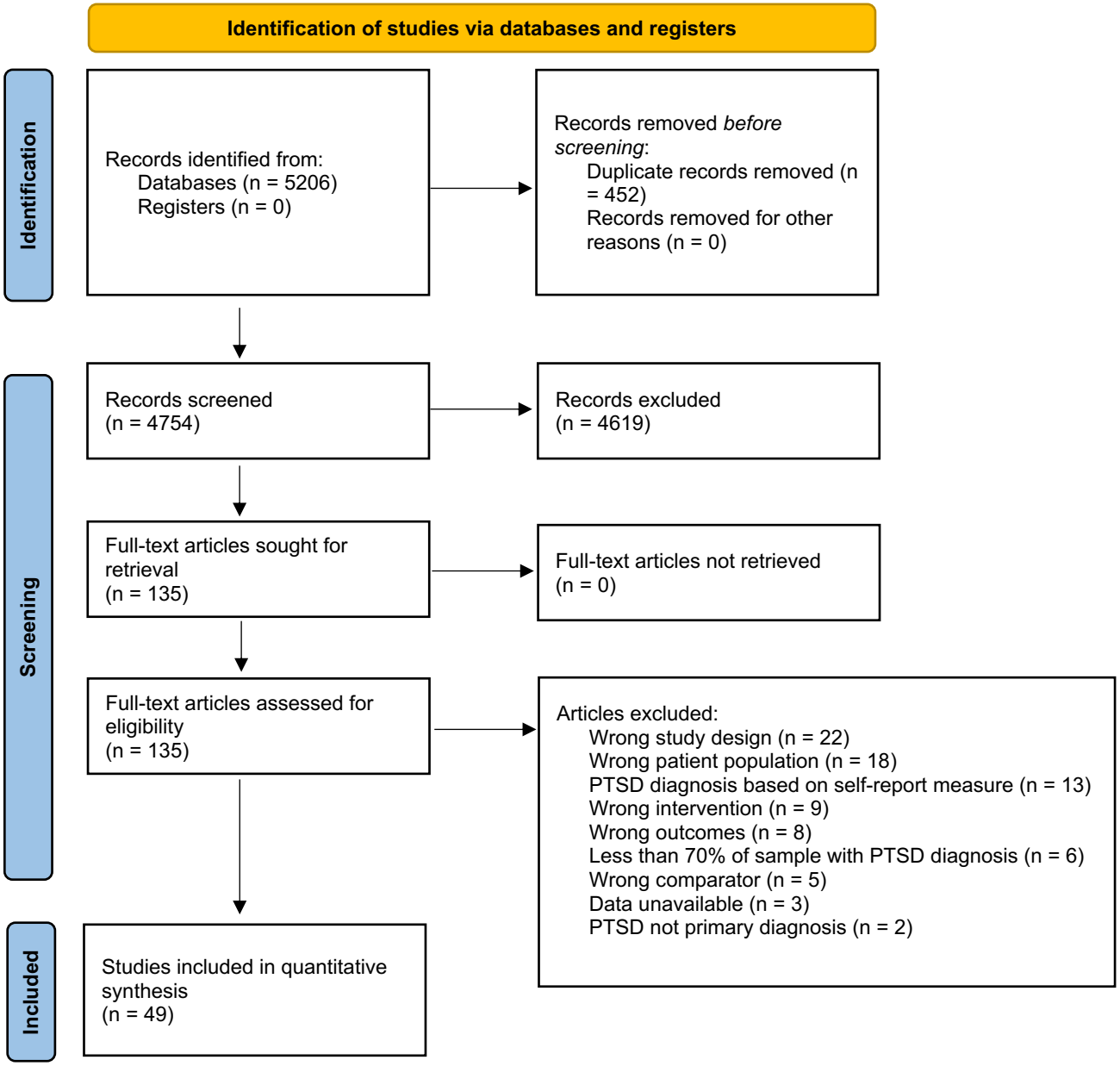
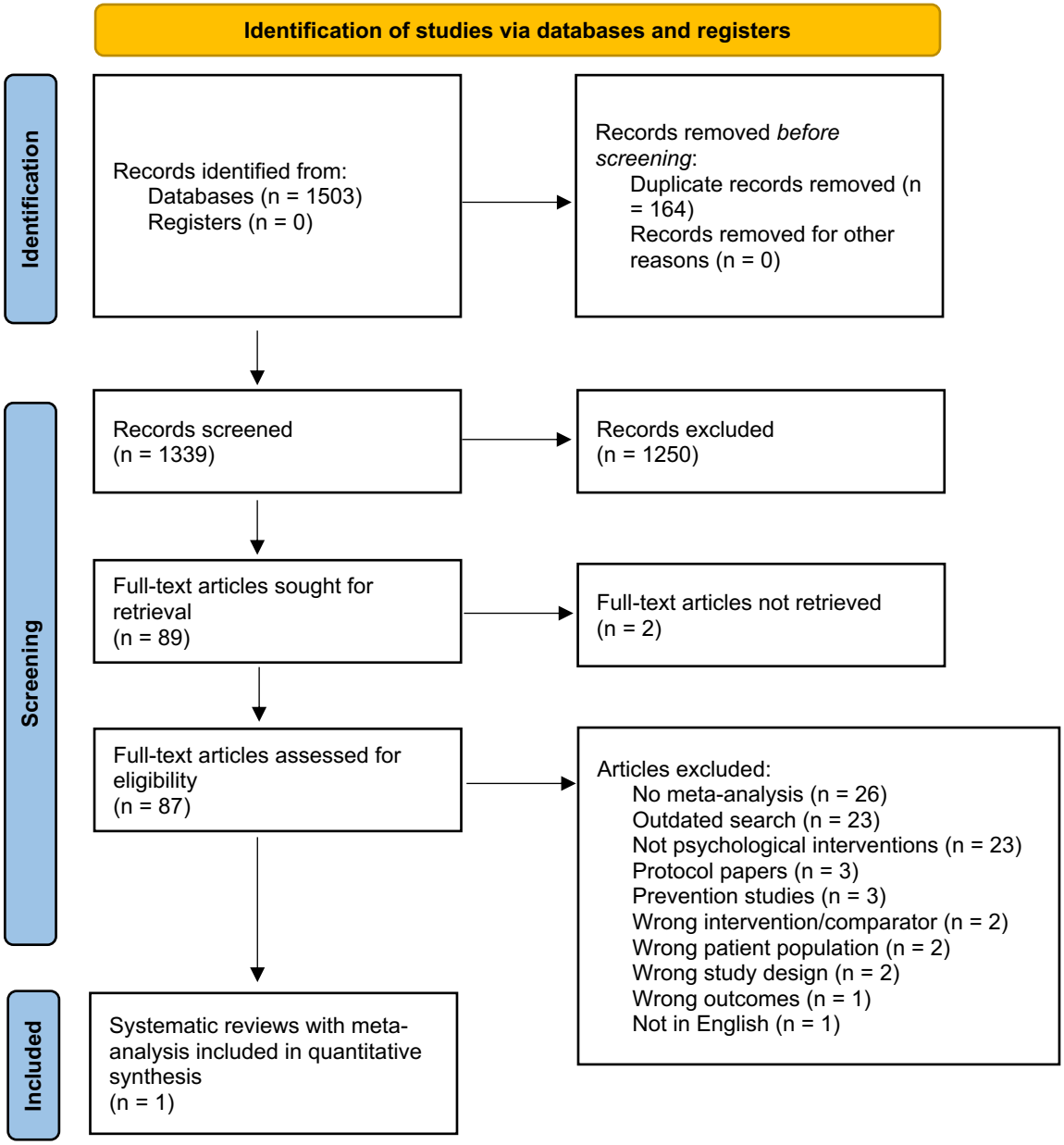


Figure 3 illustrates the flow of information resulting from a scoping search where relevant major systematic reviews with meta-analyses published in 2021 were identified.

Figure 3: PRISMA flow diagram for the scoping search of systematic reviews published in 2021, conducted by Phoenix Australia (December 2021)



3.2. Narrative description of studies that contributed to GRADE analysis for adults with PTSD

This review identified 101 RCTs which reported on 120 comparisons examining the effectiveness of psychological treatments in adults with PTSD. These comparisons were categorized into 17 comparison types, including a variety of different treatment-vs-waitlist/treatment-as-usual (TAU) and treatment-vs-treatment comparisons.

Psychological treatments identified across studies were grouped into specific treatment categories. For example, studies categorized as reporting on **Individual trauma-focused cognitive behavioural treatment (TF-CBT)** included a variety of trauma-focused treatments that were delivered to an individual by a therapist, and in addition to TF-CBT, this included cognitive processing therapy (CPT), virtual and in-person forms of prolonged exposure therapy (PE), narrative exposure therapy (NET), written exposure therapy (WET), single session CBT, and behavioural activation for PTSD.

A Digital/Remote TF-CBT category included a variety of digital forms of TF-CBT treatments including guided internet-based CBT, telehealth-based PE, and CBT with a trauma focus delivered through videoconferencing. The **Stress Management** category comprised treatments focusing on stress reduction, such as relaxation training, applied muscle relaxation, or stress inoculation training. Finally, a category was created called **'Other Psychological Treatments'** which included a range of other in-person treatment options not otherwise defined, including dialectical behaviour therapy, present centred therapy, supportive counselling. A **'Digital/Remote Other Psychological Treatments'** category was also created, which included digital or remote treatment options not otherwise defined. The **EMDR** category only included studies which solely implemented EMDR, and the **Group TF-CBT** category included studies which solely implemented CBT with a trauma focus on a group format.

Sixty-eight studies reported on treatment-vs-waitlist/TAU comparisons, and this included **Individual TF-CBT** (44 studies); **EMDR** (12 studies); **Group TF-CBT** (five studies); **Digital/Remote TF-CBT** (three studies); and **Stress management** (four studies).

Fifty-two studies reported on treatment-vs-treatment comparisons, and this included:

i) **Individual TF-CBT** vs Stress Management (3 studies); vs Other Psychological Treatments (15 studies).
ii) **EMDR** vs Individual TF-CBT (10 studies); vs Stress Management (four studies); vs Other Psychological Treatments (four studies).
iii) **Group TF-CBT** vs Individual TF-CBT (one study); vs Stress Management (one study); Other Psychological Treatments (three studies).
iv) **Digital/remote TF-CBT** vs Individual TF-CBT (seven studies); Other Psychological Treatments (one study); vs Digital/Remote Other Psychological Treatments (two studies).
v) **Stress management** vs Other Psychological Treatments (one study).

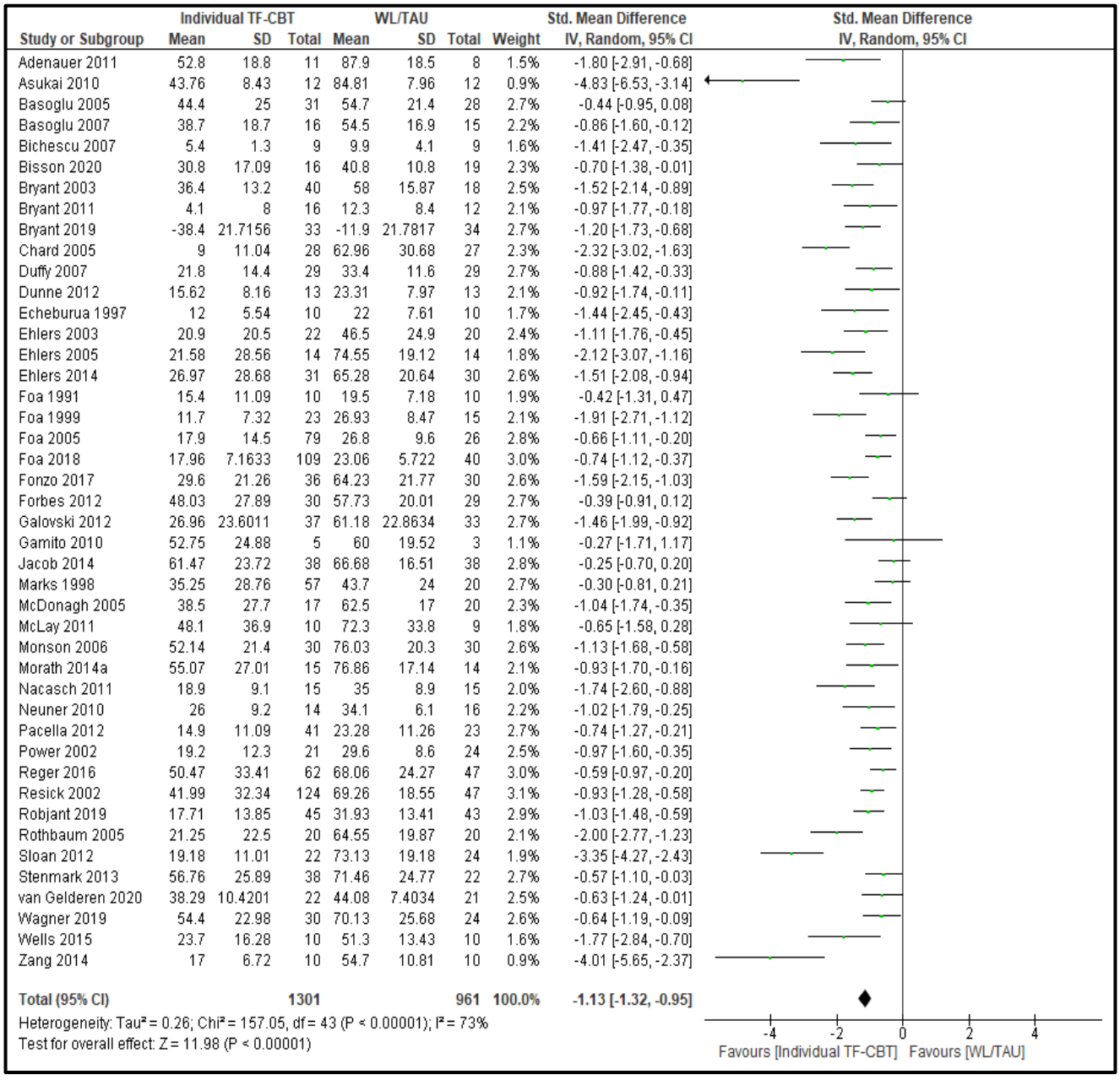
Overall, statistical heterogeneity in treatment effects across studies included for a given comparison was >30% for seven comparisons, so random effects models were applied in these meta-analyses. Statistical heterogeneity was <30% in the remaining 10 comparisons, and so fixed effects models were applied in these meta-analyses.

The relative efficacy of each treatment in comparison to waitlist/TAU as well as in comparison to one another was assessed across the 17 comparisons included in this study, and the results demonstrated important variability in the effectiveness of treatments to reduce PTSD symptom severity. These are reported in the GRADE profiles below and summarized in the Summary of Findings tables (Table 1).

