Mental health of children and young people

Service guidance

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World Health Organization

Mental health of children and young people: service guidance
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Foreword

Mental health conditions are common, and often develop early in life. Yet most health and social systems neglect the mental health of children and young people and do not provide the care and support that they need and deserve. The result is that millions of children, young people and families suffer needlessly, experience human rights violations, or struggle to function at home, school and in the wider community.

We have good evidence on what works to promote mental well-being and to prevent and care for mental health conditions in children and young people. Now we need action to act to ensure that evidence-based interventions are available, accessible and affordable for all. In all contexts, that means reorganizing existing mental health services and developing new ones that meet the needs of all children and young people, that are community-based, and contribute towards achieving universal health coverage.

This document describes the importance of strengthening mental health services for children and young people and shows that it is possible.

It emphasizes the value of community-based support that provides care in the places where children and young people live, learn and play. It stresses the need for collaboration between sectors to develop interconnected networks of community-based services and ensure continuity of care between them, as children and young people move between different types of services according to their changing mental health needs and developmental stage. It underlines the importance of meaningful participation of children, young people and their families in service design and delivery, as appropriate, to ensure mental health care options are relevant and acceptable.

Throughout this document you will find examples from around the world showcasing what effective mental health and social support for children and young people looks like in different settings, and how it can lead to better mental health and development outcomes. Every country, no matter its situation, can do something to significantly improve the mental health of its children, young people and their families.

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Abbreviations

ADHD	attention deficit hyperactivity disorder
COVID-19	Coronavirus disease 2019
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
HAT	Helping Adolescents Thrive
HICs	high-income countries
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex, queer, asexual, and other gender and sexually diverse people
LMICs	low- and middle-income countries
mhGAP	WHO Mental Health Gap Action Programme
mhGAP-IG	WHO Mental Health Gap Action Programme Intervention Guide
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Photo credit (next page): Girl holding a goat, Pakistan, 2023.
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Executive summary

Chapter 1: Introduction

Mental health conditions are prevalent and often develop early in life, with a third of conditions emerging before the age 14, and half before the age of 18 years. Yet very few of the world's children and young people receive the mental health services they need and to which they are entitled. All countries need to invest in building and improving mental health services for children and young people. This is essential to realize their full rights, ensure that they can meet their potential, alleviate unnecessary suffering, and to enable sustainable development and foster prosperous, stable communities.

There is no single best model for organizing mental health services that applies to all contexts. But every country, no matter its resource constraints, can take steps to improve the design and strengthen the delivery of mental health services for children and young people. This service guidance document aims to catalyse a much-needed global transformation of services for children and young people aged 5-24 years through its focus on community-based mental health care. This document is designed to inform and inspire policy makers and others responsible for mental health services for children and young people, through introducing key issues to consider, and by sharing a broad range of good practice approaches to developing or re-orienting services at community level.

Chapter 2: Fundamentals of public mental health for children and young people

Good mental health is important for a person's well-being, sense of identity and self-worth. Yet, mental health services for children and young people are often difficult to access, inequitably distributed, and of variable quality. Providing mental health services to children and young people who need them alleviates the suffering of individuals and their families and reduces costs for health systems and communities.

Mental health is fluid, fluctuating over time in response to changing situations and a range of individual and external factors. Services for young people should comprehensively cover promotion and prevention, support, treatment, care and recovery, and allow for easy transition between different types of support as needs change.

Mental health is experienced over the life course. Childhood and youth are sensitive periods for mental health as the developing brain is especially susceptible to positive and negative influences, with potential for lifelong impact. Services should be developmentally appropriate and consider the evolving needs and capacities of children and young people.

Mental health is influenced by a complex interplay of societal, community, family and individual level determinants that vary across the life course, often accumulating and reinforcing each other. Mental health services for children and young should be integrated and scaled up across multiple sectors - with the involvement of health, social protection, education, housing, employment and other sectors.

Everyone has a right to mental health services within their communities. Community-based mental health care is more accessible and acceptable than institutional care and delivers better outcomes for people with mental health conditions. Strengthening community-based mental health care for children and adolescents involves phasing out care in custodial institutions while simultaneously expanding community-based service options.

Yet, children and young people face many barriers to accessing mental health care. Stigma is pervasive in all countries and acts as a powerful disincentive for children and young people, and their families, to seek help. It can also deter people from providing help. Services for children and young people are often difficult to access, inequitably distributed, not developmentally appropriate, and of poor quality. They typically exclude children and young people with neurodevelopmental conditions or disabilities. There is often a lack of coordination between different levels of care, or in the transition between child and adult mental health systems, meaning that many young people with high levels of need experience interruptions in care.

Chapter 3: Designing and delivering services for children and young people's mental health

Building community-based mental health care relies on two principles: (i) establishing a network of interconnected services; and (ii) using stepped care and task-sharing.

A network of interconnected services typically includes a mix of: mental health services that are integrated in general health care, at primary care facilities and general hospitals, including within existing specific health programmes; community mental health services, which may include community centres or teams; and services beyond the health sector that deliver mental health care in non-health settings, like schools, and youth centres. Additionally, digital technologies can be used to deliver or support mental health interventions across the full network of services. Services should be well linked to ensure continuity of care, especially for children and young people who have complex needs.

The stepped care model ensures that the level of care is matched to the intensity and complexity of a young person's mental health needs. Children and young people move between levels of care, delivered by specialist or non-specialist mental health care providers, depending on their progress or changes in mental health status. In practice, this means that children and young people with low levels of need access low intensity evidence-based interventions, such as psychoeducation or guided self-help. However, should they need more support, they access a more intensive intervention delivered by a trained and supervised non-specialist, or in the case of severe and complex mental health needs, specialist support from a mental health specialist. There are different models for mental health care services for children and young people. This chapter highlights country examples from different settings and regions.

Chapter 4: Strengthening systems for children and young people's mental health

There are several standards that should underpin and guide all service development to create well-functioning mental health systems for children and young people. Mental health care services should promote children and young people's participation in all facets of life on an equal basis with their peers. They should be rights-based, safe, timely, accessible, and provide evidence-based, developmentally appropriate and inclusive care to all children and young people who need it, regardless of their background or status. Services should be responsive to children and young people's preferences, needs and values, and actively involve them in decisions about their own care. They should involve caregivers and families as appropriate and collaborate and connect with the communities in which they are based. Services should engage in ongoing monitoring and evaluation and quality improvement.

Strengthening community-based mental health services for children and young people also requires action to strengthen the core components that underpin a well-functioning mental health system. This means deepening political and financial commitment, including by securing appropriate funds and human resources across health and other sectors, adopting human rights-based laws and policies, and establishing robust information and monitoring systems.

Photo credit (next page): Adolescent boy and social worker, Cambodia, 2023.
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1 Introduction

1.1 The need for action

Mental health conditions are prevalent and often develop early in life, with a third of conditions emerging before the age of 14, and half before the age of 18 *(1)*. Globally, in 2021, an estimated 1 in 7 (15%) adolescents aged 10-19 years experienced mental health conditions *(2)*, and suicide was the fourth leading cause of death among those aged 15–19 years *(3)*.

Yet very few of the world's children and young people receive the mental health care they need and to which they are entitled *(4)*. In many communities, formal mental health services for children and young people simply do not exist. In others, where services are available, they are often fragmented and inequitably distributed. They may not be developmentally appropriate or based on the best available evidence; or they may violate children's human rights.

The dearth of quality mental health care for children and young people was brought into sharp focus during the global COVID-19 pandemic, when the psychological distress caused by widespread loss, social isolation, disruptions to routine (including through school closures), and elevated economic uncertainty, fuelled a growing crisis in child and youth mental health *(5)*.

The pandemic led to intensified calls for action to improve child and youth mental health by implementing evidence-supported practices that are scalable, expand access to care, and eliminate disparities worldwide. Such attention can be a powerful driver for change *(6)*.

All countries need to strengthen mental health services for children and young people. Investing in quality mental health care is essential to alleviate unnecessary suffering, realize the full rights of children and young people, ensure that all children and adolescents can meet their potential, and to enable sustainable development and foster prosperous, stable communities.

WHO strongly advocates for community-based mental health care, which is more accessible and acceptable than institutional care, helps prevent human rights violations, and delivers better outcomes for people with mental health conditions. WHO has called for a global transformation in mental health, including child and youth mental health *(7)*.

Overall, there is no single model for organizing community-based mental health services that applies to all contexts. But every country (or province, district or other large subnational administrative area within a country), no matter its resource constraints, can take steps to (re)organize and scale up mental health services for children and young people.

1.2 About this service guidance document

1.2.1 Purpose and audience

Building on the momentum gained during the pandemic, this service guidance document aims to inform and inspire the much-needed transformation in mental health care for children and young people worldwide. It is intended to provide an overview of approaches for designing community-based mental health services for children and young people.

This service document is primarily written for policy-makers and others responsible for planning, developing, reorienting and strengthening mental health services for children and young people. It introduces key issues and presents options and opportunities for service design in different settings.

1.2.2 Scope

Age group

This document covers mental health care for:

- children, which is anyone aged 5–9 years; and
- young people, which is anyone aged 10–24 years, and includes the overlapping groups of adolescents aged 10–19 years and young adults up to youth aged 15–24 years.

Services

This document focuses on community-based mental health services, which comprise any mental health service that is provided outside of a psychiatric hospital *(7)*. Some examples of community-based mental health services include:

- mental health services integrated into general health care, including primary health care and general hospitals;
- community mental health centres and teams as well as peer support services; and
- mental health services beyond the health sector, which are accessible to children and young people in places where they spend their time, such as schools and other learning environments, youth centres and organizations, or digital platforms *(8)*.

Some community-based mental health services are not included in the scope of this document, specifically:

- promotion and prevention programmes (see instead the *WHO-UNICEF Helping adolescents thrive toolkit (9)*);
- services for children and young people with developmental disabilities (see instead the *WHO-UNICEF Global report on children with developmental disabilities (10)*); and
- services specifically for substance use disorders and behavioural addictions.

1.2.3 Structure

The rest of this document is organized into three parts.

- **Chapter 2** outlines the fundamentals of public mental health for children and young people, including the global context, human rights considerations, core concepts, and key barriers to accessing care.
- **Chapter 3** presents the basic principles of service delivery and describes different practice models for quality mental health care services for children and young people, with examples from around the world that show what can be achieved in different settings.
- **Chapter 4** draws from the examples in Chapter 3 to set out a set of standards for mental health services for children and young people and it describes the enabling factors required to develop, deliver and sustain these services.

1.2.4 Approach to development

This document draws primarily on secondary data, in the form of published peer-reviewed and grey literature and on a consultative process. As part of the process a review of published literature and scoping of relevant grey literature were conducted with the intention of identifying examples of good practices, with particular focus on the organization, delivery and scale up of mental health services for children and young people.

Policy makers, service planners, researchers and advocates, including persons with lived experience and youth, were engaged at different stages of the process to help define the overall focus, contribute technical inputs towards content development and review relevant sections. Declarations of interest were requested from all external reviewers and contributors. A letter was sent to all potential reviewers and contributors requesting them to complete a declaration of interests form and submit a curriculum vitae. The coordination team reviewed the declarations of interest along with additional information (obtained through internet and bibliographic database searches) and assessed them to determine whether there were any conflicts of interest and, if so, whether this necessitated a management plan. No significant conflicts were identified throughout the process.

Chapter 3 includes country examples and good practices in the organization and/or delivery of children and young people's mental health services. Country examples were identified through peer-reviewed literature, review of grey literature or through submission by country stakeholders and experts. The WHO-UNICEF editorial team reviewed all country examples to establish if they met eligibility criteria, in consultation with experts as relevant. Annex 1 provides additional information on criteria for eligibility and prioritization for inclusion of country examples.

Chapter 4 presents important domains of standards for mental health services for children and young people, as well as information on approaches for leadership and governance, supporting participation of families, children and young people, financing, workforce development and health information systems for children and young people's mental health. Each of these sections was developed based on literature reviews of peer-reviewed research, national and international standards, tools and frameworks, and information drawn from online consultations with young people with lived experience of mental health conditions.

Photo credit (next page): Chypher on a swing in his home in Assin Nyankumasiat, Central Region, Ghana, 2023. © WHO / Fanjan Combrink.

2

The fundamentals of public mental health for children and young people

This chapter describes the global context of children and young people's mental health, core concepts that should underpin mental health service development for these age groups, and common barriers that prevent children and young people from accessing mental health care.

2.1 The global context

Good mental health is important for a person's well-being, sense of identity and self-worth. Children and young people with good mental health can realize their abilities, build positive family and social relationships, learn and work well, tackle challenges and manage emotions *(11–13)*. For children and young people developing the ability to cope with stress and adversity, good mental health is fundamental; and it is strengthened by knowing when and how to access support. Ultimately, mental health is an integral part of general health and enhances social and economic wellbeing and participation across the life course *(7)*.

Mental health conditions affect around 8% of children aged 5-9 years and 15% of young people aged 10-19 years worldwide *(2)*. Conditions affecting children and young people include emotional and behavioural disorders, self-harm and suicide and substance use (see Box 2.1). Few children and young people experiencing these and other conditions receive quality mental health services *(4)*. In low- and middle-income countries (LMICs), the level of unmet need can reach near 100%. But even in high-income countries (HICs), mental health services for children and young people are often difficult to access, inequitably distributed, and of variable quality *(14)*.

Without early intervention, children and young people are at risk of ongoing or recurrent mental health conditions into adulthood (see Fig. 2.1). This can cause profound short- and long-term suffering. The effects of unrecognized and untreated mental health conditions during childhood and youth – which are critical periods of development – can have devastating consequences for social, educational and vocational progress and significantly restrict life chances and opportunities *(15)*. For some young people the consequences are fatal, with suicide a leading cause of death for adolescents (see Fig. 2.2) *(3)*.

Failure to address mental health conditions early in life results in significant costs to the individual and to the health, social, and criminal justice systems *(14)*. By contrast, promoting mental health, preventing mental health conditions, and providing mental health services to children and young people alleviates the suffering of individuals and their families, and reduces costs for health systems and communities.

Despite this strong case for investment, there has been little progress in developing mental health services for children and young people. Public funding and human resources for mental health services in general is low worldwide; for mental health services aimed at children and young people it is practically non-existent, especially in LMICs *(4)*. Very little development assistance is directed towards child and adolescent services in these countries *(16)*. In both cases, funding for adult mental health services, which are also typically inadequate, is almost always prioritized over services for children and adolescents *(7)*.

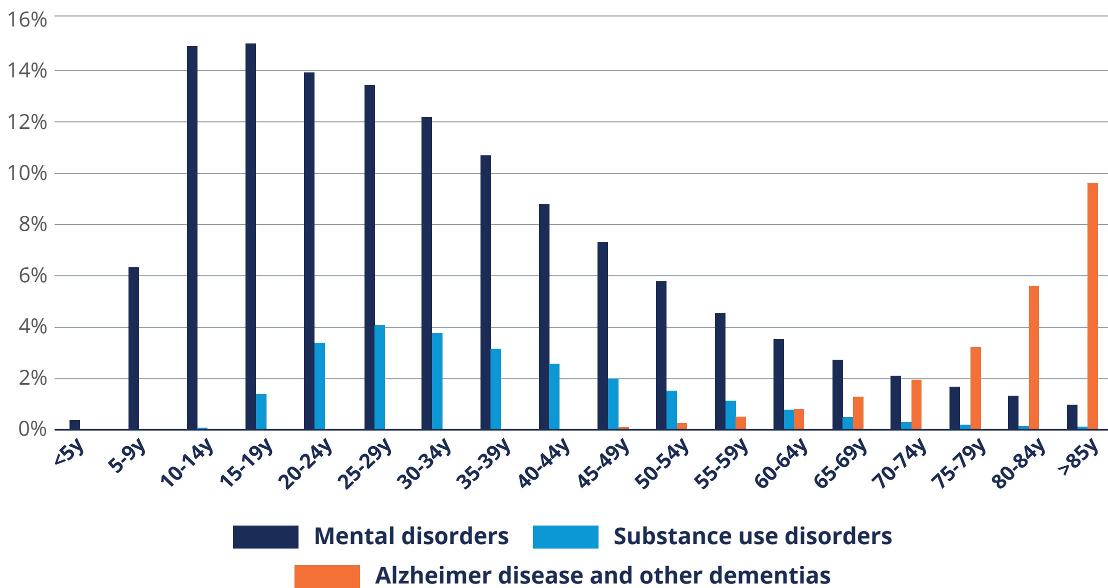
Children and young people are similarly sidelined or forgotten in efforts to achieve the Sustainable Development Goals (SDGs), including universal health coverage *(17)*. The result is a global lack of

accessible, affordable, quality and youth-friendly health services and financial protection, especially in mental health. Children and young people have benefited least from the health gains associated with economic development *(18)*.

Increasing political commitment and financial investment in mental health services for children and young people, and ensuring they are accessible to all, is essential to reduce unnecessary suffering and to realize sustainable development.

FIG. 2.1.

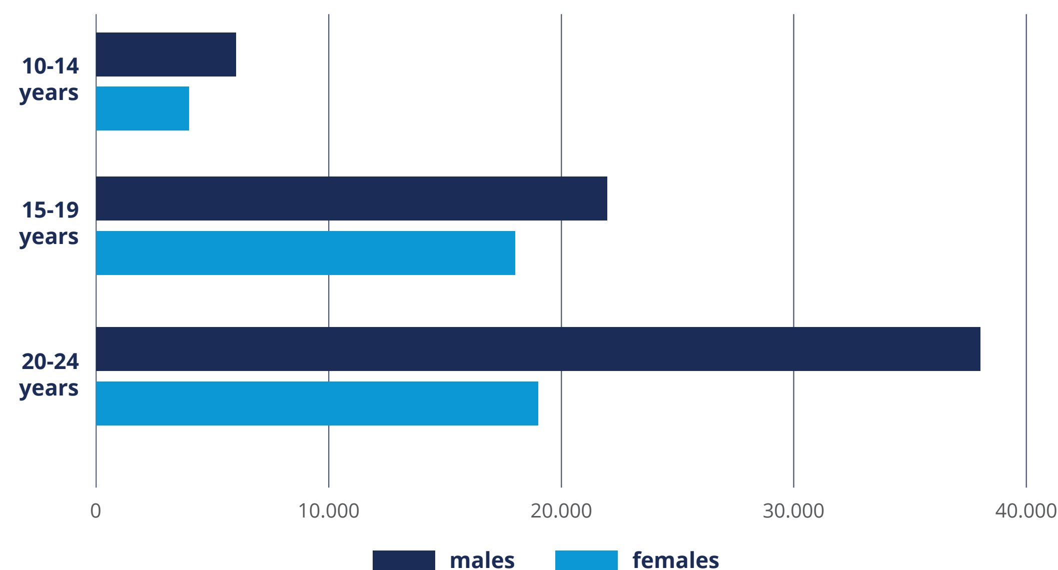
The global burden of mental and substance use disorders, dementia and self-harm in % disability-adjusted life years (DALY) across the life course.



Source: Global Health Estimates, 2024 *(19)*.

FIG. 2.2.

Global suicide deaths in young people (in 1000s), 2021.



Source: Global Health Estimates, 2024 *(19)*

BOX 2.1.

Key conditions in children and adolescents

Emotional disorders include depression and anxiety. Children and young people with emotional disorders can also experience excessive irritability, frustration or anger. Symptoms can overlap across different conditions, with rapid and unexpected changes in mood and emotional outbursts. Children and younger adolescents may also develop emotion-related physical symptoms such as stomach ache, headache or nausea.In 2021, an estimated 4.4% of 10–14-year-olds and 5.5% of 15–19-year-olds experienced an anxiety disorder. Depression was estimated to occur among 1.4% of adolescents aged 10-14 year and 3.5% of 15-19 year olds *(2)*.

Childhood behavioural disorders include conduct disorder – characterized by symptoms of destructive or challenging behaviour – and attention deficit hyperactivity disorder (ADHD), which is characterized by difficulty paying attention and/or excessive activity and acting without regards to consequences that are otherwise inappropriate for a person's age. Behavioural disorders are a leading cause of disease burden in 10–14-year-olds, potentially affecting their education and increasing the risk of criminal behaviour . In 2021, an estimated 2.9% of 10–14-year-olds and 2.2% of 15–19-year-olds experienced ADHD, and 3.5% of 10–14-year-olds and 1.9% of 15–19-year-olds experienced conduct disorder *(2)*. Globally, girls have higher rates of emotional disorder than boys, while boys have higher rates of behavioural disorders *(20, 21)*.

