Integration of Mental Health and Psychosocial Support in Primary Health Care

for Children, Adolescents, Pregnant Women and New Mothers in the Middle East and North Africa Region

SAUDI ARABIA

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Integration of Mental Health and Psychosocial Support in Primary Health Care

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Saudi Arabia Country Report 2024

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Acronyms and abbreviations

COVID-19	Coronavirus Disease 2019
DALYs	disability-adjusted life years
DHS	Demographic and Health Survey
GBD	Global Burden of Disease
GCC	Gulf Cooperation Council
GSHS	global school-based student health survey
IASC	Inter-Agency Standing Committee
IFRC	International Federation of Red Cross and Red Crescent Societies
MENA	Middle East and North Africa
mh-GAP	Mental Health Gap Action Programme (WHO)
MHPSS	mental health and psychological support
MICS	Multiple Indicator Cluster Survey (UNICEF)
NGO	non-governmental organization
PHC	primary health care
SOWC	State of the World's Children (UNICEF)
TAG	Technical Advisory Group
UHC	universal health coverage
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization

Definitions

Term	Definition
Generalized anxiety disorder	People with generalized anxiety disorder display excessive anxiety or worry, most days for at least 6 months, about a number of things such as personal health, work, social interactions and everyday routine life circumstances.
Panic disorder	People with panic disorder have recurrent unexpected panic attacks. Panic attacks are sudden periods of intense fear that come on quickly and reach their peak within minutes.
Social phobia	People with social anxiety disorder have a general intense fear of, or anxiety toward, social or performance situations.
Agoraphobia	People with agoraphobia have an intense fear of two or more of the following situations: (i) Using public transportation, (ii) Being in open spaces, (iii) Being in enclosed spaces, (iv) Standing in line or being in a crowd, (v) Being outside of the home alone.
Separation anxiety disorder	People who have separation anxiety disorder have fears about being separated from people to whom they are attached (e.g., parent or spouse). Separation anxiety is often thought to be associated with children only, but it can also be diagnosed in adulthood as well.
Obsessive-compulsive disorder	Obsessive-compulsive disorder (OCD) is a common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviours (compulsions) that he or she feels the urge to repeat over and over.
Post-traumatic stress disorder	Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, frightening, or dangerous event.
Bipolar disorder	Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels and the ability to carry out day-to-day activities.
Major depressive disorder	Major depressive disorder causes severe symptoms that affect how one feels, thinks and handles daily activities, such as sleeping, eating, or working.
Bulimia	People with bulimia have recurrent and frequent episodes of eating unusually large amounts of food and feeling a lack of control over these episodes. This is often followed by purging, excessive exercise, or fasting.
Binge-eating disorder	People with binge-eating disorder lose control over their eating. This is often followed by feelings of embarrassment, shame, guilt and anger

Term	Definition
Attention-deficit/hyperactivity disorder	Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.
Conduct disorder	People with conduct disorder exhibit a repetitive and persistent pattern of negativistic, hostile and defiant behaviour toward authority figures, continuing for at least 6 months and resulting in significant impairment in functioning.
Drug abuse	Drug abuse is characterized by the recurrent use of substances, often leading to failing to fulfil major role obligations (e.g., absence from work), repeated use in risky situations (e.g., while driving), multiple legal problems (e.g., arrest for disorderly conduct), and recurrent social and interpersonal problems (e.g., conflicts in marriage or divorce).
Drug dependence	People with drug dependence continue to use drugs (legal and/or illegal), despite significant physical or psychological problems caused by it. This pattern of repeated use usually results in tolerance (requiring more of a drug to achieve the same effect), withdraw (negative symptoms as result of discounting the drug) and compulsive drug-taking behaviour.
Intermittent explosive disorder	Intermittent explosive disorder is characterized by separated episodes of failure to resist aggressive impulses resulting in serious assaults or destruction of property.

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The National Team included:

Marwah A. Behisi

Registered Psychologist, Saudi Arabia
Clinical Child Psychology
Child and Adolescent Psychiatry and Behavioral Science Department,
King Abdullah Specialized Hospital for Children

Munirah Y. Alassaf

Registered Psychologist, Saudi Arabia
Clinical Psychologist
Prince Mohammed bin Salman Autism and Neurodevelopmental Disorders Centre, Prince Sultan Medical Military City

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Country Technical Advisory Group:

Dr. Abdulhameed A. Alhabeeb

General Supervisor, Consultant Psychiatrist, Saudi Arabia
National Center of Mental Health Promotion,
Ministry of Health, Saudi Arabia

Dr. Mohammed Al Qahtani

Full Professor, Department, King Khalid University
Consultant of Clinical Psychology,
King Abdullah bin Abdulaziz University Hospital

Regional Technical Advisory Group:

Dr. Khalid Saeed, WHO Eastern Mediterranean Region

Eoin Ryan, International Medical Corps

Alexandre Letzelter, Action Contra La Faim

Nancy Baron, Psycho-Social Services and Training Institute in Cairo (PSTIC)

Dr. Yasser Abu-Jamea, Gaza Community Mental Health Programme

Ahlem Cheffi, International Federation of Red Cross and Red Crescent Societies (IFRC)

Marta Petagna, Save the Children International

Ashraf Alkilani, World Vision International

Despina Constandinides, Danish Red Cross

Benedicte Duchesne, United Nations High Commissioner for Refugees (UNHCR)

Dr. Khaleel Hamad, United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)

Executive summary

Globally, one of the most overlooked health concerns involves the mental health and psychosocial well-being of children and adolescents (ages 0–18 years). Before the onset of COVID-19, the World Health Organization (WHO) reported that 10–20 per cent of children and adolescents worldwide experience poor mental health, and half of all mental disorders have their onset before the age of 14 years. It is estimated that 1 in 6 adolescents between" the age of 10–19 years experiences a mental health disorder, and suicide stands as a leading cause of death for individuals aged 15–19 year in the Middle East and North Africa (MENA) region. Additionally, many young individuals encounter psychological distress that may not align with the diagnostic criteria for a mental health disorder but significantly influences their health, development and overall well-being.

Poor mental health profoundly affects the health, learning and social well-being of children and adolescents, limiting their potential. Childhood and adolescence are crucial developmental stages that shape social, emotional and cognitive skills, laying the foundation for lifelong mental well-being. Mental disorders emerging during this period often persist into adulthood, posing a risk to future mental health. In the MENA region, factors such as conflict, violence, displacement and the aftermath of the COVID-19 pandemic significantly contribute to poor mental health for this age group.