3.3. Grading the Evidence – Adult population

3.3.1. Evidence profile: Individual TF-CBT vs TAU or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should individual TF-CBT vs TAU or no treatment/waitlist be used in adults with PTSD?
Reference List: Adenauer et al. (2011), Asukai et al. (2010), Basoglu et al. (2005), Basoglu et al. (2007), Bisson et al. (2020), Bryant et al. (2003), Bryant et al. (2011), Bryant et al. (2019), Chard et al. (2005), Duffy et al. (2007), Dunne et al. (2012), Echeburua et al. (1997), Ehlers et al. (2003), Ehlers et al. (2005), Ehlers et al. (2014), Foa et al. (1991), Foa et al. (1999), Foa et al. (2005), Foa et al. (2018), Fonzo et al. (2017), Forbes et al. (2012), Galvoski et al. (2012), Gamito et al. (2010), Jacob et al. (2014), Marks et al. (1998), McDonagh et al. (2005), McLay et al. (2011), Monson et al. (2006), Morath et al. (2014), Nacasch et al. (2011), Neuner et al. (2010), Pacella et al. (2012), Power et al. (2002), Reger et al. (2016), Resick et al. (2002), Robjant et al. (2019), Rothbaum et al. (2005), Sloan et al. (2012), Stenmark et al. (2013), van Gelderen et al. (2020), Wagner et al. (2019), Wells et al. (2015), Zang et al. (2014)



Study or Subgroup	Individual TF-CBT Mean	SD	Total	WL/TAU Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI
Adenauer 2011	52.8	18.8	11	87.9	18.5	8	1.5%	-1.80 [-2.91, -0.68]
Asukai 2010	43.76	8.43	12	84.81	7.96	12	0.9%	-4.83 [-6.53, -3.14]
Basoglu 2005	44.4	25	31	54.7	21.4	28	2.7%	-0.44 [-0.95, 0.08]
Basoglu 2007	38.7	18.7	16	54.5	16.9	15	2.2%	-0.86 [-1.60, -0.12]
Bichescu 2007	5.4	1.3	9	9.9	4.1	9	1.6%	-1.41 [-2.47, -0.35]
Bisson 2020	30.8	17.09	16	40.8	10.8	19	2.3%	-0.70 [-1.38, -0.01]
Bryant 2003	36.4	13.2	40	58	15.87	18	2.5%	-1.52 [-2.14, -0.89]
Bryant 2011	4.1	8	16	12.3	8.4	12	2.1%	-0.97 [-1.77, -0.18]
Bryant 2019	-38.4	21.7156	33	-11.9	21.7817	34	2.7%	-1.20 [-1.73, -0.68]
Chard 2005	9	11.04	28	62.96	30.68	27	2.3%	-2.32 [-3.02, -1.63]
Duffy 2007	21.8	14.4	29	33.4	11.6	29	2.7%	-0.88 [-1.42, -0.33]
Dunne 2012	15.62	8.16	13	23.31	7.97	13	2.1%	-0.92 [-1.74, -0.11]
Echeburua 1997	12	5.54	10	22	7.61	10	1.7%	-1.44 [-2.45, -0.43]
Ehlers 2003	20.9	20.5	22	46.5	24.9	20	2.4%	-1.11 [-1.76, -0.45]
Ehlers 2005	21.58	28.56	14	74.55	19.12	14	1.8%	-2.12 [-3.07, -1.16]
Ehlers 2014	26.97	28.68	31	65.28	20.64	30	2.6%	-1.51 [-2.08, -0.94]
Foa 1991	15.4	11.09	10	19.5	7.18	10	1.9%	-0.42 [-1.31, 0.47]
Foa 1999	11.7	7.32	23	26.93	8.47	15	2.1%	-1.91 [-2.71, -1.12]
Foa 2005	17.9	14.5	79	26.8	9.6	26	2.8%	-0.66 [-1.11, -0.20]
Foa 2018	17.96	7.1633	109	23.06	5.722	40	3.0%	-0.74 [-1.12, -0.37]
Fonzo 2017	29.6	21.26	36	64.23	21.77	30	2.6%	-1.59 [-2.15, -1.03]
Forbes 2012	48.03	27.89	30	57.73	20.01	29	2.7%	-0.39 [-0.91, 0.12]
Galovski 2012	26.96	23.6011	37	61.18	22.8634	33	2.7%	-1.46 [-1.99, -0.92]
Gamito 2010	52.75	24.88	5	60	19.52	3	1.1%	-0.27 [-1.71, 1.17]
Jacob 2014	61.47	23.72	38	66.68	16.51	38	2.8%	-0.25 [-0.70, 0.20]
Marks 1998	35.25	28.76	57	43.7	24	20	2.7%	-0.30 [-0.81, 0.21]
McDonagh 2005	38.5	27.7	17	62.5	17	20	2.3%	-1.04 [-1.74, -0.35]
McLay 2011	48.1	36.9	10	72.3	33.8	9	1.8%	-0.65 [-1.58, 0.28]
Monson 2006	52.14	21.4	30	76.03	20.3	30	2.6%	-1.13 [-1.68, -0.58]
Morath 2014a	55.07	27.01	15	76.86	17.14	14	2.1%	-0.93 [-1.70, -0.16]
Nacasch 2011	18.9	9.1	15	35	8.9	15	2.0%	-1.74 [-2.60, -0.88]
Neuner 2010	26	9.2	14	34.1	6.1	16	2.2%	-1.02 [-1.79, -0.25]
Pacella 2012	14.9	11.09	41	23.28	11.26	23	2.7%	-0.74 [-1.27, -0.21]
Power 2002	19.2	12.3	21	29.6	8.6	24	2.5%	-0.97 [-1.60, -0.35]
Reger 2016	50.47	33.41	62	68.06	24.27	47	3.0%	-0.59 [-0.97, -0.20]
Resick 2002	41.99	32.34	124	69.26	18.55	47	3.1%	-0.93 [-1.28, -0.58]
Robjant 2019	17.71	13.85	45	31.93	13.41	43	2.9%	-1.03 [-1.48, -0.59]
Rothbaum 2005	21.25	22.5	20	64.55	19.87	20	2.1%	-2.00 [-2.77, -1.23]
Sloan 2012	19.18	11.01	22	73.13	19.18	24	1.9%	-3.35 [-4.27, -2.43]
Stenmark 2013	56.76	25.89	38	71.46	24.77	22	2.7%	-0.57 [-1.10, -0.03]
van Gelderen 2020	38.29	10.4201	22	44.08	7.4034	21	2.5%	-0.63 [-1.24, -0.01]
Wagner 2019	54.4	22.98	30	70.13	25.68	24	2.6%	-0.64 [-1.19, -0.09]
Wells 2015	23.7	16.28	10	51.3	13.43	10	1.6%	-1.77 [-2.84, -0.70]
Zang 2014	17	6.72	10	54.7	10.81	10	0.9%	-4.01 [-5.65, -2.37]
Total (95% CI)			**1301**			**961**	**100.0%**	**-1.13 [-1.32, -0.95]**

Heterogeneity: Tau² = 0.26; Chi² = 157.05, df = 43 (P < 0.00001); I² = 73%
Test for overall effect: Z = 11.98 (P < 0.00001)

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
44	RCT	Serious[1]	None[2]	None	None	None	1301	961	-	SMD 1.13 lower (1.32 lower — 0.95 lower)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Selective outcome reporting.

[2] The magnitude of statistical heterogeneity was high, with I^2 = 73% however this was based on effects ranging between large and moderate and therefore not considered important.

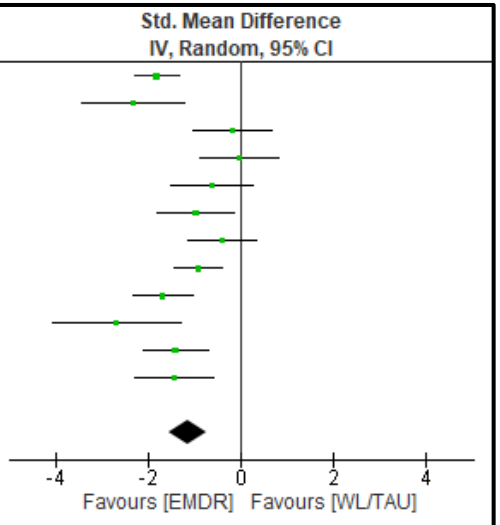
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.2. Evidence profile: EMDR vs TAU or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should EMDR vs TAU or no treatment/waitlist be used in adults with PTSD?
Reference List: Acarturk et al. (2016), Ahmadi et al. (2015), Carlson et al. (1998), Devilly et al. (1998), Hogberg et al. (2007), Jensen et al. (1994), Karatzias et al. (2019), Marcus et al. (1997), Power et al. (2002), Rothbaum et al. (1997), Rothbaum et al. (2005), Vaughan et al. (1994).

	EMDR			WL/TAU				Std. Mean Difference	Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI	IV, Random, 95% CI
Acarturk 2016	1.42	0.49	49	2.38	0.56	49	10.6%	-1.81 [-2.28, -1.34]	
Ahmadi 2015	-19.4	10.3	11	0.6	5.9	12	6.5%	-2.32 [-3.43, -1.22]	
Carlson 1998	35.2	22	10	38.7	16.2	12	8.1%	-0.18 [-1.02, 0.66]	
Devilly 1998	110.42	27.72	12	111.2	24.77	10	8.1%	-0.03 [-0.87, 0.81]	
Hogberg 2007	23.2	17.4	12	34	16.2	9	7.8%	-0.61 [-1.50, 0.28]	
Jensen 1994	35.69	12	13	46.92	10.22	12	8.1%	-0.97 [-1.81, -0.13]	
Karatzias 2019	28.5	18.77	15	35.14	13	14	8.8%	-0.40 [-1.13, 0.34]	
Marcus 1997	17.89	16.46	34	35	20.24	33	10.4%	-0.92 [-1.42, -0.41]	
Power 2002	16.8	17.2	27	45.5	16.1	24	9.4%	-1.69 [-2.34, -1.05]	
Rothbaum 1997	14.3	8.4	9	35	5.9	8	5.0%	-2.68 [-4.08, -1.28]	
Rothbaum 2005	31.65	25.27	20	64.55	19.87	20	9.0%	-1.42 [-2.12, -0.72]	
Vaughan 1994	16.8	6.2	12	28.5	8.9	17	8.1%	-1.44 [-2.28, -0.60]	
Total (95% CI)			**224**			**220**	**100.0%**	**-1.16 [-1.56, -0.75]**	

Heterogeneity: Tau² = 0.35; Chi² = 38.44, df = 11 (P < 0.0001); I² = 71%
Test for overall effect: Z = 5.55 (P < 0.00001)



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
12	RCT	Serious[1]	None[2]	None	Serious[3]	None	224	220	-	SMD 1.16 lower (1.56 lower — 0.75 lower)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, incomplete data and/or large loss to follow up, selective outcome reporting.

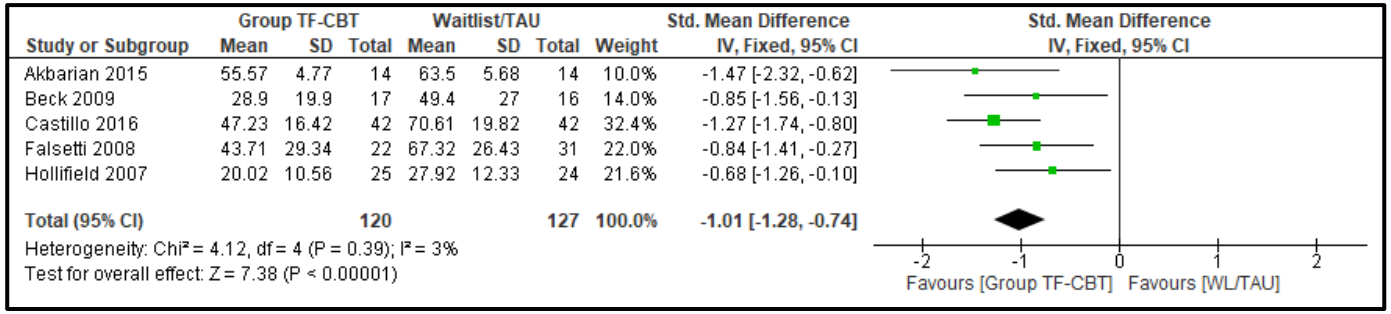
[2] The magnitude of statistical heterogeneity was high, with I^2 = 84% however this was based on effects ranging between large and moderate, and therefore not considered important.

[3]Wide confidence intervals (CI includes important benefit and unimportant benefit).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.3. Evidence profile: Group TF-CBT vs TAU or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should group TF-CBT vs TAU or no treatment/waitlist be used in adults with PTSD?
Reference List: Akbarian et al. (2015), Beck et al. (2009), Castillo et al. (2016), Falsetti et al. (2008), Hollifield et al. (2007).



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
5	RCT	Serious[1]	None	None	Serious[2]	None	120	127	-	SMD 1.01 lower (1.28 lower — 0.74 lower)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1]Selective outcome reporting, other bias.

[2] Low number of patients (n=247), wide confidence intervals (CI includes important benefit and unimportant benefit).

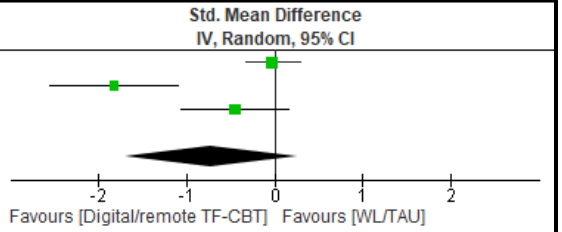
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.4. Evidence profile: Digital/Remote Trauma Focused Cognitive Behavioural Therapy (TF-CBT) vs TAU or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should Digital/Remote TF-CBT vs TAU or no treatment/waitlist be used in adults with PTSD?
Reference List: Acosta et al. (2017), Lewis et al. (2017), Spence et al. (2011)

	Digital/remote TF-CBT			WL/TAU				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Acosta 2017	40.9	12.8	81	41.2	13.1	81	36.2%	-0.02 [-0.33, 0.28]
Lewis 2017	17.93	12.25	21	36.53	7.1	21	31.1%	-1.82 [-2.55, -1.09]
Spence 2011a	44.78	17.29	23	51.79	12.51	19	32.7%	-0.45 [-1.06, 0.17]
Total (95% CI)			**125**			**121**	**100.0%**	**-0.72 [-1.71, 0.26]**

Heterogeneity: Tau² = 0.67; Chi² = 20.00, df = 2 (P < 0.0001); I² = 90%
Test for overall effect: Z = 1.44 (P = 0.15)



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
3	RCT	None	Serious[1]	None	Serious[2]	None	125	121	-	SMD 0.72 lower (1.71 lower — 0.26 higher)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

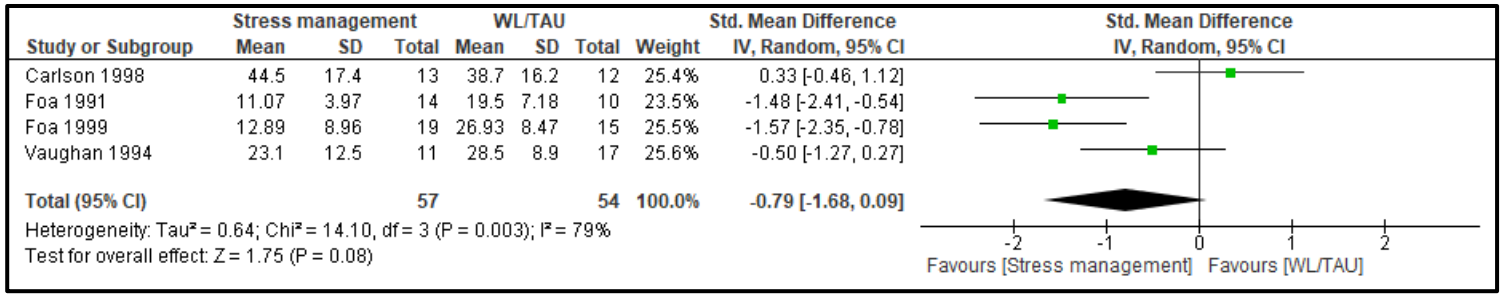
[1] Lack of overlap between CIs of studies, heterogeneity was statistically significant (p = 0.0001) and the magnitude was high with I^2 = 90%.

[2] Low number of patients (n=246).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.5. Evidence profile: Stress management vs TAU or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should stress management vs TAU or no treatment/waitlist be used in adults with PTSD?
Reference List: Carlson et al. (1998), Foa et al. (1991), Foa et al. (1999), Vaughan et al. (1994).

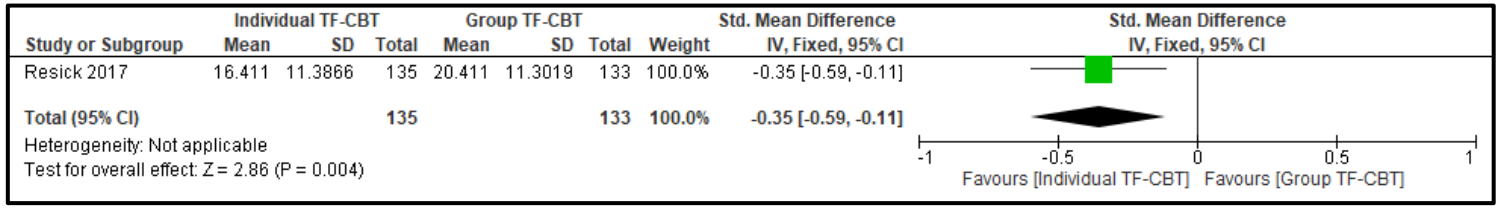


Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
4	RCT	Serious[1]	Serious[2]	None	Serious[3]	None	57	54	-	SMD 0.79 lower (1.68 lower — 0.09 higher)	Very Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, incomplete data and/or large loss to follow up, selective outcome reporting.
[2] The magnitude of statistical heterogeneity was high, with I^2 = 79%.
[3] Low number of patients (n=111), wide confidence intervals (CI includes important benefit and unimportant benefit).
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.6. Evidence profile: Individual TF-CBT vs group TF-CBT

Author(s): Phoenix Australia
Question: Should Individual TF-CBT vs group TF-CBT be used in adults with PTSD?
Reference List: Resick et al. (2017).