Eating disorders include anorexia nervosa and bulimia nervosa. These conditions are characterized by harmful eating behaviours, such as restricting calorie intake or binge eating. Girls are more commonly affected than boys. Eating disorders undermine physical health and often co-exist with depression, anxiety and substance use disorders. In 2021, they occured in an estimated 0.1% and 0.4% of 10–14-year-olds and 15–19-year-olds respectively *(2)*. They are associated with suicide.

Psychosis. Conditions with symptoms of psychosis – including hallucinations or delusions – typically emerge in late adolescence or early adulthood. These experiences can impair a young person's ability to participate in daily life and education or work. Young people with psychosis often experience stigma, resulting in social exclusion and other human rights violations. In 2021, schizophrenia occurred in 0.1% of 15–19-year-olds *(2)*.

Suicide and self-harm. Risk factors for suicide are multifaceted, including harmful use of alcohol, abuse in childhood, stigma against help-seeking, barriers to accessing care and access to means of suicide. Globally in 2021, suicide was the third leading cause of death in young people aged 15–29 years for both sexes, after road injury and interpersonal violence. For young women and young men, respectively, suicide was the second and third leading cause of death in this age group *(3)*.

Substance use. The use of psychoactive substances (such as alcohol and drugs) usually begins in adolescence. Young people are especially vulnerable to developing harmful substance use patterns that can persist across the lifespan. In 2019, the prevalence of alcohol use among 15–19-year-olds was high worldwide (22%) with very few gender differences, and showing an increase in consumption in some regions *(22)*. In 2022, the prevalence of cannabis use among adolescents was higher than that of adults globally (5.5 per cent compared with 4.4 per cent, respectively) *(23)*.

IMPLICATIONS FOR SERVICE DESIGN

- Focus on mental health services for children and young people.
- Design services to identify and manage mental health conditions early to mitigate lifelong impact.
- Make resources available to realize mental health services for children and young people.

See Chapter 3 for more information on designing mental health services for children and young people.

Photo credit : Child participating in a friendly soccer match, Venezuela, 2022.
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2.2 Core concepts in mental health of children and young people

2.2.2 Mental health exists on a continuum

The mental health of each child or young person exists on a complex continuum, rather than as a binary state of mentally healthy or mentally unhealthy. Descriptions of the continuum usually comprise an optimal state of mental well-being and thriving at one end, through to severe mental difficulties that significantly impact daily life at the other end (see Fig. 2.3).

FIG. 2.3.
An example of the mental health continuum.

Source: based on concepts described in Kleintjes et al, 2022 *(25)*.

Diagnostic systems such as the International Classification of Diseases (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) use a categorical approach to describe mental health conditions, relying on a diagnostic threshold to determine whether or not a person qualifies for a diagnosis. But for most young people there is no single point on the mental health continuum that marks an abrupt separation between wellness and ill-health. Mental health is fluid, fluctuating over time in response to changing situations and a range of individual and external factors (see section 2.2.3).

IMPLICATIONS FOR SERVICE DESIGN

- Design comprehensive services that cover promotion and prevention, support, treatment, care and recovery for children and young people's mental health.
- Make services integrated so children and young people can easily move between different types of support as their needs change.

Please see Chapter 4 for more information on standards for mental health care of children and young people.

2.2.2 Mental health is experienced over the life course

A life-course approach to mental health acknowledges the factors influencing mental health at each stage of life. It also recognizes that early experiences impact mental health not only during childhood and youth, but also in later life, sometimes shifting a person's life trajectory.

Childhood and youth are sensitive periods for mental health as the developing brain changes quickly and is vulnerable to outside influences. As children and young people mature, expectations and roles within their families and communities shift, and they develop more independence, autonomy and responsibility. Development is especially dynamic during this period, influenced by biological factors (e.g. genes), life events and structural factors such as culture and gender norms *(20)*. Evidence on the effectiveness of prevention and early interventions shows it is important to recognize mental health difficulties early and provide care quickly to stop and reverse any shift on the mental health continuum towards not coping *(24)*.

Middle childhood (5–9 years) is a critical period for developing social and emotional skills, peer relationships, and building the foundations for effective coping. This is when emotional and behavioural difficulties often begin to emerge. Caregiving factors, such as parenting style and caregivers' mental health, are major influences on child mental health. This is also the time when a child's environment expands to outside the home, and relationships within school and other community settings become increasingly important *(25)*.

Mental health during adolescence is affected by high-risk exposures and behaviours, including self-harm, substance use, risky sexual behaviours, and exposure to and perpetration of violence *(26)*. Early adolescence (10–14 years) brings big changes: the onset of puberty, peer relationships and wider community networks (online and offline) all become significant factors in mental health *(18,27)*. During this time, positive social and emotional skills can be learned; but it is also the time when risk-taking in alcohol and drug use and sexual activity is heightened *(27)*. In this age group, substance use can also be a response to mental health conditions *(28)*.

Caregivers continue to have a strong influence on mental health during early adolescence. Positive parental relationships can improve developmental outcomes and mitigate negative external factors *(29)*. Yet aspects of the caregiver relationship can also cause stress, for example, if caregivers put excessive pressure on their children to do well at school *(28)*. Caregivers may struggle to help adolescents learn how to respond to more intense experiences of sadness, anxiety, and anger *(30)*. As adolescents participating in a global UNICEF study reflected, this can lead young people to feel that their emotions, challenges and experiences are not important:

> *When I was younger, I did express my feelings much more, but they were not validated...I could say, "I have depression" or "I feel sad," and they would say, "No, you don't know what you feel because you are 12 years old."[Young girl] (28).*

During later adolescence (14–19 years), individuals continue to move from dependence on caregivers to adult independence *(31)*. Ongoing changes in body, brain and behaviour similarly continue to interact with each other and with the environment – at home and school, and in the wider community – to shape an individual's mental health trajectory into adulthood *(31)*. Gender norms can start to have a greater impact on individuals' mental health, and gender stereotyping can determine how mental health conditions in adolescents are diagnosed and treated (see Box 2.2) *(20)*.

IMPLICATIONS FOR SERVICE DESIGN

- Follow a life-course approach and adapt services to the evolving needs, capacities, and abilities of children and young people.
- Make services developmentally appropriate, gender-responsive and gender-sensitive.
- Prioritize early interventions for children and young people experiencing poor mental health e.g. for first episode psychosis to prevent or delay recurrence and focus on recovery.
- Establish suicide prevention strategies across schools, health and protection services, in line with WHO's LIVE LIFE implementation guide (32).

See Chapter 4 for more information on standards for mental health care of children and young people.

2.2.3 Mental health is influenced by a broad range of factors

Each person's mental health is determined by a complex interplay of individual, family, community and societal factors that vary over time and are experienced differently from person to person. These determinants of mental health rarely occur in isolation but rather cluster together, accumulating and reinforcing each other over the life course. Collectively, they can undermine mental health (risks) or enhance it (protective factors) (see see Table. 2.1).

TABLE 2.1.

Examples of risks and protective factors that influence the mental health of children and young people.

SOCIETAL

Example risks

- Social, economic and gender inequalities
- Social exclusion
- Stigma and discrimination
- Climate crisis, pollution or environmental degradation
- Poor quality infrastructure
- Poor access to services
- Conflict and forced displacement
- Health emergencies

Example protective factors

- Legal and policy frameworks for promotion and prevention
- Social protection systems
- Economic security
- Good quality infrastructure
- Access to services
- Social and gender equality

COMMUNITY

Example risks

- Exposure to peer or community violence and/or sexual abuse
- Limited access to recreational activities
- Limited, inaccessible mental health services
- Urban living

Example protective factors

- Access to quality health, education and social services
- Safe and healthy school environments
- Community cohesion
- Physical security and safety
- Positive social networks
- Social supports
- Green spaces

FAMILY

Example risks

- Substance use by mother during pregnancy
- Caregiver mental health problems
- Economic instability and poverty
- Family conflict
- Separation from the family (e.g. residential care)
- Maltreatment and/or violence in the home
- Being from an ethnic minority

Example protective factors

- Good perinatal nutrition
- Positive family functioning and relationships
- Positive home environment
- Employment and financial security

INDIVIDUAL

Example risks

- Genetic factors (e.g. family history of mental health conditions)
- Chronic health conditions
- Injury
- Low education
- Alcohol and drug use
- Unhealthy or deficient diet
- Obstetric complications at birth

Example protective factors

- Genetic factors (e.g. genetic variations related to potential benefits in neurological and cognitive functioning)
- Good social and emotional skills
- Good physical health and nutrition

Children and young people who are exposed to adversity such as poverty, inequality, violence, exclusion, stigma and environmental crises are at much greater risk of experiencing mental health conditions. This includes children who are: living in post-conflict or disaster settings, living or working on the streets, subjected to harmful gender norms (see Box 2.2), orphaned, LGBTIQ+, or involved with the juvenile justice system *(33)*. Exposure to some adverse events is more common in LMICs than in HICs, for example child labour, school dropout, child marriage, adolescent pregnancy, experiencing forced migration, and involvement in conflict *(34-36)*.

Of course, many children and young people living in adversity do not have a mental health condition *(6, 7, 14)*. People's resilience relates not only to their personal strengths and innate capacities but also to their broader exposure to protective factors. Many children who experience adversity grow up to become healthy adults in part because the risks to their mental health are buffered by protective factors. Evidence indicates that nurturing caregiving, including emotionally responsive parenting, promotes positive outcomes for children, even in situations of adversity *(29, 34)*. Other protective factors include being in full-time education in a school with a positive learning atmosphere that prevents violence and promote mental health; and involvement in community activities *(14, 37)*. Studies that follow individuals over time have shown that growing up in supportive environments with little conflict likely protects against developing behavioural or emotional disorders in childhood and adolescence *(14)*.

IMPLICATIONS FOR SERVICE DESIGN

- Consider the determinants of mental health among the population served.
- Use an ecological approach, engaging families, schools and communities to promote enabling environments, mobilize resources and address risks.
- Collaborate across sectors and settings to ensure services are integrated, with clear care pathways between different types of services e.g. social protection, housing, education and employment. This will alleviate the burden of care coordination on stressed caregivers and young people.
- Prioritize access for marginalized groups.

See Chapter 4 for more information on standards for mental health care of children and young people.

BOX 2.2.

How gender norms can undermine mental health

Each context has its own gender norms and expectations, which can impact identity development, mental health and help-seeking behaviour *(18)*.

In many cultures, masculine norms encourage risk-taking behaviour. This puts boys at greater risk of substance use disorders, while also making them less likely than girls to seek help for mental health issues, for fear of being seen as weak *(38-40)*.

> *There is the notion that boys must be tough, and if he complains or if he opens up, he would be…mocked...[as] weak. When he knows that he has a problem, but he is not willing to share with anyone... That thing will eat him up. [Young boy] (28).*

Expectations that girls should care for and be subservient to others may make them more sensitive to interpersonal and psychosocial stress *(20, 38, 41)*. Girls in one setting discussed the fundamental disconnect between their desires for autonomy and traditional values that encourage male dominance and control; and how this led to immense distress *(28)*.

In some contexts, girls are more encouraged and supported to express their feelings, and may be more likely to seek help for mental health issues, particularly from friends and family *(28)*. But this pattern is not universal *(42, 43)*.

Pressures and expectations around marriage, employment and economic independence mean harmful gender norms continue to undermine mental health throughout youth *(27)*. Stressful life events that negatively affect agency and choice among girls, such as child marriage and early or unintended childbearing, can drive depression and anxiety *(20, 41, 44)*. Indeed at any age, becoming a parent can be a risky time for mental health.

Harmful gender norms also mean that young people who identify as lesbian, gay, bisexual, transgender, queer and/or intersex (LGBTIQ+) are more likely to experience stigma, violence and rejection from families, neighbours and from health care professionals themselves. This heightens their risk of depression and suicidal thoughts and behaviours, as well as alcohol and drug use *(45, 46)*.

> *Almost every LGBTQ+ person I have known has faced isolation, stigma, bullying and harassment – even within our own families. Our identities have been denied, and we have been pushed to conform. It shouldn't be surprising then that the mental health of LGBTQ+ children and youth is often low. This is not a result of our identities. Our mental health is put at risk by insensitivity, prejudice and oppressive structures that deny us our human rights. [Young girl] (28).*

Strategies to address mental health determinants are beyond the scope of this this service guidance document. Yet it is important to note that any mental health service aimed at children and young people should employ strategies that consider poverty and inequality, promote social inclusion and connectedness, and address structural issues related to housing, education, and employment. This means engaging multiple sectors in mental health service design. For example, complementing mental health care with social welfare and housing for families in financial adversity. Or improving access to housing, schools and other public services to better support caregivers to engage in nurturing care *(47)*.

WHO and UNICEF's Helping Adolescents Thrive initiative emphasizes the importance of developing environments that allow mental health to flourish *(9)*. Modifying children and young people's social environments – in schools, families and online – can mitigate mental health risks and support healthy development. It can facilitate access to resources and support. It can also help build young people's capacity to regulate their behaviours and emotions, which can strengthen their social skills and increases their chances of managing stressful transitions (e.g. moving from primary to secondary school), staying in school, and achieving academically.

2.2.4 Everyone has a right to mental health care within their communities

The Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD) together provide a framework for shaping legislation, policy and planning to ensure rights-based services that have children and young people at their heart.[1] These conventions aim to ensure that children and young people with disabilities, including those with mental health conditions and developmental disabilities, can enjoy all human rights and fundamental freedoms on an equal basis with other children *(48, 49)*.

The CRC and CRPD emphasize the need for countries to:

- enable children and young people using services to participate actively and meaningfully in decisions about their care, including by giving consent, according to their evolving capacities;
- remove barriers, such as stigma and discrimination, that stop children with mental health conditions from being fully included in communities, schools and families;
- develop inclusive community-based resources, such as schools and health and rehabilitation services, that are available and fully accessible to all children and their families;
- recognize that children are best cared for in family environments where they can make the attachments that are critical for them to reach their optimal development; and
- ensure that laws, policies and services do not deprive children and young people seeking mental health care of their rights or subject them to violence or abuse.

Despite widespread ratification of the CRC and CRPD, children and young people with mental health conditions continue to be denied

1 The CRC covers anyone below the age of 18 years unless they have attained majority earlier under applicable law. The CRPD covers people of all age groups, including children and young people.

their human rights, including the right to live in and be included in the community. They are also often subjected serious abuse.

Millions of children and young people with mental health conditions worldwide (and especially in Europe and Central Asia) end up in orphanages and other custodial institutions, even though almost all of them have a living parent (50, 51). This is partly due to stigma, over-reliance on a medical model of disability and entrenched beliefs that institutions provide the best care for children with mental health conditions. Factors such as poverty, migration, discrimination and conflict also put children with mental health conditions at risk of institutionalization *(52)*.

But institutions are rarely conducive to healing *(53)*. They often provide environments that are more neglectful and abusive than they are caring. Children and young people often live far from home, receive little or no education and may even be physically restrained *(54)*. The use of psychotropic medicines as a first-choice treatment is common but often not appropriate. This reliance on institutionalization and medicines reinforces a vicious cycle of exclusion, discrimination, and helplessness.

Community-based mental health care is more accessible and acceptable than institutional care and delivers better outcomes for people with mental health conditions *(7)*. Deinstitutionalizing mental health care for children and young people involves phasing out care in custodial institutions while simultaneously expanding community-based mental-health care. Establishing structures that promote recovery and rehabilitation for children and young people in their communities is critical to ensure children can remain with their families, access health care and education, and be protected from harm.

IMPLICATIONS FOR SERVICE DESIGN

- Ensure all health and non-health settings practise a rights-based approach to mental health care that is person-centred, family-oriented, safe, inclusive, and has recovery as a key outcome.
- Enable children, young people and caregivers to meaningfully participate in planning their own care and in developing mental health services.
- Deinstitutionalize mental health services for children and young people by phasing out custodial institutions while simultaneously expanding community-based mental health care.

See Chapter 3 for more information on designing mental health services for children and young people.

2.3 Barriers to accessing mental health care

2.3.1 Low levels of health literacy in mental health

Mental health literacy includes having a basic knowledge of mental health conditions, understanding how to maintain good mental health, and being aware of when and where to seek help *(55)*. Low levels of mental health literacy are common, even in settings with significant public information and education efforts.

Caregivers, teachers and health workers may not easily recognize common conditions such as depression and anxiety in children and young people because they may present as stomach aches, headaches, irritability, frustration, anger, rapid mood changes, emotional outbursts, destructive or challenging behaviour, and early substance use. This means demand for services can be lower than actual needs. Often, the first time a young person's mental health condition is recognized is when they come to the attention of school, welfare, and youth justice services because of problem behaviour *(56)*.

2.3.2 Poor supply of accessible and acceptable services

In many places, formal mental health services for children and young people simply do not exist. When services are available, they are often inaccessible because of service cost, travel cost, location or opening times *(28)*. Or they are unacceptable to children, young people, and their families because of concerns about quality of care, providers' qualifications, or confidentiality.

Stigma within mental health services can also prevent people from seeking help. So can prevailing beliefs that people should be able to solve their own problems. Children and young people are more willing to seek help for mental health conditions if they feel respected, listened to, and not judged *(27, 57)*. Including individuals with lived experience of mental health conditions and their caregivers in service design is essential to creating services that are available, accessible and acceptable to children and young people *(7)*. It also increases the chances that investments will lead to real impact for health systems, communities and individuals *(58)*.

2.3.3 Lack of inclusive services

Mental health services typically exclude children and young people with neurodevelopmental conditions or disabilities. Yet these individuals often have co-occurring mental health conditions (e.g. depression, anxiety disorder or epilepsy). They are also at higher risk of abuse, neglect and violence; and often have significantly poorer educational outcomes than their peers. Their caregivers face challenges in accessing services for their children and require additional support *(10)*. They are also more likely than other caregivers to experience high levels of stress or to have a mental health condition themselves.

Mental health services should advance the rights and well-being of all children by maximising their developmental potential and promoting their well-being. Services should seek to include children with neurodevelopmental conditions and developmental disabilities by removing barriers to care, promoting enabling environments, using accessible communication methods, and networking with other services to reduce the burden of care coordination on caregivers and young people *(10)*.

2.3.4 Stigma and discrimination

Stigma and discrimination around mental health conditions is pervasive in all countries and acts as a powerful disincentive for children and young people, and their families, to seek help; it can also deter people from providing help *(28)*. Stigma can take different forms in different contexts. It is common among professionals in child-facing services such as teachers, social workers, and health workers who have not received appropriate training, as well as among children, young people and caregivers themselves.

The experience of being stigmatized profoundly undermines physical and psychosocial well-being. It can be more detrimental than the burden of the mental health condition itself and can impede child health and development outcomes *(59)*.

2.3.5 Poor coordination of services at transitional ages

In contexts where child and adolescent mental health services are available, the upper age limit for accessing them is around 18 years, after which a young person must transition to adult services *(60)*. Often, there is a lack of coordination and referral between systems. In some contexts, differing approaches between the two services mean that only young people with the most severe mental health conditions are eligible for adult services.

The lack of coordination between youth and adult mental health care leaves many young people with high levels of need “lost to the system” *(61)*. Interrupted mental health care during late adolescence is associated with more severe and long-lasting mental health conditions, more risky behaviours, more involvement with the justice system, less social support from caregivers, and more use of crisis care, ultimately leading to poor outcomes *(62)*. Those affected are often the most disadvantaged; and the lack of support makes them more likely to end up out of work, school and vocational training *(63, 64)*.

IMPLICATIONS FOR SERVICE DESIGN

- Make services free, accessible, effective and acceptable to the population served.
- Use campaigns and training programmes to raise awareness about mental health conditions among health care providers and the public.
- Design services to meet the needs of children and young people from different backgrounds and groups.
- Involve children, young people and families in the planning, monitoring and evaluation of mental health services using contextually and developmentally appropriate methods.
- Strengthen services by focusing on the needs of children and young people with neurodevelopmental conditions and developmental disabilities.
- Ensure service providers are aware of the multiple and overlapping stigma and discrimination that some groups of children, young people and caregivers face.
- Design mental health services to bridge transitions between youth and adulthood with the goal of enhancing service continuity during periods of increased risk.

