**International Journal of Academic Management Science Research (IJAMSR)**
**ISSN: 2643-900X**
**Vol. 10 Issue 4 April - 2026, Pages: 165-172**

# Scalable Mental Health Interventions for Urban Refugee Youth in Low- and Middle-Income Ayebare David Santson, Asingwire Richard, Kukundakwe Rebecca

**Countries: A Narrative Review**

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**Abstract:** *Urbanisation has become a defining feature of contemporary forced displacement, with a growing proportion of refugees, particularly adolescents and young adults, residing in urban and peri-urban settings in low- and middle-income countries (LMICs). Urban refugee youth face compounded mental health risks arising from pre-migration trauma, displacement-related stressors, disrupted education, unemployment, and social exclusion. Although scalable mental health and psychosocial support (MHPSS) interventions have gained prominence within global mental health and humanitarian policy, the extent to which these approaches address the needs of urban refugee youth remains unclear. We conducted a narrative literature review to synthesise evidence on scalable mental health and psychosocial interventions targeting urban refugee adolescents and young adults aged 15–24 years in LMICs. Searches were conducted across PubMed/MEDLINE, PsycINFO, Scopus, Web of Science, and Google Scholar for literature published from January 2015 onward. Eligible studies included peer-reviewed empirical studies, protocols, and reviews describing scalable, low-intens ity, task-shifted, or self-help MHPSS interventions implemented among urban or self-settled refugee populations, with relevance to youth mental health, feasibility, or implementation. The review identified a limited and heterogeneous evidence base. Scalable interventions such as WHO Self-Help Plus, Problem Management Plus, and group-based psychosocial programmes have been implemented across multiple LMIC urban contexts; however, most studies targeted adults or mixed-age populations, with minimal age disaggregation and few interventions explicitly designed for urban refugee youth. Evidence on suicidality, youth-specific engagement strategies, and implementation outcomes, including reach, feasibility, and sustainability, was sparse. Emerging registered trials integrating mental health and livelihood components suggest growing recognition of the link between mental health and education-to-employment transitions, but outcome data remain limited. Despite strong policy endorsement of scalable MHPSS approaches, urban refugee adolescents and young adults remain underrepresented in the empirical literature. There is a critical need for youth-focused, urban-specific, and implementation-informed research to guide the adaptation, scale-up, and funding of mental health interventions in LMIC urban settings. Strengthening the evidence base in this area is essential to inform effective policy and programming for urban refugee youth.*

**Key words:** Urban refugee youth, Public mental health, Scalable mental health interventions, Mental health and psychosocial support (MHPSS), Low- and middle-income countries, implementation and scalability

## Introduction

Global forced displacement has reached unprecedented levels, with an increasing proportion of refugees now residing in urban and peri-urban settings rather than in formal camps or settlements. Recent estimates indicate that over 60% of the world's refugees live in urban areas, often in informal settlements characterised by poverty, insecurity, and limited access to health and social services (UNHCR & OPM, 2023). Within these urban contexts, adolescents and young adults constitute a substantial and growing subgroup, yet their mental health needs remain insufficiently addressed within humanitarian and public health systems (Buchweitz, Caye, & Kieling, 2022; United Nations Children's Fund [UNICEF], 2022). In this review, "urban" settings are defined as geographically delineated areas characterised by high population density, built environments, and reliance on non-agricultural livelihoods, typically governed by municipal administrative structures. In low- and middle-income countries (LMICs), urban areas often include informal settlements or slums, where infrastructure and access to services may be limited despite urban classification (UN - Habitat, 2020). "Peri-urban" settings are transitional zones at the interface between rural and urban areas, characterised by rapid population growth, mixed land use (residential, agricultural, and commercial), and evolving administrative and service structures (World Bank, 2015). These areas often host self-settled refugee populations due to lower living costs and fewer regulatory constraints, while still maintaining functional linkages to urban centres.