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
1	RCT	None	None	None	Serious[1]	None	135	133	-	SMD 0.35 lower (0.59 lower — 0.11 lower)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1]Wide confidence intervals (CI includes important benefit and unimportant benefit).

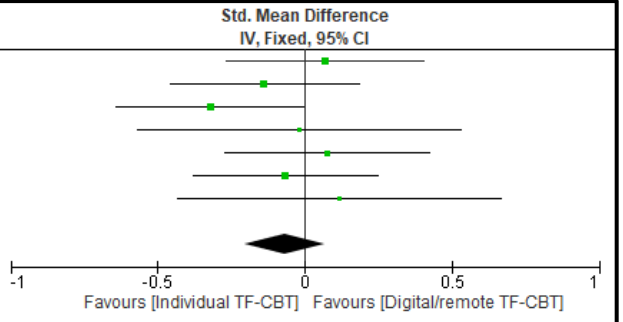
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.7. Evidence profile: Individual TF-CBT vs digital/remote TF-CBT

Author(s): Phoenix Australia
Question: Should individual TF-CBT vs digital/remote TF-CBT be used in adults with PTSD?
Reference List: Acierno et al. (2016), Acierno et al. (2017), Liu et al. (2020), Maieritsch et al. (2016), Moreland et al. (2015), Moreland et al. (2019), Yuen et al. (2015).

	TF-CBT in-person			Digital/remote TF-CBT				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Acierno 2016	48.56	18.49	73	47.33	17.14	63	16.5%	0.07 [-0.27, 0.41]
Acierno 2017	42.5	13.32	76	44.35	13.36	74	18.3%	-0.14 [-0.46, 0.18]
Liu 2020	53.4	26.2	74	62.1	27.5	80	18.5%	-0.32 [-0.64, -0.00]
Maieritsch 2016	50.7	22.1	26	51.2	28.3	25	6.2%	-0.02 [-0.57, 0.53]
Morland 2015	53.6	38.5155	63	50.5	42.0891	63	15.4%	0.08 [-0.27, 0.43]
Morland 2019	20.6	12.86	58	21.55	14.87	117	18.9%	-0.07 [-0.38, 0.25]
Yuen 2015	38.33	22.25	29	35.91	17.66	23	6.2%	0.12 [-0.43, 0.66]
Total (95% CI)			**399**			**445**	**100.0%**	**-0.07 [-0.21, 0.07]**

Heterogeneity: Chi² = 4.38, df = 6 (P = 0.62); I² = 0%
Test for overall effect: Z = 0.98 (P = 0.33)

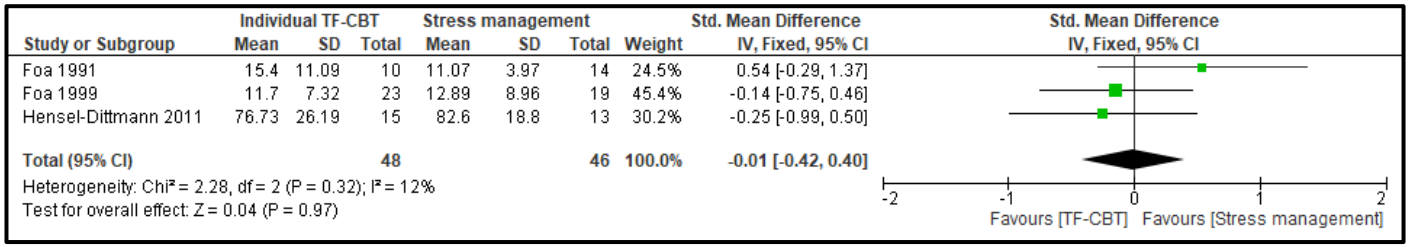


Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
7	RCT	Serious[1]	None	None	Serious[2]	None	399	455	-	SMD 0.07 lower (0.21 lower — 0.07 higher)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, incomplete data and/or large loss to follow up.
[2] Wide confidence intervals (CI includes important benefit and unimportant benefit).
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.8. Evidence profile: Individual TF-CBT vs stress management

Author(s): Phoenix Australia
Question: Should individual TF-CBT vs stress management be used in adults with PTSD?
Reference List: Foa et al. (1991), Foa et al. (1999), Hensel-Dittmann et al. (2011).

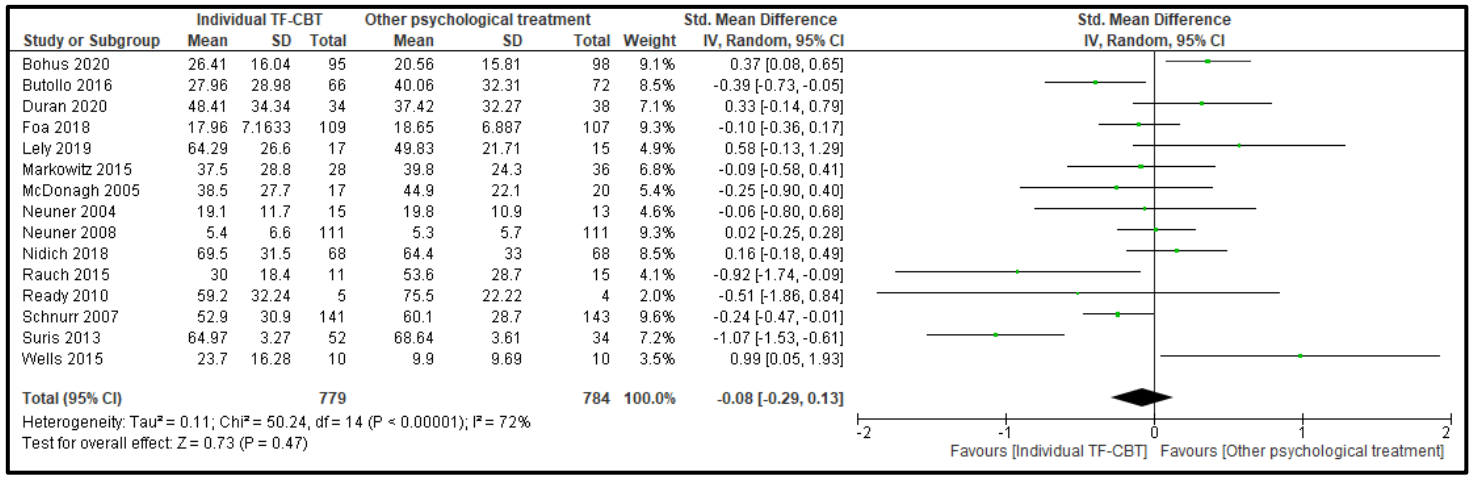


Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
3	RCT	Serious[1]	None	None	Serious[2]	None	48	46	-	SMD 0.01 lower (0.42 lower — 0.40 higher)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, incomplete data and/or large loss to follow up, selective outcome reporting.
[2] Low number of patients (n=94), wide confidence intervals (CI includes important benefit and unimportant benefit).
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.9. Evidence profile: Individual TF-CBT vs other psychological treatments

Author(s): Phoenix Australia
Question: Should individual TF-CBT vs other psychological treatments be used in adults with PTSD?
Reference List: Bohus et al. (2020), Butollo et al. (2016), Duran et al. (2020), Foa et al. (2018), Lely et al. (2019), Markowitz et al. (2015), Neuner et al. (2004), Neuner et al. (2008), Nidich et al. (2018), Rauch et al. (2015), Ready et al. (2010), Schnurr et al. (2007), Suris et al. (2013), Wells et al. (2015).



	Individual TF-CBT			Other psychological treatment				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Bohus 2020	26.41	16.04	95	20.56	15.81	98	9.1%	0.37 [0.08, 0.65]
Butollo 2016	27.96	28.98	66	40.06	32.31	72	8.5%	-0.39 [-0.73, -0.05]
Duran 2020	48.41	34.34	34	37.42	32.27	38	7.1%	0.33 [-0.14, 0.79]
Foa 2018	17.96	7.1633	109	18.65	6.887	107	9.3%	-0.10 [-0.36, 0.17]
Lely 2019	64.29	26.6	17	49.83	21.71	15	4.9%	0.58 [-0.13, 1.29]
Markowitz 2015	37.5	28.8	28	39.8	24.3	36	6.8%	-0.09 [-0.58, 0.41]
McDonagh 2005	38.5	27.7	17	44.9	22.1	20	5.4%	-0.25 [-0.90, 0.40]
Neuner 2004	19.1	11.7	15	19.8	10.9	13	4.6%	-0.06 [-0.80, 0.68]
Neuner 2008	5.4	6.6	111	5.3	5.7	111	9.3%	0.02 [-0.25, 0.28]
Nidich 2018	69.5	31.5	68	64.4	33	68	8.5%	0.16 [-0.18, 0.49]
Rauch 2015	30	18.4	11	53.6	28.7	15	4.1%	-0.92 [-1.74, -0.09]
Ready 2010	59.2	32.24	5	75.5	22.22	4	2.0%	-0.51 [-1.86, 0.84]
Schnurr 2007	52.9	30.9	141	60.1	28.7	143	9.6%	-0.24 [-0.47, -0.01]
Suris 2013	64.97	3.27	52	68.64	3.61	34	7.2%	-1.07 [-1.53, -0.61]
Wells 2015	23.7	16.28	10	9.9	9.69	10	3.5%	0.99 [0.05, 1.93]
Total (95% CI)			**779**			**784**	**100.0%**	**-0.08 [-0.29, 0.13]**

Heterogeneity: Tau² = 0.11; Chi² = 50.24, df = 14 (P < 0.00001); I² = 72%
Test for overall effect: Z = 0.73 (P = 0.47)

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
15	RCT	None	Serious[1]	None	None	None	779	784	-	SMD 0.08 lower (0.29 lower — 0.13 higher)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

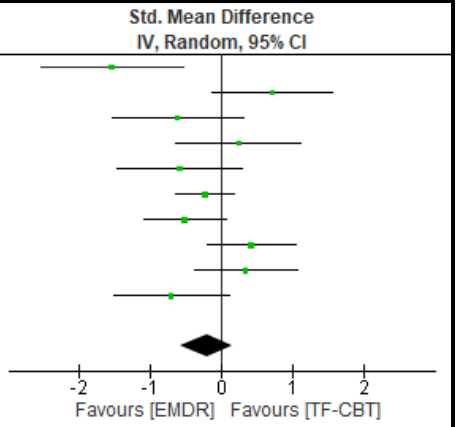
[1] Direction of effects are inconsistent, heterogeneity was statistically significant (p = 0.00001) and the magnitude was high with I^2 = 72%.
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.10. Evidence profile: Eye Movement Desensitization and Reprocessing (EMDR) vs individual Trauma Focused Cognitive Behavioural Therapy (TF-CBT)

Author(s): Phoenix Australia
Question: Should EMDR vs individual TF-CBT be used in adults with PTSD?
Reference List: Capezzani et al. (2013), Devilly et al. (1999), Ironson et al. (2002), Laugharne et al. (2016), Lee et al. (2002), Nijdam et al. (2012), Power et al. (2002), Rothbaum et al. (2005), Taylor et al. (2003), Vaughan et al. (1994).

	EMDR			TF-CBT				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Capezzani 2013	20.55	17.85	11	46.6	14.13	10	7.6%	-1.54 [-2.55, -0.54]
Devilly 1999	49.54	20.39	11	34.17	20.63	12	9.0%	0.72 [-0.13, 1.57]
Ironson 2002	9.1	11.22	10	15.78	9.16	9	8.2%	-0.62 [-1.55, 0.31]
Laugharne 2016	28.4	27.85	10	22.3	19.17	10	8.7%	0.24 [-0.64, 1.12]
Lee 2002	17.03	12.92	10	25.06	13.27	11	8.7%	-0.59 [-1.47, 0.29]
Nijdam 2012	17.67	11.06	48	20.5	12.79	42	14.3%	-0.24 [-0.65, 0.18]
Power 2002	16.8	17.2	27	25.9	17.9	21	12.2%	-0.51 [-1.09, 0.07]
Rothbaum 2005	31.65	25.27	20	21.25	22.5	20	11.6%	0.43 [-0.20, 1.05]
Taylor 2003	-39.2166	11.9935	15	-43.7333	13.9087	15	10.4%	0.34 [-0.38, 1.06]
Vaughan 1994	16.8	6.2	12	23	10.2	13	9.4%	-0.70 [-1.52, 0.11]
Total (95% CI)			**174**			**163**	**100.0%**	**-0.21 [-0.57, 0.15]**

Heterogeneity: Tau² = 0.20; Chi² = 22.52, df = 9 (P = 0.007); I² = 60%
Test for overall effect: Z = 1.13 (P = 0.26)



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
10	RCT	Serious[1]	Serious[2]	None	Serious[3]	None	174	163	-	SMD 0.21 lower (0.57 lower — 0.15 higher)	Very Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, selective outcome reporting.

[2] Direction of effects are inconsistent, heterogeneity was statistically significant (p = 0.0007), and the magnitude was moderately high with I^2 = 60%.

[3] Wide confidence intervals (CI includes important benefit and unimportant benefit).

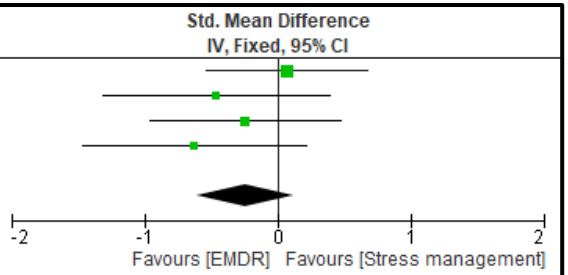
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.11. EMDR vs stress management

Author(s): Phoenix Australia
Question: Should EMDR vs stress management be used in adults with PTSD?
Reference List: Carletto et al. (2016), Carlson et al. (1998), Taylor et al. (2003), Vaughan et al. (1994).

	EMDR			Stress management				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Carletto 2016	22.5	13.59	20	21.5	14.76	22	36.6%	0.07 [-0.54, 0.67]
Carlson 1998	35.2	22	10	44.5	17.4	12	18.5%	-0.46 [-1.31, 0.40]
Taylor 2003	-39.2166	11.9935	15	-35.6667	16.3618	15	26.0%	-0.24 [-0.96, 0.48]
Vaughan 1994	16.8	6.2	12	23.1	12.5	11	18.9%	-0.62 [-1.47, 0.22]
Total (95% CI)			**57**			**60**	**100.0%**	**-0.24 [-0.61, 0.13]**

Heterogeneity: Chi² = 2.05, df = 3 (P = 0.56); I² = 0%
Test for overall effect: Z = 1.28 (P = 0.20)

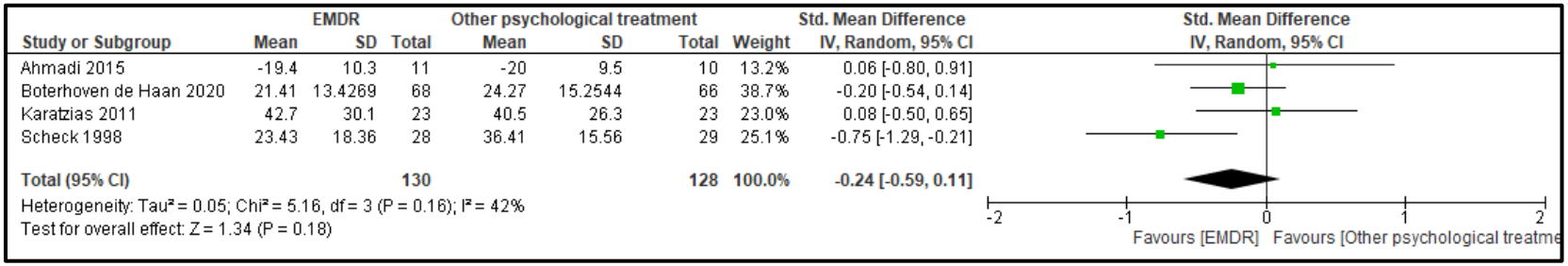


Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
4	RCT	Serious[1]	None	None	Serious[2]	None	57	60	-	SMD 0.24 lower (0.61 lower — 0.13 higher)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, incomplete data and/or large loss to follow up, selective outcome reporting.
[2] Low number of patients (n=117), wide confidence intervals (CI includes important benefit and unimportant benefit).
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.12. Evidence profile: EMDR vs other psychological treatments

Author(s): Phoenix Australia
Question: Should EMDR vs other psychological treatments be used in adults with PTSD?
Reference List: Ahmadi et al. (2015), Beterhoven de Haan et al. (2020), Karatzias et al. (2011), Scheck et al. (1998).