See Chapter 4 for more information on standards for mental health care of children and young people.

Photo credit (next page): Young boy holding an umbrella, Bangladesh, 2018.
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3 Designing and delivering mental health services for children and young people's mental health

This chapter focuses on key issues in the design of mental health services for children and young people that are good quality, rights based, developmentally appropriate, gender responsive and evidence based. It outlines principles of service delivery and describes different models for mental health care services, highlighting country examples and good practices.

3.1 Principles for service delivery

For most countries, building mental health care services for children and young people will mean both expanding and reorganizing services. The task is to responsibly phase out services in psychiatric hospitals and other residential institutions while simultaneously scaling up community-based mental health care.

WHO uses the term “community-based mental health care” for any mental health care that is provided outside of a psychiatric hospital (see section 1.2.2). This includes services available through primary health care, specific health programmes (such as adolescent health clinics), general hospitals and social services. It also includes a range of specialist community mental health services, including community mental health centres and teams or early intervention services.

Community-based mental health care promotes social inclusion and allows children and young people to continue their education and maintain relationships with family and friends. In practice, delivering community-based mental health care relies on two principles: (i) establish a network of interconnected services; and (ii) use stepped care and task-sharing.

3.1.1 Network of community-based services

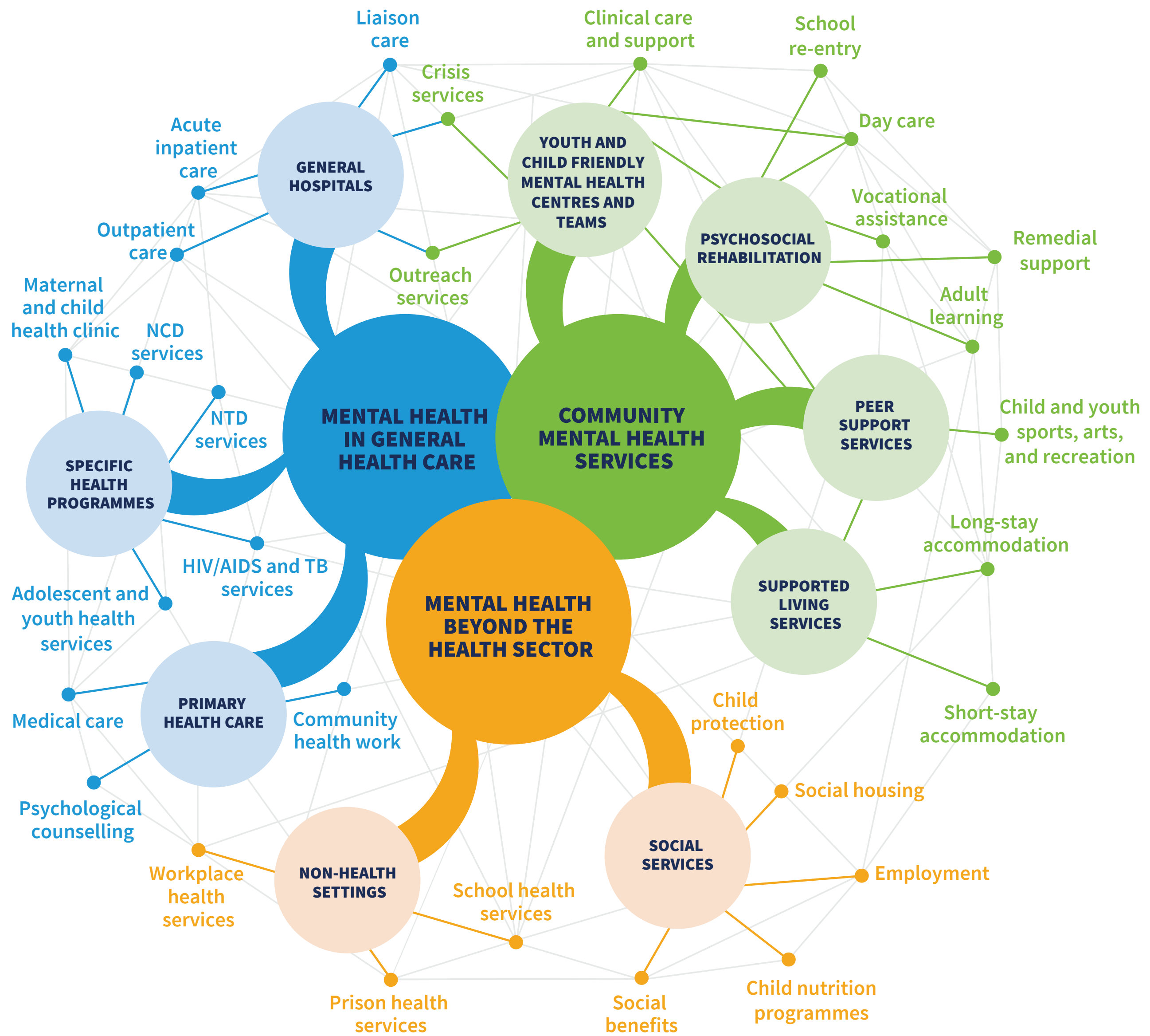
A community-based mental health system for children and young people is a network of interconnected services (see Fig. 3.1). It typically includes a mix of:

- **mental health services that are integrated in general health care**, at primary health care facilities and general hospitals, including within existing specific health programmes, for example for mother and child health (see section 3.2);
- **community mental health services**, which may include community mental health centres or teams (see section 3.3); and
- **services beyond the health sector** that deliver mental health care in non-health settings like schools and youth centres, and that support access to key social services for children and young people and families through social welfare, law enforcement and justice, and community-based organizations (see section 3.4).

The organization of these interconnected services varies worldwide. Primary health care is delivered in many ways and by professionals and paraprofessionals with differing skill sets. The reach of school-based services depends on local norms around school attendance. The optimal design of the network of services will depend on the level of need among children and young people and their families in the population served, and how local services are structured *(65)*.

FIG. 3.1.

Network of community-based mental health services for children and young people's mental health.



Source: adapted from WHO, 2022 *(7)*.

3.1.2 Stepped care and task-sharing

The stepped care model is a well-established and efficient way of organizing mental health services to deliver care. It is based on the principle that the level of care should be matched to the intensity and complexity of a young person's mental health needs. A young person experiencing mild symptoms requires a different level of care to one experiencing a severe mental health condition. In this model, children and young people can move between levels of care based on their progress or changes in symptom intensity.

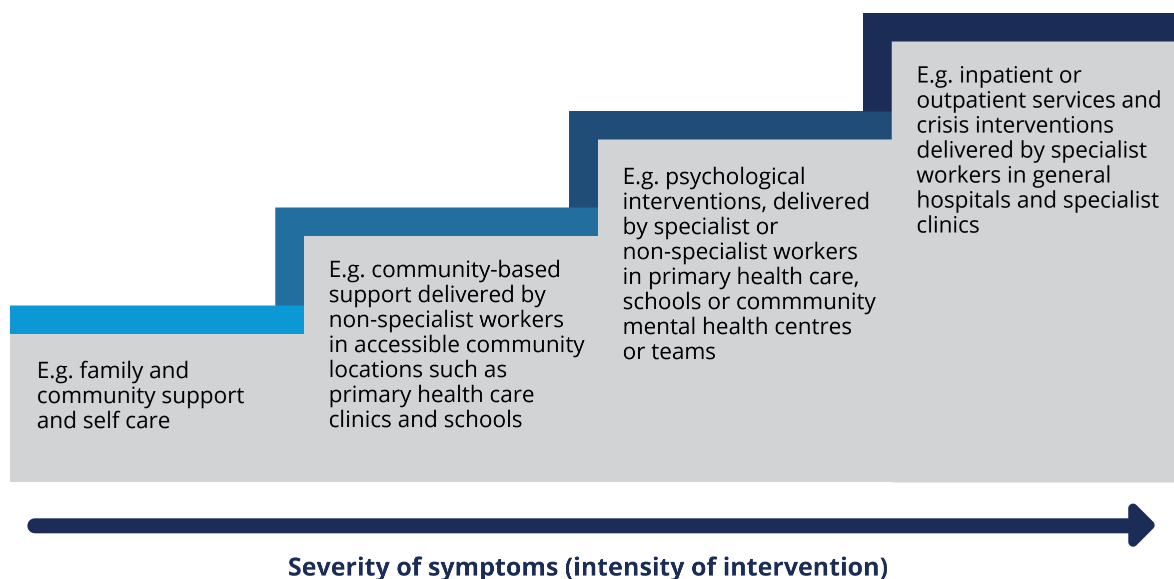
The stepped care model ensures that children and young people receive timely, appropriate care for their needs, and that the available resources for mental health are optimized. It relies on collaboration between service providers, including schools, primary health care, community organizations, and specialized mental health services.

Task-sharing between specialist and non-specialist mental health care providers enables diverse care options of varied intensity *(66)*. For example, children and young people may first be offered a low intensity evidence-based intervention, such as psychoeducation or guided self-help. This is usually delivered by a trained and supervised non-specialist, such as a primary health care worker, counsellor, school nurse, or peer worker. Those individuals who do not respond adequately would then be stepped up to more intensive intervention, such as group counselling, which could also be delivered by a trained and supervised non-specialist. A final step might then be to access support from a mental health specialist for more severe and complex mental health problems (see Fig. 3.2).

It is not always necessary to progress through all steps in the model before accessing specialist mental health support. For example, a young person may progress directly to a crisis response team in the event of a severe condition that benefits from early intervention, such as first episode psychosis (see section 3.3.3).

FIG. 3.2.

An example of stepped care for child and adolescent mental health.



There are many benefits to implementing stepped care and task-sharing.

- Training and supervision of non-specialists in brief, evidence-based interventions helps ensure effectiveness of care.
- Using trained and supervised non-specialists to assess children and young people's mental health and provide evidence-based interventions substantially increases the availability of care.
- By providing care through known, trusted workers in familiar settings, task-sharing decreases stigma and increases the acceptability of the support offered (although in schools care must be taken to ensure children accessing support are not singled out by teachers or peers as this can increase stigma).
- By delivering support locally through primary health care, schools and community-based organizations, task-sharing minimizes the time and cost of care for individuals and their families, increasing the affordability of care.

3.2 Mental health care integrated in general health services

Integrating mental health care into general health services is essential to scale up availability of care, and it is a crucial element of mental health reform *(67, 68)*. Yet in many countries general health care workers receive little to no training in mental health; and any training that is given rarely covers children and young people.

3.2.1 Mental health care in primary health care

Integrating mental health into primary health care can boost mental health promotion and the prevention, early detection and care of common mental health conditions in children and young people. It can, for example, eliminate key barriers to access, including gender-related restrictions that exist for women and girls in some contexts (for example, where access is limited by family members, or where girls are not allowed to attend services alone) *(69)*.

Various approaches are used to integrate mental health care into primary health care. Ideally, primary health care providers are equipped with the skills to combine basic mental health assessment and care with routine physical health care through training and supervision (see section 4.5). They can then integrate mental health care with standard services such as well-child visits. Or they can provide dedicated mental health interventions, such as psychoeducation and family support, in homes or primary health care facilities as needed (see Box 3.1).

Primary health care providers are well-placed to deliver mental health care because they often have insight into the local factors affecting families. Sharing mental health care tasks with them has been shown to boost the overall quality of primary health care, as well as increasing access to mental health care (see Box 3.2).

BOX 3.1.

Nigeria: integrating mental health into primary health care in Benue State

CONTEXT

A largely rural state in a lower-middle income country.

ACTION

Trained community psychiatric nurses provide outpatient mental health services in primary health care clinics, supported by community health care workers and supervised by a psychiatrist and a clinical psychologist.

OUTCOME

Mental health care is accessible in 23 clinics across Benue State, reaching hundreds of children and young people each year.

EVALUATION?

Yes *(70)*.

The Benue State Comprehensive Community Mental Health Programme has been running since 2011. Established in the largely rural state of Benue State, Nigeria – home to an estimated 5.8 million people *(71)* – the programme aims to strengthen mental health care provision by integrating it into the state's primary health care system. The project started as a public–private partnership between the Methodist Church Nigeria, the nongovernment organization CBM, and the Benue State Ministry of Health; after 10 years, it became fully government owned.

Through the programme, more than 200 primary health care providers in more than 100 health facilities across all 23 districts of the state were trained and supervised to provide mental health services for people of all ages *(72)*.

Each district within the state has at least one outpatient clinic that is run by a community psychiatric nurse within a Comprehensive Health Centre. The clinic is the base for mobile outreach services to provide home-based care, community awareness activities, and support for self-help groups (organized by service users and caregivers). In 2020, 935 children and young people (aged 6–25 years) received mental health care through these services; in 2021, it was 609 children and young people (P. Ode, personal communication, 2022).

Each community psychiatric nurse has completed an 18-month psychiatric nursing course, which includes training on child and adolescent mental health. They deliver family education and support, as well as a broad range of psychosocial interventions. Their work is supported by trained community health care workers who also provide services in primary health care facilities outside the Comprehensive Health Centres. Health care workers have undergone basic training on community mental health as part of their degree qualifications and can volunteer for additional brief mental health training based on the WHO mhGAP Intervention Guide (mhGAP-IG) *(70)*.

Health care workers are supervised through biannual visits to the clinics from a psychiatrist, quarterly visits from a clinical psychologist, a quarterly peer review meeting with clinic supervisors, and regular phone contact as needed. A Community Mental Health Project Officer also visits regularly to supervise non-clinical work, such as record-keeping and supplies management (P. Ode, personal communication, 2022).

BOX 3.2.

Haiti: scaling up mental health care through task-sharing

CONTEXT

Lower-middle income country with complex, long-term humanitarian needs.

ACTION

Primary health care workers share mental health tasks with specialists after receiving culturally adapted mental health training.

OUTCOME

A broad range of psychosocial and clinical support services are delivered, reaching up to 400 young people under the age of 18 each year in two of Haiti's poorest regions.

EVALUATION?

Yes *(73)*.

Children and young people in Haiti face a high burden of mental health conditions but low access to services *(74)*. The catastrophic earthquake in 2010 catalysed a response that became a decade-long programme to integrate mental health care into the country's primary health care system. The programme was developed by two nongovernmental organizations – the US-based Partners in Health and Haiti-based Zanmi Lasante – in partnership with the Ministry of Health *(75)*.

Before the programme, primary health care staff were not equipped to provide mental health care, there were no guidelines on care pathways, and the only source of care was at overstretched psychiatric facilities in the capital Port-au-Prince. The programme enabled task-sharing through culturally adapted training in mental health care. Initially, intensive training and supervision in psychosocial assessment and care was prioritized for psychologists, and tailored to the Haitian context, where many individuals seeking help had experienced extensive exposure to traumatic events. Later, trained psychologists became responsible for training and supervising other health workers.

The programme provided a broad range of mental health services for people of all ages, including culturally relevant psychoeducation, psychosocial support, and appropriate clinical services as needed. Stepped care pathways tailored to the Haitian context were used, in which each type of health worker had defined roles and responsibilities. For example, community health workers and teachers were trained to recognize and respond to mental health conditions in children and adolescents. They used a structured screening tool that had local expressions of distress related to depression in Haitian Creole and that had been validated for use in schools *(73)*. They provided basic psychoeducation and care to children, young people and their families, and formed a bridge between the community, schools, and primary health care clinics, referring children and young people to psychologists as needed.

Another approach to achieving integration is to embed dedicated mental health care providers into primary health care. These approaches usually fall into three categories: co-location, consultation and collaborative care.

Co-location

Co-location models involve locating mental health specialists, such as counsellors or psychologists, in primary health care facilities. Co-location can work well if the specialist's care is truly integrated into stepped care and they work with primary health care physicians and off-site specialists, as in the Haitian example in Box 3.2. Depending on the local health system's structure, co-location may involve embedding entire teams of specialists in primary health care facilities (see Box 3.3).

Consultation

Consultation models have mental health specialists on call to advise primary health care providers.

For example, the Massachusetts Child Psychiatry Access Project (MCPAP) provides specialized child and adolescent psychiatry services to primary health care providers across the US state of Massachusetts *(76)*. The project maintains service hubs for geographical regions comprising a child psychiatrist, child and family psychotherapist, and a care coordinator. Primary health care providers can access the service hub via a hotline, and the care coordinator routes the call to the most appropriate team member. MCPAP team members respond to a request for consultation within 30 minutes and often immediately. Depending on the need, the hub can provide support for primary health care or direct care. Hubs also provide training for primary health care providers.

Collaborative care

In collaborative care models, a health team shares tasks to provide mental health care within primary health care. The team typically comprises a care manager and general medical provider based in a primary health care facility, supported by a mental health care specialist (who may be based at a specialist facility). The care manager plays a central role in performing tasks and coordinating care.

Children and young people receiving collaborative care will be assessed for a mental health condition by the care manager or general medical provider. Depending on their needs, they may receive evidence-based psychological interventions and be linked with relevant resources in the community to address any social or other needs. Regular meetings with the specialist are used to receive supervision, review cases and adjust care plans as appropriate (see Box 3.4).

A large body of evidence – including in LMICs – supports the use of collaborative care for adults with depression and other common mental health conditions *(77)*. There is evidence that collaborative care is also effective and cost–effective for children and young people *(78)*. Research is underway to assess the best way of scaling it up *(79)*.

How tasks are allocated in collaborative care varies depending on local contexts, including the availability of local resources and socio-cultural considerations. For example, the task of delivering psychosocial interventions may be allocated to care managers (see Box 3.4) or to general practitioners (see Box 3.5). In all cases, the general medical care provider is responsible for any medicines.

In all models of collaborative care, the role of the mental health care specialist is to provide advice and supervision to non-specialist team members. Maintaining a robust and accurate record of cases is essential so that the team can review progress efficiently and adjust care plans as needed. Referrals for more specialist care are kept to a

BOX 3.3.

Bosnia and Herzegovina: primary health care mental health centres

CONTEXT

An upper-middle income country recovering from the impacts of armed conflict.

ACTION

Psychiatrists, psychologists and nurses working in community mental health centres were trained in child and adolescent mental health; and intersectoral collaboration was increased to promote mental health among children and young people.

OUTCOME

Significant improvements for children and young people experiencing mental health conditions.

Against the backdrop of war, mental health reform began in Bosnia and Herzegovina in 1996. This eventually led to a nationwide network of 74 mental health centres that are embedded within primary health care facilities and funded from the public health budget. Person-centred, recovery-oriented care at the centres is provided by multidisciplinary teams of psychiatrists, psychologists, nurses and social workers, who also coordinate mental health promotion and prevention efforts. From 2010 to 2022, this transformation was supported by the Swiss Agency for Development and Cooperation, through a programme that focused on improving and expanding existing services, without creating parallel structures.

Since 2020, the focus for reform has shifted to improving and expanding services for children, young people and their families at the primary health care level. This has included expansion of training of health workers in child and adolescent mental health and has led to documented improvements in mental health outcomes for children and young people. The mental health reforms have fuelled intersectoral collaboration, with mental health centres increasingly working with sectors such as social welfare, education and local government. This has, for example, enabled universal prevention and promotion programmes in schools, including focused activities – such as peer violence prevention and gambling prevention – to fit local needs.

Mental health care provision has also expanded beyond the mental health centres. For example, a counselling centre has been established at the University of Banja Luka following research revealing a high prevalence of mental health conditions among students. The centre also offers an opportunity to supervise psychotherapists in training (DH Hasečić, personal communication, 2022).

BOX 3.4.

Nepal: collaborative care in a general hospital's primary health care clinic

CONTEXT

Rural area in a lower-middle income country.

ACTION

Collaborative care was provided by psychosocial counsellors and general practitioners at a primary health care clinic in a district hospital, supervised by an off-site psychiatrist.

OUTCOME

Improved accessibility and acceptability of mental health care.

EVALUATION?

Yes *(80)*.