Despite the significant burden of mental health issues in children and adolescents, there is a substantial unmet need for mental health and psychosocial support (MHPSS). Globally, only 2 per cent of total health expenditure is allocated to mental health, despite the fact that it constitutes 7 per cent of the disease burden. In low- and middle-income countries, the ratio of mental health specialists for children and adolescents is estimated to be <0.5 per 100,000. Similar challenges exist in the MENA region, marked by fragmented approaches, limited resources, poor sector coordination, and persistent stigma. Addressing child and adolescent mental health in non-emergency contexts receives less attention compared to humanitarian settings.

MHPSS plays a crucial role in promoting well-being, preventing mental health issues, and ensuring quality care for those with conditions. Achieving this requires collaboration across sectors, involving health, education, social welfare and justice, along with engagement from communities, schools, parents, service providers and young individuals. Despite global frameworks emphasizing the importance of integrating mental health into primary care, challenges persist, including inadequate training and support for primary care providers, high caseloads, coordination issues with specialized services, insufficient funding, and the absence of clear guidelines for integrating MHPSS into primary health care (PHC).

The Kingdom of Saudi Arabia (KSA) is the largest sovereign nation in the Middle East. Its total population is 33.4 million, 20.7 million are Saudi citizens and the other 12.7 million are guest workers. According to the General Authority for Statistics, 2018, of the whole Saudi population, 51 per cent are male and 49 per cent are female. Thirty per cent of the population are under the age of 14 years, 19 per cent are age 15–24 years, 18 per cent are age 25–34 years, 19 per cent are age 35–49 years, and 14 per cent are age 50 years and older. Among the Saudi population of age 15 years and older, 37 per cent are unmarried, 58 per cent are married, 2 per cent are divorced, and 3 per cent are widowed (General Authority for Statistics, 2017). According to the Human Development Index, Saudi Arabia ranked as the 39th best high-income state in the world for its health and education systems in 2014 (Carlisle, 2018).

With the establishment of a national mental health policy in 2006, Saudi Arabia witnessed significant growth in mental health services. Specialty programmes and consultation-liaison services in general medical settings were implemented for various demographics, including children, adolescents and the elderly, and for addiction. The 2007 Saudi Arabian Mental and Social Health Atlas (SAMHA) aimed to address a broad range of mental health needs. A study in 2013, based on the WHO Assessment for Mental Health Systems, reported milestones such as allocating 4 per cent of total healthcare spending to mental health, which surpassed the global average of less than 2 per cent. Despite these achievements, the Kingdom's hospital-based mental health system, developed over three decades and fortified by a mental health law in 2014, lacks sufficiently independent and robust mechanisms for safeguarding the human rights of psychiatric patients. In addition, there are gaps in outpatient and primary care level services.

Approach and rationale for the project

This study aims to understand how MHPSS for children's, adolescents' and maternal mental health can be effectively integrated and delivered through primary health care in Saudi Arabia. The specific objectives are to explore current challenges and opportunities to strengthen the integration and delivery of MHPSS through primary health care, identify supports and steps required, determine the key recommendations for MHPSS implementation within primary health care, and explore linkages between primary health care and other key sectors. This study is based on three main sources of data including peer-reviewed and grey literature, a country-level workshop, and interviews with stakeholders.

A review and synthesis of all available peer-reviewed and grey literature describing mental health needs, barriers and enablers to accessing mental health services at the primary or community level were conducted. The review included all available national policies to identify what MHPSS services are delivered through primary health care and existing linkages with other key sectors. In addition, the review and synthesis included peer-reviewed and grey literature on current MHPSS programmes delivered through primary health care to determine approaches and gaps.

A consultative workshop was conducted to present the key findings of the desk review and to co-develop recommendations for Saudi Arabia. As a result, key informants and relevant stakeholders were identified and selected for interviews. The interviews were to provide qualitative data through collecting and analysing respondents' ideas, opinions and experiences about MHPSS integration into primary health care. The interviews were conducted through Zoom and in-person (face-to-face) with key stakeholders, partners and MHPSS implementers. These interviewees included primary health care providers, mental health specialists, academics and stakeholders from the health policy sector and youth-led organizations. The qualitative data helped uncover intricate details about the subject matter.

Key findings

When mapping the populations at the highest risk of mental health disorders, it was generalized that all residents, whether children, youth, adults, or elderly, were at high risk, given that the majority or people are dealing with a high prevalence of stressors. Notably, the most imperative needs among children were behavioural and social difficulties, as well as learning and intellectual disorders. In addition, bullying and depression were found as high-priority areas of need for support for children and adolescents, followed by other areas such as substance abuse, attention-deficit/hyperactivity disorder (ADHD), and domestic violence. The most frequently reported key risks or determinants of mental health challenges by participants were mainly contextualized and cultural factors, followed by other social and personal stressors.

The current model of care in Saudi Arabia is the delivery of MHPSS through primary, secondary and tertiary care facilities combined with outreach activities that include awareness and screening activities at the community level. The mode of service delivery is currently not systematic. Covering the full range of services from screening to referrals is not always feasible, accessible or sustainable, and this may be attributed to many reasons. For example, there are limited tools and guidelines that support screening, diagnosis, collaborative care and referral for children and adolescents at the primary care level, along with limited intersectoral communication, training opportunities and workforce shortages, and insufficient legal protection for children and adolescents within the health care system. Therefore, MHPSS implementation relies heavily on secondary and tertiary care facilities.

The integration of MHPSS for children, adolescents and mothers into primary health care in Saudi Arabia can be significantly improved. Findings of this study have led to several broad recommendations for MHPSS integration into primary health care.

Governance and coordination

Short term:

- United Nations agencies, non-governmental organizations (NGOs), youth organizations and academics should continue to advocate with health leaders to increase awareness and prioritization of child, adolescent and maternal mental health. This should include better use of existing data to describe the burden of poor mental health, economic modelling to estimate health and economic impacts, and evidence of best practice and gaps in service delivery to direct efforts.

Intermediate term:

- Establish a high-level national coordinating body for child and adolescent mental health led by the Ministry of Health with representatives from key sectors and youth organizations to support cross-sectoral policy development, planning and implementation with clearly defined roles for primary health care.

- Enhance coordination between primary health care and the mental health system, with joint training programmes established that bring together professions from various fields (medicine, psychology, psychiatry, social services and education) to improve collaborative roles. Moreover, a working group or committee that represents all sectors at the sub-national level can be selected to hold regular meetings for sharing insights and conducting workshops. In addition, utilize telemedicine services, which can be more effective in remote areas, to connect mental health specialists to primary health care providers.

Legislation, policy, strategy, budget and financing

Short term:

- Strengthen mental health legislation to provide specific protection and considerations for children, adolescents, pregnant women and new mothers.