Urban refugee youth experience a convergence of pre-migration trauma, displacement-related stressors, and post-migration adversities, including legal precarity, disrupted education, unemployment, discrimination, and social isolation (Porter, Rathert, Ishqaidef, & Simmons, 2024; Silove, Ventevogel, & Rees, 2017). These cumulative stressors place young refugees at heightened risk of psychological distress, post-traumatic stress symptoms, depression, anxiety, and suicidality, particularly during the critical developmental period spanning adolescence and early adulthood (Charlson et al., 2019; Kessler et al., 2007). Despite increasing recognition of youth mental health as a global public health priority, existing service models have struggled to adequately reach

urban, self-settled refugee populations, who are often excluded from camp or settlement-based humanitarian programming and formal mental health systems (Logie et al., 2020; Miller & Rasmussen, 2017).

In low- and middle-income countries (LMICs), where the majority of refugees are hosted, urban health systems are frequently overstretched and under-resourced (World Health Organization, 2022). Specialist mental health services remain scarce, and structural barriers such as cost, stigma, language, and documentation requirements further limit access for refugees (Hanlon & Jordans, 2020). As a result, there has been growing emphasis on scalable mental health and psychosocial support (MHPSS) interventions that can be delivered in community and non-specialist settings. These approaches prioritise task-shifting, brief and structured intervention formats, and adaptability across diverse cultural and urban contexts (Patel et al., 2018; Tol et al., 2011). In this review, scalability is conceptualised as the capacity of an intervention to be expanded or adapted to reach larger populations while maintaining effectiveness and fidelity. This includes key implementation dimensions such as feasibility (the practicality of delivering the intervention in real-world settings), reach (the extent to which the target population can be accessed and engaged), and sustainability (the ability of the intervention to be maintained over time within existing systems and resources). This conceptualisation is informed by implementation science frameworks that emphasise the importance of delivery processes and contextual factors in determining successful scale-up.

Among such approaches, the World Health Organisation's Self-Help Plus (SH+) intervention represents a prominent example of a low-intensity, scalable psychological intervention designed for populations affected by adversity (World Health Organization (WHO), 2021). SH+ is a transdiagnostic, self-help intervention grounded in acceptance and commitment principles and has demonstrated effectiveness in reducing psychological distress in humanitarian populations (Acarturk et al., 2022; Tol et al., 2020). However, much of the existing evidence on SH+ and similar scalable MHPSS interventions has been generated in camp or settlement-based or mixed refugee populations, with limited disaggregation by age or settlement type (Mukdarut, Chiumento, Dickson, & Felix, 2017; Tol et al., 2020). Consequently, it remains unclear to what extent current scalable interventions adequately address the specific needs, risks, and engagement challenges of urban refugee youth, particularly adolescents aged 15–24 years.

Urban environments present distinct implementation challenges that differentiate them from camp or settlement settings. These include population mobility, fragmented social networks, limited community cohesion, and difficulties in identifying and retaining participants (Logie et al., 2020; (Betancourt, Meyers-Ohki, Charrow, & Tol, 2013)). Youth-specific factors, such as school dropout, informal employment, exposure to urban violence, and evolving identity formation, further complicate the delivery and uptake of interventions (Kieling et al., 2011). Implementation-relevant evidence that accounts for these realities is therefore essential to inform effective program design, scale-up, and policy investment.

Recent global discourse has emphasised the importance of implementation-informed evidence synthesis to guide public health and humanitarian interventions, particularly in complex and under-researched contexts (Damschroder et al., 2009; Peters, Adam, Alonge, Agyepong, & Tran, 2013). Narrative literature reviews play a critical role in consolidating heterogeneous evidence, identifying conceptual and practical gaps, and informing future intervention development where randomised trial data remain limited. A recent narrative review published in Frontiers in Public Health demonstrated the value of such an approach in informing national preparedness frameworks by integrating diverse forms of evidence and emphasising implementation considerations (Snyder, 2021).

To date, no comprehensive narrative review has specifically examined scalable mental health interventions targeting urban refugee adolescents and young adults, with a focus on implementation-relevant insights applicable to LMIC urban settings. Existing reviews often aggregate adults and children, conflate camp/settlement and urban populations, or prioritise clinical efficacy over feasibility and scalability (Mukdarut et al., 2017; Tol et al., 2011). This lack of focused synthesis limits the ability of researchers, practitioners, and funders to design context-appropriate interventions and to justify investment in youth-centred urban mental health programming.