	EMDR			Other psychological treatment				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Ahmadi 2015	-19.4	10.3	11	-20	9.5	10	13.2%	0.06 [-0.80, 0.91]
Boterhoven de Haan 2020	21.41	13.4269	68	24.27	15.2544	66	38.7%	-0.20 [-0.54, 0.14]
Karatzias 2011	42.7	30.1	23	40.5	26.3	23	23.0%	0.08 [-0.50, 0.65]
Scheck 1998	23.43	18.36	28	36.41	15.56	29	25.1%	-0.75 [-1.29, -0.21]
Total (95% CI)			**130**			**128**	**100.0%**	**-0.24 [-0.59, 0.11]**

Heterogeneity: $Tau^2 = 0.05$; $Chi^2 = 5.16$, df = 3 (P = 0.16); $I^2 = 42\%$
Test for overall effect: Z = 1.34 (P = 0.18)

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
4	RCT	Serious[1]	None	None	Serious[2]	None	130	128	-	SMD 0.24 lower (0.59 lower — 0.11 higher)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

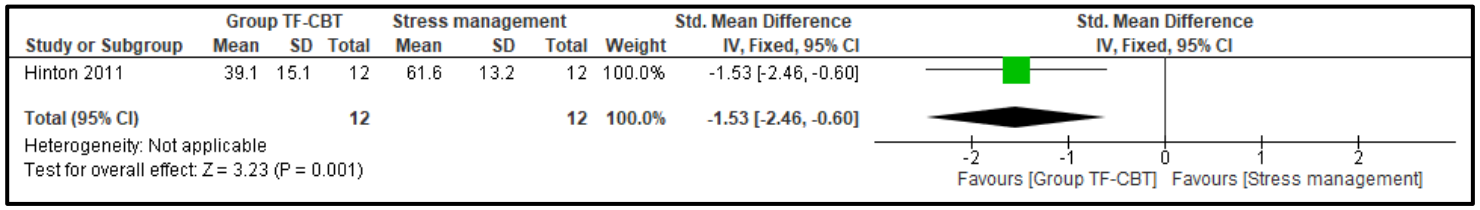
[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, incomplete data and/or large loss to follow up, selective outcome reporting.

[2] Low number of patients (n=158), wide confidence intervals (CI includes important benefit and unimportant benefit).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.13. Evidence profile: Group TF-CBT vs stress management

Author(s): Phoenix Australia
Question: Should group TF-CBT vs stress management be used in adults with PTSD?
Reference List: Hinton et al. (2011)

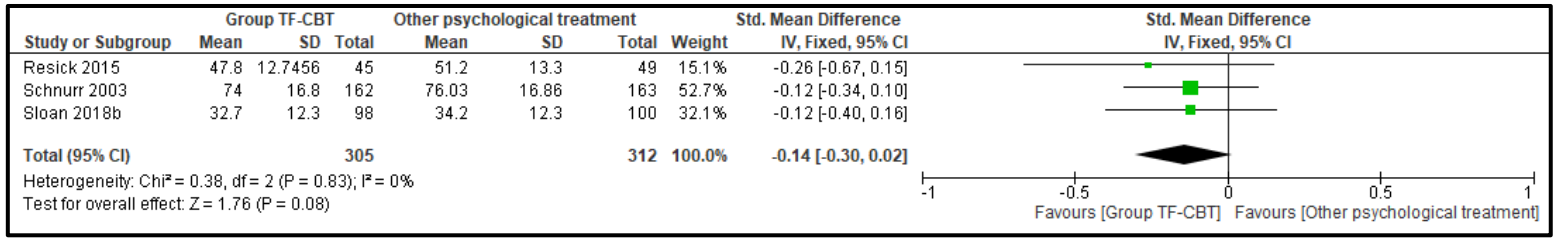


Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
1	RCT	Serious[1]	None	None	Serious[2]	None	12	12	-	SMD 1.53 lower (2.46 lower — 0.60 lower)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, selective outcome reporting.
[2] Low number of patients (n=24). CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.14. Evidence profile: group TF-CBT) vs other psychological treatments

Author(s): Phoenix Australia
Question: Should group TF-CBT vs other psychological treatments be used in adults with PTSD?
Reference List: Resick et al. (2015), Schnurr et al. (2003), Sloan et al. (2018).



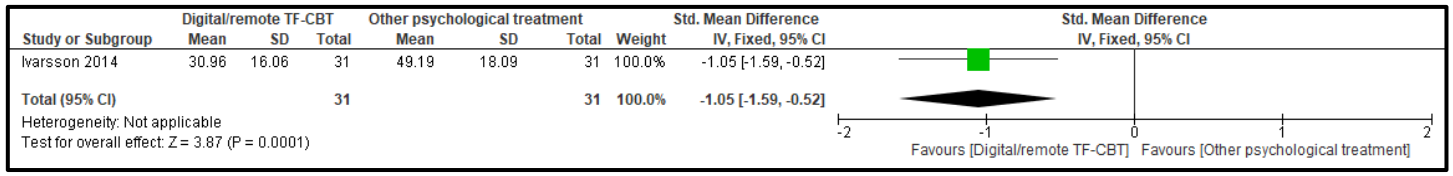
Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
3	RCT	None	None	None	Serious[1]	None	305	312	-	SMD 0.14 lower (0.30 lower — 0.02 higher)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Wide confidence intervals (CI includes important benefit and unimportant benefit).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.15. Evidence profile: digital/remote TF-CBT vs other psychological treatments

Author(s): Phoenix Australia
Question: Should digital/remote TF-CBT vs other psychological treatments be used in adults with PTSD?
Reference List: Ivarsson et al. (2014).



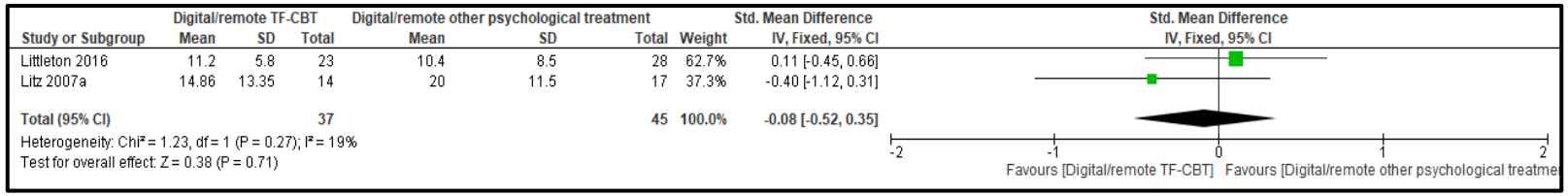
Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
1	RCT	None	None	None	Serious[1]	None	31	31	-	SMD 1.05 lower (1.59 lower — 0.52 lower)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Low number of patients (n=62).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.16. Evidence profile: digital/remote TF-CBT vs digital/remote other psychological interventions

Author(s): Phoenix Australia
Question: digital/remote TF-CBT vs digital/remote other psychological interventions be used in adults with PTSD?
Reference List: Littleton et al. (2016), Litz et al. (2007).



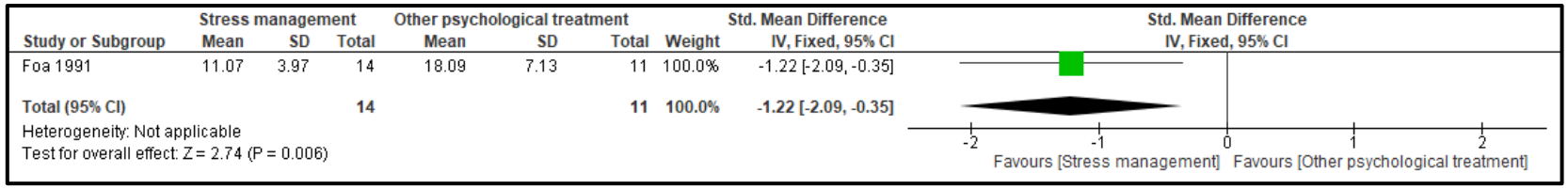
Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
2	RCT	None	None	None	Very serious[1]	None	37	45	-	SMD 0.08 lower (0.52 lower — 0.35 higher)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Low number of patients (n=82), wide confidence intervals (CI includes important benefit and unimportant benefit).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.3.17. Evidence profile: Stress management vs other psychological treatments

Author(s): Phoenix Australia
Question: Should stress management vs other psychological treatments be used in adults with PTSD?
Reference List: Foa et al. (1991).



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
1	RCT	Serious[1]	None	None	Serious[2]	None	14	11	-	SMD 1.22 lower (2.09 lower — 0.35 lower)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, incomplete data and/or large loss to follow up, selective outcome reporting.
[2] Low number of patients (n=25).
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.4. Narrative description of studies that contributed to GRADE analysis for children and adolescents with PTSD

This review identified 45 RCTs which reported on 49 comparisons examining the effectiveness of psychological treatments in children and adolescents with PTSD. These comparisons were categorized into six distinct comparison types, including different treatment-vs-waitlist/TAU and treatment-vs-treatment comparisons.

Psychological treatments identified across studies were grouped into specific treatment categories. For example, studies categorized as reporting on **Individual TF-CBT** included a variety of TF-CBT based treatments in addition to CBT with a trauma focus for child, TF-CBT for caregiver and child, kidNET, and individual and group TF for caregiver and child. Studies categorized as reporting on **'Other Psychological Treatments'** included a range of other treatment options not otherwise defined, including non-directive counselling, psychoeducation, reminder-focused positive psychiatry (RFPP), parent-child relationship enhancement therapy, supportive group therapy, and group resilience building intervention. The **EMDR** category only included studies solely implementing EMDR, and the **group TF-CBT** category included studies solely implementing CBT with a trauma focus for child in group format.

Thirty-two studies reported on treatment-vs-waitlist/TAU comparisons, and this included individual TF-CBT (26 studies); EMDR (four studies); and group TF-CBT (two studies). Seventeen studies reported on treatment-vs-treatment comparisons, and this included Individual TF-CBT vs EMDR (three studies); Individual TF-CBT vs Other Psychological Treatments (12 studies); and Group TF-CBT vs Other Psychological Treatments (two studies).

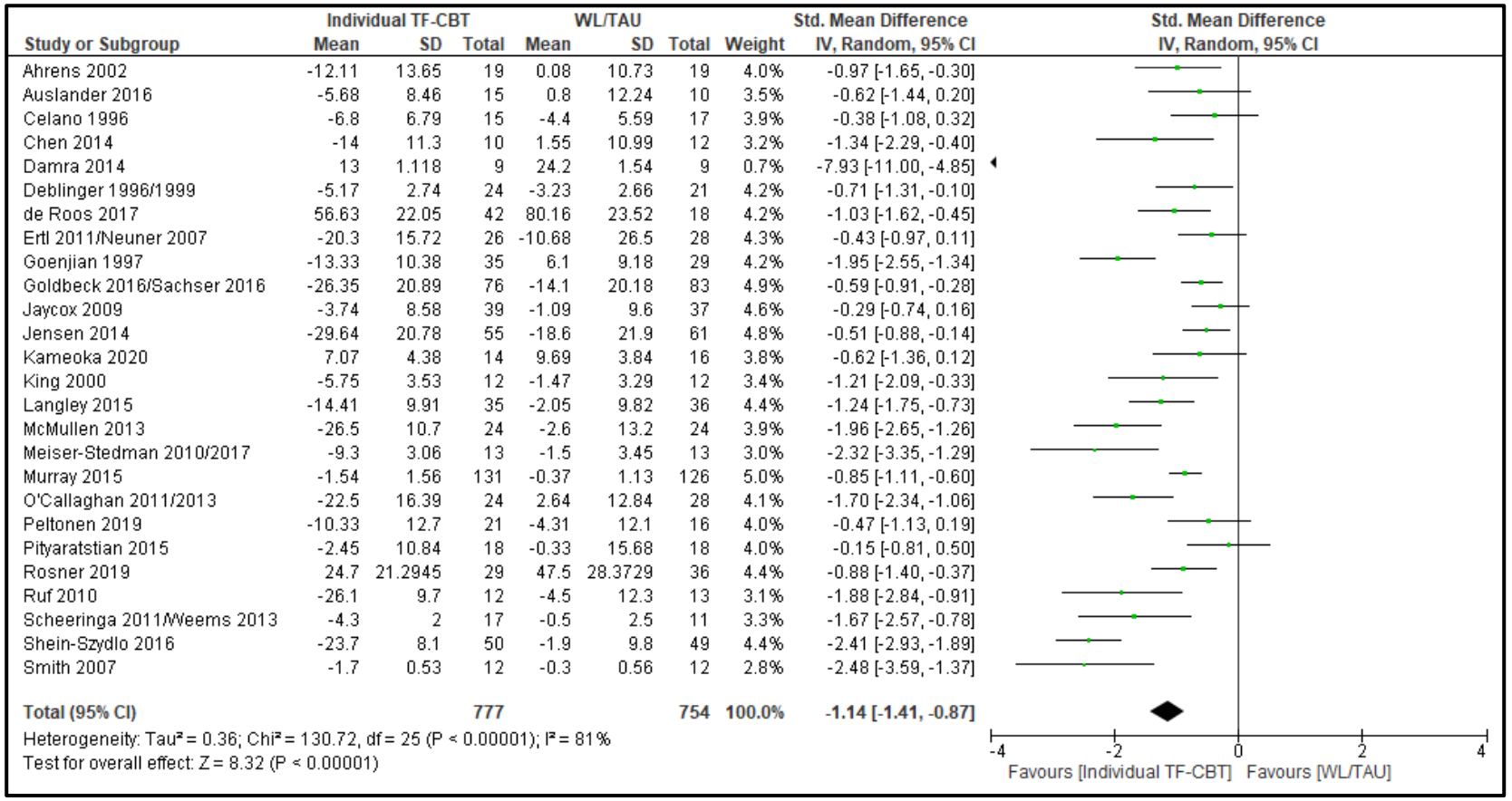
Overall, statistical heterogeneity was >30% for four comparisons, so random effects models were applied in these meta-analyses. Statistical heterogeneity was <30% in the remaining two comparisons, where fixed effects models were applied.

The relative efficacy of each treatment in comparison to waitlist/TAU, as well as in comparison to one another, was assessed across the six comparisons included in this study and the results demonstrated important variability in the effectiveness of treatments to reduce PTSD symptom severity. These are reported in the GRADE profiles below and summarized in the Summary of Findings tables (Table 2).

3.5. Grading the Evidence – Children and adolescents

3.5.1. Evidence profile: Individual Trauma Focused Cognitive Behavioural Therapy (TF-CBT) vs treatment as usual or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should individual TF-CBT vs TAU or no treatment/waitlist be used in children with PTSD?
Reference List: Ahrens et al. (2002), Auslander et al. (2016), Celano et al. (1996), Chen et al. (2014), Damra et al. (2014), Deblinger et al. (1999), de Roos et al. (2017), Ertl et al. (2011), Goenjian et al. (1997), Goldbeck et al. (2016), Jaycox et al. (2009), Jensen et al. (2014), Kameoka et al. (2020), King et al. (2000), Langley et al. (2015), McMullen et al. (2013), Meiser-Stedman et al. (2017), Murray et al. (2015), O'Callaghan et al. (2013), Peltonen et al. (2019), Pityaratstian et al. (2015), Rosner et al. (2019), Ruf et al. (2010), Scheeringa et al. (2011), Shein-Szydlo et al. (2016), Smith et al. (2007).