Intermediate term:

- The Ministry of Health should develop clear clinical guidelines to support screening, diagnosis and collaborative care of children, adolescents and mothers at the primary health care level by non-specialist providers, and establish referral protocols to facilitate referral for specialist care when required. This should include guidance on the integration of MHPSS into maternal and child health care programmes.

Long term:

- Develop a multisectoral child, adolescent and maternal health strategy with clearly defined roles for primary health care, in addition to strengthening the integration of child, adolescent and maternal mental health into existing policies. This includes a focus on actions for prevention and promotion of mental health.

- Increase investment in child and adolescent mental health, informed by economic analyses to determine the costs of effectively implementing MHPSS at the primary care level.

Referral system and linkages with other sectors

Short term:

- Strengthen coordination and communication between different sectors (health, education and social services, and include NGOs) with regular meetings, joint trainings, shared databases, and the creation of designated focal points within each sector to foster mutual understanding, trust and collaboration in delivering mental health care and support.

Intermediate term:

- Enhance sector-specific capacity and awareness regarding mental health issues. Education, training, supervision and support tailored to the unique needs of each sector will increase the knowledge, skills and attitudes of staff members in identifying, assessing, referring and following up on mental health concerns.

- Develop clear and consistent guidelines (informed by global best practices) for referral within and between sectors (health, education, social services and justice) and outline roles and responsibilities for identifying, assessing and transferring patients across sectors. This also involves linking the Ministry of Education to the Ministry of Health to facilitate teacher referrals for developmental and behavioural disorders, and maintaining electronic health records for children that ensure timely mental health care.

Workforce

Long term:

- The Ministry of Health, with professional associations, and academic and training institutions, should establish a workforce development strategy for mental health, including roles and skills of non-specialist providers, training needs and mechanisms to improve supervision and support. Supporting the existing workforce and providing training to medical staff who provide mental health services can potentially alleviate the high costs associated with dedicated psychologists.

Models of care and service delivery

Short term:

- Improve access through subsidizing mental health services and improve transportation infrastructure to connect people to facilities.

Intermediate term:

- The Ministry of Health should strengthen existing primary health care and mental health policy and guidelines to provide clear guidance on what MHPSS services can be delivered through primary health care and how these services could be integrated into existing service delivery platforms (for example, integration of positive-parenting skills into maternal health, or screening for perinatal mood disorders and risks through antenatal and postnatal care).

Long term:

- Implement a comprehensive family doctor programme along with recommendation to develop tools that would integrate mental health into routine assessment of children and adolescents (for example, the HEADS assessment for adolescents). In addition, advocate for flexibility in the health insurance market and establish national programmes that contribute to an overarching strategy for improving overall well-being.

Engagement of the community and other stakeholders

Short term:

- It is important to engage young people and their families in mental health programmes. This will improve their understanding of mental health and allow them to provide feedback on the quality of their experiences. This will help in determining how service delivery can be optimized.

Intermediate term:

- To improve care-seeking and access to MHPSS, raising awareness and reducing stigma is crucial. This can be achieved by engaging the communities in national campaigns and working with community organizations at the local level to reduce stigma.

Data, health information, research, monitoring and evaluation

Short term:

- Continuously evaluate and monitor referral systems through data collection, analysis and reporting. The performance, quality, efficiency, effectiveness and impact of these systems can be measured through implementation of a quality evaluation tool for children, adolescents, their families, and services providers to determine their satisfaction and suggestions for can be changed. Identifying strengths, weaknesses, opportunities and challenges will guide improvements, utilizing standardized indicators, tools, methods and formats for consistent evaluation.

Long term:

- Promoting mental health research in Saudi Arabia requires increased funding and incentives, support for researchers, and ethical guidelines. Defining clear goals, collecting and using data, and allocating resources for monitoring and evaluation are essential for programme impact and effectiveness.

1. Introduction

One of the most unrecognized health issues globally is the mental health of children and adolescents (aged 0–18 years). Prior to COVID-19, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of the mental disorders starting in adolescents before the age of 14 years, and 1 in 6 adolescents aged from 10–19 years is estimated to have a mental health disorder. Suicide is a leading cause of death for 15–19-year-olds in the Middle East and North Africa (MENA) region. In addition, many children and adolescents experience psychological distress but do not meet the diagnostic criteria for a mental health disorder. However, this condition can significantly impact their health, development and well-being.

Box 1: Definitions

'Mental health and psychosocial well-being' is a positive state in which children and adolescents are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn, and have a positive sense of self and identity.

'Mental health conditions' is a broad term that encompasses the continuum of mild psychological distress through to mental disorders, that may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, behavioural health conditions include anxiety disorder, worry, unhappiness or loneliness; and disorders such as depression, anxiety, conduct disorder, psychosis, bipolar disorder, eating disorder, substance-use disorder, attention-deficit/hyperactivity disorder, intellectual disability, autism, and post-traumatic stress disorder.

Adapted from the UNICEF report The State of the World's Children 2021

Mental health conditions can have profound impacts on children's and adolescents' health, learning, social well-being and participation, restricting opportunities for them to reach their full potential. Childhood and adolescents are times of crucial brain growth and development during which social, emotional and cognitive skills are formed, laying the foundation for mental health and well-being into adulthood. Additionally, mental disorders that may be a risk factor for adult inadequate mental health typically have their onset during this developmental stage. In the MENA region, exposure to conflict and violence, displacement and the consequences of the COVID-19 pandemic are likely to be significant contributors to poor mental health.

Box 2: Mental health psychosocial support (MHPSS)

MHPSS refers to any support, service or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Originally defined by the Inter-agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Humanitarian Settings, this composite term is now widely used and accepted by UNICEF, partners and practitioners in development contexts, humanitarian contexts and the humanitarian-peace nexus. It serves to unite as broad a group of stakeholders as possible and underscores the need for diverse, complimentary approaches to support children, adolescents and their families. The focus of this project is primarily on actions required in non-humanitarian settings.

Despite this substantial burden, there is a significant unmet demand for mental health and psychosocial support (MHPSS) for children and adolescents. The governmental expenditure globally on mental health accounts for only 2 per cent of the total health expenditure, despite the burden of disease for mental health, which accounts for 7 per cent of the total health expenditure. The estimated ratio of mental health specialists with expertise in treating children and adolescents is <0.5 per 100,00 in low- and middle-income countries. These limitations in financing and specialization are also found in the MENA region. There are gaps and overlooked opportunities to prevent poor mental health and facilitate well-being. Approaches are often small-scale and fragmented. In addition to insufficient monetary and human resources, there is a shortage of coordination between sectors (including health, child protection and education), and significant stigma remains a substantial barrier to ensuring children, adolescents and their families have access to quality services and support. Many endeavours have focused on humanitarian settings with less attention to actions needed to address child and adolescent mental health and well-being in non-emergency contexts.