The aim of this narrative review is therefore to synthesise existing evidence on scalable mental health and psychosocial interventions for urban refugee youth aged 15–24 years in low- and middle-income countries, with particular attention to MHPSS and SH+-aligned approaches. By examining intervention characteristics, target populations, delivery modalities, and implementation considerations, this review seeks to identify evidence gaps and inform the development of future research, policy, and funding initiatives addressing the mental health needs of urban refugee youth.

## Methods

### Narrative Review Design

This study adopted a narrative literature review approach to synthesise and interpret existing evidence on scalable mental health and psychosocial support (MHPSS) interventions targeting urban refugee adolescents and young adults. A narrative approach was selected to integrate heterogeneous study designs, intervention models, and implementation contexts, which is appropriate when the evidence base is limited, diverse, and emerging, and when policy- and implementation-relevant insights are prioritised over quantitative effect estimation.

### Data Sources and Search Strategy

A structured literature search was conducted across multiple electronic databases, including PubMed/MEDLINE, Scopus, PsycINFO, and Web of Science, to identify peer-reviewed studies. Google Scholar was additionally searched to capture relevant interdisciplinary literature and early publications that may not yet be indexed in traditional databases. Reference lists of included articles and relevant reviews were manually screened to identify additional eligible sources.

Search terms were developed iteratively and combined keywords related to population (e.g., refugee, asylum seeker, displaced), setting (e.g., urban, city, informal settlement), age group (e.g., youth, adolescent, young adult), and intervention type (e.g., mental health, psychosocial, MHPSS, self-help, scalable, task-shifting, Self-Help Plus). Search strings were adapted for each database to optimise sensitivity while maintaining relevance.

Although this study was conducted as a narrative review, elements of structured reporting were incorporated to enhance transparency and reproducibility. The search strategy, eligibility criteria, and study selection processes were defined a priori and applied consistently across databases. Titles and abstracts were screened for relevance, followed by full-text review of potentially eligible studies. Reasons for exclusion at the full-text stage were documented. While a formal PRISMA flow diagram and risk-of-bias assessment were not undertaken, the review was guided by principles of systematic searching and transparent reporting to ensure methodological rigour appropriate for a narrative synthesis of heterogeneous and emerging evidence.

Given the substantial heterogeneity across included studies in terms of populations, intervention types, study designs, and outcome measures, a quantitative synthesis, such as a meta-analysis, was not appropriate. Instead, a narrative review approach was employed to integrate diverse forms of evidence and to identify conceptual, methodological, and implementation gaps within an emerging, under-researched field. Narrative synthesis is particularly suited to complex public health topics where interventions are context-dependent, and evidence is fragmented (Peters et al., 2013).

**Timeframe**

The search covered literature published from January 2015 to the most recent complete month prior to manuscript submission. The year 2015 was selected as the starting point because it corresponds to a period of increased global emphasis on scalable, low-intensity mental health interventions, the expansion of task-shifted MHPSS models, and the emergence and early implementation of WHO Self-Help Plus (SH+) within humanitarian and public health contexts. This timeframe also aligns with post–Sustainable Development Goals discourse and growing recognition of urban displacement as a distinct humanitarian challenge.

**Eligibility Criteria**

**Inclusion Criteria**

Studies were included if they met the following criteria:

1. Population: Refugees or asylum seekers residing in urban or peri-urban settings, including self-settled populations.
2. Age: Participants aged 15–24 years. Where studies did not disaggregate outcomes by age but targeted youth and young adults up to age 30, inclusion was permitted if adolescents and young adults were the primary focus of the intervention.
3. Intervention: Scalable mental health and psychosocial support (MHPSS) interventions, defined in line with Inter-Agency Standing Committee (IASC) guidelines as interventions that aim to protect or promote psychosocial well-being and/or prevent or treat mental disorders. These include low-intensity, community-based, task-shifted, group-based, digital, or self-help approaches, with particular attention to WHO Self-Help Plus (SH+) or SH+-aligned interventions
4. Study focus: Evaluation, implementation, adaptation, or description of mental health or psychosocial interventions with relevance to delivery, feasibility, or scalability.
5. Publication type: Peer-reviewed empirical studies, study protocols, and high-quality reviews providing implementation-relevant insights.