In the government-run, district hospital of Achham, one of Nepal's poorest regions, collaborative care transformed services for young people and adults. The hospital sees more than 100 000 outpatient visits each year and is staffed by 15–20 physicians and health assistants (health care workers with 3 years of medical training). Access to mental health care here is limited, with the nearest psychiatrist 14 hours away by road *(80)*.

The collaborative care model was implemented in the hospital's primary health care clinic. Psychosocial counsellors with 3–6 months of training were recruited as care managers to coordinate care and provide psychosocial evaluations and support using relaxation techniques, psychoeducation, and brief psychological interventions. An off-site consultant psychiatrist fulfilled the role of mental health specialist in the collaborative care team.

When individuals arrived at the clinic, they were seen by a general practitioner or health assistant, who screened for mental health conditions and directed the person to the psychosocial counsellor as appropriate. The counsellor did a thorough psychosocial assessment with validated tools and, where needed, worked with the person and the physician to draw up a care plan on the same day. The off-site psychiatrist met the counsellor each week to review cases, provide supervision and adjust care plans as needed. A key part of the programme was that rather than using case meetings to simply issue instructions, the psychiatrist would support ongoing learning, for example by explaining why adjustments were necessary. This built capacity and increased buy in among the team at the primary health care level. The psychiatrist also attended the hospital quarterly for in-person training and supervision.

By providing care at the local level, the programme increased accessibility and acceptability of care, while the specialist input ensured quality. Evaluation of the programme found it improved clinical outcomes for people with depression. An early challenge was that staff were used to a hierarchical structure and working individually. Regular case meetings allowed the care manager and specialist to discuss people's progress from their own perspective, which improved understanding of each other's role and facilitated respect and team working.

BOX 3.5.

Iran: general practitioners providing collaborative care

CONTEXT

Capital city in a lower-middle income country.

ACTION

Collaborative care is provided in 60 health clinics by general practitioners trained in child and adolescent mental health, supported by receptionists trained as care managers.

OUTCOME

children and families can access more accessible and acceptable mental health care, enabling whole-of-family care at the primary health care level.

EVALUATION?

Yes *(81, 82)*.

The Tehran University Collaborative Care Programme (TUCCP) is an established service through which more than 60 urban general practitioners provide first-line mental health care. In this model, the practice receptionists have been trained to act as care managers: they follow up on service users by phone to check their status, reinforce interventions, and remind them of appointments. The primary health care team record each person's care plan and progress in an information system shared with the local community mental health centre. A psychologist and psychiatrist from that centre regularly monitors this information and meets the general practitioners to review cases and discuss management.

Initially, this collaborative care was for adults only and general practitioners were advised to refer children and young people to the local community mental health centre. But it soon became clear that this was creating a large unmet need. General practitioners reported that parents would often refuse referral because of distance, stigma and concerns that specialists would offer medicines rather than psychosocial interventions. At the same time, specialists at the community mental health centre reported that, of the small number of children and young people referred, more than 75% had conditions that could be treated in primary health care. As a result, the TUCCP was expanded. General practitioners were trained to provide direct care for common mental health conditions in children and young people, enabling whole-of-family care at the primary health care level.

A randomized controlled trial of the expanded programme found that children receiving care from these trained general practitioners were more likely to access support for mental health concerns than children receiving care from general practitioners who relied on referral. Mental health outcomes however were similar for both groups of children. Although when looking at a subset of general practitioners with more children as patients, researchers found that children attending trained practitioners had better outcomes than those attending referral-only practitioners. *(81, 82)*.

minimum because their care and progress have been reviewed by the mental health specialist.

The specialist does not have to be on site so, assuming there is good internet access or other ways to connect, collaborative care can be used to provide mental health care in rural, remote, or sparsely populated areas. For example, in Kosrae – a remote island state of the Federated States of Micronesia that is accessible only by air or sea – collaborative care has been achieved using a videoconferencing system. The care manager was a clinical psychologist at the primary health care centre on the island and the specialist role was fulfilled by staff at the University of Hawaii's Department of Psychiatry *(83)*.

In Araucanía, Chile, it is shared electronic health records that enabled collaborative care for adolescents with depression. The remote region is the poorest in Chile and has the highest number of suicides in children and adolescents. Specialists at the Universidad de Chile's Faculty of Medicine and primary health care providers used a secure virtual environment as a discussion forum, enabling confidential, real-time discussions of case management *(84)*.

3.2.2 Mental health care in specific health programmes

Integrating mental health in health care programmes for people with specific physical conditions has proven feasible and cost–effective, improving both mental and physical health *(85-87)*. For children, young people and families, mental health care provided as an integral part of routine physical health care may be more acceptable and accessible than through separate services *(88)*. Importantly, using an integrated care approach can be a more efficient way of delivering services that reach children and young people at higher risk of mental health conditions.

There are two broad categories of mental health services integrated into specific health programmes. The first is integration in programmes for defined populations, such as services for pregnant adolescents. The second is integration in disease-specific programmes, such as services for young people living with HIV or TB.

Mental health services for perinatal mental health

Around 21 million girls aged 15–19 years in LMICs become pregnant every year, and approximately 12 million of them give birth, most of whom are in sub-Saharan Africa *(89)*. Adolescent pregnancy can have serious health, social and economic consequences for individuals, families and communities *(89)*. Complications from pregnancy and childbirth are the leading cause of death in girls aged 15–19 years globally *(90)*, and there are higher infant mortality rates among children born to adolescents in sub-Saharan Africa and south Asia *(91)*.

Depression and anxiety during pregnancy, birth, and early parenthood are common, affecting an estimated 10% of pregnant women in HICs and 20% in LMICs *(92)*. Pregnancy at ages 12–24 years is associated with a 30% higher prevalence of mental health conditions than in adult or non-pregnant women *(93)*. Girls in many LMIC settings face additional stressors that negatively affect their mental health, including poverty, stigma, family and community rejection, school exclusion and drop-out, intimate partner violence, and living with HIV *(94)*.

Left untreated, mental health conditions can have significant, intergenerational, adverse effects on both mother and child. WHO emphasizes the need to integrate mental health care into perinatal

services, including for adolescents *(92)*. An example of the type of comprehensive, integrated services required is described in Box 3.6.

Mental health in HIV care

In 2022, 2.58 million children and adolescents aged 0–19 years were living with HIV *(95)*. Among adolescents living with HIV in eight countries in sub-Saharan Africa, 30–50% have behavioural or emotional distress and 25% meet the criteria for diagnosis of a mental disorder. Increased access to antiretroviral therapy and HIV care has enabled these young people to survive, but mental health support is needed if they are thrive).

The opportunities offered by integrating mental health in adolescent HIV services are now well recognized, and the most recent WHO guidelines strongly recommend that psychosocial interventions should be provided to all adolescents and young adults living with HIV *(96)*. Documented approaches and examples of such integration exist (see Box 3.7). Identifying emerging best practices and strategic actions to ensure that sustained investments in the health and well-being of young people are important to building and expanding access to mental health and HIV services *(97)*.

3.2.3 Mental health care in general hospitals

Children and young people with more complex needs require clear care pathways that allow step up to community-based secondary level mental health services.

Mental health care professionals in general hospitals can have multiple roles in delivering such services for children and young people. They provide outpatient care to assess and manage children and young people with complex or severe needs that cannot be dealt with in primary health care. They provide short-term inpatient care for children and young people experiencing acute episodes or mental health crises that may benefit from hospitalisation. They support the long-term care of children and young people living with chronic mental health conditions in cases where community mental health service cannot help sufficiently. They provide liaison psychiatric care for children and young people hospitalized for physical health problems.

General hospitals may also host mobile teams to provide outreach or crisis services in the community (see section 3.3.2 and 3.3.4). Such teams may be large and multidisciplinary, comprising a psychiatrist, psychologist, psychiatric nurse, social worker, special needs teacher and various other professionals. Or they may be much smaller and made up of one or two mental health professionals that focus on specific services.

In addition to directly providing care, mental health specialists in general hospitals help ensure mental health care throughout the community-based mental health system by providing training, supportive supervision and mentoring for non-specialist providers working in primary health care or other settings where children and young people in need may be found, such as schools, one-stop centres, and juvenile detention facilities. Specialists in general hospitals should also be involved in the pre-service education of future health professionals (see section 4.5.1). They may have a coordinating role for the area they cover.

Mental health services based in general hospitals are usually well accepted by communities and provide the opportunity for integrated care to address mental and physical health

BOX 3.6.

South Africa: supporting perinatal mental health for adolescent girls

CONTEXT

Urban area in an upper-middle income country.

ACTIONS

A comprehensive, stepped care mental health service was integrated into maternity care, with referral to support organizations in other sectors as needed.

OUTCOME

All young women using the service receive tailored mental health support, as well as support in other areas.

Each year, around 2 000 pregnant women and adolescents, including some 150 12–18-year-olds, receive antenatal care at Hanover Park Midwife Obstetric Unit (MOU) – a community-based maternity clinic in Cape Town, South Africa run by the provincial Department of Health. The legacy of Apartheid has left areas like Hanover Park contending with high rates of gang-related crime, unemployment, poverty, domestic and sexual violence, and alcohol and drug abuse.

Around a third of the individuals using the MOU experience symptoms of perinatal mental conditions such as depression and anxiety. A comprehensive, stepped care mental health service provided by the Perinatal Mental Health Project (PMHP) was integrated in the MOU's maternity care offerings. All health care workers at the unit were trained in maternal mental health, including on the specific needs of adolescents and those experiencing gender-based violence.

They reviewed people coming for their first appointment and offered targeted screening. All adolescents (regardless of their screening results) were offered an EAT (engage, assess, and triage) session with a counsellor, who engaged empathically with the individual to assess her needs and arrange needs-based support. Girls requiring additional care were referred to for psychological interventions. To increase the service's uptake, counselling sessions were set to coincide as far as possible with scheduled antenatal visits, with out-of-schedule visits available for crises situations.

Extra support could be provided via referrals to the community mental health team at the adjacent health centre and to nongovernmental organizations and other agencies for specific needs such as food support, social work, and housing shelters for those experiencing violence at home. Counsellors, as much as possible, would engage with the adolescent's family, sometimes providing family counselling, to optimize support during pregnancy, labour and postpartum. The possibility of returning to school also formed part of the therapeutic process (S Honikman & L Hermanus, personal communication, 2022).

BOX 3.7.

Zimbabwe: delivering mental health care to young people living with HIV

CONTEXT

Nationwide in a low-income country.

ACTION

Two mentoring programmes use trained peer counsellors to provide mental health support for adolescents living with HIV.

OUTCOME

Improved physical and mental health outcomes for participating adolescents.

EVALUATION?

Yes *(98)*

The Zvandiri programme in Zimbabwe aims to provide health, happiness, and hope for children and young people living with HIV. The programme, which is integrated in government HIV services nationwide, is delivered by trained youth lay counsellors aged 18–24 years who are living with HIV, called community adolescent treatment supporters (CATS). CATS are trained and employed by the Ministry of Health and Child Care. They work out of health facilities and are supervised by government health care workers. CATS connect with their peers in homes, clinics, support groups and through mobile health services. The Zvandiri approach has been adopted by ten other countries in sub-Saharan Africa *(99)*.

Research has shown the Zvandiri programme to be better than standard care at improving HIV viral suppression in adolescents – but no more effective in reducing common mental health conditions *(100)*. This led to a cross-pollination partnership with another well-established Zimbabwean programme – the Friendship Bench.

The Friendship Bench is an evidence- and community-based service that was developed and scaled up in Zimbabwe and then implemented in other countries *(101, 102)*. Since 2019, Friendship Bench has worked in partnership with the Zimbabwe Ministry of Health and Child Care. Trained lay counsellors deliver a brief six-session programme of problem-solving therapy on wooden benches in the grounds of primary health care facilities, to people referred by the primary health care providers. All people are screened with a questionnaire, which combines items common in psychiatric screening questionnaires, such as problems with concentration, with terms in the local Shona language, such as kufungisisa (thinking too much). For most individuals, the lay counselling is sufficient, but people whose score indicates specialist care are referred to mental health specialists.

In the original Friendship Bench model, the lay counsellors were older women, known as "grandmothers". When it was adapted for younger people, CATS were brought in as a new type of peer support worker or "buddy". Buddies are mainly psychology and sociology students and their training is the same as for grandmothers, but with added focus on issues like relationships, sexuality, young parenthood and bullying *(103)*.

A cluster randomized controlled trial involving adolescents living with HIV and taking antiretroviral therapy compared the effects of usual Zvandiri CATS care with CATS who had been trained to provide the Friendship Bench programme. After a year, unsuppressed HIV viral load was low in both groups. While mental health also improved in both groups, the outcomes were significantly better among the adolescents whose peer supporters had been trained in the Friendship Bench approach *(98)*.

problems simultaneously including via the emergency department. In all cases, the type of mental health services provided in general hospitals should reflect the needs of the families and children and young people in the local population. To that end, when designing such services it is critical to engage young service users and families in planning (see section 4.3).

3.3 Community mental health services

Community mental health services provide secondary care and can be delivered in various ways including through community mental health centres and teams.

3.3.1 Community mental health centres

Unlike general hospitals, community mental health centres usually provide specialist services for children and young people at physically separate facilities (see Box 3.8 and Box 3.9).

This is important because children and young people may be deterred from seeking care when youth services are co-located with services for adults. If care for the services for both age groups need to be located in the same community mental health centre, separate entrances and waiting areas for the two services can be a solution.

3.3.2 Community mental health teams

Community mental health teams are groups of practitioners who provide a broad range of interventions to the population within a defined geographical area. These teams may provide regular outreach clinics at convenient locations, such as community health centres in rural areas, which are easier for families to access than the nearest hospital. They may also provide home-based specialist care and support, which can be less distressing for individuals than visiting a hospital or clinic. Home-based care also allows the mental health team to understand the living situation of the child or young person and their family.

Home-based specialist care for children and young people is more common in HICs than LMICs (see Box 3.10). The United Kingdom, for example, offers it as part of its routine mental health services. In Austria, a home-based service for children and young people was launched in 2021 as a way of rapidly expanding mental health care in response to rising demand prompted by the COVID-19 pandemic *(104)*. The Czechia and Portugal have similarly piloted multidisciplinary mental health teams for children and adults *(105)*.

Even in LMICs, such as Georgia, South Africa and Ukraine, the use of community mental health teams can be found. Where such teams include expertise in child and adolescent mental health, they can offer an important way of bringing specialist care to children and young people.

The composition of community mental health teams, and the services they offer, vary.

BOX 3.8.

Brazil: nationwide community mental health centres for children and adolescents

CONTEXT

Nationwide in an upper-middle income country.

ACTION

Community mental health centres were established to provide multidisciplinary care for children and young people with severe mental health conditions, and to coordinate local provision of mental health services across relevant sectors.

OUTCOME

Children and families have access to an individualized plan of care and community inclusion, with very little hospitalization.

EVALUATION?

Yes (106).

For children and young people with mental health needs in Brazil, day care at the nearest community child psychosocial care centre (Centro de Atenção Psicossocial Infantil, CAPSi) is available free of charge. CAPSi are available nationwide and families and children and adolescents can access them directly, or through referral from another agency *(107)*.

Each CAPSi aims to be a colourful, welcoming centre for children and adolescents that provides a range of activities to promote recovery and social inclusion, such as music, dancing, sports, cooking, crafts, arts, and trips to the cinema, swimming pool, or park. The emphasis is on providing a child- and family-friendly environment and avoiding any resemblance to a hospital clinic. CAPSi are part of the nationwide community mental health centres (CAPS) that cover all age groups. Most CAPS are physically separate from general hospitals, and even those that are linked to a hospital must be housed separately, with their own entrance and team of staff.

Each CAPSi provides services for a designated population with a dual mandate to: (i) provide multidisciplinary care for children and adolescents with severe mental health conditions; and (ii) coordinate and strengthen the local provision of mental health services across relevant sectors, such as health, social welfare, education and justice. This includes activities such as training and supervising non-specialists working in primary health care.

Each CAPSi is staffed by a multidisciplinary team comprising a child and adolescent psychiatrist and nurse, and a mix of other professionals such as psychologists, social workers, occupational therapists, speech therapists, and teachers. Designated members of the team are on call to coordinate care in case of emergencies. CAPSi services also include home visits and home-based care. Together with the individual and their family, the CAPSi team develops an individualized plan of care and community inclusion for the child or adolescent.

Psychosocial support is delivered in individual and group formats and caregivers and families also receive support. Since each CAPSi is the focal point for intersectoral collaboration in the local area, it can coordinate an integrated package of services from the other child-facing sectors.

Since establishing the CAPSi network, children and adolescents are rarely hospitalized; when they are, it is almost always in a general hospital and for an average of just one week *(108)*.

BOX 3.9

Republic of Korea: Community-based, youth-specific early intervention centres

CONTEXT

An urban area in a high-income country.

ACTION

A community-based, early intervention centre specifically for young people aged 15–30 years was established to provide mental health care alongside health, education and employment support, separate from community mental health centres for adults.

OUTCOME

Greater accessibility and acceptability of services, leading to increased uptake and plans to roll out the service nationwide.

EVALUATION?

Yes.

In 2016, the first Mindlink centre opened in Gwangju city, Republic of Korea. Mindlink was the country's first community-based, early intervention centre to offer services specifically for young people. A formal evaluation of the centre's effectiveness in 2019 prompted the government to prioritize youth mental health, and new Mindlink centres are being established in other metropolitan provinces.

Mindlink was conceived after young people were found to be reluctant to use the country's existing community mental health centres that mainly serve adults. A pilot of an early intervention youth team at the Gwangju community mental health centre had successfully increased the enrolment of young people, but stigma was still high, and a youth-focused approach was difficult to maintain when many of the centre's attendees were significantly older. It was clear that a separate facility was needed.

The Gwangju Mindlink centre is located near a large university and offers mental health care alongside a range of health, education and employment support to young people aged 15–30 years. It is staffed by social workers and psychologists, alongside a nurse and peer support specialist. Five psychiatrists work at the centre for half a day each week, and are involved in group therapy, assessment of new clients, and supervision.

Mindlink was developed in collaboration with Orygen, an Australian research institute and non-profit organization. Significant changes were made to tailor the programme to Korean culture, including adapting and validating screening tools. To fit with the role of parents in the lives of Korean youth, culturally appropriate family intervention programmes were developed. Accessibility is also increased through a range of digital services.

The impact of moving to a more acceptable, youth-friendly model is evident from the proportion of self- and family-referrals, which rose from 14% in 2016–2017 to 52% in 2018–2019. Ongoing monitoring and evaluation of the service not only ensures the quality of care being provided, it has also resulted in a robust evidence base showing the importance of early intervention and persuading government officials to invest in expanding the Mindlink model (SW Kim, personal communication, 2022).

BOX 3.10

Netherlands (Kingdom of the) : flexible assertive community treatment (F-ACT) for youth

CONTEXT

Nationwide in a high-income country.

ACTION

Multidisciplinary teams work with young people experiencing severe mental health conditions and other complex needs, focusing on supporting the young person's developmental needs as they move to independence.

OUTCOME

Effective multisectoral coordination means that the needs of young people are met holistically, while flexibility allows care to shift between routine case management and more intensive team care.

EVALUATION?

Yes *(109)*.

F-ACT services started in the Netherlands (Kingdom of the) in 2003. By 2023 there were around 200 teams in operation, with plans for further expansion *(109)*. The youth version for people aged up to 24 years was introduced in 2011, with 60 teams in operation *(110)*. It has a special focus on supporting the developmental needs of young people. This includes moving from family dependence to autonomy; stimulating contact with peers; participating in education or work; and developing leisure activities. Personal growth and strengths are also emphasized *(111)*.

Youth F-ACT supports a subset of young people with severe mental health conditions who also have problems with education, employment, peer relationships, family, housing, finances, health, substance abuse, and the criminal justice system. The resulting complex array of services is challenging for young people and their families to navigate; and also for primary health care providers to coordinate, and young people frequently disengage from services. Youth F-ACT was designed to meet the many needs of this group in an integrated way *(111)*.

Youth F-ACT works through multidisciplinary teams made up of psychiatrists, nurses, psychologists, employment specialists, psychiatric nurses, addiction specialists, peer support workers, social workers, and family and systemic therapists. Each team collaborates with professionals from other services and coordinates support for the multiple needs of the young person. Team members visit the young person at their home or at other preferred locations to build and maintain trust with them and their family; and to motivate the person to receive treatment and support.