While a comprehensive package of MHPSS requires coordinated interventions delivered by multiple sectors, the health sector (particularly primary care) provides an important platform for identifying and responding to mental health needs, providing key interventions to address risk factors, and engaging communities and families to support health promotion and mental health literacy. Since 1975, WHO has advocated for the integration of mental health care into primary care, moving away from the over-reliance on highly specialized and institutional services. Most mental health conditions can be effectively diagnosed and treated by non-specialized providers in the primary care setting. These services are also likely to be more accessible, affordable, acceptable to children and their families, less stigmatizing, and have greater capacity for person-centred care and support. There are also critical opportunities to identify and address risk factors (such as family violence) and integrated mental health promotion.

The role of the MHPSS is to promote well-being, prevent poor mental health by addressing risks and enhancing protective factors, and ensure quality and accessible care for those with mental health conditions. This needs the cooperation and collaboration of all sectors – including health, education, social welfare and justice – as well as engagement with communities, schools, parents, service providers, and children and adolescents themselves. The need to reinforce primary and community mental health care is emphasized in the WHO Mental Health Action Plan, UNICEF's Global Multisectoral Operational Framework, and the Scaling up of mental health care: a framework for action for the Eastern Mediterranean Region. Nevertheless, effective integration of mental health into primary health care remains an unmet goal in many countries and contributes to a significant unmet need for services. Inadequate training and support for primary care providers, high caseloads and time pressure, poor coordination of referral with specialized services, insufficient funding, and lack of clear guidelines and protocols for integrating MHPSS into primary health care (including maternal and child health care) are common challenges worldwide.

Box 3: Addressing MHPSS and well-being in children and adolescents

To address the mental health and psychosocial well-being of children and adolescents there is an urgent need to:

- Shift the current approach: Transform the emphasis from medicalization of mental illness to the value of ensuring mental health and well-being to society and communities.
- Move to providing diverse services that support and promote mental health across sectors rather than scaling up only specialist clinical services for mental disorders.
- Widen the scope of mental health to include a focus on creating an enabling environment that increases protective factors and decreases risk factors across the life cycle, recognizing the gendered nature of mental health and the importance of resilience, empowerment and social cohesion for psychosocial well-being.
- Ensure that the perceptions, experiences and views of children and adolescents are central not only to understanding their mental health needs but also to shaping and enhancing mental health services and systems.

Saudi Arabia is regarded as the largest sovereign nation in the Middle East. Its total population is 33.4 million. With this, 20.7 million people are Saudi citizens, and 12.7 million people are guest workers. According to the General Authority for Statistics, 2018, of the whole Saudi population, 51 per cent are male and 49 per cent are female. Thirty per cent of the population is under the age of 14 years, 19 per cent is aged 15–24 years, 18 per cent is 25–34 years, 19 per cent is 35–49 years, and 14 per cent is aged 50 years old and above. Among the Saudi population aged 15 years and older, 37 per cent are unmarried, 58 per cent are married, 2 per cent are divorced, and 3 per cent are widowed (General Authority for Statistics, 2017). According to the Human Development Index in 2006, Saudi Arabia ranks as the 39th best high-income state in the world for its health and education systems in 2014 (Carlisle, 2018).[1]

In Saudi Arabia, mental health services have expanded over time. By 2006, the country had a national mental health policy, specialty programmes for addiction, children, adolescents, the elderly, and consultation-liaison services in general medical settings. The 2007, Saudi Arabian Mental and Social Health Atlas (SAMHA) was designed to recognize and address the population's mental health needs (Al-Habeeb and Qureshi, 2010).[2] In 2013, Qureshi, Al-Habeeb and Koenig published the first study on Saudi Arabia's mental health system. The study was based on the World Health Organization (WHO) Assessment for Mental Health Systems, and the data was collected from the Ministry of Health in 2009 and 2010. The researchers noted that they have already accomplished several key milestones, 4 per cent of total healthcare spending was devoted to mental health, compared to less than 2 per cent worldwide (World Health Organization, 2018).[3] Saudi Arabia has developed an extensive hospital-based mental health system over the past three decades, culminating in the passage of a mental health law in 2014. This law incorporates a number of the international health standards promoted by WHO. However, the mechanisms for protecting psychiatric patients' human rights are neither sufficiently independent nor robust (Carlisle, 2018).[4]

In 2003, a WHO report identified that there was *"limited attention to the mental health of children and adolescents that may result in lifelong consequences to mental disorders."* Data on psychopathology in children and adolescents are lacking. According to a Western study, only 27 per cent of children with psychiatric disorders had been in contact with a specialist (Meltzer et al, 2002).[5] The Arab community sample exhibited 1 in 7 children who had a psychiatric disorder that impacted functioning significantly, and none received professional health care. In the past decade, child and adolescent psychiatric epidemiology studies have been common in developing countries. In contrast, such studies are less common in the Arab world and Gulf countries. Epidemiological studies of children and adolescents with mental health problems are important to plan service delivery, develop prevention programmes and improve early detection.

2. Aims and objectives

The aims of the desk review are to summarize current knowledge about child, adolescent and maternal mental health needs, and to record policies and programmatic interventions to date that provide MHPSS through primary care in Saudi Arabia. This will provide context for the country-level analysis and support the qualitative component of the study.

Specific objectives are to:

1. Review and summarize available peer-reviewed and grey literature describing mental health needs, barriers and prerequisites to accessing primary or community mental health services for children and adolescents aged 0–18 years, and maternal mental health, particularly among underserved or high-risk groups.

2. Review and summarize available national policies addressing mental health, child and adolescent health, maternal and child health, child protection and education to identify what MHPSS services are provided (or recommended) by primary care and the linkages among key sectors.

3. Develop a regional framework for the delivery of multi-tiered MHPSS services for children and adolescents specific to this region identifying:

   - Actions needed for responsive care, promotion and mental health prevention
   - Sectoral roles (with a focus on the health, social welfare, education and justice sectors)
   - Roles of key government agencies, NGOs, UNICEF, other United Nations agencies and the private sector
   - Considerations for strengthening a multisectoral mental health system.

3. Methodology

This project was led by Burnet Institute in partnership with UNICEF Middle East and North Africa (MENA). At the national level, there was cooperation between the UNICEF focal point in Saudi and the Ministry of Health.