**Exclusion Criteria**

Studies were excluded if they:

1. Focused exclusively on refugee camp/settlement settings with no relevance to urban or self-settled populations.
2. Examined specialist, clinic-based psychiatric treatments not designed for scalability or delivery by non-specialists.
3. Included refugee populations without any age-specific relevance to adolescents or young adults.
4. Addressed mental health outcomes only tangentially (e.g., as a minor secondary outcome without intervention relevance).
5. Were non-peer-reviewed commentaries, opinion pieces, or editorials without substantive methodological or empirical contribution.
6. Studies published in languages other than English, due to feasibility constraints and the need to ensure consistent screening and interpretation of included studies.

**Study Selection and Synthesis**

Titles and abstracts were screened for relevancebased on predefined eligibility criteria, followed by a full-text review of potentially eligible studies. Included studies were synthesised narratively, with attention to intervention characteristics, target populations, delivery modalities, urban implementation challenges, and evidence gaps. Rather than formal quality scoring, emphasis was placed on conceptual contribution, contextual relevance, and applicability to scalable intervention design, consistent with narrative review methodology. As this study adopted a narrative review design, a formal quality appraisal or risk-of-bias assessment was not conducted. Instead, emphasis was placed on the methodological rigour, conceptual contribution, and contextual relevance of included studies to inform the synthesis, consistent with established approaches to narrative reviews.

**Results**

**Overview**

Across the reviewed literature, studies were conducted mainly in low- and middle-income countries, including Uganda, Kenya, Turkey, Lebanon, Jordan, Pakistan, and other conflict-affected or refugee-hosting settings (Acarturk et al., 2022; Mukdarut et al.,

2017; Tol et al., 2011). However, urban refugee youth aged 15–24 years were rarely the explicit target population**,** with most studies focusing on adults (≥18 years) or mixed-age samples without youth-specific analyses (Charlson et al., 2019) (Betancourt et al., 2013).

A total of [INSERT NUMBER] studies met the inclusion criteria and were included in this review. The included studies comprised a heterogeneous mix of designs, including randomised controlled trials, quasi-experimental studies, feasibility and pilot studies, and study protocols. Geographically, studies were conducted across multiple low- and middle-income countries, including Uganda, Kenya, Turkey, Lebanon, Jordan, and Pakistan. Most studies targeted adult or mixed-age refugee populations, with relatively few explicitly focusing on adolescents and young adults aged 15–24 years.

Thematic analysis of the included studies resulted in four overarching categories: (1) characteristics of scalable MHPSS interventions, (2) mental health outcomes among urban refugee youth, (3) implementation and delivery considerations in urban contexts, and (4) critical evidence gaps and methodological limitations. Although this review focuses on adolescents and young adults aged 15–24 years, most included studies did not explicitly centre this population. As such, findings were interpreted with a specific focus on youth relevance, including developmental stage, social context, and engagement patterns. Where studies included mixed-age populations, particular attention was given to implications for adolescents and young adults in urban refugee settings.

**Theme 1: Characteristics of Scalable MHPSS Interventions**

Across the reviewed studies, scalable MHPSS interventions were predominantly low-intensity, structured, and transdiagnostic, designed for delivery by non-specialist providers through task-shifting models (Patel et al., 2018; Tol et al., 2011). These interventions were implemented in diverse humanitarian contexts, including urban refugee communities in East Africa and the Middle East**,** though most studies did not restrict inclusion to urban youth populations.

Interventions such as WHO Self-Help Plus (SH+)**,** Problem Management Plus (PM+), and group-based psychosocial programs were evaluated primarily among adult refugees (≥18 years) or mixed-age samples (e.g., 16–65 years) in countries such as Turkey, Uganda, and Pakistan (Tol et al., 2020; Acarturk et al., 2022). This pattern highlights a significant gap in the evidence base, as few interventions were specifically designed, adapted, or evaluated for adolescents and young adults aged 15–24 years in urban refugee settings. While these interventions were designed to be scalable and adaptable**,** age-specific tailoring for adolescents and young adults aged 15–24 years was rarely reported**,** limiting conclusions regarding developmental appropriateness. In this review, adolescents and young adults are defined as individuals aged 15–24 years, consistent with widely used global youth classifications.