Study or Subgroup	Individual TF-CBT Mean	SD	Total	WL/TAU Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI
Ahrens 2002	-12.11	13.65	19	0.08	10.73	19	4.0%	-0.97 [-1.65, -0.30]
Auslander 2016	-5.68	8.46	15	0.8	12.24	10	3.5%	-0.62 [-1.44, 0.20]
Celano 1996	-6.8	6.79	15	-4.4	5.59	17	3.9%	-0.38 [-1.08, 0.32]
Chen 2014	-14	11.3	10	1.55	10.99	12	3.2%	-1.34 [-2.29, -0.40]
Damra 2014	13	1.118	9	24.2	1.54	9	0.7%	-7.93 [-11.00, -4.85]
Deblinger 1996/1999	-5.17	2.74	24	-3.23	2.66	21	4.2%	-0.71 [-1.31, -0.10]
de Roos 2017	56.63	22.05	42	80.16	23.52	18	4.2%	-1.03 [-1.62, -0.45]
Ertl 2011/Neuner 2007	-20.3	15.72	26	-10.68	26.5	28	4.3%	-0.43 [-0.97, 0.11]
Goenjian 1997	-13.33	10.38	35	6.1	9.18	29	4.2%	-1.95 [-2.55, -1.34]
Goldbeck 2016/Sachser 2016	-26.35	20.89	76	-14.1	20.18	83	4.9%	-0.59 [-0.91, -0.28]
Jaycox 2009	-3.74	8.58	39	-1.09	9.6	37	4.6%	-0.29 [-0.74, 0.16]
Jensen 2014	-29.64	20.78	55	-18.6	21.9	61	4.8%	-0.51 [-0.88, -0.14]
Kameoka 2020	7.07	4.38	14	9.69	3.84	16	3.8%	-0.62 [-1.36, 0.12]
King 2000	-5.75	3.53	12	-1.47	3.29	12	3.4%	-1.21 [-2.09, -0.33]
Langley 2015	-14.41	9.91	35	-2.05	9.82	36	4.4%	-1.24 [-1.75, -0.73]
McMullen 2013	-26.5	10.7	24	-2.6	13.2	24	3.9%	-1.96 [-2.65, -1.26]
Meiser-Stedman 2010/2017	-9.3	3.06	13	-1.5	3.45	13	3.0%	-2.32 [-3.35, -1.29]
Murray 2015	-1.54	1.56	131	-0.37	1.13	126	5.0%	-0.85 [-1.11, -0.60]
O'Callaghan 2011/2013	-22.5	16.39	24	2.64	12.84	28	4.1%	-1.70 [-2.34, -1.06]
Peltonen 2019	-10.33	12.7	21	-4.31	12.1	16	4.0%	-0.47 [-1.13, 0.19]
Pityaratstian 2015	-2.45	10.84	18	-0.33	15.68	18	4.0%	-0.15 [-0.81, 0.50]
Rosner 2019	24.7	21.2945	29	47.5	28.3729	36	4.4%	-0.88 [-1.40, -0.37]
Ruf 2010	-26.1	9.7	12	-4.5	12.3	13	3.1%	-1.88 [-2.84, -0.91]
Scheeringa 2011/Weems 2013	-4.3	2	17	-0.5	2.5	11	3.3%	-1.67 [-2.57, -0.78]
Shein-Szydlo 2016	-23.7	8.1	50	-1.9	9.8	49	4.4%	-2.41 [-2.93, -1.89]
Smith 2007	-1.7	0.53	12	-0.3	0.56	12	2.8%	-2.48 [-3.59, -1.37]
Total (95% CI)			**777**			**754**	**100.0%**	**-1.14 [-1.41, -0.87]**

Heterogeneity: Tau² = 0.36; Chi² = 130.72, df = 25 (P < 0.00001); I² = 81%
Test for overall effect: Z = 8.32 (P < 0.00001)

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
26	RCT	Serious[1]	None[2]	None	None	None	777	754	-	SMD 1.14 lower (1.41 lower — 0.87 lower)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias, inadequate concealment of allocation during randomization process, resulting in potential for selection bias, selective outcome reporting.

[2] The magnitude of statistical heterogeneity was high, with I^2 = 81% however inconsistency is between large and moderate effects and is therefore not important.

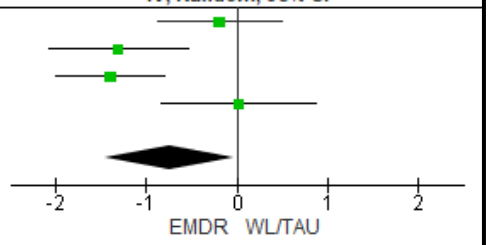
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.5.2. Evidence profile: EMDR vs TAU or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should EMDR vs TAU or no treatment/waitlist be used in children with PTSD?
Reference List: Ahmad et al. (2007), Chemtob et al. (2002), de Roos et al. (2017), Soberman et al. (2002).

	EMDR			WL/TAU				Std. Mean Difference	Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI	IV, Random, 95% CI
Ahmad 2007	17.7	10.1	17	19.7	10.2	16	25.8%	-0.19 [-0.88, 0.49]	
Chemtob 2002	16.47	12.98	17	39.6	21.04	15	24.2%	-1.31 [-2.08, -0.54]	
de Roos 2017	51.03	19.23	43	80.16	23.52	18	27.2%	-1.40 [-2.01, -0.79]	
Soberman 2002	-5.5	10.2	10	-5.73	12.39	11	22.8%	0.02 [-0.84, 0.88]	
Total (95% CI)			**87**			**60**	**100.0%**	**-0.74 [-1.46, -0.02]**	

Heterogeneity: Tau² = 0.40; Chi² = 11.94, df = 3 (P = 0.008); I² = 75%
Test for overall effect: Z = 2.02 (P = 0.04)



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
4	RCT	None	Serious[1]	None	Serious[2]	None	87	60	-	SMD 0.74 lower (1.46 lower — 0.02 lower)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

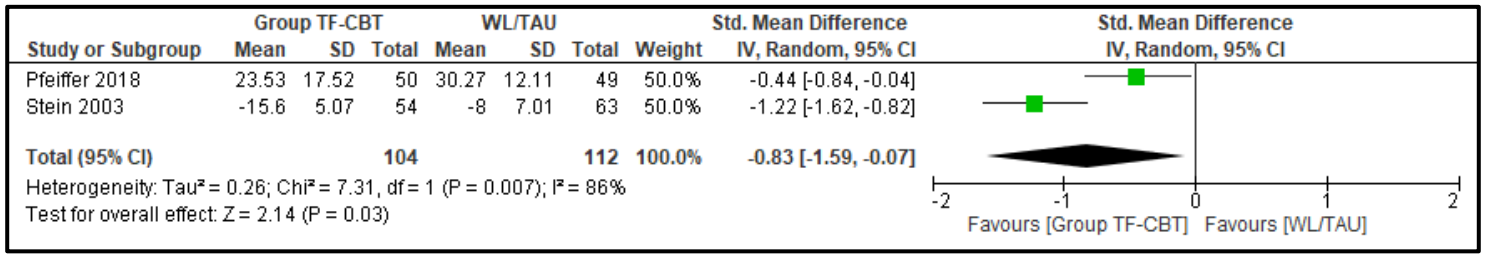
[1] Heterogeneity was statistically significant (p = 0.008) and the magnitude was high with I^2 = 75%.

[2] Low number of patients (n=147), wide confidence intervals (CI include important benefit and unimportant benefit).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.5.3. Evidence profile: Group TF-CBT vs TAU or no treatment/waitlist

Author(s): Phoenix Australia
Question: Should group TF-CBT vs TAU or no treatment/waitlist be used in children with PTSD?
Reference List: Pfeiffer et al. (2018), Stein et al. (2003).



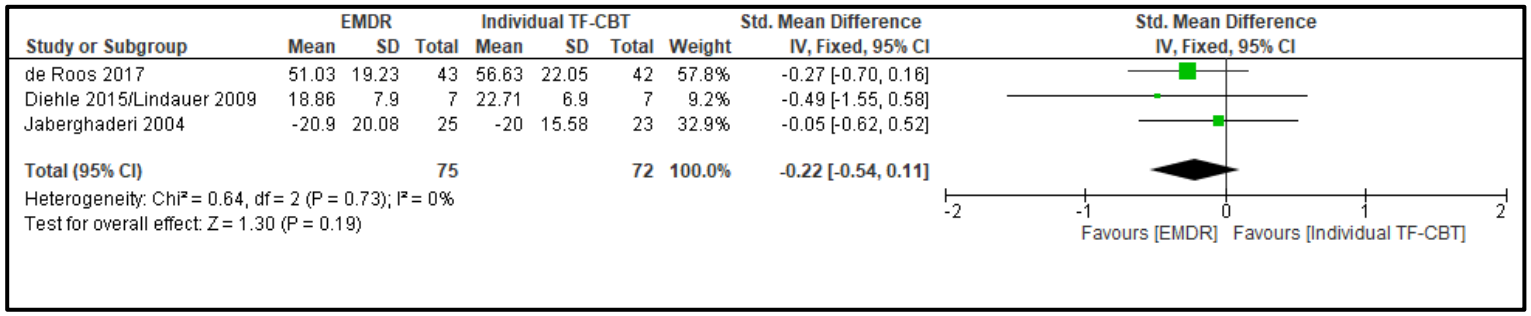
Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
2	RCT	None	None	None	Serious[1]	None	104	112	-	SMD 0.83 lower (1.59 lower — 0.07 lower)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Low number of patients (n=216).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.5.4. Evidence profile: EMDR vs Individual TF-CBT

Author(s): Phoenix Australia
Question: Should EMDR vs individual TF-CBT be used in children with PTSD?
Reference List: de Roos et al. (2017), Diehl et al. (2015), Jaberghaderi et al. (2004).



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
3	RCT	None	None	None	Serious[1]	None	75	72	-	SMD 0.22 lower (0.54 lower — 0.11 higher)	Moderate	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Low number of patients (n=147), wide confidence intervals (CI includes important benefit and unimportant benefit).

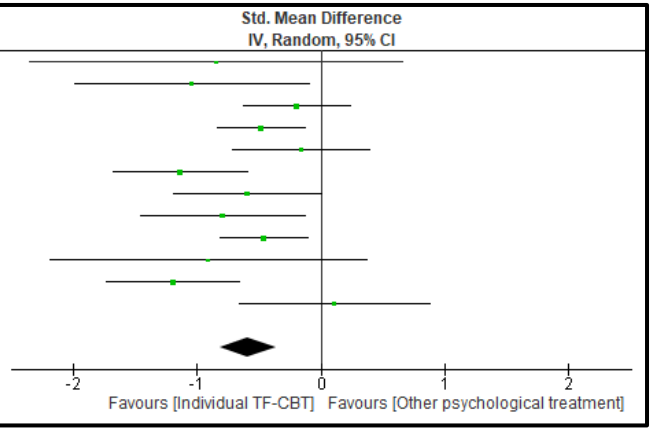
CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.5.5. Evidence profile: Individual TF-CBT vs other psychological treatments

Author(s): Phoenix Australia
Question: Should individual TF-CBT vs other psychological treatments be used in children with PTSD?
Reference List: Ahmadi et al. (2020), Chen et al. (2014), Cohen et al. (1998), Cohen et al. (2011), Ertl et al. (2011), Foa et al. (2013), Ford et al. (2012), Gilboa-Schechtman et al. (2010), Layne et al. (2008), Rossouw et al. (2016), Rossouw et al. (2018), Schottelkorb et al. (2012).

	Individual TF-CBT			Other psychological treatment				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Ahmadi 2020	24	3	4	28	5	4	2.1%	-0.84 [-2.35, 0.66]
Chen 2014	-14	11.3	10	-2.8	9.23	10	4.5%	-1.04 [-1.99, -0.09]
Cohen 1998/2005a	-1.85	4.5	41	-0.91	4.99	41	11.9%	-0.20 [-0.63, 0.24]
Cohen 2011/2005b	-3.31	3.48	64	-1.68	3.22	60	13.9%	-0.48 [-0.84, -0.13]
Ertl 2011/Neuner 2007	-20.3	15.72	26	-16.87	25.61	24	9.3%	-0.16 [-0.72, 0.40]
Foa 2013	-20.6	6.31	31	-13.3	6.38	30	9.6%	-1.14 [-1.68, -0.59]
Ford 2012	-24.4	13.93	26	-17	9.53	20	8.6%	-0.59 [-1.19, 0.00]
Gilboa-Schechtman 2004/2010	-19.37	10.64	19	-10.79	10.51	19	7.5%	-0.79 [-1.46, -0.13]
Layne 2008	-11.85	13.96	66	-5.67	12.71	61	14.0%	-0.46 [-0.81, -0.11]
Rossouw 2016	2.8	7.27	6	10	7.17	5	2.8%	-0.91 [-2.19, 0.37]
Rossouw 2018	5.89	7.367	31	18.37	12.564	32	9.7%	-1.19 [-1.73, -0.65]
Schottelkorb 2012	-2.25	10	12	-3.36	9.4	14	6.2%	0.11 [-0.66, 0.88]
Total (95% CI)			**336**			**320**	**100.0%**	**-0.59 [-0.81, -0.36]**

Heterogeneity: Tau² = 0.06; Chi² = 19.59, df = 11 (P = 0.05); I² = 44%
Test for overall effect: Z = 5.06 (P < 0.00001)

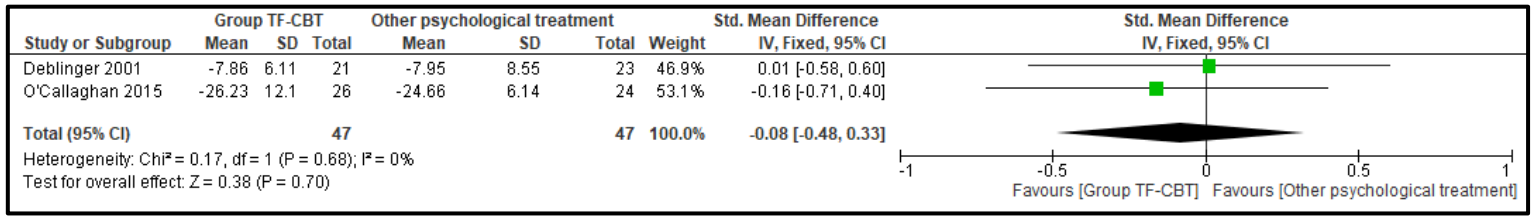


Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
12	RCT	None	None	None	None	None	336	320	-	SMD 0.59 lower (0.81 lower — 0.36 lower)	High	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

3.5.6. Evidence profile: Group TF-CBT vs other psychological treatments

Author(s): Phoenix Australia
Question: Should group TF-CBT vs other psychological treatments be used in children with PTSD?
Reference List: Deblinger et al. (2001), O'Callaghan et al. (2015).



Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interventions	Control	Relative (95% CI)	Absolute (95% CI)		
PTSD symptom severity												
2	RCT	Serious[1]	None	None	Serious[2]	None	47	47	-	SMD 0.08 lower (0.48 lower — 0.33 higher)	Low	Critical
Functioning/quality of life												
0	Outcome not assessed in review											
Presence of mental disorder at 6- to 12-months												
0	Outcome not assessed in review.											
Adverse effects												
0	Outcome not assessed in review											

[1] Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, incomplete data and/or large loss to follow up, selective outcome reporting.

[2] Low number of patients (n=94), wide confidence intervals (CI includes important benefit and unimportant benefit).

CI: confidence interval; PTSD: post-traumatic stress disorder; RCT: randomized controlled trial; SMD: standardized mean difference.