3.1 Project overview

Phase 1: Overview of mental health needs of children, adolescents and caregivers across MENA		
1. Establishment of a Regional Technical Advisory Group (TAG) 2. Desk-based review of available national-level data to describe outcomes and risks 3. Review and synthesis of regional and global MHPSS frameworks to identify key actions for primary health care 4. Review of national mental health policies		
Phase 2: Country level in-depth analysis		
In depth desk-based review of data and policies	**Country-level stakeholder meetings** to co-develop recommendations, identify key knowledge gaps and identify priorities for further research	**Key informant interviews** to explore how priority actions for MHPSS can be more effectively integrated into primary health care
Regional dissemination and regional and country-level reports		

3.2 Country-level analysis components

3.2.1 Desk-based reviews

Review available national-level and comparable data describing mental health needs of children and adolescents aged 0–19 years. In addition, review available peer-reviewed grey literature examining mental health and mental health risks and determinants or psychosocial well-being, barriers and requirements to access quality MHPSS, and evidence-based interventions and approaches to improve mental health and/or psychosocial well-being. As well as mapping policies, strategies, and plans.

Synthesis of peer-reviewed and grey literature

Literature was sought to describe enablers and barriers to accessing mental health services for children, adolescents, pregnant women and mothers, specifically in high-risk and underserved populations. Both Arabic and English articles were found in Google Scholar, PubMed and Psycinfo. Mental health, children and adolescents, maternal health, Saudi were the bases of the search strategy.

Identifying existing regional policies, strategies and legislation

Government websites were reviewed regarding maternal and child health, child protection, education and children's and adolescents' health to identify recommended or established MHPSS delivery through primary health care and links to key sectors. The aim was to identify to what extent actions related to children and/or adolescents (aged 0-19 years) were included in policies, strategies and legislation.

3.2.2 Interviews with stakeholders

A total of 12 stakeholders from different sectors were interviewed. Interviews were conducted in person or using Zoom. Interviews were recorded after obtaining consent from the interviewees. Ethical approval was obtained from SHARIK.

The analysis of the interviews was conducted by adding notes to the analysis framework, which was later reviewed and edited by a second researcher to add any additional details. The interviews mainly focused on two sections:

- Current services and approaches to the implementation of MHPSS, and
- Primary health care levers

The current services included the priority of mental health needs, current MHPSS, and priority of MHPSS services. In addressing the primary health care levers, the interviews focused on:

- Government and policy framework,
- Funding and allocating resources,
- Models of care,
- Engagement of communities and stakeholders,
- Physical infrastructure,
- Medicines and other health products,
- Engagement with the private and NGO sectors,
- Quality of care,
- Digital technologies for mental health,
- Research, and
- Monitoring and evaluation.

The interviews were conducted in Arabic language, then got translated to be added to the framework sheet.

3.2.3 Country-level Workshop

An online and an in-person workshop was held with non-governmental, government and stakeholders from the health, education, social welfare and justice sectors to provide feedback on the regional framework, prioritize MHPSS actions and propose sectoral roles as well as identifying possible barriers. The stakeholders were invited from various sectors and programmes (**see Table: 1**).

Table 1: Participants in the stakeholder workshop by sector and programme

Sector/Programme	Number
Family Affairs Council	6
UNICEF	4
Burnet Institute	1
The National Centre for Mental Health	3
Research and Social Administration at the Ministry of Human Resources and Empowerment	3
Ministry of Culture	2
Rehabilitation and Social Guidance Agency	1
Ministry of Education	2
Public Health Authority	1
National Family Safety Programme	1
Early Childhood Programme	1
World Health Organization	2
National Health Transformation Project	1
Human Rights Authority	1
Ministry of Health • Child Health Programme in the General Administration of Health • Primary Healthcare Programme in the General Administration of Health Programmes	7
Ministry of Justice	2

3.2.4 Global and regional MHPSS frameworks

Key steps to support the mental health and psychosocial well-being of children, adolescents and caregivers are outlined in global and regional frameworks, guidelines, plans and other guidance documents in a manner that broadly relates to:

1. Responsive care for those with mental health conditions
2. Prevention of poor mental health by addressing risk and protective factors
3. Mental health promotion

These guidance documents go beyond concentrating on the clinical treatment and management of people with mental health disorders and take important steps to prevent poor mental health by addressing risk and protective factors within the health sector. Numerous MHPSS-related interventions can be successfully provided through primary healthcare, either as standalone mental health programmes or as parts of other service delivery models (such as maternity and child health care, nutrition programmes, and physical health services).

4. OVERVIEW OF MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS INCLUDING BARRIERS TO ACCESS

4.1 Mental health outcomes for children, adolescents

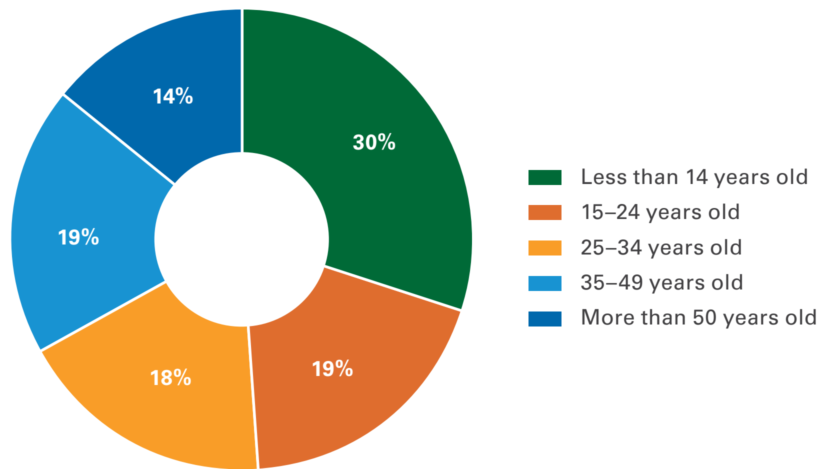
Globally, it is estimated that one in seven (14 per cent of) 10–19-year-olds suffers from a mental health condition (World Health Organization, 2022)[6] yet these conditions go largely unnoticed and untreated. Adolescents with mental health conditions are particularly vulnerable to social exclusion, discrimination, stigma (which affects their willingness to seek help), educational challenges, risk-taking behaviours, physical illnesses, and human rights violations. Children's and adolescents' developmental opportunities are impacted by mental health issues, which can last into adulthood (Haller et al., 2016).[7] More than three quarters of young adults with psychiatric disorders were diagnosed between the ages of 11 and 18 years, (Ferdinand et al, 1995)[8] (Burke et al, 1991)[9] implying that childhood and adolescent mental illness must be considered as a key risk factor for later psychiatric problems. However, important questions about diagnostic prediction from childhood to adolescence and adulthood remain (Kessler et al., 2007).[10]