Digital or technology-assisted interventions were infrequently represented and, where present, were broadly feasibility studies conducted in urban LMIC settings**,** with youth included as part of broader adult samples (Mukdarut et al., 2017; Naslund et al., 2017). For example, Self-Help Plus (SH+) was implemented among Syrian refugees in Turkey through group-based audio-guided sessions delivered by non-specialist facilitators, demonstrating feasibility in humanitarian contexts. Similarly, Problem Management Plus (PM+) has been delivered in community settings in Uganda through task-shifting, highlighting its adaptability across LMIC contexts.

**Theme 2: Mental Health Outcomes among Urban Refugee Youth**

Across contexts, studies consistently documented high levels of psychological distress among refugee populations residing in urban settings, including symptoms of post-traumatic stress, depression, anxiety, and functional impairment (Silove et al., 2017; Charlson et al., 2019). Evidence specific to urban refugee adolescents and young adults (15–24 years) was limited. However, available studies and sub-analyses suggested that youth experience comparable or higher levels of distress than older adults, particularly in relation to cumulative trauma and post-displacement stressors (Betancourt, Keegan, Farrar, & Brennan, 2020; Betancourt et al., 2013).

In studies conducted in urban refugee communities in Uganda, Kenya, and Lebanon**,** youth and young adults (typically defined as 16–29 years) reported elevated psychological distress linked to unemployment, disrupted education, discrimination, and social isolation (Logie et al., 2020; Miller & Rasmussen, 2017). However**,** direct evaluation of intervention effects on suicidality among urban refugee youth was rare**,** as many studies excluded individuals at imminent risk or did not measure suicidality as a primary outcome (Hetrick et al., 2016; Tol et al., 2020). For example, Self-Help Plus (SH+) was implemented among Syrian refugees in Turkey through group-based audio-guided sessions delivered by non-specialist facilitators, demonstrating feasibility in humanitarian contexts. Similarly, Problem Management Plus (PM+) has been delivered in community settings in Uganda through task-shifting, highlighting its adaptability across LMIC contexts.

**Theme 3: Implementation and Delivery in Urban Refugee Contexts**

Implementation findings highlighted that urban refugee settings differ substantially from camp/settlement-based environments**.** Studies conducted in cities such as Kampala, Nairobi, Beirut, and Istanbul reported challenges related to population mobility, weak community cohesion, informal housing, and limited access to organised service delivery platforms (Betancourt et al., 2013) (Logie et al., 2020).

Task-shifted delivery by lay providers, peer facilitators, or community workers was consistently identified as feasible and acceptable, particularly when facilitators shared cultural or linguistic backgrounds with participants (Patel et al., 2018; Tol et al., 2011). However, studies rarely described youth-specific engagement strategies, and retention of adolescents and young adults was reported as a challenge due to competing livelihood demands and mobility.

For SH+ and similar interventions implemented in LMIC urban settings**,** suicidality was typically managed through screening, exclusion, and referral protocols**,** rather than integrated within intervention delivery. While ethically appropriate, this approach

highlights the need for implementation models that explicitly address suicidality management among youth populations (World Health Organization (WHO), 2021). For instance, studies in Kampala and Nairobi reported challenges with participant retention due to high mobility and competing livelihood demands among urban refugee youth, underscoring the need for flexible, context-sensitive delivery models.

However, youth-specific analyses were rarely reported, limiting the ability to draw age-specific conclusions for adolescents and young adults.

**Theme 4: Evidence Gaps and Methodological Limitations**

Several critical gaps were identified across the PCC domains. First, there is a near absence of completed intervention trials explicitly targeting urban refugee youth aged 15–24 years**,** with most available evidence derived from adult or mixed-age refugee samples in countries such as Turkey, Uganda, and Pakistan **(**Mukdarut et al., 2017; Charlson et al., 2019). Second, few studies disaggregated outcomes by age or settlement type**,** limiting interpretation for urban youth populations. Third, implementation outcomes, including reach, acceptability, feasibility, and sustainability, were inconsistently reported, despite frequent claims of scalability (Peters et al., 2013). Finally, implementation-oriented designs**,** such as hybrid effectiveness implementation approaches or interrupted time-series analyses, were rarely applied in urban refugee mental health research, particularly among youth (Damschroder et al., 2009; Bernal et al., 2017).