4. Summary of findings

4.1. Summary of findings table for comparisons reported in studies examining the effectiveness of PTSD treatments on PTSD symptom severity in adults

Table 1: Summary of findings table from GRADE tables in adults

GRADE Table	Comparison	Outcome (Timeframe)	Study results and measurements	Absolute effect estimates	Certainty of Evidence	Plain text summary
3.3.1	TF-CBT vs WL/TAU	PTSD symptom severity	Based on 2262 participants in 44 studies	Difference: SMD 1.13 lower (CI 95% 1.32 lower – 0.95 lower)	Moderate	TF-CBT probably decreases PTSD symptom severity
3.3.2	EMDR vs WL/TAU	PTSD symptom severity	Based on data from 444 participants in 12 studies	Difference: SMD 1.16 lower (CI 95% 1.56 lower – 0.75 lower)	Low	EMDR may decrease PTSD symptom severity
3.3.3	Group TF-CBT vs WL/TAU	PTSD symptom severity	Based on data from 247 participants in 5 studies	Difference: SMD 1.01 lower (CI 95% 1.28 lower – 0.74 lower)	Low	Group TF-CBT may decrease PTSD symptom severity
3.3.4	Digital/Remote TF-CBT vs WL/TAU	PTSD symptom severity	Based on 246 participants in 3 studies	Difference: SMD 0.72 lower (CI 95% 1.71 lower – 0.26 higher)	Low	Digital/Remote TF-CBT may decreased PTSD symptom severity slightly
3.3.5	SM vs WL/TAU	PTSD symptom severity	Based on 111 participants in 4 studies	Difference: SMD 0.79 lower (CI 95% 1.68 lower – 0.09 higher)	Very Low	We are uncertain whether SM improves or worsens PTSD symptom severity
3.3.6	TF-CBT vs Group TF-CBT	PTSD symptom severity	Based on data from 268 participants in 1 study	Difference: SMD 0.35 lower (CI 95% 0.59 lower – 0.11 lower)	Moderate	TF-CBT is probably more beneficial than Group TF-CBT on PTSD symptom severity
3.3.7	TF-CBT vs Digital/Remote TF-CBT	PTSD symptom severity	Based on 854 participants in 7 studies	Difference: SMD 0.07 lower (CI 95% 0.21 lower – 0.07 higher)	Low	There may be little or no difference in TF-CBT vs TF-CBT Digital/Remote on PTSD symptom severity

GRADE Table	Comparison	Outcome (Timeframe)	Study results and measurements	Absolute effect estimates	Certainty of Evidence	Plain text summary
3.3.8	TF-CBT vs SM	PTSD symptom severity	Based on 94 participants in 3 studies	Difference: SMD 0.01 lower (CI 95% 0.42 lower – 0.40 higher)	Low	There may be little or no difference between TF-CBT and SM on PTSD severity
3.3.9	TF-CBT vs Other	PTSD symptom severity	Based on 1563 participants in 15 studies	Difference: SMD 0.08 lower (CI 95% 0.29 lower – 0.13 higher)	Moderate	There is probably little or no difference between TF-CBT and other psychological interventions on PTSD symptom severity
3.3.10	EMDR vs TF-CBT	PTSD symptom severity	Based on data from 337 participants in 10 studies	Difference: SMD 0.21 lower (CI 95% 0.57 lower – 0.15 higher)	Very Low	We are uncertain if there is a difference between the effectiveness of EMDR and TF-CBT on PTSD symptom severity
3.3.11	EMDR vs SM	PTSD symptom severity	Based on 117 participants in 4 studies	Difference: SMD 0.24 lower (CI 95% 0.61 lower – 0.13 higher)	Low	EMDR may be more effective at reducing PTSD symptom severity than SM
3.3.12	EMDR vs Other	PTSD symptom severity	Based on 158 participants in 4 studies	Difference: SMD 0.24 lower (CI 95% 0.59 lower – 0.11 higher)	Low	EMDR may be more effective at reducing PTTSD symptom severity than other psychological treatments
3.3.13	Group TF-CBT vs SM	PTSD symptom severity	Based on 24 participants in 1 study	Difference: SMD 1.53 lower (CI 95% 2.46 lower – 0.60 lower)	Low	Group TF-CBT may be more effective at reducing PTSD symptom severity than SM
3.3.14	Group TF-CBT vs Other	PTSD symptom severity	Based on 617 participants in 3 studies	Difference: SMD 0.14 lower (CI 95% 0.30 lower – 0.02 higher)	Moderate	There is probably little or no difference between Group TF-CBT and other psychological

GRADE Table	Comparison	Outcome (Timeframe)	Study results and measurements	Absolute effect estimates	Certainty of Evidence	Plain text summary
						interventions on PTSD symptom severity
3.3.15	Digital/Remote TF-CBT vs Other	PTSD symptom severity	Based on 62 participants in 1 study	Difference: SMD 1.05 lower (CI 95% 1.59 lower – 0.52 lower)	Moderate	Digital/Remote TF-CBT is probably more effective at reducing PTSD symptom severity than other psychological treatments
3.3.16	Digital/Remote TF-CBT vs Digital/Remote Other	PTSD symptom severity	Based on 82 participants in 2 studies	Difference: SMD 0.08 lower (CI 95% 0.52 lower – 0.34 higher)	Low	There may be little or no difference between Digital/Remote TF-CBT than Digital/Remote other psychological treatments on PTSD symptom severity
3.3.17	SM vs Other	PTSD symptom severity	Based on 25 participants in 1 study	Difference: SMD 1.22 lower (CI 95% 2.09 lower – 0.35 lower)	Low	SM may be more effective at reducing PTSD symptom severity than other psychological treatments

TF-CBT = Individual trauma-focused cognitive behavioural therapy, EMDR = eye movement desensitization and reprocessing, WL/TAU = waitlist/no treatment or treatment as usual, SM = stress management, Other = other psychological interventions, SMD = standard mean difference.

4.2. Summary of findings table for comparisons reported in studies examining the effectiveness of PTSD treatments on PTSD symptom severity in children and adolescents.

Table 2: Summary of findings table from GRADE tables in children and adolescents

Grade Table	Comparison	Outcome (Timeframe)	Study results and measurements	Absolute effect estimates	Certainty of Evidence	Plain text summary
3.5.1	TF-CBT vs WL/TAU	PTSD symptom severity	Based on data from 1531 participants in 26 studies	Difference: SMD 1.14 lower (CI 95% 1.41 lower – 0.84 lower)	Moderate	TF-CBT probably decreases PTSD symptom severity
3.5.2	EMDR vs WL/TAU	PTSD symptom severity	Based on data from 147 participants in 4 studies	Difference: SMD 0.74 lower (CI 95% 1.46 lower – 0.02 lower)	Low	EMDR may decrease PTSD symptom severity slightly
3.5.3	Group TF-CBT vs WL/TAU	PTSD symptom severity	Based on 216 participants in 2 studies	Difference: SMD 0.83 lower (CI 95% 1.59 lower – 0.07 lower)	Moderate	Group TF-CBT probably decreases PTSD symptom severity
3.5.4	EMDR vs TF-CBT	PTSD symptom severity	Based on data from 147 participants in 3 studies	Difference: SMD 0.22 lower (CI 95% 0.54 lower – 0.11 higher)	Moderate	EMDR is probably more effective at reducing PTSD symptom severity than TF-CBT
3.5.5	TF-CBT vs Other	PTSD symptom severity	Based on data from 356 participants in 12 study	Difference: SMD 0.59 lower (CI 95% 0.81 lower – 0.36 lower)	High	TF-CBT is more effective at reducing PTSD symptom severity than other psychological treatments
3.5.6	Group TF-CBT vs Other	PTSD symptom severity	Based on 94 participants in 2 studies	Difference: SMD 0.08 lower (CI 95% 0.48 lower – 0.33 higher)	Low	There may be little or no difference between Group TF-CBT and other psychological treatments on PTSD symptom severity

TF-CBT = Individual Trauma Focused Cognitive Behavioural Therapy, EMDR = Eye Movement Desensitization and Reprocessing, WL/TAU = Waitlist/no treatment or treatment as usual, SM = Stress management, Other = other psychological interventions, SMD = standard mean difference.

5. Evidence to decision tables

5.1. Adult population

Please note * indicates evidence from overarching qualitative review by Gronholm et al, 2023.

Table 3: Evidence to decision table in adults

Criteria, questions		Judgement	Research evidence	Additional considerations
Priority of the problem	Is the problem a priority? The more serious a problem is, the more likely it is that an option that addresses the problem should be a priority (e.g. diseases that are fatal or disabling are likely to be a higher priority than diseases that only cause minor distress). The more people who are affected, the more likely it is that an option that addresses the problem should be a priority.			
	• Are the consequences of the problem serious (that is, severe or important in terms of the potential benefits or savings)? • Is the problem urgent? • Is it a recognized priority (such as based on a political or policy decision)? [Not relevant when an individual patient perspective is taken]	☐ No ☐ Probably no ☐ Probably yes ☒ **Yes** ☐ Varies ☐ Don't know	At the end of 2021, there were 274 million people in need of humanitarian assistance across the world (1) and nearly 84 million people had been forcibly displaced from their homes due to warfare and conflict (2), the highest numbers since the Second World War. People surviving these situations are faced with incredible and often overwhelming adversity. While it is true that the majority of people facing these circumstances can and will recover, particularly if they are able to reconnect with their social support systems and meet their basic needs and safety, some will continue to struggle. For example, a WHO meta-analysis indicated that one in five persons exposed to conflict in the last 10 years experiences some form of mental health	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
			condition (3), often conditions specifically related to stress,[5] including PTSD. PTSD demonstrates a lifetime prevalence ranging from 5-10% in community samples, with 12-month prevalence often closer to 5% (Koenen et al., 2017; Goldstein et al., 2016). Despite the prevalence, only half of those with severe cases of PTSD report receiving any treatment, and in many countries, there are large gaps in access to care (Koenen et al., 2017). These gaps in care are costly, given that PTSD can result in 3.6 days of productivity lost per month (Kessler et al., 2000) and estimates of total costs have been very high (Davis et al., 2022).	
Desirable Effects	How substantial are the desirable anticipated effects? The larger the benefit, the more likely it is that an option should be recommended.			
	• Judgements for each outcome for which there is a desirable effect • How substantial (large) are the desirable anticipated effects (including health and other benefits) of the option (considering the severity or importance of the desirable consequences and the number of people affected)?	☐ Trivial ☐ Small ☒ **Moderate** ☐ Large ☐ Varies ☐ Don't know	**Individual TF-CBT** Evidence from 44 RCTs (see Table 3.3.1) suggests a large benefit of individual TF-CBT on PTSD symptom severity relative to waitlist/no treatment or treatment as usual. Evidence from 1 RCT (see Table 3.3.6) suggests a small benefit of individual TF-CBT on PTSD symptom severity relative to group TF-CBT. Evidence from 7 RCTs (see Table 3.3.7) suggests no significant difference between individual TF-CBT and digital/remote TF-CBT on PTSD symptom severity.	No additional considerations.

[5] The term conditions specifically related to stress refers here to problems such as PTSD, acute stress reaction and bereavement reactions that require an exposure to a defined stressor as a precursor. There are numerous other stress-related disorders and problems (e.g. depression, behavioural disorders, alcohol/substance use problems, self-harm/suicide, medically unexplained somatic complaints), but these are not specifically related to stress (i.e. they may also occur in the absence of identifiable stressful life events).

Criteria, questions	Judgement	Research evidence	Additional considerations
		Evidence from 3 RCTs (see Table 3.3.8) suggests no significant difference between individual TF-CBT and stress management on PTSD symptom severity. Evidence from 15 RCTs (see Table 3.3.9) suggests no significant difference between individual TF-CBT and other psychological treatments on PTSD symptom severity. Evidence from 10 RCTs (see Table 3.3.10) suggests no significant difference between EMDR and individual TF-CBT on PTSD symptom severity. **EMDR** Evidence from 12 RCTs (see Table 3.3.2) suggests a large benefit of EMDR on PTSD symptom severity relative to waitlist/no treatment or treatment as usual. Evidence from 10 RCTs (see Table 3.3.10) suggests no significant difference between EMDR and individual TF-CBT on PTSD symptom severity. Evidence from 4 RCTs (see Table 3.3.11) suggests no significant difference between EMDR and stress management on PTSD symptom severity. Evidence from 4 RCTs (see Table 3.3.12) suggests no significant difference between EMDR and other psychological treatments on PTSD symptom severity.	

Criteria, questions	Judgement	Research evidence	Additional considerations
		Group TF-CBT Evidence from 5 RCTs (see Table 3.3.3) suggests a large benefit of group TF-CBT on PTSD symptom severity relative to waitlist/no treatment or treatment as usual. Evidence from 1 RCT (see Table 3.3.6) suggests a small benefit of individual TF-CBT on PTSD symptom severity relative to group TF-CBT. Evidence from 1 RCT (see Table 3.3.13) suggests a large benefit of group TF-CBT on PTSD symptom severity relative to stress management. Evidence from 3 RCTs (see Table 3.3.14) suggests no significant difference between group TF-CBT and other psychological treatments on PTSD symptom severity. **Digital/remote TF-CBT** Evidence from 3 RCTs (see Table 3.3.4) suggests no significant difference between digital/remote TF-CBT and waitlist/no treatment or treatment as usual on PTSD symptom severity. Evidence from 7 RCTs (see Table 3.3.7) suggests no significant difference between individual TF-CBT and digital/remote TF-CBT on PTSD symptom severity. Evidence from 1 RCT (see Table 3.3.15) suggests a large benefit of digital/remote TF-CBT on PTSD symptom severity relative to other psychological treatments. Evidence from 2 RCTs (see Table 3.3.16) suggests no significant difference between	

Criteria, questions	Judgement	Research evidence	Additional considerations
		digital/remote TF-CBT and digital/remote other psychological treatments on PTSD symptom severity. **Stress management** Evidence from 4 RCTs (see Table 3.3.5) suggests no significant difference between stress management and waitlist/no treatment or treatment as usual on PTSD symptom severity. Evidence from 3 RCTs (see Table 3.3.8) suggests no significant difference between individual TF-CBT and stress management on PTSD symptom severity. Evidence from 4 RCTs (see Table 3.3.11) suggests no significant difference between EMDR and stress management on PTSD symptom severity. Evidence from 1 RCT (see Table 3.3.13) suggests a large benefit of group TF-CBT on PTSD symptom severity relative to stress management. Evidence from 1 RCT (see Table 3.3.17) suggests a large benefit of stress management on PTSD symptom severity relative to other psychological treatments. **Other psychological interventions** Evidence from 15 RCTs (see Table 3.3.9) suggests no significant difference between individual TF-CBT and other psychological treatments on PTSD symptom severity.	

Criteria, questions		Judgement	Research evidence	Additional considerations
			Evidence from 4 RCTs (see Table 3.3.12) suggests no significant difference between EMDR and other psychological treatments on PTSD symptom severity. Evidence from 3 RCTs (see Table 3.3.14) suggests no significant difference between group TF-CBT and other psychological treatments on PTSD symptom severity. Evidence from 1 RCT (see Table 3.3.15) suggests a large benefit of digital/remote TF-CBT on PTSD symptom severity relative to other psychological treatments. Evidence from 1 RCT (see Table 3.3.17) suggests a large benefit of stress management on PTSD symptom severity relative to other psychological treatments. **Digital/remote other psychological interventions** Evidence from 2 RCTs (see Table 3.3.16) suggests no significant difference between digital/remote TF-CBT and digital/remote other psychological treatments on PTSD symptom severity.	
Undesirable Effects	How substantial are the undesirable anticipated effects? The greater the harm, the less likely it is that an option should be recommended.			
	• Judgements for each outcome for which there is an undesirable effect • How substantial (large) are the undesirable anticipated effects (including harms to health and other harms) of the option (considering the severity or	☐ Large ☐ Moderate ☐ Small ☐ Trivial ☐ Varies ☒ **Don't know**	**Individual TF-CBT** Not assessed. **EMDR** Not assessed. **Group TF-CBT**	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
	importance of the adverse effects and the number of people affected)?		Not assessed. **Digital/remote TF-CBT** Not assessed. **Stress management** Not assessed.	
Certainty of evidence	What is the overall certainty of the evidence of effects? The less certain the evidence is for critical outcomes (those that are driving a recommendation), the less likely that an option should be recommended (or the more important it is likely to be to conduct a pilot study or impact evaluation, if it is recommended).			
	• What is the overall certainty of this evidence of effects, across all of the outcomes that are critical to making a decision? • See GRADE guidance regarding detailed judgements about the quality of evidence or certainty in estimates of effects	☐ Very low ☒ **Low** ☐ Moderate ☐ High ☐ No included studies	**Individual TF-CBT** The overall certainty of evidence for TF-CBT was MODERATE. Certainty of evidence for individual TF-CBT vs waitlist/no treatment or treatment as usual was MODERATE due to serious risk of bias. Certainty of evidence for individual TF-CBT vs group TF-CBT was MODERATE due to serious imprecision. Certainty of evidence for individual TF-CBT vs digital/remote TF-CBT was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for individual TF-CBT vs stress management was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for individual TF-CBT vs other psychological treatments was MODERATE due to serious inconsistency. Certainty of evidence for EMDR vs individual TF-CBT was VERY LOW due to serious risk of bias, serious inconsistency, and serious imprecision.	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
			EMDR The overall certainty of evidence for EMDR was LOW. Certainty of evidence for EMDR vs waitlist/no treatment or treatment as usual was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for EMDR vs individual TF-CBT was VERY LOW due to serious risk of bias, serious inconsistency, and serious imprecision. Certainty of evidence for EMDR vs stress management was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for EMDR vs other psychological treatments was LOW due to serious risk of bias and serious imprecision. **Group TF-CBT** The overall certainty of evidence for group TF-CBT was LOW. Certainty of evidence for group TF-CBT vs waitlist/no treatment or treatment as usual was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for individual TF-CBT vs group TF-CBT was MODERATE due to serious imprecision. Certainty of evidence for group TF-CBT vs stress management was LOW due to serious risks of bias and serious imprecision. Certainty of evidence for group TF-CBT vs other psychological treatments was MODERATE due to serious imprecision.	