According to the Global Burden of Disease (GBD) study, the estimates of mental health disorders in the Gulf Cooperation Council (GCC) are as common as they are globally. However, they are underreported due to limited awareness, minimal actions to seek support, shortage of mental healthcare professionals and low financing. According to the GBD study, in the GCC (the United Arab Emirates, Saudi Arabia, Qatar, Oman, Kuwait and Bahrain), the estimate of mental disorders to the total burden of disease ranged between 9 per cent and 14 per cent in comparison to 7 per cent in high-income countries globally. In a recent meta-analysis by Chan et al. (2021)[11] on children and adolescents in the GCC, the reported the rate of depression is 6.12 per cent to 45.09 per cent, anxiety 17.27 per cent to 57.04 per cent, stress 43.15 per cent, eating disorders 31.55 per cent, and attention-deficit/hyperactivity disorder (ADHD) 12.83 per cent to 26.14 per cent.

Previous research on mental health problems in Saudi Arabia came from two primary sources: the Global Burden of Disease (GBD) Initiative run by the Institute of Health Metrics at the University of Washington (Memish et al., 2014);[12] and small studies based on limited samples of patients in Saudi Arabia. According to General Authority of Statistics (2018) The age distribution in Saudi Arabia is much younger than the in the majority of other high-income countries. According to the General Authority of Statistics (2017), 37 per cent of Saudis aged 15 years and older are unmarried, 58 per cent are married, 2 per cent are divorced, and 3 per cent are widowed. In Saudi Arabia, an estimated prevalence of mental disorders, according to IHME, 2019, is approximately 14.79 per cent. According to the same report, the percentage of disability-adjusted life years (DALYs) lost due to mental disorders in Saudi Arabia is approximately 9 per cent (IHME, 2019).[13]

In 2003, a World WHO report identified that there is *"limited attention to the mental health of children and adolescents that may result in lifelong consequences to mental disorders".* Data on psychopathology in children and adolescents is lacking. According to a Western study, only 27 per cent of children with psychiatric disorders had been in contact with a specialist; Most children with significant mental health problems (71 per cent) sought help from a general practitioner or secondary care provider, but 30% did not seek assistance from any healthcare service. Children with emotional disorders were less likely to receive help, possibly because parents may be unaware or not take their child's emotional problems as seriously (Meltzer et al, 2002).[5] The Arab community sample exhibited 1 in 7 children who had a psychiatric disorder that impacted functioning significantly and none received professional health care. In the past decade, child and adolescent psychiatric epidemiology studies have been common in developing countries. In contrast, such studies are less common in the Arab world and Gulf countries. Epidemiological studies of children and adolescent mental health problems is important to plan service delivery, develop prevention programmes and improve early detection.

Figure 1: Age distribution of population in Saudi Arabia



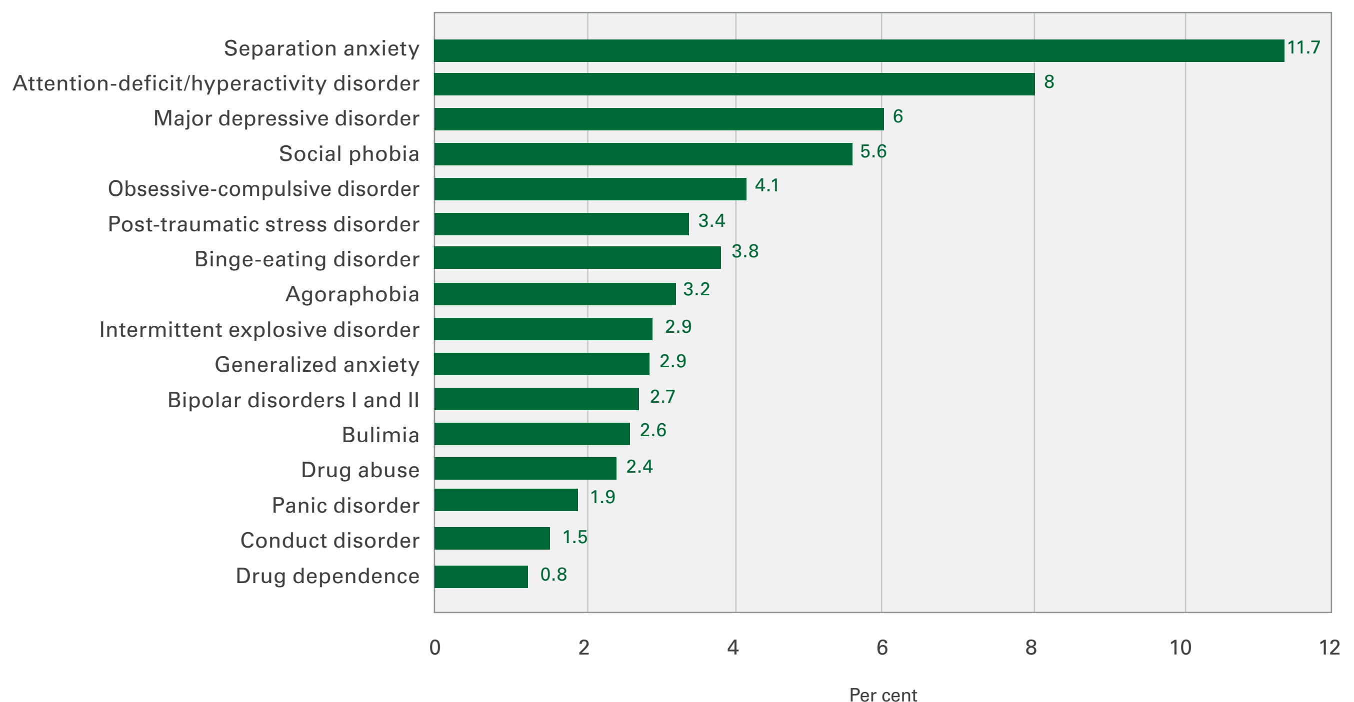
Source: General Authority of Statistics (2018).

The Saudi National Mental Health Survey (SNMHS) is a national survey that aims to understand all aspects of mental health in Saudi Arabia, including:

- the prevalence of mental health problems and its burden in communities,
- the individuals who are most at-risk, and
- the best ways of offering mental health services.

This project is important in providing a vision for clinicians and health policy makers to establish relevant preventive, therapeutic and rehabilitation services in Saudi Arabia.