Notably, emerging intervention research targeting urban refugee youth is beginning to appear in the form of registered and protocolized trials. For example, a livelihoods-integrated mental health intervention for urban refugee youth aged 16–24 years in Kampala, Uganda, has been registered on ClinicalTrials.gov (NCT06270160) and described in a published study protocol (Logie et al., 2024). However, outcome data from this trial are not yet available, underscoring the continued scarcity of completed and published intervention evidence specific to urban refugee youth populations. For example, while emerging trials such as the Kampala-based livelihoods-integrated intervention (NCT06270160) signal progress, outcome data remain limited, reinforcing the scarcity of completed youth-focused intervention studies.

Overall, the reviewed evidence indicates that scalable MHPSS interventions, including SH+ and related approaches, have been implemented across multiple LMIC contexts but rarely with an explicit focus on urban refugee adolescents and young adults aged 15–24 years**.** The limited availability of age-specific and urban-focused evidence, combined with insufficient reporting of implementation outcomes, underscores a critical gap in the literature. Addressing this gap is essential to inform the design, scale-up, and funding of mental health interventions responsive to the needs of urban refugee youth.

**Discussion**

This narrative review synthesised evidence on scalable mental health and psychosocial support (MHPSS) interventions for urban refugee adolescents and young adults aged 15–24 years in low- and middle-income countries**.** The findings indicate that although scalable interventions such as WHO Self-Help Plus (SH+)**,** Problem Management Plus (PM+), and other low-intensity psychosocial approaches are increasingly promoted within humanitarian and global mental health policy**,** very few studies explicitly target urban refugee youth**,** and even fewer disaggregate outcomes by age or settlement type (Mukdarut et al., 2017; Tol et al., 2011). The predominance of adult-focused evidence limits the ability to draw developmentally appropriate conclusions for adolescents and young adults, whose mental health needs, engagement patterns, and responsiveness to interventions may differ substantially from those of older populations. Most available evidence is derived from adult or mixed-age refugee populations**,** often implemented in camp- or settlement-based or mixed settings, limiting direct applicability to urban, self-settled youth populations(Betancourt et al., 2013) (Charlson et al., 2019). A key contribution of this review is its explicit focus on urban refugee adolescents and young adults, a population that remains underrepresented in the existing evidence base. Despite this focus, most available studies do not disaggregate findings by age or tailor interventions specifically to youth, which requires cautious interpretation of the results. Adolescents and young adults experience distinct developmental, social, and economic challenges, including identity formation, educational disruption, and transition to employment, which have important implications for mental health and intervention engagement.

Across the reviewed literature, scalable MHPSS interventions consistently emphasised task-shifting, brief structured formats, and delivery by non-specialists, in line with global recommendations for addressing mental health needs in resource-constrained settings (Tol et al., 2011; Patel et al., 2018). However, a substantial gap persists between the conceptual promise of scalability and the availability of implementation-relevant, youth-specific evidence for urban refugee contexts (Peters et al., 2013; Damschroder et al., 2009).

The high burden of psychological distress identified across refugee populations, including symptoms of post-traumatic stress, depression, anxiety, and functional impairment, aligns with global estimates demonstrating the disproportionate mental health impact of forced displacement (Silove et al., 2017; Charlson et al., 2019). Evidence from urban refugee contexts in Uganda, Kenya, Lebanon, Turkey, and Pakistan suggests that adolescents and young adults experience distinct and compounded vulnerabilities**,** shaped by prolonged displacement, disrupted education, social exclusion, and persistent exposure to urban poverty and insecurity (Betancourt et al., 2013)( Miller & Rasmussen, 2017; Logie et al., 2020).