Mental health workers have a small case load and the intensity of care they provide can be stepped up or down, as needed. When a young person is going through a period of intensive care, their case is discussed daily and team members can be added, as needed, to provide specific elements of care. When the crisis or the need for intensive care is over, individual case management is resumed. Since F-ACT is a long-term service that provides support for years, the young person and their family get uninterrupted support from the same team, and in crisis situations they are helped by professionals they already know.

A 2023 evaluation found that F-ACT clients had improved social interaction with peers, quality of life, and feelings of empowerment *(112)*. They also had fewer contacts with the police/legal system, and experienced fewer psychosocial difficulties, depressive symptoms, and subclinical psychosis symptoms.

For example, medium-term multisectoral services (usually 3–6 months) have emerged as a viable alternative to hospital admission. Members of the community mental health team work together to provide early, multidisciplinary interventions involving the family, for example multisystemic therapy (MST).

Longer-term services provide children or young people with a multidisciplinary case management team that coordinates their care using a person-centred, recovery-based approach to support multiple needs. Condition-specific services enable specialized early interventions for children and young people experiencing specific mental health conditions, such as psychosis and eating disorders (see section 3.3.3).

3.3.3 Early interventions for specific mental health conditions

For certain mental health conditions that emerge in adolescence and early adulthood, prompt detection and evidence-based care is essential. The division of mental health services between child and adolescent and adult at the age of 18 years significantly interferes with this approach.

Community-based early intervention services for young people originally emerged to treat psychosis, revolutionizing care in many countries including Australia, Canada, India and the United Kingdom. They have since also been developed for eating disorders and depression *(113)*.

Early intervention services for psychosis

With prompt, community-based care, many young people recover from a first episode of psychosis and do not experience another episode. Community-based, youth-friendly, recovery-focused services were pioneered three decades ago by the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne, Australia. EPPIC provides early detection and evidence-based care in the community for those aged 12–25 years experiencing a first episode of psychosis. Since EPPIC launched, many specialist early psychosis centres have opened in HICs. They have proven to be effective and cost–effective *(114)*. Yet services in LMICs are rarely available *(115)*. Examples from Canada and India have comparable results, despite functioning in very different settings (see Box 3.11).

Eating disorder services

Eating disorders are especially common in high-income countries where, like psychoses, they benefit from early intervention and are can be effectively treated on an outpatient basis (see Box 3.12) *(116)*.

Restructuring eating disorder services from an inpatient model to an outpatient, community-based model can be complex and treatments also require adaptation to local contexts. For example, restructuring in Singapore included adapting Family-Based Therapy to account for local family structures in which extended family members and domestic helpers are heavily involved in childcare. Schools were engaged to encourage families to seek treatment, helping families prioritize mental health care over school, and implementing meal support at school *(117)*.

Examples from countries such as Mexico show that community-based early intervention services are also possible in LMICs (see Box 3.13).

BOX 3.11

India and Canada: comparing early intervention services for first-episode psychosis

CONTEXT

Urban areas in a lower-middle income country and a high-income country.

ACTION

Early intervention services for young people with first-episode psychosis, using a mix of medication, case management, family interventions and cognitive behavioural therapy (CBT).

OUTCOME

Young people in India fared better than young people in Canada, with lower remission for negative symptoms, more consistent family engagement, and fewer individuals dropping out of the programme.

EVALUATION?

Yes *(118)*.

The Schizophrenia Research Foundation (SCARF) early intervention service for young people with first-episode psychosis in Chennai, India has shown that outcomes in LMIC settings can be better than those in HIC settings.

The SCARF service was based on the Prevention and Early Intervention for Psychosis (PEPP) in Montreal, Canada. It was adapted to the Indian context and resource constraints. Both sites provide free care based on international standards for early psychosis services and accept referrals of any kind, including self-referrals. Both sites use the same service model: the lowest effective doses of second-generation antipsychotic medicines, case management, family psychoeducation and individual family intervention, CBT when indicated, and an overall recovery programme.

Since both Indian and Canadian services have been running in parallel for several years, their outcomes can be compared. Studies show that young people in Chennai fared significantly better than their counterparts in Montreal, with more than 80% in remission for negative symptoms at three months compared with 39% of young people in Montreal *(115)*.

Families in Chennai were also significantly more likely to stay in touch with the mental health team than families in Montreal. In 80% of cases in Chennai, family members participated in monthly follow-up meetings for the entire duration of the young person's care, which ranged from 4–25 months. In Montreal, only 4% of families maintained contact for the full length of care.

Disengagement with services was also more likely in Montreal. Fewer young people with first-episode psychosis dropped out in Chennai than in Montreal. More follow-up contact with the clinic team was done by phone than in person in Chennai, which may have been an important facilitator for individuals for whom distance, travel costs, and interruption of social reintegration are barriers to using in-person specialist services *(118)*.

BOX 3.12

United Kingdom: early intervention services for eating disorders

CONTEXT

Capital city in a high-income country.

ACTION

Specialist outpatient service for children and adolescents experiencing eating disorders, comprising family-based therapy, individual interventions and, where necessary, an intensive day programme of enhanced support or brief inpatient care.

OUTCOME

Symptomatic remission, body image, body-mass index, co-morbid mental health conditions, functioning and quality of life.

Serving a population of about 2.2 million people, the Maudsley Centre for Child and Adolescent Eating Disorders in London, UK is one example of a community-based specialist service for eating disorders in a high-income setting. Care at the centre is provided by a multidisciplinary team that looks after the young person's mental and physical health, and offers a range of family-based and individual psychological treatments, depending on need. Most young people who go to the centre have anorexia nervosa and many also have other mental health symptoms. Most receive Family-Based Therapy and the programme of care is completed entirely in the outpatient setting *(119)*.

Around 10% of young people – usually those with more severe problems at the outset – require enhanced support. This is provided through an intensive day programme in which young people can attend the centre up to five days a week for a highly structured timetable of education, therapy, group meetings and positive meal support. A parents' group offers support and practical advice; caregivers are also invited to participate in the day programme, for example by bringing in a family meal once a week *(120)*. Less than 4% of young people going to the centre require brief inpatient care, which is provided in a general psychiatric adolescent unit or a specialist adolescent eating disorders unit.

Most young people are discharged from the Maudsley Centre to primary health care if no further mental health care is needed. For some, additional support is needed for mental health conditions other than eating disorders and this is provided by community child and adolescent mental health services, or by adult eating disorder services if they have reached the age of 18 years *(119)*. At nearly seven years follow up, most young people were doing relatively well, performing similarly to their peers at school and work and with few reporting a diagnosable eating disorder. Around 70% had sought help for other mental health difficulties *(121)*.

BOX 3.13

Mexico: community-based specialist service for eating disorders

CONTEXT

Urban area in an upper-middle income country.

ACTION

Specialist, non-hospital-based service for eating disorders run by a multidisciplinary team.

OUTCOME

Service users have access to community support and a crisis intervention programme.

Comenzar de Nuevo in Monterrey, Mexico, is a specialist service for eating disorders in a non-hospital setting. Young people using the service come from all over Mexico and 11 other Latin American countries. Care is provided by a multidisciplinary team of doctors, nutritionists, psychologists, family therapists, therapeutic and nutritional companions, nurses, occupational therapists, exercise therapists and other support professionals specialized in treating eating disorders. The centre also provides community support via a helpline and has a specialist crisis intervention programme for mental health and medical emergencies associated with eating disorders.

Involving families and caregivers to develop a strong support system for the young person is an essential component of the care provided. Caregivers are helped to develop practical supportive skills and a psychoeducation programme is delivered through family days, nutrition groups, and support and crisis intervention groups for caregivers.

In addition to providing clinical services, Comenzar de Nuevo is active in research, prevention, and advocacy to increase awareness of eating disorders and access to services. A major focus is providing evidence-based information to parents, carers, educators, and the public (EM Trujillo Chi Vacuán, personal communication, 2022).

3.3.4 Crisis services

> *"From personal experience, what happens when someone is at crisis point and what response they receive can dramatically affect the rest of their lives. A kind, compassionate, caring, and effective response followed by the right support can transform lives for the better." [Person with lived experience] (122).*

Crisis services that support children and young people experiencing acute mental health needs are a critical component of community-based mental health care. Without them, law enforcement is often the default response to children and young people in crisis, which can simply increase the individual's distress *(123).*

Community-based crisis services should aim to provide a timely response, be age appropriate and needs led, have a single point of access, be accessible 24 hours a day and seven days a week, involve multi-agency working, be staffed by suitably qualified and experienced health workers, and involve crisis planning and risk assessment using evidence-based practice *(124)*.

Crisis services must be equipped to care for mental health crises in children and young people. In practice, this means training staff to provide developmentally appropriate crisis mental health care and having access to essential medicines.

Too often, the focus in emergency departments and other community-based crisis settings is on resolving the immediate crisis rather than initiating a package of care to reduce the risk of recurrence *(123)*. As a result, in some locations, nearly half of all child and adolescent mental health visits to emergency departments are repeat visits *(125)*.

Efforts to improve emergency departments include:

- improving the environment by creating a separate quiet area for children and families;
- education and training for frontline workers who might deal with crisis situations
- training and collaborative working with off-site specialists, including tele-mental health *(124).*

Importantly, emergency departments should be networked with specialist outpatient care services with the capacity for urgent referrals. In these rapid-response services, a child and adolescent psychiatrist and nurse follow up with the individual immediately after assessment in the emergency department. The child or young person's care then continues with the same team over the long term, during which time the child or young person can quickly contact the team in the event of another crisis *(126)*. This follow-up care can be home-based, clinic-based, or a mixture of both.

The challenge with this approach is the limited supply of child and adolescent mental health specialists, which means that specialist services are often unable to accept urgent referrals to community-based care. The demand for follow-up care can fast outstrip supply. An innovative solution to this is to create a buffer service that provides temporary care to fill the gap between emergency and longer-term specialist services (see Box 3.14).

Mobile response teams

Mobile response teams provide an emergency version of home-based care. Introducing this type of service has shown many benefits, including fewer emergency department visits *(127)*.

BOX 3.14

France: a buffer service for younger adolescents in crisis

CONTEXT

Capital city in a high-income country.

ACTION

Short-term, multidisciplinary day service for younger adolescents and their families in crisis.

OUTCOME

Adolescents can access temporary care with an individualized care plan, until transition to longer term services is possible.

The COVID-19 pandemic prompted a significant increase in children and young people requiring crisis mental health care in Paris, France. Demand for follow-up care quickly outstripped the supply of services available, and emergency departments had nowhere to refer the children and young people. Accueil Temporaire Rapide Ados Parisiens (ATRAP) was set up as a short-term day service for adolescents aged 10–15 years in crisis when there was no service availability in their local area (128).

The temporary care delivered by ATRAP provides a buffer between emergency services to manage the adolescent's crisis and any longer-term mental health services they might need. The agreement between ATRAP and the adolescent is a renewable one-month contract. This provides the time, space and specialist help required to deal with the immediate crisis, plan for further care and work with relevant services to ensure a smooth transition.

A team comprising a child and adolescent psychiatrist, nurse and psychologist and special needs teachers does a rapid multidisciplinary assessment and works with the adolescent and their family to develop an individualized care plan. All adolescents are seen within 24–48 hours of being referred, usually by an emergency department. During their time with the ATRAP team, each adolescent has a personalized schedule of care, which may include individual therapy, family therapy and mediation workshops.

In the USA, Connecticut's Mobile Crisis Intervention Services are provided free of charge to all children in the state through a network of 14 provider sites. Mental health professionals respond within 45 minutes to children and young people in crisis at home, in schools and in other community locations and provide in-person crisis stabilization services and link individuals to ongoing care *(129)*. The mobile services are part of the Connecticut School-Based Diversion Initiative, designed to prevent in-school arrests and reduce out-of-school suspensions and expulsions for children and young people experiencing mental health challenges. This comprehensive package includes school staff training and embeds the school in a community-based network of services and supports.

3.3.5 One-stop services

In response to the weakness in mental health services at transitional ages (see section 2.3.5), there has been a growing movement to develop community-based, integrated hubs that allow uninterrupted services for young people. These youth-friendly hubs are sometimes referred to as "one-stop services" and they exist in various forms. Some focus exclusively on mental health care. In others, mental health care is just one part of a complementary array of youth-relevant services.

This innovation in mental health care started in 2006 with Headspace in Melbourne, Australia, for young people aged 12–25 years who were experiencing mental health conditions and related substance-use problems *(60, 130, 131)*. There are now 150 Headspace centres across the country, each of which is co-designed by young people. Headspace centres aim to be non-stigmatizing, welcoming spaces where young people can access evidence-based mental health care and support for substance use issues in the same venue as physical and sexual health services. Work and study support are also available, and centres provide outreach training to school staff, health professionals, employers, parents, caregivers, and community members. A key feature of Headspace is the "no wrong door" policy. This means that young people can refer themselves or be referred from any service.

The Headspace model has expanded to other settings, including Denmark, where the centres are run almost entirely by trained volunteers *(132)*. Similar one-stop services can also be found in many countries, including LMICs (see Box 3.15).

In Singapore, the Community Health Assessment Team (CHAT) is another example of a one-stop drop-in service located near a large retail centre in a building with many other youth-related services *(133)*. CHAT offers free mental health assessments to young people aged 16–30 years. Based on the assessment and if the young person agrees, CHAT refers on to the most appropriate agency, including social services, outpatient services, and school counsellors. CHAT also provides brief support directly in certain situations, such as when there is long waiting time before counselling can begin.

BOX 3.15

India: one-stop service for young people

CONTEXT

Urban area in a lower-middle income country.

ACTION

Centre run by youth volunteers promotes mental health, staffs a helpline, and provides comprehensive mental health services co-designed by a case manager, psychiatrist and the young person in need.

OUTCOME

Young people and families receive a needs-based assessment and care plan, including evidence-based psychological therapies, peer mentoring and workshops.

The Resource Centre for Youth Mental Health Services (rYMs) in Chennai, India is an inclusive, co-designed safe space for young people. It is maintained by youth volunteers who produce a varied programme of activities – from comedy nights to advocacy campaigns – to promote mental health. The centre's already large social media presence was expanded to support young people during the COVID-19 pandemic. The social media handles for the centre are one of the ways that young people can self-refer for assessment and care. rYMS also runs a telephone helpline staffed by trained volunteers.

The centre opens the door to a comprehensive programme of services co-designed with young people at the Schizophrenia Research Foundation (SCARF). Clinical care pathways are streamlined to reduce barriers to young people seeking help. A case manager and psychiatrist provide a needs-based structured assessment and care plan for the young person and their family. The programme provides evidence-based psychological therapies, peer mentoring and workshops. Tele-mental consultations are also available *(134)*.

3.3.6 Psychosocial rehabilitation

Rehabilitation and recovery services support children and young people with severe mental health conditions and psychosocial disabilities. Recovery services often have the same eligibility requirements as treatment services and there is often a disconnect between child and adult services at transitional ages of around 18 years.

Many recovery programmes have been designed for adults. A small but growing number of them offer services that are developmentally appropriate, relevant and acceptable to children and young people, and are also effective in achieving positive outcomes *(135)*. Although these initiatives are largely found in HICs, successful programmes in LMIC (such as the one in Uganda described in Box 3.16) show that low-cost, scalable community-based mental health services focused on recovery are possible in low-resource settings.

In many countries, there is also a shift towards established, community-based psychosocial rehabilitation services including programmes tailored to the needs of young people. For example, Clubhouse International is a global network of independent social enterprises that provide community-based vocational and educational support to people who have used mental health services *(136)*. All clubhouses undertake a formal accreditation programme and adhere to best practice standards.

3.4 Mental health services beyond the health sector

Other sectors and community providers have a key role in complementing the mental health care for children and young people provided by the health sector. This section describes mental health supports delivered through parenting programmes (which can be provided in different sectors); schools; and juvenile justice and law enforcement; as well as innovative outreach programmes delivered by community-based organizations. While not discussed here, social and child protection agencies also play a significant role in delivering mental health care for the most vulnerable children, including those in state care.

3.4.1 Parenting and family support programmes

The family environment has a powerful influence on children and young people's mental health. Positive family functioning and relationships are protective of mental health. On the other hand, neglectful or abusive family environments can increase the risk of children and young people experiencing mental health conditions.

Parenting programmes can have several aims, including helping parents and other caregivers improve their understanding of child and adolescent development, strengthening relationships between parents and offspring, developing skills in positive parenting, and providing mutual support to other caregivers. They can

BOX 3.16

Uganda: a family-focused recovery programme

CONTEXT

Urban area in a low-income country.

ACTION

Family-focused recovery programme delivered by a multidisciplinary team, working with families and community health workers to support young people pre- and post-discharge from hospital.

OUTCOME

Young people and their families are supported to transition back to living in the community, with a focus on strengthening family supports and addressing stigma.

EVALUATION?

Yes *(137)*.

YouBelong HOME is a low-cost, scalable model of community-based mental health recovery in Uganda that is tailored to the local setting and centred on belonging to family, local community and culture *(138)*. It is the flagship programme of YouBelong, a Ugandan nongovernmental organization that acts as a bridge between the National Mental Hospital at Butabika and the wider community. YouBelong works within the existing health systems and with the Ministry of Health, rather than as a parallel system. It is also embedded in other important community bodies such as religious organizations.

Butabika is Uganda's only psychiatric hospital. It is overcrowded and understaffed, partly because many people who have received treatment cannot be safely discharged. Many families are unwilling to take hospitalized young people back home because of community stigma, traditional beliefs, and fear of mental health conditions. Young people can spend weeks or months waiting to leave. YouBelongHOME enables them to get back to their families and communities as quickly as possible and establishes local support services.

A multidisciplinary team of YouBelong social workers, occupational therapists, and mental health nurses provides a culturally sensitive, family-focused recovery programme. Before discharge, the team works on strengthening family supports and addressing any stigma. After discharge, in addition to recovery support, YouBelong also trains and supervises village health teams and primary health care staff to provide community-based mental health care (BB Mutamba, personal communication, 2022).

be delivered as universal programmes for all caregivers. Typically delivered by non-specialists, universal programmes such as WHO's Parenting for Lifelong Health interventions have been found to be effective in reducing the risk of child maltreatment across different settings *(139)*.

Targeted or selective parenting programmes are delivered to at-risk caregivers or to caregivers with at-risk children, while recognising that individual needs of children and young people and their families within these groups may vary (e.g. Box 3.17). Indicated parenting programmes are delivered to caregivers with complex needs who could benefit from tailored and more intensive parenting support (e.g. Box 3.18).

In many countries, the responsibility for families and caregivers is spread across several ministries, which can lead to disjointed planning and funding *(140)*. Better systems for detecting and supporting families and caregivers in need are required almost everywhere.

3.4.2 Mental health in schools

Before the COVID-19 pandemic, 258 million children and young people of primary and secondary school age were out of school *(141)*. During the pandemic, this number rose dramatically, especially in LMICs, and major efforts are now underway to reverse the pandemic's effects on education *(142)*. There is growing recognition that mental health conditions can hinder academic attainment, and that meeting the mental health needs of schoolchildren is crucial for learning recovery *(143)*. This presents an opportunity to ensure that schools are better equipped to support learners' mental health needs.

School-based mental health programmes are expanding in many settings; and evidence shows that they are effective in improving mental health outcomes *(144, 145)*. Schools can also play an important role in suicide prevention (see Box 3.19) *(8, 32)*. Schools can offer a unique and powerful platform for detecting and supporting children and young people experiencing mental health conditions and substance use issues. Delivering mental health care in schools can also help address stigma and other barriers to care. Yet school-based programmes can face significant implementation challenges, including staff overload and competing pressures to focus on educational outcomes.

WHO, UNESCO and UNICEF have defined five pillars for school-based programmes and encourage all governments to embed them in their education policies, plans, and budgets *(37)*. These are to:

- create an enabling learning environment for positive mental health and well-being;
- guarantee access to early intervention and mental health services and support;
- promote teacher well-being;
- enhance mental health and psychosocial capacity in the education workforce; and
- ensure meaningful collaboration between the school, family, and community to build a safe and nurturing learning environment.