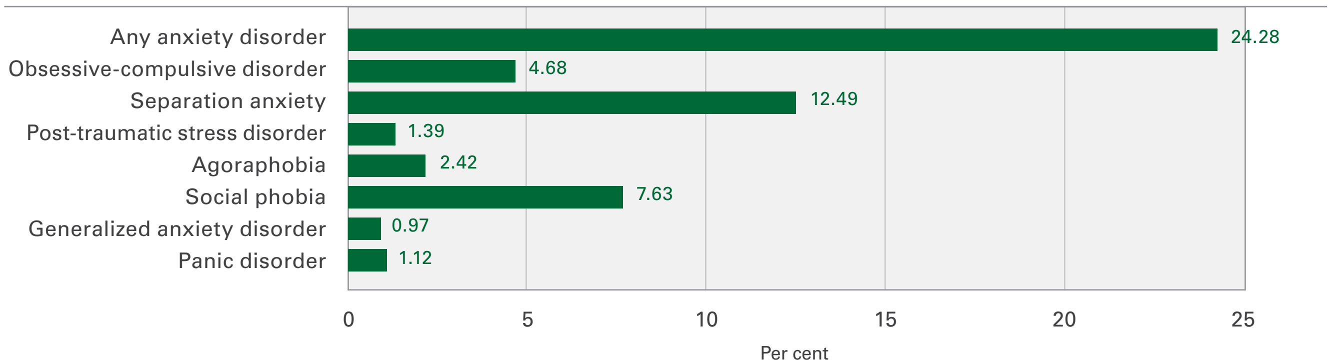
Figure 2: Most common mental health conditions across lifetime



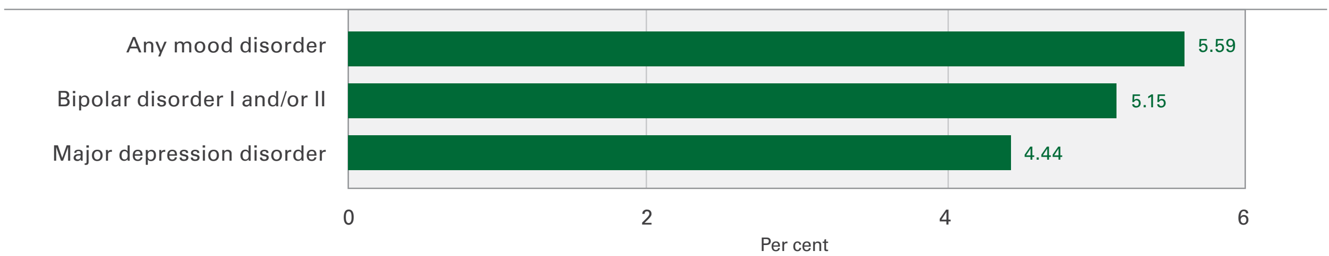
Source: Saudi National Mental Health Survey (SNMHS).

Figure 3: Prevalence of selected disorders, youth ages 15–22 years-old

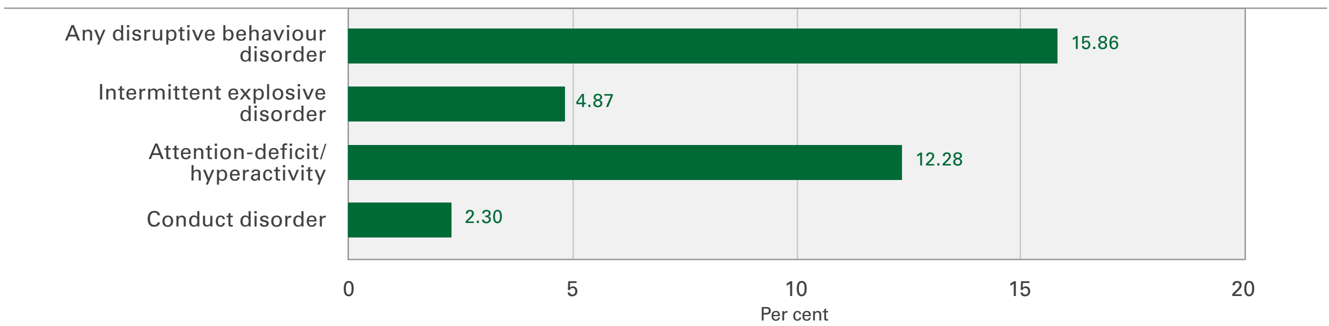
Anxiety disorder



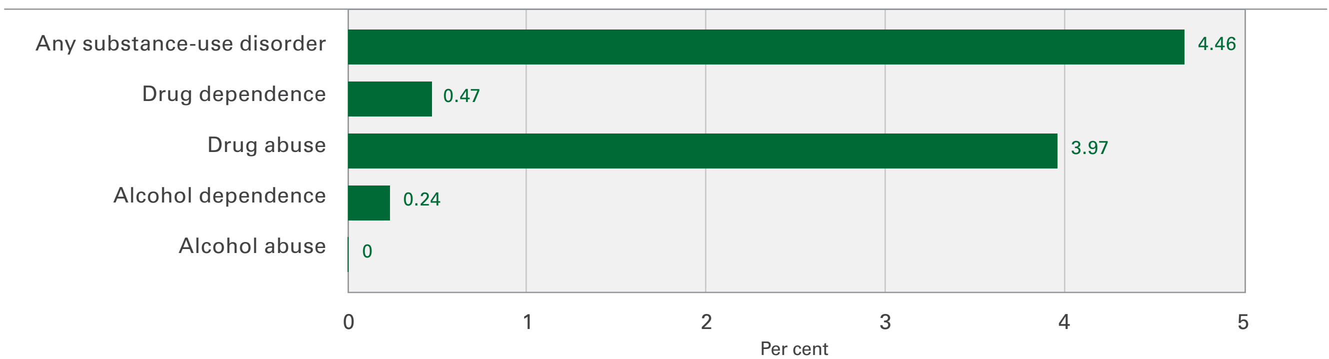
Mood disorder



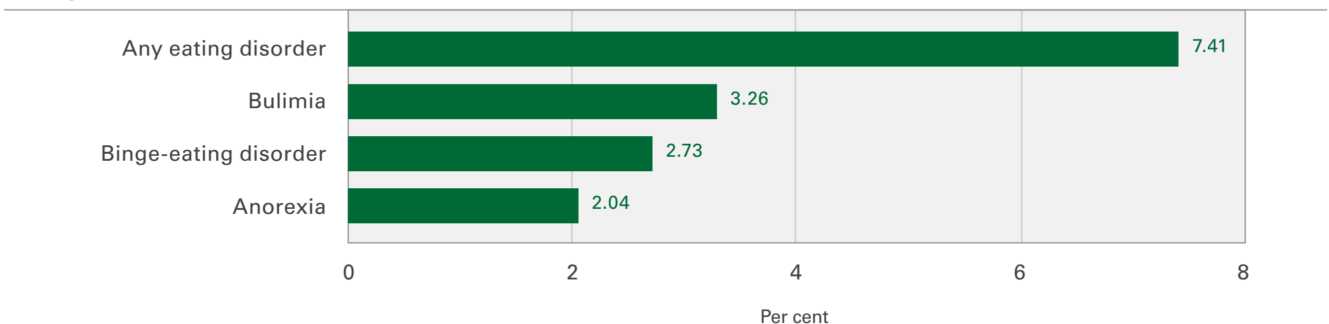
Disruptive behaviour disorder



Substance-use disorder



Eating disorder



Source: Saudi National Mental Health Survey (SNMHS).