While scalable MHPSS interventions, including SH+ and PM+, have shown effectiveness in reducing general psychological distress among adults and mixed-age refugee populations (Tol et al., 2020; Acarturk et al., 2022), the lack of age-disaggregated analyses limits understanding of their developmental appropriateness for youth aged 15–24 years. Developmental and global mental health

literature consistently identifies adolescence and early adulthood as critical periods for emotional regulation, identity formation, and social integration, during which exposure to adversity may have long-lasting consequences (Kessler et al., 2007; Kieling et al., 2011). Interventions that do not explicitly account for these developmental processes may therefore face challenges related to engagement, acceptability, and sustained impact among urban refugee youth (Betancourt et al., 2013).

Despite growing recognition of youth suicidality as a global public health priority, direct evidence on the impact of scalable MHPSS interventions on suicidality among urban refugee youth remains extremely limited**.** Most reviewed studies excluded individuals at imminent suicide risk or addressed suicidality indirectly through broader measures of psychological distress (World Health Organization, 2020)(Hetrick et al., 2016; Tol et al., 2020). While ethically appropriate, this pattern underscores the need for intervention research that more explicitly integrates suicide risk pathways within scalable mental health frameworks, particularly in urban humanitarian settings.

An important and under-examined dimension highlighted by this review concerns mental health during the transition from school to employment**,** a critical developmental stage for urban refugee youth aged 15–24 years. This transition is frequently disrupted by forced displacement, interrupted education, limited access to formal labour markets, and legal or documentation barriers to employment in host countries (Betancourt et al., 2013)(Miller & Rasmussen, 2017). Recent registered trials integrating mental health and livelihoods components among urban refugee youth, such as the Kampala-based intervention registered as NCT06270160, reflect growing recognition of the link between mental health and education-to-employment transitions (Logie et al., 2024). Subsequent peer-reviewed findings from the Tushirikiane-4-MH (Supporting Each Other for Mental Health) mobile health–supported virtual reality randomised controlled trial among urban refugee youth in Kampala provide emerging empirical evidence supporting the feasibility and potential effectiveness of integrated, youth-centred intervention models in urban humanitarian settings (Logie et al., 2025).

Evidence from urban refugee populations in East Africa and the Middle East indicates that difficulties navigating the education-to-employment transition are associated with elevated psychological distress, hopelessness, and increased suicide risk**,** particularly among out-of-school and unemployed youth (Charlson et al., 2019; Logie et al., 2020). Despite this, most scalable MHPSS interventions reviewed focused primarily on symptom reduction and stress management, without explicitly addressing livelihood insecurity, future uncertainty, or structural barriers to employment**.**

Psychological distress during this life stage is often driven not only by past trauma but also by ongoing socioeconomic stressors**,** including unemployment, underemployment, and social marginalisation in urban environments (Silove et al., 2017). Scalable interventions such as SH+ may be particularly relevant during this transition, as they are designed to enhance coping and psychological flexibility in the context of ongoing adversity (World Health Organization, 2020)( Tol et al., 2020). However, the reviewed literature provides limited guidance on how SH+ and similar interventions can be integrated with education, vocational training, or livelihood-oriented programs**,** highlighting a critical area for future research and programmatic innovation (Patel et al., 2018).

This review reinforces that urban refugee settings present distinct implementation challenges compared to camp/settlement-based contexts. High population mobility, fragmented social networks, informal housing arrangements, and limited access to organised service delivery platforms complicate recruitment, retention, and follow-up in urban environments (Betancourt et al., 2013)(Miller & Rasmussen, 2017). Studies conducted in cities such as Kampala, Nairobi, Beirut, and Istanbul consistently reported difficulties engaging youth who balance informal employment, caregiving responsibilities, and unstable living conditions (Logie et al., 2020).

Task-shifted delivery by lay providers and peer facilitators was found to be feasible and acceptable across settings, particularly when facilitators shared cultural and linguistic backgrounds with participants (Tol et al., 2011; Patel et al., 2018). However, inconsistent reporting of training, supervision, fidelity monitoring, and implementation outcomes limits the ability to conclude optimal delivery models. Implementation science frameworks emphasise the importance of systematically documenting reach, acceptability, feasibility, and sustainability alongside effectiveness (Damschroder et al., 2009; Peters et al., 2013), yet such outcomes were rarely reported in the reviewed studies. These findings highlight that scalability is not solely a function of intervention effectiveness but is critically dependent on feasibility, reach, and sustainability within complex urban refugee contexts.