Criteria, questions		Judgement	Research evidence	Additional considerations
			Digital/remote TF-CBT The overall certainty of evidence for digital/remote TF-CBT was LOW. Certainty of evidence for digital/remote TF-CBT vs waitlist/no treatment or treatment as usual was LOW due to serious inconsistency and serious imprecision. Certainty of evidence for individual TF-CBT vs digital/remote TF-CBT was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for digital/remote TF-CBT vs other psychological treatments was MODERATE due to serious imprecision. Certainty of evidence for digital/remote TF-CBT vs digital/remote other psychological treatments was LOW due to very serious imprecision. **Stress management** The overall certainty of evidence for stress management was LOW. Certainty of evidence for stress management vs waitlist/no treatment or treatment as usual was VERY LOW due to serious risk of bias, serious inconsistency, and serious imprecision. Certainty of evidence for individual TF-CBT vs stress management was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for EMDR vs stress management was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for stress management vs other psychological treatments was LOW	

Criteria, questions		Judgement	Research evidence	Additional considerations
			due to serious risk of bias and serious imprecision. Certainty of evidence for individual TF-CBT vs stress management was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for group TF-CBT vs stress management was LOW due to serious risks of bias and serious imprecision. **Other psychological interventions** The overall certainty of evidence for other psychological interventions was MODERATE. Certainty of evidence for EMDR vs other psychological treatments was LOW due to serious risk of bias and serious imprecision. Certainty of evidence for individual TF-CBT vs other psychological treatments was MODERATE due to serious inconsistency. Certainty of evidence for group TF-CBT vs other psychological treatments was MODERATE due to serious imprecision. Certainty of evidence for digital/remote TF-CBT vs other psychological treatments was MODERATE due to serious imprecision. Certainty of evidence for stress management vs other psychological treatments was LOW due to serious risk of bias and serious imprecision. **Digital/remote other psychological interventions**	

Criteria, questions		Judgement	Research evidence	Additional considerations
			The overall certainty of evidence for digital/remote other psychological interventions was LOW. Certainty of evidence for digital/remote TF-CBT vs digital/remote other psychological treatments was LOW due to very serious imprecision.	
Values	Is there important uncertainty about or variability in how much people value the main outcomes? The more likely it is that differences in values would lead to different decisions, the less likely it is that there will be a consensus that an option is a priority (or the more important it is likely to be to obtain evidence of the values of those affected by the option). Values in this context refer to the relative importance of the outcomes of interest (how much people value each of those outcomes). These values are sometimes called 'utility values'.			
	• Is there important uncertainty about how much people value each of the main outcomes? • Is there important variability in how much people value each of the main outcomes?	☐ Important uncertainty or variability ☐ Possibly important uncertainty or variability ☒ **Probably no important uncertainty or variability** ☐ No important uncertainty or variability	The intervention is consistent with the value of promotion of individual and family members' capacity and skills and the value of increasing access to care with low-intensity interventions. The qualitative systematic review (Gronholm et al., 2023) also assessed values, resources, cost effectiveness, health equity quality and non-discrimination, feasibility and human rights related factors in mental healthcare and mental health services. Overall, the studies reviewed highlighted importance and recognition of importance of mental health interventions and the outcomes of those interventions on people's mental health and wellbeing. The utility value could be limited by certain factors and barriers present in the health systems. For instance, low awareness, poor funding and poor political buy-in, or other social barriers. Social networks or raising awareness can facilitate adoption and recognition of mental health	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
			issues and the perceived value of the interventions.	
Balance of effects	Does the balance between desirable and undesirable effects favour the intervention or the comparison? The larger the desirable effects in relation to the undesirable effects, considering the values of those affected (i.e., the relative value they attach to the desirable and undesirable outcomes) the more likely it is that an option should be recommended.			
	• Judgements regarding each of the four preceding criteria • To what extent do the following considerations influence the balance between the desirable and undesirable effects: - How much less people value outcomes that are in the future compared to outcomes that occur now (their discount rates)? - People's attitudes towards undesirable effects (how risk averse they are)? - People's attitudes towards desirable effects (how risk seeking they are)?	☐ Favours the comparison ☐ Probably favours the comparison ☐ Does not favour either the intervention or the comparison ☒ **Probably favours the intervention** ☐ Favours the intervention ☐ Varies ☐ Don't know	There was no direct evidence to evaluate undesirable effects. Evidence suggests reduced PTSD symptom severity in adults using these interventions.	
Resources required	How large are the resource requirements (costs)? The greater the cost, the less likely it is that an option should be a priority. Conversely, the greater the savings, the more likely it is that an option should be a priority.			
	• How large is the difference in each item of resource use for which fewer resources are required? • How large is the difference in each item of resource use for which more resources are required? • How large an investment of resources would the option require or save?	☐ Large costs ☐ Moderate costs ☐ Negligible costs and savings ☐ Moderate savings ☐ Large savings ☐ Varies ☒ **Don't know**	No reviews identified directly examined resources required.	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
Certainty of evidence of required resources	What is the certainty of the evidence of resource requirements (costs)?			
	• Have all-important items of resource use that may differ between the options being considered been identified? • How certain is the evidence of differences in resource use between the options being considered (see GRADE guidance regarding detailed judgements about the quality of evidence or certainty in estimates)? • How certain is the cost of the items of resource use that differ between the options being considered? • Is there important variability in the cost of the items of resource use that differ between the options being considered?	☐ Very low ☐ Low ☐ Moderate ☐ High ☒ **No included studies**	No reviews identified directly examined resource requirements.	No additional considerations.
Cost effectiveness	Does the cost-effectiveness of the intervention favour the intervention or the comparison? The greater the cost per unit of benefit, the less likely it is that an option should be a priority.			
	• Judgements regarding each of the six preceding criteria • Is the cost effectiveness ratio sensitive to one-way sensitivity analyses? • Is the cost effectiveness ratio sensitive to multivariable sensitivity analysis? • Is the economic evaluation on which the cost effectiveness estimate is based reliable? • Is the economic evaluation on which the cost effectiveness estimate is based applicable to the setting(s) of interest?	☐ Favours the comparison ☐ Probably favours the comparison ☐ Does not favour either the intervention or the comparison ☐ Probably favours the intervention ☐ Favours the intervention ☐ Varies ☒ **No included studies**	No reviews identified examined cost-effectiveness.	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
Health equity, equality and non-discrimination	What would be the impact on health equity, equality and non-discrimination? Health equity and equality reflect a concerted and sustained effort to improve health for individuals across all populations, and to reduce avoidable systematic differences in how health and its determinants are distributed. Equality is linked to the legal principle of non-discrimination, which is designed to ensure that individuals or population groups do not experience discrimination based on their sex, age, ethnicity, culture or language, sexual orientation or gender identity, disability status, education, socioeconomic status, place of residence or any other characteristics. All recommendations should be in accordance with universal human rights standards and principles. The greater the likelihood that the intervention increases health equity and/or equality and that it reduces discrimination against any particular group, the greater the likelihood of a general recommendation in favour of this intervention.			
	• How are the condition and its determinants distributed across different population groups? Is the intervention likely to reduce or increase existing health inequalities and/or health inequities? Does the intervention prioritise and/or aid those furthest behind? • How are the benefits and harms of the intervention distributed across the population? Who carries the burden (e.g. all), who benefits (e.g. a very small sub-group)? • How affordable is the intervention for individuals, workplaces, or communities? • How accessible - in terms of physical as well as informational access - is the intervention across different population groups? • Is there any suitable alternative to addressing the condition, does the intervention represent the only available option? Is this option proportionate to the need, and will it be subject to periodic review?	☐ Reduced ☐ Probably reduced ☐ Probably no impact ☒ **Probably increased** ☐ Increased ☐ Varies ☐ Don't know	The qualitative review (Gronholm et al., 2023) noted considerations for ensuring MNS interventions are equitable, equally available, and non-discriminatory: • accessibility, physical/practical considerations, • time & travel constraints, • accessibility, informational barriers, • affordability - medication and treatment costs. These factors may be exacerbated for certain groups: • people with low education/literacy (e.g., written instructions, psychoeducation materials), • women - travel restrictions, stronger stigma/shame, caregiving responsibilities. • low resource settings - affordability/cost considerations exacerbated.	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
Feasibility	Is the intervention feasible to implement? The less feasible (capable of being accomplished or brought about) an option is, the less likely it is that it should be recommended (i.e., the more barriers there are that would be difficult to overcome).			
	• Can the option be accomplished or brought about? • Is the intervention or option sustainable? • Are there important barriers that are likely to limit the feasibility of implementing the intervention (option) or require consideration when implementing it?	☐ No ☐ Probably no ☐ Probably yes ☐ Yes ☒ **Varies** ☐ Don't know	The qualitative review (Gronholm et al., 2023) also considered feasibility, and how this can be enhanced in the following areas: • Acceptability of interventions for stakeholders - requires increased engagement with specialist staff, increased visibility of the task-sharing workforce within health facilities, perception of usefulness by providers and service users (e.g., via positive feedback), context-specific interventions, standardized implementation steps for simpler decision-making and delivery. • Health worker workload, competency - requires training, refreshers, supervision, networking with others in same role. • Availability of a task-sharing workforce. • Availability of caregivers. • Participant education and literacy requires verbal explanations/tasks. • Logistical issues - such as e.g., mobile populations, affordability of travel to receive care, lack of private space. • Limited resources/mental health budget. Sustainability considerations identified were:	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
			• Training and supervision. • Integrating into routine clinical practice.	
Human rights and sociocultural acceptability	Is the intervention aligned with human rights principles and socioculturally acceptable? This criterion encompasses two distinct constructs: The first refers to an intervention's compliance with universal human rights standards and other considerations laid out in international human rights law beyond the right to health (as the right to health provides the basis of other criteria and sub-criteria in this framework). The second, sociocultural acceptability, is highly time-specific and context-specific and reflects the extent to which those implementing or benefiting from an intervention as well as other relevant stakeholder groups consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the intervention. The greater the sociocultural acceptability of an intervention to all or most relevant stakeholders, the greater the likelihood of a general recommendation in favour of this intervention.			
	• Is the intervention in accordance with universal human rights standards and principles? • Is the intervention socioculturally acceptable to patients/beneficiaries as well as to those implementing it? To which extent do patients/beneficiaries value different non-health outcomes? • Is the intervention socioculturally acceptable to the public and other relevant stakeholder groups? Is the intervention sensitive to sex, age, ethnicity, culture or language, sexual orientation or gender identity, disability status, education, socioeconomic status, place of residence or any other relevant characteristics? • How does the intervention affect an individual's, population groups or organization's autonomy, i.e., their ability to make a competent, informed, and voluntary decision? • How intrusive is the intervention, ranging from low intrusiveness (e.g.	☐ No ☐ Probably no ☒ **Probably yes** ☐ Yes ☐ Varies ☐ Don't know	The qualitative review (Gronholm et al., 2023) noted several considerations which would impact the right to health and access to healthcare. (e.g. stigma and discrimination and lack of confidentiality could affect the help-seeking among service users). The importance of sociocultural acceptability of mental, neurological and substance use interventions was clearly expressed. Pre-intervention considerations that consider cultural and social aspects improve the acceptability of implemented interventions. When interventions were perceived as appropriate for the culture and target group, the content and medium of the intervention received more positive feedback from service users and caregivers Also, considerations of age, sex and language have been highlighted as important to acceptability and accessibility. Mitigating steps to improve sociocultural acceptability include:	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
	providing information) to intermediate intrusiveness (e.g. guiding choices) to high intrusiveness (e.g. restricting or eliminating choices)? Where applicable, are high intrusiveness and/or impacts on the privacy and dignity of concerned stakeholders justified?		• to train health workers in non-judgemental care, • integrate preventative mental health awareness messages to reduce the stigma, • train acceptable counsellors for the local settings and target groups, • facilitate the use of indigenous/ local phrases and terms to increase acceptability, accessibility, and fidelity.	

5.2. Summary of judgements

Table 4: Summary of judgements in adults

This provides a snapshot of the evidence to decision table.

Priority of the problem	- Don't know	- Varies		- No	- Probably No	- Probably Yes	✓ **Yes**
Desirable effects	- Don't know	- Varies		- Trivial	- Small	✓ **Moderate**	- Large
Undesirable effects	✓ **Don't know**	- Varies		- Large	- Moderate	- Small	- Trivial
Certainty of the evidence	- No included studies			- Very low	✓ **Low**	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	✓ **Probably no important uncertainty or variability**	- No important uncertainty or variability
Balance of effects	- Don't know	- Varies	- Favours comparison	- Probably favours comparison	- Does not favour either	✓ **Probably favours intervention**	- Favours intervention
Resources required	✓ **Don't know**	Varies	- Large costs	- Moderate costs	- Negligible costs or savings	- Moderate savings	- Large savings
Certainty of the evidence on required resources	✓ **No included studies**			- Very low	- Low	- Moderate	- High
Cost–effectiveness	✓ **No included studies**	- Varies	- Favours comparison	- Probably favours comparison	- Does not favour either	- Probably favours intervention	- Favours intervention
Equity, equality and non-discrimination	- Don't know	- Varies	- Reduced	Probably reduced	- Probably no impact	✓ **Probably increased**	- Increased
Feasibility	- Don't know	✓ **Varies**		- No	- Probably No	- Probably Yes	- Yes
Human rights and sociocultural acceptability	- Don't know	- Varies		- No	- Probably No	✓ **Probably Yes**	- Yes

✓Indicates category selected, -Indicates category not selected.

5.3. Children and adolescents

Please note * indicates evidence from overarching qualitative review by Gronholm et al, 2023.

Table 5: Evidence to decision table in children and adolescents

Criteria, questions		Judgement	Research evidence	Additional considerations
Priority of the problem	Is the problem a priority? The more serious a problem is, the more likely it is that an option that addresses the problem should be a priority (e.g. diseases that are fatal or disabling are likely to be a higher priority than diseases that only cause minor distress). The more people who are affected, the more likely it is that an option that addresses the problem should be a priority.			
	• Are the consequences of the problem serious (that is, severe or important in terms of the potential benefits or savings)? • Is the problem urgent? • Is it a recognized priority (such as based on a political or policy decision)? [Not relevant when an individual patient perspective is taken]	☐ No ☐ Probably no ☐ Probably yes ☒ **Yes** ☐ Varies ☐ Don't know	At the end of 2021, there were 274 million people in need of humanitarian assistance across the world (1) and nearly 84 million people had been forcibly displaced from their homes due to warfare and conflict (2), the highest numbers since the Second World War. People surviving these situations are faced with incredible and often overwhelming adversity. While it is true that the majority of people facing these circumstances can and will recover, particularly if they are able to reconnect with their social support systems and meet their basic needs and safety, some will continue to struggle. For example, a WHO meta-analysis indicated that one in five persons exposed to conflict in the last 10 years experiences some form of mental	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
			health condition (3), often conditions specifically related to stress,[6] including PTSD. PTSD demonstrates a lifetime prevalence ranging from 5-10% in community samples, with 12-month prevalence often closer to 5% (Koenen et al., 2017; Goldstein et al., 2016). Despite the prevalence, only half of those with severe cases of PTSD report receiving any treatment, and in many countries, there are large gaps in access to care (Koenen et al., 2017). These gaps in care are costly, given that PTSD can result in 3.6 days of productivity lost per month (Kessler et al., 2000) and estimates of total costs have been very high (Davis et al., 2022).	
Desirable Effects	How substantial are the desirable anticipated effects? The larger the benefit, the more likely it is that an option should be recommended.			
	• Judgements for each outcome for which there is a desirable effect • How substantial (large) are the desirable anticipated effects (including health and other benefits) of the option (considering the severity or importance of the desirable consequences and the number of people affected)?	☐ Trivial ☐ Small ☒ **Moderate** ☐ Large ☐ Varies ☐ Don't know	**Individual TF-CBT** Evidence from 26 RCTs (see Table 3.5.1) suggests a large benefit of individual TF-CBT on PTSD symptom severity relative to waitlist/no treatment or TAU. Evidence from 3 RCTs (see Table 3.5.4) suggests no significant difference between EMDR and individual TF-CBT on PTSD symptom severity.	No additional considerations.

[6] The term conditions specifically related to stress refers here to problems such as PTSD, acute stress reaction and bereavement reactions that require an exposure to a defined stressor as a precursor. There are numerous other stress-related disorders and problems (e.g. depression, behavioural disorders, alcohol/substance use problems, self-harm/suicide, medically unexplained somatic complaints), but these are not specifically related to stress (i.e. they may also occur in the absence of identifiable stressful life events).