The organization of school-based mental health services varies between and within countries and is shaped by the structure and governance of health and school systems. They may be included-integrated within school health screenings services. For example, in Finland, a health and welfare team is embedded into every school,

BOX 3.17

Chile: three-tiered support for at-risk young people

CONTEXT

Nationwide in a high-income country.

ACTION

Family programme for young people who have engaged in criminal behaviour or displayed at-risk behaviours, with three levels of support depending on need.

OUTCOME

Low- and medium-risk young people and their families are put on a parenting programme; high-risk young people receive specialist, individualized, home-based support from a multidisciplinary team.

EVALUATION?

Yes *(146)*.

The Lazos programme in Chile works with adolescents who have engaged in criminal behaviour or who are displaying at-risk behaviours such as substance use, school absenteeism and negative peer associations. The programme is free and open to young people aged 10–17 and their families. Potential participants may be referred by the police, health services, schools, neighbourhood associations, or at the request of a caregiver.

The young person is assessed by a psychologist and, if needed, offered one of three services of varying intensity, according to their level of need and risk.

- Low-risk young people and families are offered a universal parenting programme.
- Medium-risk young people and families are offered a programme to reduce risky behaviours and improve communication.
- High-risk young people and families are offered a short-term intensive programme and a medium-term specialist, home-based service that uses a family approach and typically lasts four months. A multidisciplinary team works with the whole family to identify and change individual, family, and environmental factors thought to contribute to problem behaviours. The mix of interventions is tailored to the specific needs of the young person and family.

A retrospective analysis of high-risk young people who had been through the Lazos programme during 2014–2016 suggested that they had lower rates of recidivism and increased school attendance than those who had not participated in the programme *(147)*. They also went on to have fewer convictions as adults. This analysis however was not a rigorous study and more robust studies have shown that the benefits of the same programme in the USA are not seen elsewhere *(148)*.

BOX 3.18

Kenya: leveraging trusted community advisors to support at-risk families

CONTEXT

Lower middle-income country.

ACTION

Evidence-based family support programme for families in distress, delivered in homes by lay counsellors from within the target communities.

OUTCOME

High acceptability with improvements in parent–child relationships and mental health of individual family members.

EVALUATION?

Yes (149).

Meaning "we are together" in Kiswahili, the Tuko Pamoja programme uses trusted lay counsellors to deliver an evidence-based family psychoeducational counselling programme. Tuko Pamoja focuses on families who need more support than a parenting programme. In a context of conflict, gender-based violence, and substance use, these are families who are already experiencing high levels of distress, increasing their children's risk of developing mental health conditions (150).

The lay counsellors are people such as religious leaders, who have an established role as a trusted community advisor and who habitually visit the homes of troubled families to counsel and advise them. Past Tuko Pamoja counsellors have included a mosque elder, a Sunday school teacher, and married couples.

Under Tuko Pamoja, the lay counsellor works with a suite of psychoeducation modules that focus on different aspects of family relationships and mental health. Topics include building stronger parent–child relationships and coping with distressed children and adolescents. The family works with the counsellor to choose the modules that are best suited to their situation and co-create a programme tailored to their needs.

Modules follow a standard structure, which streamlines training and helps counsellors acquire core competencies in family support. In the pilot programme, lay counsellors were supervised by student medical psychologists, who were themselves supervised by a psychiatrist. The students received course credits for the supervisory work and gained important experience of community-based mental health care (see section 4.5.1).

When the trained lay counsellors approached families, the offer of counselling was framed as a process to strengthen families and bring them together. This way of introducing the programme was well received by families, as was the fact that counselling sessions took place in their home. Caregivers and children showed great willingness to speak openly with a familiar counsellor from their community. In the pilot, there were improvements in overall family functioning, parent–child relationships, marital relationship quality and mental health of individual family members.

Work is underway to embed Tuko Pamoja in a stepped care programme where the first tier is a universal prevention programme, focused on building family communication skills, is delivered to all families with young people aged 10–17 years. Families requiring more support would then be stepped up to receive Tuko Pamoja counselling at home. The stepped care system will be scaled up through church congregations.

consisting of a school nurse, school doctor, social worker, and psychologist. Students meet the school nurse every year and are offered an appointment with the school doctor at specific points. Teachers are encouraged — with the student's permission — to contact the health and welfare team with any concerns *(151)*.

In England, the Children and Young People's Improving Access to Psychological Therapies Programme used task-sharing to create a new type of non-specialist mental health care worker to support schools and colleges *(152)*. These Educational Mental Health Practitioners are linked to a designated mental health lead at each school and serve to enable earlier interventions for children and young people with mild-to-moderate difficulties. The approach has been implemented as a large-scale pilot involving more than a thousand schools and colleges *(153)*.

These types of school-based mental health services are less common in LMICs, in part because of a scarcity of mental health care providers to deliver support. Yet several initiatives have shown that school-based mental health interventions are possible by training and supervising non-specialists to identify and support children and young people with mental health conditions. For example, in Malawi and United Republic of Tanzania, a multicomponent programme linked schools with community health clinics and trained teachers and community health care providers to identify depression *(154)*. By doing so it enhanced mental health literacy in the community and schools and improved access to effective mental health care for children and young people with depression.

In Kenya, the lack of mental health professionals was overcome by training high school and college graduates as peer counsellors and clinical supervisors who deliver and oversee evidence-based risk assessment and interventions in schools (described in Box 3.20).

The lack of mental health specialists can also be a barrier to school-based programmes in HICs. In Texas, USA, this problem was overcome by using tele-mental health services that link multiple schools with teams of specialists in academic institutions for free, direct support for children, young people and their families (see Box 3.21). Tele-mental health also has the advantage of reducing the stigma experienced by children and young people when they approach mental health services *(155)*.

School-based mental health services may also be provided as universal promotion and prevention activities, such as social and emotional learning programmes, anti-bullying interventions and initiatives to improve the quality of environments in schools and digital spaces *(9)*. Universal activities in schools can also help combat stigma and discrimination. For example, in Nigeria and United Republic of Tanzania, a school-based programme to increase mental health literacy was found to significantly increase students' knowledge about mental health conditions, shift their attitudes towards them and boost their willingness to seek help *(156, 157)*.

In practice, school-based mental health services often combine multiple strategies to cater to multiple needs. In all cases, intersectoral collaboration is essential, especially for at-risk students who have multiple needs and requite an integrated support package (see Box 3.22). Intersectoral collaboration is also crucial to design and implement school-based programmes at scale. In the Eastern Mediterranean region, collaboration between health and education ministries and practitioners enabled the design of the School Mental Health Program, which was rolled out across multiple schools in Egypt, Iran and Pakistan from 2017–2019 *(158)*.

In many school-based programmes, teachers have an important role in detecting and responding torecognizing mental health issues in children and young people experiencing mental health conditions and facilitating appropriate support.

BOX 3.19.

Suicide prevention in schools

Social and emotional life skills training in schools is one of the most effective and cost–effective suicide prevention strategies available. Other complementary activities that schools can implement are listed below.

- Provide staff with gatekeeper training on how to create a supportive school environment, how to recognize risk factors and warning signs of suicidal behaviour, how to support distressed young people and how to refer young people for extra help.
- Facilitate a safe school environment, for example through anti-bullying programmes, initiatives to increase social connection, and staff training.
- Create and strengthen links to external support services and give this information to students.
- Give extra support to students at risk, such as those who have previously attempted suicide, have been bereaved by suicide or are from groups at risk of suicide (e.g. LGBTQI+ young people).
- Establish a clear policy and protocols for: staff to follow when they identify a suicide risk; communicating a suicide attempt or death among staff or students; and supporting a student to return to school after a suicide attempt.
- Promote staff mental health, including through training and access to support.
- Involve parents to increase parental awareness of mental health and risk factors.
- Educate students on healthy use of the internet and social media (e.g. safe internet use, how to use social media to build healthy social supports, and how to recognize and respond to unhealthy online activity such as bullying).
- Develop initiatives to address other risks for young people, such as parental violence, traumatic events in the family, and substance use.

Source: WHO, 2021 *(32)*.

BOX 3.20

Kenya: a culturally-adapted, school-based programme of stepped care

CONTEXT

Capital city in a lower-middle income country.

ACTION

School-based programme providing three tiers of culturally adapted mental health support, delivered primarily by peer counsellors, with a focus on supporting personal growth.

OUTCOME

Wide acceptance, leading to reduced symptoms of depression and anxiety.

EVALUATION?

Yes *(159)*.

Developed by the non-profit Shamiri (Kiswahili for "thrive") Institute in Nairobi, Kenya, the Anansi programme is a promising model for an acceptable, evidence-based, mental health service delivering stepped care in high schools. Students are screened for depression and anxiety and those with elevated scores are offered three tiers of support: peer counselling, individual support and referral to a specialist.

The bulk of the support is provided by tier 1 peer counsellors, who are recent high school graduates aged 18–24 years. Tier 2 clinical supervisors are graduates with a background in clinical social work, counselling, psychology, or similar and are trained in evidence-based psychotherapeutic and risk-assessment strategies. They receive 10 hours of training and weekly supervision and are the main point of contact between the Shamiri Institute and school administrations. They support individual students as needed and "step up" students requiring more intensive support to tier 3 clinical psychologists.

Peer counsellors facilitate four one-hour sessions in which students work in groups to develop and practice new skills for personal growth, gratitude, and values *(160)*. These sessions are presented as positive, character-enhancing school activities and do not use words such as "depression", "anxiety", and "therapy" to avoid stigmatization.

A randomized controlled trial found that students rated both the Shamiri and another study skills programme as highly useful. Both programmes also reduced symptoms of depression and anxiety, although the effects were greater for students in the Shamiri programme. Both programmes also reduced symptoms of depression and anxiety, although the effects were greater for students in the Shamiri programme *(159)*. Further research is underway to determine the impact of each tier in the Shamiri programme compared to the full Shamiri protocol and a control group *(161)*.

BOX 3.21

Texas, USA: tele-mental health to boost students' access to mental health care

CONTEXT

State-wide in a high-income country.

ACTION

Tele-mental health services to schools, delivered by mental health specialists, with each child referred eligible for an evaluation and follow-up sessions.

OUTCOME

Rapid at-school care for urgent mental health needs, increased access to early mental health interventions for at-risk students; and reduced time spent attending psychiatric appointments.

In Texas, USA, the number of child and adolescent psychiatrists is low and the mental health needs of children and young people is high (1602). The state-funded Texas Child Mental Health Care Consortium aims to address the gap by simultaneously boosting training opportunities for child mental health specialists while increasing children and young people's access to mental health care.

One of its initiatives is the Texas Child Health Access Through Telemedicine (TCHATT) programme, which links teams of mental health specialists at 12 academic institutions with schools across the state to provide free, direct, tele-mental health services. TCHATT aims to: increase access to early mental health care for at-risk students; provide rapid at-school care for students with urgent mental health needs; and reduce the amount of time families are away from work and school to attend psychiatric appointments *(163)*.

School counsellors and teachers identify students in need of support and, subject to parental agreement, refer the student to the TCHATT team. Teams include child and adolescent psychiatrists, counsellors, psychologists, and social workers, including trainees. After referral, the student may receive an evaluation and up to four follow-up sessions.

Students in need of further support are linked to mental health care providers for continued care, including if needed the Texas Child Psychiatry Access Network. Primary health care providers can also use this network to contact a child and adolescent psychiatrist to discuss the care of specific children and young people or for general information on care coordination *(164)*.

By the end of August 2022, TCHATT had been rolled out to more than 40% of the state's school districts, covering a student population of around 2.5 million *(165)*.

It is important that teacher-led programmes consider teachers' limited time and capacity to deliver mental health services; and provide supportive supervision, especially because teachers are often exposed to the same environmental and social adversities as their students.

Educating teachers on mental health awareness and intervention strategies is essential for fostering a nurturing learning environment for students. Even though school-based programmes rely on teachers' participation, mental health is seldom included in teacher training curricula. Still, many teachers are aware of challenges in their students' lives and mental well-being. In Nicaragua, teachers and lecturers reported being acutely aware of the high burden of mental health conditions among their students and the link with the poverty, domestic violence, and parental migration affecting students' home environments. They were frustrated by short-term donor projects and wanted a formal, sustained system of mental health services to support their students *(166)*.

Where mental health literacy is low, training teachers to better understand mental health and how it presents in children and young people can be transformative in creating supportive school environments. For example, in Liberia, teacher training enabled teachers to manage behavioural problems in the classroom and know when to refer children for extra support (described in Box 3.23). In Haiti, teachers trained in foundational mental health competencies were better able to support their students, many of whom had been exposed to traumatic stressors *(167)*.

The training really helped me because it enabled me to change my behaviour with the children, […][…) it helps me manage the class differently and also helps me understand when children react in a certain way in the classroom, it is because they are facing a problem that makes them react the way they do, and it helps me approach the child and ask questions. [Teacher in Haiti] (167).

BOX 3.22

Chile: life skills training within an integrated package of support

CONTEXT

Nationwide in a high-income country.

ACTION

School-based social and emotional learning programme delivered by teachers, combined with referral to community-based mental health services as needed, and a wider package of support for at-risk children and young people.

OUTCOME

improved teacher-rated behaviour, parent-rated mental health, and school attendance.

EVALUATION?

Yes

Every year, around 700 000 children in Chile enrol into the country's Habilidades para la Vida (Skills for Life) social and emotional learning programme. Launched in 2010, Skills for Life was initially developed for elementary school children but has since expanded to include middle- and high-school students.

Teachers are trained to deliver mental health promotion to all students. Teachers, parents and older students are also screened on a range of psychosocial factors. The screening results are used to identify: students who would benefit from the Skills for Life programme; and high-risk students in need of more support, who are then referred to community-based mental health services.

The Skills for Life programme comprises ten workshops over six months. These are delivered by trained psychologists or social workers and use age-appropriate ways to develop students' resilience and psychosocial skills including conflict resolution. The focus is on strengthening interpersonal, social, cognitive and affective skills that are relevant to positive classroom and psychosocial adaptation. Another two or three workshops are run for parents. Although the workshops are standardized, there is flexibility to tailor content to students' needs and schools' contexts (e.g. if they are in remote, rural areas) *(168)*.

Skills for Life is administered by a branch of the Ministry of Education dedicated to supporting disadvantaged students, and schools serving low-income communities are prioritized. The programme is part of a package of support for at-risk students that includes a school meals programme, health programme, housing assistance, and psychosocial support *(169)*.

Research on the programme's initial deployment in elementary schools followed the progress of more than 40 000 children who were screened at age 6–7 years, of whom around 14% were offered the workshop programme. At-risk students who participated in the workshops had improved teacher-rated behaviour, parent-rated mental health, and school attendance *(170)*. Further assessment of 11–14-year-olds in more than 750 schools also showed that higher workshop participation was associated with better school attendance and peer relationships *(168)*.

BOX 3.23

Liberia: school-based mental health clinicians and teacher training

CONTEXT

Nationwide in a low-income country.

ACTION

School-based mental health clinics established in schools, teachers trained on child and adolescent mental health to preschool, elementary, and secondary school teachers.

OUTCOME

Teachers can better detect and support children with social, emotional and behavioural difficulties, and manage behavioural problems in the classroom.

The Liberian Ministry of Health, together with key partners, has been working to strengthen the national mental health system, resulting in improvements in policy, workforce development, and service user engagement *(171)*. The 2014–2016 Ebola virus epidemic further catalysed actions to scale up mental health care for children and young people.

School-based clinics were established in selected settings and staffed by mid-level health-care workers from community-based health facilities to address the mental health and psychosocial needs of children and adolescents. The WHO EMRO School Mental Health Manual was adapted to the Liberian context and used to train preschool, elementary and secondary school teachers in detecting and supporting children with social, emotional and behavioural difficulties. Teachers were also taught skills such as managing behavioural problems in the classroom and knowing when to refer a child to the school-based clinic *(171)*.

In addition, teachers were trained in the neuroscience of learning, memory, stress and emotions. A two-tiered training programme for school science teachers on the basic brain mechanisms that underpin learning, memory, emotions, and stress and how they relate to teaching styles and students' mental health needs. was completed. This allowed teachers to understand, for example, that shaming and punishing a student creates a stress response in the brain that blocks the student's ability to learn *(172)*.

3.4.3 Mental health in the juvenile justice system

International treaties, norms and standards stress that the detention, arrest and imprisonment of young people should be a measure of last resort *(173)*. Yet all around the world, children and young people in the juvenile justice system are held in custodial settings, including first-time offenders, even for minor offences. Prejudice related to race, ethnicity or social and economic status may bring a child into conflict with the law or result in harsh treatment by law enforcement officials, even when no crime has been committed *(174)*.

Weaknesses in data management mean that the true number of young people in pre-trial detention and prisons worldwide is unknown. It is estimated that on any given day in 2020, 261 200 children were detained in pre-trial and pre- or post-sentencing *(173)*.

Children and young people in the juvenile justice system are more likely to experience mental health conditions than those in the general population. One systematic review in 19 mainly HICs showed that about one in ten adolescent boys in juvenile detention and correctional facilities had depression and one in five had ADHD, while one in four detained adolescent girls had depression and one in five had PTSD *(175)*. Children whose caregivers are in prison are also at higher risk of mental health conditions than others, particularly if the caregiver is female *(176)*.

Once detained, children and young people are also at significant risk of experiencing human rights violations that make them more vulnerable to mental health problems. Research from Australia found that indigenous young people and young people with mental health conditions or cognitive disabilities were over-represented in the juvenile justice system, and that once detained, risked being exposed to harmful practices such as solitary confinement, segregation, excessive force, mechanical restraints, and even physical abuse *(177)*. The researchers also noted that mental health services in juvenile detention facilities were severely overstretched, while provision of services that could improve mental well-being (such as educational and recreational programmes and visiting facilities) were inadequate.

Research on children in the criminal justice system in Northern Ireland similarly found excessive use of physical restraint in juvenile detention centres, as well as other practices that adolescents found humiliating. Girls in detention here reported finding it isolating and distressing, with a lack of gender-specific responses to their personal needs *(178)*.

During the COVID-19 pandemic, amid concerns about the vulnerability of detained children, an unprecedented number of children were released from detention. At least half of 152 countries during pandemic reported releasing children from detention and stopping new admissions and arrests for minor offences *(179)*. If sustained, the initiatives started during the pandemic could help make justice systems everywhere more child-friendly and gender-responsive, thereby upholding the rights of every child who comes into conflict with the law.

Alternative approaches to detention include “second chance” programmes that promote emotional learning, and ultimately lead to better life and health outcomes. Liaison and diversion programmes that identify people with possible mental health conditions when they first come into contact with the juvenile justice system have been designed to support young people through the system, divert them towards more appropriate settings and refer them for appropriate mental health or social care (see Box 3.24) *(18)*.

BOX 3.24

Jamaica: diversion programme for young people in conflict with the law

CONTEXT

Nationwide in an upper-middle income country.

ACTION

Diversion programme for young people in conflict with the law, who undergo mental health assessment and receive a tailored care plan of psychosocial interventions and support from an adult mentor.

OUTCOME

Graduates have their criminal case dismissed, and both mentees and mentors benefit from their interactions.

In Jamaica, each of the island's 14 parishes has a Child Diversion Committee and Child Diversion Officer who are implementing a diversion programme that is changing the lives of young people in conflict with the law. Referrals to the programme are made by the police or juvenile court.

Both the alleged victim and perpetrator and their families must agree to the diversion before it can proceed. The alleged perpetrator also must accept responsibility for the action that led to their court appearance but this is not an admission of guilt in law.

After referral, the Child Diversion Officer takes a full psychosocial history and does a mental health assessment to understand the young person's family, educational and social situation. The officer then develops a child-centred, tailored care plan and works with the young person to agree and coordinate actions. Care plans may include individual and family counselling, substance misuse counselling, and sexual and reproductive health support. Depending on the assessment findings, the diversion officer may also refer the young person to other health care services, such as assessment of a possible learning disability. Psychosocial interventions are largely provided through Jamaica's Child Guidance Centres, which are run by the Ministry of Health as part of the primary health care system, although overstretched services mean that there is much use of private care.