For SH+ and related interventions, suicide risk management was typically addressed through screening and referral mechanisms**,** rather than integrated intervention components (World Health Organization, 2020). While consistent with ethical guidance, this approach may be insufficient in urban contexts where referral pathways are fragmented or inaccessible, underscoring the need for context-sensitive, stepped-care implementation models for youth populations (Hetrick, Robinson, Spittal, & Carter, 2016).

The findings of this review highlight a persistent misalignment between global policy priorities and empirical investment in mental health for urban refugee youth. Despite strong advocacy for scalable MHPSS interventions**,** evidence supporting their application among urban refugee adolescents and young adults remains underdeveloped (Mukdarut et al., 2017). This gap constrains policymakers' and funders' ability to design evidence-informed programs for this population.

Implementation-oriented study designs, including hybrid effectiveness–implementation approaches and interrupted time series designs**,** are particularly well suited to complex urban humanitarian settings, where randomised controlled trials may be impractical or ethically challenging (Bernal et al., 2017; Damschroder et al., 2009). However, such designs were rarely employed in the reviewed literature, highlighting a critical opportunity for future research investment.

This review has several notable strengths. First, it synthesises a diverse and emerging body of evidence on scalable mental health and psychosocial support (MHPSS) interventions in low- and middle-income country (LMIC) urban contexts, addressing a critical, under-researched population: urban refugee adolescents and young adults. Second, by adopting a narrative and implementation-informed approach, the review integrates heterogeneous study designs and intervention models to generate contextually relevant insights. Third, the focus on scalability, delivery modalities, and real-world implementation challenges provides practical relevance for policymakers, practitioners, and researchers working in humanitarian and urban health settings.

However, this review has several limitations.

First, this review was limited to peer-reviewed literature and did not include grey literature, such as reports from non-governmental organisations, United Nations agencies, and humanitarian actors. As a result, relevant programmatic evidence and implementation experiences, particularly those not formally published in academic journals, may have been omitted. Given that many mental health and psychosocial support (MHPSS) interventions in humanitarian settings are implemented and evaluated outside of academic contexts, future reviews should incorporate grey literature to provide a more comprehensive understanding of intervention delivery and real-world effectiveness.

Second, the scarcity of age-disaggregated data limited the ability to draw definitive conclusions specific to adolescents and young adults aged 15–24 years. Third, as a narrative review, this study did not formally assess the risk of bias or study quality. However, emphasis was placed on conceptual and implementation relevance consistent with narrative synthesis methodology (Peters et al., 2013). Additionally, including only English-language studies may have excluded relevant evidence published in other languages, potentially limiting the global representativeness of the findings.

Future research should prioritise urban refugee youth as a distinct population**,** with explicit age disaggregation and developmental considerations embedded in study design. Rigorous evaluation of scalable interventions, including SH+ and SH+-aligned approaches, is needed using implementation-informed designs that capture both outcomes and delivery processes (Bernal, Cummins, & Gasparrini, 2017). Research should also explore integrated models linking mental health support with education, employment, and livelihood interventions**,** particularly during the transition from school to work (Patel et al., 2018; WHO, 2022). There is a clear need for the design, adaptation, and rigorous evaluation of scalable MHPSS interventions specifically tailored to urban refugee youth, with explicit consideration of developmental stage, social context, and engagement strategies.

**Conclusion and Recommendations**

Scalable MHPSS interventions offer considerable promise for addressing mental health needs among refugee populations; however, urban refugee adolescents and young adults remain largely invisible within the current evidence base**.** Addressing this gap requires deliberate investment in youth-focused, urban-specific, and implementation-informed research, with explicit attention to developmental transitions and structural determinants of mental health. Strengthening the evidence base in this area is essential to inform policy, guide funding decisions, and ensure that scalable mental health interventions effectively reach and benefit urban refugee youth. Future research should prioritise youth-centred study designs, including age-disaggregated analyses and interventions specifically adapted to the needs of adolescents and young adults in urban refugee contexts.

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