Criteria, questions		Judgement	Research evidence	Additional considerations
			Evidence from 12 RCTs (see Table 3.5.5) suggests a moderate benefit of individual TF-CBT on PTSD symptom severity relative to other psychological treatments. **EMDR** Evidence from 4 RCTs (see Table 3.5.2) suggests a moderate benefit of EMDR on PTSD symptom severity relative to waitlist/no treatment or TAU. Evidence from 3 RCTs (see Table 3.5.4) suggests no significant difference between EMDR and individual TF-CBT on PTSD symptom severity. **Group TF-CBT** Evidence from 2 RCTs (see Table 3.5.3) suggests a large benefit of group TF-CBT on PTSD symptom severity relative to waitlist/no treatment or treatment as usual. Evidence from 2 RCTs (see Table 3.5.6) suggests no significant difference between group TF-CBT and other psychological treatments on PTSD symptom severity. **Other psychological interventions**	

Criteria, questions		Judgement	Research evidence	Additional considerations
			Evidence from 12 RCTs (see Table 3.5.5) suggests a moderate benefit of individual TF-CBT on PTSD symptom severity relative to other psychological treatments. Evidence from 2 RCTs (see Table 3.5.6) suggests no significant difference between group TF-CBT and other psychological treatments on PTSD symptom severity.	
Undesirable Effects	How substantial are the undesirable anticipated effects? The greater the harm, the less likely it is that an option should be recommended.			
	• Judgements for each outcome for which there is an undesirable effect • How substantial (large) are the undesirable anticipated effects (including harms to health and other harms) of the option (considering the severity or importance of the adverse effects and the number of people affected)?	☐ Large ☐ Moderate ☐ Small ☐ Trivial ☐ Varies ☒ **Don't know**	**Individual TF-CBT** Not assessed. **EMDR** Not assessed. **Group TF-CBT** Not assessed.	No additional considerations.
Certainty of evidence	What is the overall certainty of the evidence of effects? The less certain the evidence is for critical outcomes (those that are driving a recommendation), the less likely that an option should be recommended (or the more important it is likely to be to conduct a pilot study or impact evaluation, if it is recommended).			
	• What is the overall certainty of this evidence of effects, across all of the outcomes that are critical to making a decision?	☐ Very low ☐ Low ☒ **Moderate** ☐ High	**Individual TF-CBT** The overall certainty of evidence for individual TF-CBT was MODERATE. Certainty of evidence for individual TF-CBT vs waitlist/no treatment or	. No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
	• See GRADE guidance regarding detailed judgements about the quality of evidence or certainty in estimates of effects	☐ No included studies	treatment as usual was MODERATE due to serious risk of bias. Certainty of evidence for EMDR vs individual TF-CBT was MODERATE due to serious imprecision. Certainty of evidence for individual TF-CBT vs other psychological treatments was HIGH. **EMDR** The overall certainty of evidence for EMDR was LOW. Certainty of evidence for EMDR vs waitlist/no treatment or treatment as usual was LOW due to serious inconsistency and serious imprecision. Certainty of evidence for EMDR vs individual TF-CBT was MODERATE due to serious imprecision. **Group TF-CBT** The overall certainty of evidence for group TF-CBT was MODERATE. Certainty of evidence for group TF-CBT vs waitlist/no treatment or treatment as usual was MODERATE due to serious imprecision. Certainty of evidence for group TF-CBT vs other psychological treatments was LOW	

Criteria, questions		Judgement	Research evidence	Additional considerations
			due to serious risk of bias and serious imprecision. **Other psychological interventions** The overall certainty of evidence for other psychological treatments was MODERATE. Certainty of evidence for individual TF-CBT vs other psychological treatments was HIGH. Certainty of evidence for group TF-CBT vs other psychological treatments was LOW due to serious risk of bias and serious imprecision.	
Values	Is there important uncertainty about or variability in how much people value the main outcomes? The more likely it is that differences in values would lead to different decisions, the less likely it is that there will be a consensus that an option is a priority (or the more important it is likely to be to obtain evidence of the values of those affected by the option). Values in this context refer to the relative importance of the outcomes of interest (how much people value each of those outcomes). These values are sometimes called 'utility values'.			
	• Is there important uncertainty about how much people value each of the main outcomes? • Is there important variability in how much people value each of the main outcomes?	☐ Important uncertainty or variability ☐ Possibly important uncertainty or variability ☒ **Probably no important uncertainty or variability** ☐ No important uncertainty or variability	The intervention is consistent with the value of promotion of individual and family members' capacity and skills and the value of increasing access to care with low-intensity interventions. The qualitative systematic review (Gronholm et al., 2023) also assessed values, resources, cost effectiveness, health equity quality and non-discrimination, feasibility and human	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
			rights related factors in mental healthcare and mental health services. Overall, the studies reviewed highlighted importance and recognition of importance of mental health interventions and the outcomes of those interventions on people's mental health and wellbeing. The utility value could be limited by certain factors and barriers present in the health systems. For instance, low awareness, poor funding and poor political buy-in, or other social barriers. Social networks or raising awareness can facilitate adoption and recognition of mental health issues and the perceived value of the interventions.	
Balance of effects	Does the balance between desirable and undesirable effects favour the intervention or the comparison? The larger the desirable effects in relation to the undesirable effects, considering the values of those affected (i.e., the relative value they attach to the desirable and undesirable outcomes) the more likely it is that an option should be recommended.			
	• Judgements regarding each of the four preceding criteria • To what extent do the following considerations influence the balance between the desirable and undesirable effects: - How much less people value outcomes that are in the future	☐ Favours the comparison ☐ Probably favours the comparison ☐ Does not favour either the intervention or the comparison ☒ **Probably favours the intervention** ☐ Favours the intervention ☐ Varies	There was no direct evidence to evaluate undesirable effects. Evidence suggests reduction in PTSD symptom severity in children and adolescents using these interventions.	

Criteria, questions		Judgement	Research evidence	Additional considerations
	compared to outcomes that occur now (their discount rates)? - People's attitudes towards undesirable effects (how risk averse they are)? - People's attitudes towards desirable effects (how risk seeking they are)?	☐ Don't know		
Resources required	How large are the resource requirements (costs)? The greater the cost, the less likely it is that an option should be a priority. Conversely, the greater the savings, the more likely it is that an option should be a priority.			
	• How large is the difference in each item of resource use for which fewer resources are required? • How large is the difference in each item of resource use for which more resources are required? • How large an investment of resources would the option require or save?	☐ Large costs ☐ Moderate costs ☐ Negligible costs and savings ☐ Moderate savings ☐ Large savings ☐ Varies ☒ **Don't know**	No reviews identified directly examined resources required.	No additional considerations.
Certainty of evidence of required resources	What is the certainty of the evidence of resource requirements (costs)?			
	• Have all-important items of resource use that may differ between the options being considered been identified? • How certain is the evidence of differences in resource use between the options being considered (see GRADE guidance regarding detailed	☐ Very low ☐ Low ☐ Moderate ☐ High ☒ **No included studies**	No reviews identified directly examined resource requirements.	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
	judgements about the quality of evidence or certainty in estimates)? • How certain is the cost of the items of resource use that differ between the options being considered? • Is there important variability in the cost of the items of resource use that differ between the options being considered?			
Cost effectiveness	Does the cost-effectiveness of the intervention favour the intervention or the comparison? The greater the cost per unit of benefit, the less likely it is that an option should be a priority.			
	• Judgements regarding each of the six preceding criteria • Is the cost effectiveness ratio sensitive to one-way sensitivity analyses? • Is the cost effectiveness ratio sensitive to multivariable sensitivity analysis? • Is the economic evaluation on which the cost effectiveness estimate is based reliable? • Is the economic evaluation on which the cost effectiveness estimate is based applicable to the setting(s) of interest?	☐ Favours the comparison ☐ Probably favours the comparison ☐ Does not favour either the intervention or the comparison ☐ Probably favours the intervention ☐ Favours the intervention ☐ Varies ☒ **No included studies**	No reviews identified examined cost-effectiveness.	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
Health equity, equality and non-discrimination	What would be the impact on health equity, equality and non-discrimination? Health equity and equality reflect a concerted and sustained effort to improve health for individuals across all populations, and to reduce avoidable systematic differences in how health and its determinants are distributed. Equality is linked to the legal principle of non-discrimination, which is designed to ensure that individuals or population groups do not experience discrimination based on their sex, age, ethnicity, culture or language, sexual orientation or gender identity, disability status, education, socioeconomic status, place of residence or any other characteristics. All recommendations should be in accordance with universal human rights standards and principles. The greater the likelihood that the intervention increases health equity and/or equality and that it reduces discrimination against any particular group, the greater the likelihood of a general recommendation in favour of this intervention.			
	• How are the condition and its determinants distributed across different population groups? Is the intervention likely to reduce or increase existing health inequalities and/or health inequities? Does the intervention prioritise and/or aid those furthest behind? • How are the benefits and harms of the intervention distributed across the population? Who carries the burden (e.g. all), who benefits (e.g. a very small sub-group)? • How affordable is the intervention for individuals, workplaces, or communities? • How accessible - in terms of physical as well as informational access - is the intervention across different population groups? • Is there any suitable alternative to addressing the condition, does the intervention represent the only	☐ Reduced ☐ Probably reduced ☐ Probably no impact ☒ **Probably increased** ☐ Increased ☐ Varies ☐ Don't know	The qualitative review (Gronholm et al., 2023) noted considerations for ensuring MNS interventions are equitable, equally available, and non-discriminatory: • accessibility, physical/practical considerations, • time & travel constraints, • accessibility, informational barriers, • affordability - medication and treatment costs. These factors may be exacerbated for certain groups: • people with low education/literacy (e.g., written instructions, psychoeducation materials), • women - travel restrictions, stronger stigma/shame, caregiving responsibilities. • low resource settings - affordability/cost considerations exacerbated.	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
	available option? Is this option proportionate to the need, and will it be subject to periodic review?			
Feasibility	Is the intervention feasible to implement? The less feasible (capable of being accomplished or brought about) an option is, the less likely it is that it should be recommended (i.e., the more barriers there are that would be difficult to overcome).			
	• Can the option be accomplished or brought about? • Is the intervention or option sustainable? • Are there important barriers that are likely to limit the feasibility of implementing the intervention (option) or require consideration when implementing it?	☐ No ☐ Probably no ☐ Probably yes ☐ Yes ☒ **Varies** ☐ Don't know	The qualitative review (Gronholm et al., 2023) also considered feasibility, and how this can be enhanced in the following areas: • Acceptability of interventions for stakeholders - requires increased engagement with specialist staff, increased visibility of the task-sharing workforce within health facilities, perception of usefulness by providers and service users (e.g., via positive feedback), context-specific interventions, standardized implementation steps for simpler decision-making and delivery. • Health worker workload, competency - requires training, refreshers, supervision, networking with others in same role. • Availability of a task-sharing workforce. • Availability of caregivers. • Participant education and literacy requires verbal explanations/tasks. • Logistical issues - such as e.g., mobile populations, affordability of	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
			travel to receive care, lack of private space. • Limited resources/mental health budget. Sustainability considerations identified were: • Training and supervision. • Integrating into routine clinical practice.	
Human rights and sociocultural acceptability	Is the intervention aligned with human rights principles and socioculturally acceptable? This criterion encompasses two distinct constructs: The first refers to an intervention's compliance with universal human rights standards and other considerations laid out in international human rights law beyond the right to health (as the right to health provides the basis of other criteria and sub-criteria in this framework). The second, sociocultural acceptability, is highly time-specific and context-specific and reflects the extent to which those implementing or benefiting from an intervention as well as other relevant stakeholder groups consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the intervention. The greater the sociocultural acceptability of an intervention to all or most relevant stakeholders, the greater the likelihood of a general recommendation in favour of this intervention.			
	• Is the intervention in accordance with universal human rights standards and principles? • Is the intervention socioculturally acceptable to patients/beneficiaries as well as to those implementing it? To which extent do patients/beneficiaries value different non-health outcomes? • Is the intervention socioculturally acceptable to the public and other relevant stakeholder groups? Is the intervention sensitive to sex, age, ethnicity, culture or language, sexual orientation or gender identity, disability status, education,	☐ No ☐ Probably no ☒ **Probably yes** ☐ Yes ☐ Varies ☐ Don't know	The qualitative review (Gronholm et al., 2023) noted several considerations which would impact the right to health and access to healthcare. (e.g. stigma and discrimination and lack of confidentiality could affect the help-seeking among service users). The importance of sociocultural acceptability of mental, neurological and substance use interventions was clearly expressed. Pre-intervention considerations that consider cultural and social aspects improve the acceptability of implemented interventions. When interventions were perceived as appropriate for the culture and target group, the content and medium of the intervention received more positive feedback from service	No additional considerations.

Criteria, questions		Judgement	Research evidence	Additional considerations
	socioeconomic status, place of residence or any other relevant characteristics? • How does the intervention affect an individual's, population groups or organization's autonomy, i.e., their ability to make a competent, informed and voluntary decision? • How intrusive is the intervention, ranging from low intrusiveness (e.g. providing information) to intermediate intrusiveness (e.g. guiding choices) to high intrusiveness (e.g. restricting or eliminating choices)? Where applicable, are high intrusiveness and/or impacts on the privacy and dignity of concerned stakeholders justified?		users and caregivers Also, considerations of age, sex and language have been highlighted as important to acceptability and accessibility. Mitigating steps to improve sociocultural acceptability include: • to train health workers in non-judgemental care, • integrate preventative mental health awareness messages to reduce the stigma, • train acceptable counsellors for the local settings and target groups, • facilitate the use of indigenous/ local phrases and terms to increase acceptability, accessibility, and fidelity.	

5.4. Summary of judgements

Table 6: summary of judgements in children and adolescents

This provides a snapshot of the evidence to decision table.

Priority of the problem	- Don't know	- Varies		- No	- Probably No	- Probably Yes	✓ **Yes**
Desirable effects	- Don't know	- Varies		- Trivial	- Small	✓ **Moderate**	- Large
Undesirable effects	✓ **Don't know**	- Varies		- Large	- Moderate	- Small	- Trivial
Certainty of the evidence	- No included studies			-- Very low	- Low	✓ **Moderate**	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	✓ **Probably no important uncertainty or variability**	- No important uncertainty or variability
Balance of effects	- Don't know	- Varies	- Favours comparison	- Probably favours comparison	- Does not favour either	✓ **Probably favours intervention**	- Favours intervention
Resources required	✓ **Don't know**	- Varies	- Large costs	- Moderate costs	- Negligible costs or savings	- Moderate savings	- Large savings
Certainty of the evidence on required resources	✓ **No included studies**			- Very low	- Low	- Moderate	- High
Cost–effectiveness	✓ **No included studies**	- Varies	- Favours comparison	- Probably favours comparison	- Does not favour either	- Probably favours intervention	- Favours intervention
Equity, equality and non-discrimination	- Don't know	- Varies	- Reduced	Probably reduced	- Probably no impact	✓ **Probably increased**	- Increased
Feasibility	- Don't know	✓ **Varies**		- No	- Probably No	- Probably Yes	- Yes
Human rights and sociocultural acceptability	- Don't know	- Varies		- No	- Probably No	✓ **Probably Yes**	- Yes

✓Indicates category selected, - Indicates category not selected.

6. References

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Appendix I

AGREE II ratings of the Australian Guidelines for PTSD provided by independent reviewers as part of the Guidelines endorsement process

Domain	*Item*	Appraiser 1	Appraiser 2	Total item score	Scaled domain score:
1: Scope and purpose	*1*	6	6	12	94%
	2	7	7	14	
	3	7	7	14	
2: Stakeholder involvement	*4*	6	6	12	83%
	5	5	5	10	
	6	7	7	14	
3: Rigour of Development	*7*	6	6	12	91%
	8	7	7	14	
	9	7	7	14	
	10	7	7	14	
	11	6	6	12	
	12	7	7	14	
	13	7	6	13	
	14	5	5	10	
4: Clarity of presentation	*15*	7	6	13	94%
	16	7	6	13	
	17	7	7	14	
5: Applicability	*18*	5	5	10	60%
	19	5	5	10	
	20	4	4	8	
	21	4	5	9	
6: Editorial Independence	*22*	7	6	13	96%
	23	7	7	14	

Appendix II

AGREE II ratings of the Australian Guidelines for PTSD, reported in the Martin et al (2021) systematic review

Guideline (Abbreviation)	Domain 1 *Scope and Purpose*	Domain 2 *Stakeholder Involvement*	Domain 3 *Rigour of development*	Domain 4 *Clarity of presentation*	Domain 5 *Applicability*	Domain 6 *Editorial independence*	Recommended for Use?
Australian Guidelines for the Treatment of Acute Stress Disorder & Posttraumatic Stress Disorder (Phoenix) [16]	100%	93%	89%	92%	74%	95%	Y