Each young person in the programme is assigned a mentor – a member of the community such as a retired teacher – who provides extra personal support. Mentors are carefully vetted and trained in mentoring skills. Other interventions are also being explored, such as community service. Graduates of the programme have their case officially dismissed and so have no criminal record.

Each Child Diversion Officer is responsible for regular reporting to the parish Child Diversion Committee. The committee is multidisciplinary and can advise on aspects of the tailored programme for each child (CA Coore & V Clarke-Lee, personal communication, 2022).

3.4.4. Innovative mental health outreach programmes

Embedding mental health care in existing community programmes is an effective way of scaling up accessible, acceptable care that can also reach more marginalized groups.

For example, in Sierra Leone, a group counselling programme delivered by lay providers was embedded into a programme teaching out-of-work and out-of-school young people employment and entrepreneurship skills (see Box 3.25).

In Uganda, the BRAC-StrongMinds initiative has embedded mental health support into an existing network of girls' clubs that offer safe spaces, mentoring, and vocational training to out-of-school girls (see Box 3.26). At a global level, girls' clubs (for in-school and out-of-school girls) have been found to improve girls' psycho-social well-being and self-confidence and positively shift gender norms that can increase girls' risk of mental distress *(180, 181)*.

Photo credit: Teenage girls in a youthclub, Sweden, 2018.
© WHO / Malin Bring.

BOX 3.25

Sierra Leone: livelihood skills programme for unemployed youth

CONTEXT

Nationwide in a low-income country, still recovering from years of civil conflict.

ACTION

A group counselling programme was delivered by lay counsellors in schools and as part of a programme teaching employment and entrepreneurship skills to young people.

OUTCOME

Young people gain skills to deal with symptoms of post-traumatic stress disorder and to address their anger and interpersonal challenges.

EVALUATION?

Yes *(182)*.

In Sierra Leone, in recognition of the association between the political and social disenfranchizement of young people and the civil conflict of 1991–2002, the government has prioritized youth participation in governance and decision-making *(183)*. Since 2012, youth councils at the district and village level ensure youth involvement through identifying vulnerable, rural, and undereducated young people in their communities and linking them to an income-improvement programme teaching employment and entrepreneurship skills *(184)*.

Many young people struggled to access the programme because they were exposed to war and have psychosocial problems that compromise their ability to engage with employment and education opportunities *(185)*. The Youth Readiness Intervention (YRI) aims to help war-affected young people deal with symptoms of post-traumatic stress disorder and address the anger and interpersonal challenges that impede their progress at school and work. YRI is a culturally relevant group counselling programme delivered by lay providers. In schools, it has been shown to improve young people's emotional regulation, school enrolment and attendance, and classroom behaviour *(184)*.

YRI has now been integrated into the income-improvement training programme, enabling young people to address their mental health problems while simultaneously getting ready for employment. The programme has proven to be feasible and acceptable and is being implemented at scale. An implementation–effectiveness trial among over 1 100 young people comparing the effects of no intervention, entrepreneurship training only, and YRI plus entrepreneurship training demonstrated overall improvements in depression and anxiety symptoms for youth taking part in YRI plus entrepreneurship training compared with control participants *(186)*.

BOX 3.26

Uganda: embedding mental health support into clubs for out-of-school girls

CONTEXT

Nationwide in a low-income country.

ACTION

Mental health support was integrated into an existing network of girls' clubs aiming to boost girls' economic and social empowerment.

OUTCOME

Girls have access to group-based, culturally adapted and locally validated interpersonal therapy for depression alongside other supports.

EVALUATION?

Ongoing (187).

The nongovernmental organization BRAC Uganda's Empowerment and Livelihood for Adolescents programme comprises a nationwide network of clubs for in- and out-of-school girls aged between 13 and 21 years. The clubs offer safe spaces for the girls to interact with peers and mentors and learn about issues such as sexual and reproductive health, early marriage, gender-based violence, and drug misuse. The clubs also provide vocational training suited to the local labour market. The programme's primary goal is to help girls achieve greater economic and social empowerment and become agents of change in their families and communities *(188)*.

In 2016, BRAC spotted an unmet need for mental health support in its clubs. It required a low-cost solution that could be deployed at scale. And so it began working with the social enterprise StrongMinds, which had been providing group therapy to women and girls at scale in Uganda and Zambia since 2014 *(189)*. The BRAC mentors were trained to provide a group-based, culturally adapted and locally validated type of interpersonal therapy for depression to the girls in their clubs. StrongMinds provided technical assistance, supervised the mentors, and monitored and evaluated the groups.

The BRAC–StrongMinds collaboration is being evaluated in a cluster randomized controlled trial. Primarily focused on whether this cost–effective approach improves the mental health of girls with symptoms of depression, the trial is also assessing other outcomes, such as school enrolment, pregnancy and child marriage *(187)*.

3.5 Digital interventions

Digital technologies can be used to deliver or support mental health interventions across the full network of services, and across a wide range of mental health needs, including among children and young people *(190)*. Example interventions from WHO include the chatbot-based Sustainable Technology for Adolescents to Reduce Stress (STARS) *(191)*, and Step-by-Step, a digital self-help intervention for adults with depression *(192)*, which has been culturally adapted for use by Chinese young adults *(193)*.

The increase in availability and affordability of digital technologies around the world creates a new opportunity for scaling up services, particularly for young people, who are the most digitally connected age group in all regions of the world. They value the internet as an important source of information about health because it offers anonymity, enables access to a variety of reliable sources, allows glimpses of peers' experiences, and provides links to professional support *(194)*.

The COVID-19 pandemic catalysed a surge in digital services. Overnight, all services had to be provided remotely, enabling a natural experiment in tele-mental health. Many services began using digital technology in a range of different ways, from sending SMS messages for appointment reminders to holding full scale online eClinics providing the same level of care as in-person services.

Then and now, various issues must be considered when implementing digital interventions for mental health. For example, delivery format. For children and families, an assessment may be done in person, and follow-up with parents done online, on the telephone, or through a messaging application. Although more evidence is needed, use of self-directed digital mental health interventions may be more effective when used to supplement face-to-face care or as part of a stepped care model, with the support of a trained health professional *(195)*.

In all cases, supportive home environments are needed to enable positive outcomes when using digital tools for children and young people. There are also ethical issues to be considered. Children and young people may, for example, take risks in sharing confidential information and may not understand the full complexity of how digital data are collected, analysed and used for commercial or other purposes. Or they may accidentally access inappropriate or potentially harmful content when they are seeking information online *(194)*.

Even as a burgeoning number of digital interventions is being developed, there are caveats when considering their widespread implementation as part of mental health service delivery for children and young people.

- The digital divide persists and for many families in LMICs, internet access is based on a shared mobile phone. The lack of smartphone coverage and high internet costs make app-based support inaccessible to many.
- Gender inequality also affects digital access. For example, if there is just one smartphone at home, women and girls in the household may have limited access and may not be allowed to use it unsupervised. As a consequence, women and girls have lower levels of digital literacy in many contexts *(196)*.
- Digital solutions may be inappropriate for children and young people whose screen time is already high, since this may exacerbate harmful effects such as attention-deficit symptoms. Time spent online has also been associated with depression, anxiety, and psychological distress in adolescents. Addictive behaviour among children and young people is an increasing concern and gaming disorder is now recognized as a condition in the International Classification of Diseases 11th Revision (ICD-11) *(7)*.

- As with in-person care, digital interventions need to be guided by ethical principles and implemented in line with professional codes of conduct. Key areas are privacy, consent, data protection, safety and accountability *(7)*.
- Digital solutions must pass the same tests of effectiveness as any other health intervention. This leads to a tension between commercial and non-commercial interventions. Investments in commercial tools commonly focus on optimizing user experience rather than clinical value. With constrained budgets, developers of non-commercial interventions tend to sacrifice usability over content and the inclusion of evidence-based clinical practices *(195)*.
- Although the common elements of a digital tool may be universal, the content needs to be adapted to fit the context and culture of the target population of children and young people.

Photo credit : Group of local adolescents meet to discuss a community project, Altai, Gobi-Altai province, Mongolia, 2018. © UNICEF/ Pasquall.

4

Strengthening systems for children and young people's mental health

This chapter considers the core components that underpin a well-functioning mental health system for children and young people. It describes the standards that should guide all service development and underscores the importance of strong leadership and governance, sufficient finance, a skilled and diverse workforce, robust health information systems and the meaningful participation of children, young people and their families in service design to enable and sustain mental health care for children and young people. A checklist outlining steps for strengthening systems for children and young people's mental health is included in Annex 2.

4.1 Standards for mental health care

The table below (Table 4.1) outlines important domains for standards emerging for assessment and monitoring of mental health services for children and young people, and associated examples in practice, based on a review of:

- national and international standards, tools and frameworks *(197-200)*;
- information drawn from published consultations on mental health with young people and caregivers in different countries *(28, 201, 202)*;
- an ongoing process by the WHO Regional Office for Europe to develop quality standards for child and adolescent mental health services *(203)*; and
- country examples and good practices compiled for this document.

TABLE 4.1.

Important domains for standards for mental health care of children and young people, and what they look like in practice

- Accessible
- Appropriate
- Community-embedded
- Continuously improving
- Equitable and inclusive
- Family-oriented
- Human rights-based
- Integrated
- Participatory
- People-centred
- Quality
- Recovery-oriented
- Safe

ACCESSIBLE

Mental health care services are planned and delivered to eliminate structural and social barriers to care.

Examples in practice

- Easily understandable and accessible information about what mental health care is available, what it can address, and where and when it can be accessed.
- Physically accessible services provided close to where people live, go to school or work, including through mobile clinics.
- Active outreach activities that give children and young people opportunities to express their needs and identify those who need extra support as early as possible.
- Services with convenient operating hours (e.g after school), and minimal waiting periods.
- Clear and straightforward admission procedures.
- Services that are affordable, including through free online platforms.
- Clean and welcoming environments, that are appealing and comfortable for children and young people.

APPROPRIATE

Services deliver care that is evidence based, comprehensive, developmentally appropriate and responds to contextual priorities and the social determinants of mental health in the population served.

Examples in practice

- Tailored care that meets the needs and preferences of diverse service users in local context (as opposed to a one-size-fits-all approach).
- Differing engagement of children and young people depending on their people's evolving capacities, including their independence or maturity. in health-related decision-making and accommodation of their changing needs and requirements.
- Consideration of social and economic conditions detrimental to mental health, e.g. coupling services with income generation in impoverished communities.
- Child-friendly facilities, e.g. age-appropriate equipment designed to meet children's needs in medical care, learning, recreation and play available.

COMMUNITY-EMBEDDED

Mental health care services are planned and delivered to eliminate structural and social barriers to care.

Examples in practice

- Outreach and educational workshops that foster strong connections with different segments of the community.
- Partnerships with existing community organizations and services.
- Consultations with different segments of the community structures about mental health needs and priorities and how prevailing beliefs might affect access and uptake.
- Co-designed service delivery with community members; and their meaningful involvement in planning and delivering mental health services.
- Promoting the value of locally available mental health care to encourage help-seeking.

CONTINUOUSLY IMPROVING

Services engage in continuous quality improvement.

Examples in practice

- Keeping up to date with new issues and trends that affect young people's mental health (e.g. new social media trends, latest evidence on medicines).
- Service data collection and analysis to better understand service users, including who they are, what support they receive, and their experiences and perspectives.
- Service provision is planned and refined as new information is received.

EQUITABLE AND INCLUSIVE

Services provide consistent high-quality care to all children and young people, regardless of their age, developmental stage, sex, gender, race, ethnicity, disability, neurodivergent profile, geographic location, religion, socioeconomic status, sexual orientation, linguistic or political affiliation.

Examples in practice

- Services that are designed to meet the needs and preferences of children and young people from different backgrounds and groups.
- Prioritized access or additional services for children and young people from populations who are less likely to access mental health care.
- Accessible and disability-responsive services in terms of physical infrastructure, communication, and interfaces with assistive technologies.

FAMILY-ORIENTED

Service providers recognize that caregivers and families have an important role in children and young people's mental health, and actively involve family members in mental health care, as appropriate in the best interests of the child or young person.

Examples in practice

- Caregivers are active in their children's mental health care as appropriate e.g. informing them about services, including them in sessions, providing updates.
- Contact points with caregivers to check on their own mental health and to build skills to support their children.
- Psychoeducation to address stigma from caregivers about accessing mental health services.
- Working with older adolescents to determine when and how to engage caregivers, with respect to their evolving capacities and growing autonomy.
- Support networks that engage other trusted adults and peers that young people are connected to according to their preferences.

HUMAN RIGHTS-BASED

Services are designed to respect, protect and fulfil children and young people's human rights, including rights to information, privacy, confidentiality, non-discrimination, non-judgement and respect, inclusion and freedom from exploitation, violence and abuse.

Examples in practice

- Easy-to-understand information for children and young people about their rights.
- Ongoing training for staff on issues relating to confidentiality, privacy, non-discrimination and inclusion, including equal opportunities for education.
- No coercive practices (such as seclusion and restraint); and promotion of alternatives such as de-escalation and communication skills.
- Non-stigmatizing attitudes and practices within services e.g. not having different systems for young people accessing mental health care within primary health care settings.

INTEGRATED

Services are designed to respect, protect and fulfil children and young people's human rights, including rights to information, privacy, confidentiality, non-discrimination, non-judgement and respect, inclusion and freedom from exploitation, violence and abuse.

Examples in practice

- Services complement each other without gaps and without undue overlap.
- Clear and easy referral and transfer across services as needed by children and young people e.g. when being referred from one level of support to another, or when transitioning between youth and adult services.

PARTICIPATORY

Children, young people and families are involved in decisions about their own care; and in planning, monitoring and evaluating mental health services in general.

Examples in practice

- Mental health services that are co-designed with persons with lived experiences, including children, caregivers and young people, with a focus on local needs and priorities.
- Data collection and analysis methods for service design that are defined with meaningful involvement of young people.
- Meaningful participation of children and young people in decisions about their care that elicits and respects their opinions.

PEOPLE-CENTRED

Care is responsive to the child or young person's preferences, needs and values.

Examples in practice

- Services that are organized around the health needs and expectations of children and young people.
- Services that engage in meaningful conversations about people's needs and concerns
- Provision of information and support to young people and their caregivers to make decisions and participate in their own care

QUALITY

Services increase the likelihood of desired health and social outcomes and are delivered by competent staff who act in the best interests of the child or young person, in line with evidence-based professional knowledge. Services are developmentally appropriate, safe, evidence based, delivered in a timely manner, culturally sensitive to contextual issues, manner, responsive to individual needs and preferences

Examples in practice

- Training for service providers to provide evidence-based, culturally competent care to children and young people and their caregivers.
- Service improvements to enhance children and young people's experiences in the system e.g. set appointment times.
- Sufficient and appropriate supplies and technology for services to operate.
- Recruitment and support for health care workers to be professional, display respect and kindness to children and young people.
- Strategies to address the generational gap between service providers and young people e.g. selecting and training peer workers, and training older workers to work with young people.

RECOVERY-ORIENTED

Services are oriented to promote hope and meaning, equip children and young people to make choices and decisions, and ensure that they are connected to their communities.

Examples in practice

- Focus on the right to participate in all facets of life on an equal basis with all other children and young people
- Support for children and young people to find hope, develop self-esteem and resilience, build healthy relationships, regain independence and to live a life that has meaning for them, e.g. through school, vocational training, work, friendships, community engagement, spirituality.

SAFE

Services keep children, young people, caregivers and providers safe from preventable harm.

Examples in practice

- Services in secure environments e.g. areas that are safe for children and young people.
- Partnerships with community providers, such as schools, community organizations, law enforcement agencies, and child protection services.
- A supportive child protection system that includes policies and procedures for ensuring that children and young people are protected from harm e.g. referral processes, reporting mechanisms, criminal record checks for staff.
- Training for health care workers, teachers and other providers on what child abuse is and how to recognize, respond and report it.
- Advocacy programmes and skills building that empower children and young people to speak up when they are concerned about safety.

4.2 Leadership and governance

Strong leadership and governance are key to ensure that services can meet the mental health needs of children and young people. It includes strengthening policy and legislative frameworks to promote and protect the mental health of children and young people; and supporting their implementation through health system design and quality assurance *(204)*.

4.2.1 Strengthening legislation and policy

Adopting robust laws and policies is a strong public signal that children and young people's mental health is a priority at the highest level. It also helps stimulate national conversations on children and young people's mental well-being and their need for mental health care.

Mental health legislation refers to legal provisions related to mental health. Such provisions typically focus on issues such as civil and human rights protection for people with mental health conditions, along with treatment facilities, personnel, professional training and service structure *(4)*. For children and young people, attention is needed to ensure that legislation overcomes rather than exacerbates barriers to access. For example, requiring primary caregivers for under 18-year-olds to consent to mental health care may impede help-seeking *(205)*.

A mental health policy is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental health conditions in a population, defining a vision for future action *(4)*. A well-articulated policy, when matched with a clear implementation plan and budget, is a proven powerful driver for change *(67)*. Yet, fewer than half of WHO Member States, mostly HICs, have a mental health plan or policy for children and young people *(4)*. Low awareness, lack of local data, stigma, cultural attitudes towards childhood and youth, and lack of investment in human resources and infrastructure likely impede policy development in this area *(206)*.

All mental health laws and policies should align with international human rights conventions and treaties, as applicable, including, in particular the CRC and the CRPD *(207)*. The WHO Quality-Rights Initiative includes a comprehensive set of training, guidance materials and tools designed to support countries develop policies, plans, laws and services that promote the rights of people with mental health conditions, improve quality of care, and address coercive practices *(208)*.

Examples of law and policy development in practice

There are several recent examples of newly developed laws and policies from countries, including LMICs, to promote better mental health outcomes for children and young people.

These include:

- In India, the Mental Health Care Act 2017 decriminalized suicidal behaviours *(209)*;
- The President's Programme to Promote Mental Health of Pakistanis 2019–2024 promoted the development of school-based mental health services *(210)*;
- In Viet Nam, the government formally has initiated a process to create social work and counselling positions in all health and education

institutions. This will increase access to skilled workers who can provide mental health interventions for children and young people. Positions for school counsellors will be created in all primary and secondary schools, providing services directly and coordinating with other linked services *(211)*.

4.3 Active participation of families, children and young people

Children, young people and their caregivers have expert knowledge about mental health that is gained through lived experience. WHO encourages all Member States to ensure that people with lived experience, and their organizations, can actively participate in the development and implementation of mental health policies, laws and services *(212)*. Yet only a third of middle-income countries – and just 16% of low-income ones – have a formal mechanism for involving service user associations in the mental health system *(4)*. Similarly, while the need for participatory approaches in child and youth mental health care is increasingly recognized in theory, in practice there are low levels of in-depth engagement with children and young people *(213)*.

Meaningfully engaging children, young people and families in service design can be achieved in many ways, including viewing them as experts, promoting their active participation in their care, investing in relationships and therapeutic alliances, addressing barriers to engagement, ensuring culturally responsive services, and tailoring services to fit families' needs and preferences.

At the organizational level, family perspectives should be integrated within governance, programming, policy and evaluation activities. For example, by using youth or caregiver advisory panels, and giving young people and caregivers decision-making roles on mental health service boards. Commitment from leadership is a key facilitating factor. Other ways to support participatory approaches include modifying organizational structures and processes to integrate children and young people's voices, building and sustaining relationships with service users, training staff and leaders in family engagement, and evaluating engagement efforts *(214)*.

The extent to which participatory approaches consider local needs and contexts can determine whether an engagement initiative succeeds or fails. Communities might be reluctant to participate in service design because of a lack of trust engendered by human rights abuses, marginalization, racism and the damaging legacies of colonialism *(215)*. The practicalities of participation also need to be accommodated, particularly for young people and families who are daily wage earners *(215)*.

Examples of participatory approaches to service design

- One-stop services for integrated youth mental health care (see section 3.3.5) puts youth and family participation at the centre of service design. For example, from the inception of the one-stop service Foundry in British Columbia, Canada, children, young people and families were hired, trained, and engaged to inform and support decisions that would impact service provision *(216)*.

- In Maharashtra, India, the Centre for Mental Health Law and Policy has engaged young adults to co-produce Outlive!, a prevention programme targeting urban suicides among at-risk young people aged 18–24 years who are marginalized by caste, class, gender and sexuality. Operating in Delhi, Mumbai, and Pune, Outlive!'s activities include a chat-based, peer-led suicide prevention support service, and training for youth advocates to work with policy-makers in shaping suicide prevention strategies *(217)*.
- Ember is an international initiative designed to help amplify the voices of community-members in mental health initiatives, including children and young people. Ember finds, mentors and funds small-scale community initiatives in LMICs for 12 to 24 months to help them strengthen and grow. One Ember activity involves Child, Adolescent and Family Services (CAFS) in Sri Lanka, which has grown from a volunteer-driven project to a social enterprise with a clear identity and sustainable vision.

4.4 Financing

Investing in the mental health of children and young people improves well-being and quality of life and has long-term economic benefits, such as reduced costs of health care and other public services and increased potential for future earnings *(218)*. The economic rationale for investing in mental health care early in the life-course is gaining traction. Economic analysis performed in 36 countries indicated that implementing a package of care interventions for adolescent's mental health offered a return on investment of 23.6 and a cost of $102.9 per disability adjusted life year (DALY) averted over 80 years *(219)*.

Yet, to date, governments' investment in children and young people's mental health has been low. Even in countries with well-developed health systems, relatively little is spent on children's mental health. It has been estimated that only 0.1% of development assistance for health primarily targets the mental health of children and adolescents. Of that, most is channelled to the humanitarian assistance sector (41%), followed by government and civil services (31%), the health sector (20%), and the education sector (8%) *(16)*.

The factors that influence children and young people's mental health are very diverse (see section 2.2.3) and the power to influence these often lies outside the health sector. Aligning health system investment with those outside the health sector can have significant effects on mental health. Adding a mental health component to education, housing or welfare programmes can make a big difference at relatively little cost. For example, mental health care can be linked with initiatives to improve learning outcomes and prevent school drop-out and exclusion for children and young people experiencing mental health problems *(180, 181)*.

Example of financing approach

- International partnerships with governments, private organizations and research institutions are important sources of support and in some LMICs are the mainstay of care provision for children and young people. For example, in Bosnia and Herzegovina (see Box 3.3), sustained technical and financial support effectively strengthened and expanded existing services. In all cases of international support, care is needed to avoid: short-term, project-oriented

funding that inhibits sustainable service planning; narrowly defined programmes that divert limited country resources away from holistic service planning; and reduced opportunities for local experts and policymakers to shape services *(206)*.

- Combining financial support with a psychological intervention led to reductions in engagement in criminal behaviour and aggression among young, unemployed men in Liberia with high rates of baseline engagement in theft or drug dealing *(220)*.

4.5 Workforce

A skilled and diverse workforce is essential to delivering effective community-based mental health services. The composition of mental health workforces varies globally but, in stepped care models (see section 3.1.2), they broadly include:

- a large base of trained and supervised non-specialist providers that can provide first-level support; and
- a more limited number of specialists – such as psychiatrists, psychologists, and mental health nurses – who provide more intensive support to children and young people with more severe or complex needs.

There is a worldwide shortage of both specialists and non-specialists. Beyond training and task-sharing, service planning should also consider how to sustain and support the workforce, for example by providing ongoing training and professional development opportunities, creating supportive supervision structures, and addressing issues related to motivation and staff turnover.

4.5.1 Pre-service education in mental health for all health professionals

Pre-service education is the learning that takes place in preparation for a future profes-sional role as a health worker. It takes place in universities, colleges and professional schools; and it includes the undergraduate education of nursing and medical students. In many countries, pre-service education in mental health is brief, mostly theoretical and does not give students enough practical experience of mental health care in general health services. Yet pre-service education can instill practical skills. It can also help destigmatize mental health conditions and attract more students into mental health. Pre-service education is the foundation for sustainable mental health care.

Examples of pre-service education in mental health

- Reforms in Tunisia to anchor mental health in primary health care were made possible by an earlier reform of training for family practitioners that mandated three years of specialist training, including a compulsory six months in mental health *(221)*.
- WHO's mhGAP intervention guide (mhGAP-IG) has been successfully integrated into pre-service training programmes for medical students, interns and residents in a range of settings (see also section 4.5.3) *(222, 223)*. For example, in Armenia, Georgia, Kyrgyzstan and

Ukraine, a process took place to include the mhGAP-IG in university curricula, with special emphasis on child and adolescent mental and behavioural disorders. Following an initial workshop and training, each participating university went through a curriculum adaptation phase, and enhanced curricula integrating mhGAP-IG modules were then introduced for medical and nursing students at both undergraduate and postgraduate levels. Evaluations of the enhanced curricula one year after they were implemented showed that the mhGAP-IG modules and materials were well received by students and contributed to increased awareness about mental health and recognition of mental health professionals *(224)*.

4.5.2 Expanding the specialist mental health workforce

Globally, there are just 13 trained mental health providers per 100 000 population; in low-income countries there are fewer than 1 per 100 000 *(4)*. The shortage of specialized mental health workers for children and adolescents is even starker: there are just three mental health workers of any kind per 100 000 population, and a median rate as low as 0.01 per 100 000 population in low-income countries *(4)*.

Examples of initiatives to expand the specialist workforce

- Established to build capacity in child and adolescent mental health in west Africa and other lower-resource settings, the Centre for Child and Adolescent Mental Health at the University of Ibadan, Nigeria has trained 157 professionals from 14 countries in sub-Saharan Africa since 2013. Alumni have pioneered new services, such as the multidisciplinary Centre for Early Development and Learning and Care in Ibadan; the first child and adolescent mental health clinic at Ola During Children's Hospital in Sierra Leone; and a multidisciplinary clinic at the Komfo Anokye Teaching Hospital in Kumasi, Ghana. The centre's graduates run a pioneering counselling service for students at the University of Ibadan and also have key roles in various research initiatives (O.O. Omigbodun, personal communication, 2022).
- In Kampala, Uganda, the Butabika National Referral Hospital runs an advanced diploma course in child and adolescent mental health, training a wide range of health specialists (not just psychiatrists). The programme equips trainees with the clinical, teaching, and managerial skills to provide care, develop child mental health services, and train others. Graduates have gone on to train large numbers of primary health care workers, teachers, and community groups in their local areas *(225)*.
- In Lebanon, the Psychosis Recovery Outreach Programme (PROP) shows how the roles of existing mental health staff can be reconfigured to provide community-based care. PROP, which started in 2016 at the American University of Beirut Medical Center, provides early intervention and recovery-based community services to people aged 16 years and over. PROP has required mental health specialists to move from practising in a siloed hospital environment to working as part of a multidisciplinary community-based team *(226)*.

4.5.3 Expanding the non-specialist mental health workforce

As with adult mental health, individuals without a background in child mental health can be trained to deliver mental health care effectively. Task-sharing can be done with individuals with and without clinical backgrounds, including youth lay counsellors.

In task-sharing approaches, non-specialist mental health workers are trained to provide interventions that broadly apply across a range of mental health conditions. Specialist diagnostic skills are not required: non-specialized providers instead use brief interviews and/or screening tools to select the best approach to care. Key to a non-specialist provider's skill set is the ability to recognize when higher levels of care may be needed.

Supportive supervision

Training needs to be reinforced through regular supervision. Supervision allows continuous development of skills and provides essential emotional support. Lack of supportive supervision in mental health programmes is associated with low provider competency and is a common reason for services to fail *(227)*.

Programmes delivered by youth lay counsellors and peer helpers have potential for scaling up mental health care for children and adolescents. But they need to bear in mind that youth lay counsellors are also managing life transitions and taking on challenging community roles. The Youth Friendship Bench (YouFB) initiative in Zimbabwe has proposed principles for service delivery involving youth lay counsellors *(228)*. These include: provide high-quality training and ongoing appropriate supervision; establish clear roles, responsibilities and boundaries; set parameters for starting and ending counselling; support youth counsellors' own mental health needs; and give youth counsellors adequate and appropriate compensation.

Quality assurance

While the competencies of mental health specialists are usually assessed and maintained by professional licensing organizations, there is often no equivalent quality-assurance mechanism for non-specialists.

Developed by WHO, the Ensuring Quality in Psychological Support (EQUIP) initiative provides a suite of training and assessment tools. EQUIP has been used in: competency-based training in psychological interventions with children and young people for non-specialists; mhGAP training for primary health care workers; and basic skills training for teachers, nurses, and community health workers *(229)*.

mhGAP

mhGAP has enabled training for a wide range of non-specialist health care providers, including general physicians, family doctors, nurses, and community health workers *(230)*. There is also a substantial body of other task-sharing initiatives, including for child and adolescent care, that pre-date mhGAP or use training that is not based on mhGAP *(231)*.

mhGAP has developed a suite of tools to support training and service delivery, including intervention guides, training materials and an operations manual. The mhGAP Evidence Resource Centre houses the background material, process documents, and the evidence

profiles and recommendations for WHO guidelines for mhGAP priority conditions (mental, neurological and substance use).

mhGAP's main implementation tool is the mhGAP Intervention Guide (mhGAP-IG), which comprises a series of modules with simple clinical protocols to guide decision-making around assessment, management and follow-up *(232)*. This includes one module specifically on child and adolescent mental and behavioural disorders.

Although mhGAP training and supervision has been introduced in more than 100 countries, to date many of these initiatives have not included the child and adolescent component.

Structural aspects of health care systems – including workloads, workforce motivation and protocols for delivering mental health care tasks – appear to play a fundamental part in the success or failure of mhGAP implementation.

4.6 Health information systems for monitoring and research

One of the four objectives of WHO's *Comprehensive mental health action plan 2013–2030* is to strengthen information systems, evidence, and research for mental health *(212)*. Robust routine mental health information systems are an essential component of effective service delivery. This means that any plans to scale up services for children and young people's mental health must ensure efficient and sufficient systems for capturing data on key indicators in a way that requires the least additional work necessary from clinical providers.

Child and adolescent mental health programmes need robust health information systems to provide policymakers and planners with reliable data on which population subsets are receiving care and whether available resources are being used efficiently. Reliable data on key indicators can inform decisions and guide improvements related to mental health care.

Yet mental health indicators are typically absent or under-represented in most routine information systems, which can significantly undermine:

- Data-driven decision-making: governments are unable to make informed decisions based on the incidence and prevalence of conditions or use of mental health services.
- Accountability: with no way to streamline reporting, mental health services are not accountable to governments for their performance.
- Research: essential information for designing and implementing effective mental health research is not readily available *(233)*.

Example approach for strengthening health information systems

- The International Consortium of Health Outcome Measurement (ICHOM) is an international initiative to develop core outcome sets that can be used to harmonize measurements globally and across different settings *(234)*. At present, there are existing outcome sets for youth anxiety, depression, psychosis, substance use, autism and with plans to develop a set for neurodevelopmental disorders (P Szatmari, personal communication, 2023).
- In the Western Cape Province, South Africa, child and adolescent mental health services are required to collect a formally defined set of data using the provincial digital information system. The system is set up to collect both in- and outpatient data on admission, attendance, diagnoses, and discharge, from different facilities, including at primary health care level *(235)*.

Conclusion

All countries need to and can strengthen mental health services for children and young people. The benefits of investing in mental health care are clear: reduced suffering, stronger protection of human rights, and better social, developmental and economic outcomes.

In practice, strengthening mental health services means reorienting, reorganizing and building new services and supports to develop a network of community-based care that can cater to all the needs that children and young people experiencing mental health conditions may have. Such networks should comprise a mix of: mental health services integrated in general health care, community mental health services, and services that deliver mental health care in non-health settings. All services should be interconnected, ensuring continuity of care between different services and support, especially for those children and young people who have complex needs or require ongoing care. All services should also be accessible, affordable, appropriate and human rights-based, embedded in communities and engaged with children, young people and their caregivers as key stakeholders in service design and delivery.

There is no single model for organizing community-based mental health services and their exact configuration will vary widely depending on country contexts, local mental health needs, other priorities and the existing state and structure of each mental health system. Yet every country, regardless of resource constraints, can do something substantial to restructure and scale up mental health care for its children and young people. This document has provided an overview of the approaches available and presents several options and opportunities for service design in different settings. The many examples given here show that strategic changes can make a big difference.

In all cases, efforts to strengthen community-based mental health services should be developed with the meaningful participation of children, young people and their caregivers and families. Service strengthening efforts should also be undertaken as part of broader action to address the social and structural determinants of mental health in ways that reduce risks and strengthen protective factors so that all children and young people have an equal opportunity to thrive. This includes integrating mental health promotion and prevention within health, education and social services, as well as initiatives to counter stigma, discrimination, abuse and violence in homes, schools and communities.

Strengthening community-based mental health services for children and young people also requires action to strengthen the core components that underpin a well-functioning mental health system. This means deepening political and financial commitment, including by securing appropriate funds and human resources across health and other sectors, adopting human rights-based laws and policies, and establishing robust information and monitoring systems.

Mental health interventions for children and young people should be included in universal health coverage basic packages of essential services and financial protection schemes. Making mental health care accessible and affordable for all should be a key priority in every country.

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Annex 1: Approach to inclusion of country examples and good practices

Country examples were identified through peer-reviewed literature, review of grey literature or through submission by country stakeholders and experts. The WHO-UNICEF editorial team reviewed all examples to establish if they met eligibility criteria, in consultation with experts as relevant.

Examples and case studies that focused on the following areas of quality improvement were prioritized:

- Services and practices respect evolving legal capacities of children, engage caregivers in decisions and care as required and implement strategies to end coercion, promote recovery and optimize participation and connectedness in local communities.
- Services and practices are child and family-centred and consider the ecology of children and adolescents including social determinants, risks and quality of environments within schools, families and communities, with engagement of all relevant sectors and delivery platforms and integrated into relevant activities.
- Services and practices enhance equity in access to evidence-based care, with attention to reach and benefit vulnerable populations and groups.
- Services and practices promote a life-course approach and continuity of support, with tailored strategies to ensure services are responsive to the needs and acceptable to different age groups and are adapted to the evolving needs and abilities.
- Services and practices are sustainable and scalable (already scaled up efforts OR documenting strategies to increase workforce competency and system capacity to sustainably adopt changes OR documenting innovative strategies to reduce resource requirement for implementation of practice compared to usual practice)
- Services and practices are relevant and acceptable to the local context and designed with engagement of local communities including users.

In addition, the selection of examples was influenced by: the needs to ensure good geographical representation; inclusion of examples from low-resource settings, and; inclusion of good practices that span across various good practice domains, different delivery strategies, age groups and vulnerable populations. Adaptability of the practice to other contexts was also considered.

Efforts were made to document successful evaluated experiences with delivering services. When required, promising practices were also included.

Annex 2: Checklist for action: building mental health services for children and young people

Developing supportive laws and policies for children and young people's mental health services

- Gather information from key stakeholders, including service providers, children, young people and caregivers.
  - ☐ Identify the key concerns for children and young people's mental health.
  - ☐ Identify the existing services, and relevant service improvements that are planned or underway.
  - ☐ Identify the key human rights challenges being experienced by children, young people and their caregivers.
  - ☐ Assess existing policies and laws.
  - ☐ Identify any relevant policies and laws that exist to address children and young people's mental health, including those addressing related issues such as children's rights and child protection.
  - ☐ Determine if there are existing policies and laws for adult mental health services (that do not explicitly include children and young people).
  - ☐ Assess whether the existing framework is sufficient to cover the proposed service strengthening for children and young people.
  - ☐ Identify any obstacles to effective implementation and enforcement.
  - ☐ Assess the level of public support for implementing laws and policies for children and young people's mental health, including understanding of, and agreement with, the rights of young people.
- Develop new laws and policies as needed.
  - ☐ Define strategies for coordinating across sectors and engaging children, young people and caregivers in the process.
  - ☐ Define the vision, values, principles and objectives of the policy or law.
  - ☐ Complete the steps needed to develop new policy in the given setting.
  - ☐ Develop a strategic plan to ensure the policy or law is implemented.
  - ☐ Establish activities and key indicators of success
  - ☐ Determine the time frame for each activity.
  - ☐ Determine the costs and sources of financial support for each activity. Consider alternate sources of funding that are dedicated to children and young people in your context (see section 4.4).
  - ☐ Define how children, young people and caregivers will be involved in monitoring and evaluation.

Co-developing mental health services with children, young people and caregivers

- Determine the roles and responsibilities that children, young people and caregivers should have in strengthening mental health care systems in your context, for example:
  - ☐ formal advisory roles on design and content of services, as experts on cultural and contextual issues;

- caregivers or young people as service providers of early identification, recruitment and/or peer-led interventions;
- champions for mental health advocacy and anti-stigma efforts

- Identify different groups of children, young people and caregivers who can fulfil these roles, ensuring that people from marginalized groups are included.
- Consider the best ways of recruiting and engaging with these groups, for example:
  - identify barriers to participation for marginalized groups, such as stigma, ageism, and any practical barriers such as time and resources needed to participate; and
  - devise engagement strategies that address key barriers.

- Assess whether health care workers need training or retraining on how to promote children and young people's active participation in their care and recovery.
- Assess whether health care workers need training about how to engage caregivers in ways that are appropriate to young people's evolving capacities and growing autonomy.

Securing investment in children and young people's mental health services

- Consider the broader context of health system financing. Where possible, governments should attempt to ensure universal access through either automatic coverage for citizens or, for example, through some form of national mandatory social insurance.
- Find out whether children and young people's mental health services are publicly financed through existing government health funding or insurance.
- Establish whether people need to pay for mental health care out of pocket. If so, this is likely a barrier to access, particularly because of the increased prevalence of mental health conditions among people living in poverty.
- Identify services that are delivered outside the health sector, for example in, youth organisations, schools, universities, or colleges.
- Map the mental health system to understand the level of current resources and how they are used for children and young people.
- Calculate infrastructure and administrative costs for existing children and young people's mental health services.
- Find out where these costs lie, for example in hospitals, child mental health clinics, child psychologists, paediatric mental health units, residential care facilities, outpatient services, information systems or policy/administrative support.
- Identify the source of funding for each cost.
- Develop a resource base for mental health services for children and young people.
- Consider why mental health services are underfunded in the given context. For example, is it because of a general lack of resources, limited understanding of mental health in children and young people, inability of people to pay for services, or an imbalance in resource use among different services?
- Consider whether existing resources may be re-allocated to community-based care for children and young people, with an emphasis on early intervention to reduce the load on other services.
- Explore ways to share costs with existing structures beyond the health sector. For example, leveraging funded youth and nongovernmental organisations, schools or colleges to deliver mental health services.
- Look for any opportunities to attract seed funding for innovative projects, in partnership with non-governmental organisations or academic partners working with children and young people.
- Build budgets for management and accountability.
- Tie the budget to priorities in plans and policies for children and young people's mental health that can be used to track progress.

- Ensure that budgets include costs for policy development, planning and advocacy as well as service delivery.
- In the case of de-institutionalization, consider the costs of expanding community-based services in parallel and the possible need for doubling funding during the transitional period.
- Explore ways to use budgeting and financing to encourage the shift towards community-based mental health care for children and young people, for example through budget flexibility, financial incentives or dedicated funds for community-based service development.
- Track and draw attention to expenditure for children and young people's mental health services, for example by developing specific reporting lines.

Designing information systems for mental health services for children and young people

- Establish what information is needed from children and young people's mental health services.
- Convene a task team to take responsibility for designing and implementing the information system, including representatives from different sectors and components of the mental health system, considering the views of children, young people and caregivers.
- Consider policy and planning objectives to ensure that information system design matches national priorities and can measure progress in implementation.
- Consult all stakeholders to identify information needs and measure the policy and planning objectives for children and young people's mental health services.
- Determine what information on children and young people is being collected.
- Do a walk-through of the full system to understand any process-related challenges and how these might apply to information for children and young people.
- Identify key indicators; these should be feasible to collect, relevant, and specific to children and young people.
- Map how information will be collected and managed, how frequently it will be collected and roles and responsibilities.
- Consider how information will be gathered from different partners e.g. school-based services or non-governmental organizations.
- Develop relevant data collection tools and manuals.
- Train all staff in the new system.
- Pilot the new system and address any practical barriers to data collection.
- Refine the system and begin using it in line with an operational plan.
- Evaluate how well the system is working.

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