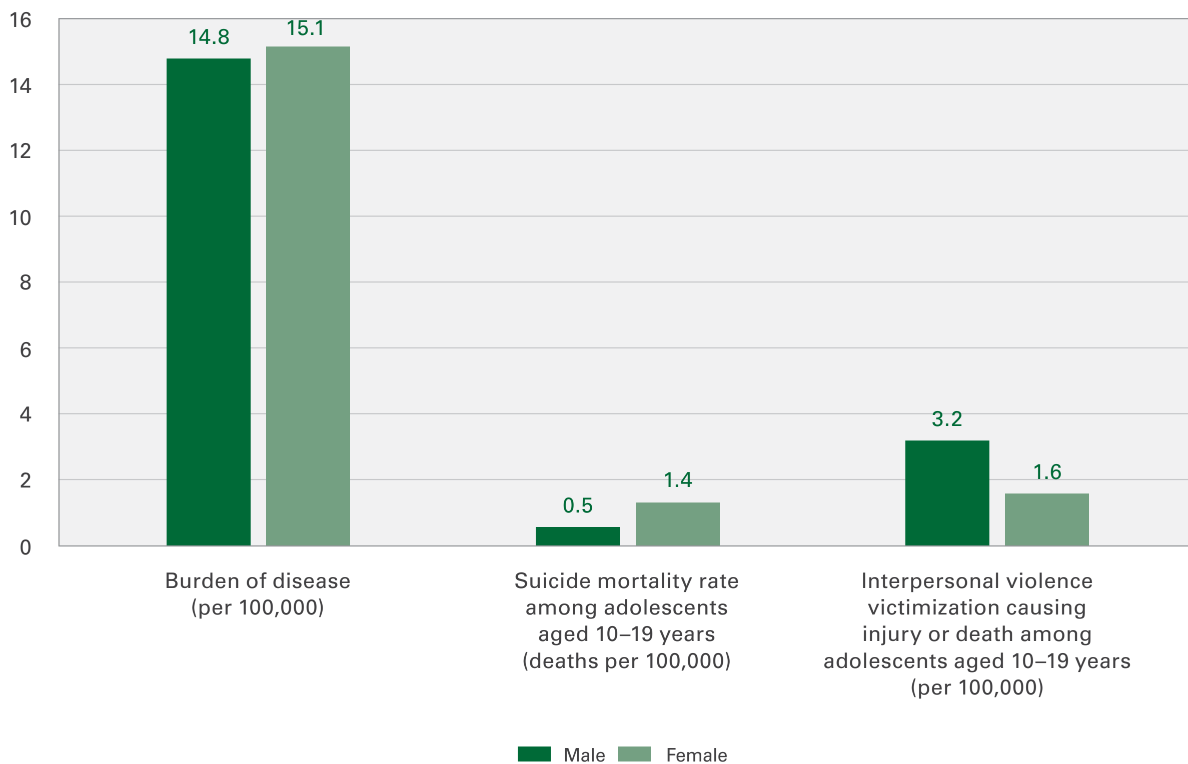
4.2 Child and adolescents' mental health

4.2.1 Suicide

In a study conducted by Ahmed et al. (2020) shows that Saudi youth had a similar suicide attempt rate to English and French youth. The study revealed a prevalent occurrence of repeated suicide attempts among Saudi Arabian youth, with 26.1 per cent of the 157 participants exhibiting such behaviour during the study period. This aligns with findings of 27.3 per cent among youth aged 10–18 years in England and 30 per cent in France, as reported in previous studies. Repeated suicide attempts are linked to age, family issues, mental illness and hospitalization. Adolescent suicide prevention programmes may address family issues, psychiatric screening and suicidal behaviour. A study examined how racial and cultural factors affect Saudi suicide rates. The Dammam, Saudi Arabia, Medico-legal Center examined 221 suicide cases from 1986 to 1995. The study found that 1.1 per 100,000 people committed suicide annually. The male-female ratio was 4.5 to 1. The suicide rate was highest (44.3 per cent) in the age group of 30–39 years, followed by the age group0 of 20–29 years (32.6 per cent) and the age of 20 years (1.8 per cent). Despite rising youth suicide attempts in Saudi Arabia, no risk assessment tool has been developed. The study assessed Saudi Arabian youth's repeated suicide attempts risk.

According to the Global Burden of Disease (GBD) study findings, suicide is higher in males than females in Saudi Arabia. However, interpersonal violence and victimization causing injury or death are higher for females.

Figure 4: Burden of disease, suicide mortality rate and interpersonal violence and victimization rate, by sex



Source: GBD, 2019.

4.2.2 Depression

Depression is a common mental disorder that can occur for various reasons. However, several factors increase the vulnerability to depression, such as genetics, family environment, personal characteristics and severe stress. The total number of people living with depression worldwide is 322 million. Regional studies of young persons have also reported relatively high rates of emotional symptoms. Reporting from previous studies conducted in Saudi Arabia show the prevalence of depression in adolescents falling within a wide range from 14.2 per cent to 42.9 per cent. In a study cohort of 960 Saudi male and female adolescent students aged between 12 and 19 years, 32.4 per cent were found to have moderate to severe depression as determined by using the Center for Epidemiological Studies Depression Scale, the Beck Depression Inventory (BDI)-II, and the Patient Health Questionnaire (PHQ-9). In another study, a systematic sample of 490 secondary school students in Taif were assessed using the 21-item BDI (Alibrahim et al 2010).[14] From this assessment, 33 per cent scored 19< on the BDI scale, which is moderate to severe depression, and 11 per cent scored in the severe to very severe range. Females were about 33 per cent more likely to score 19 or higher than males (40 per cent vs. 29 per cent). In addition, birth order (the oldest child), family history of chronic physical disease, and history of loss were other predictors of depression according to a multivariate analysis (AlYousefi et al., 2021).[15]

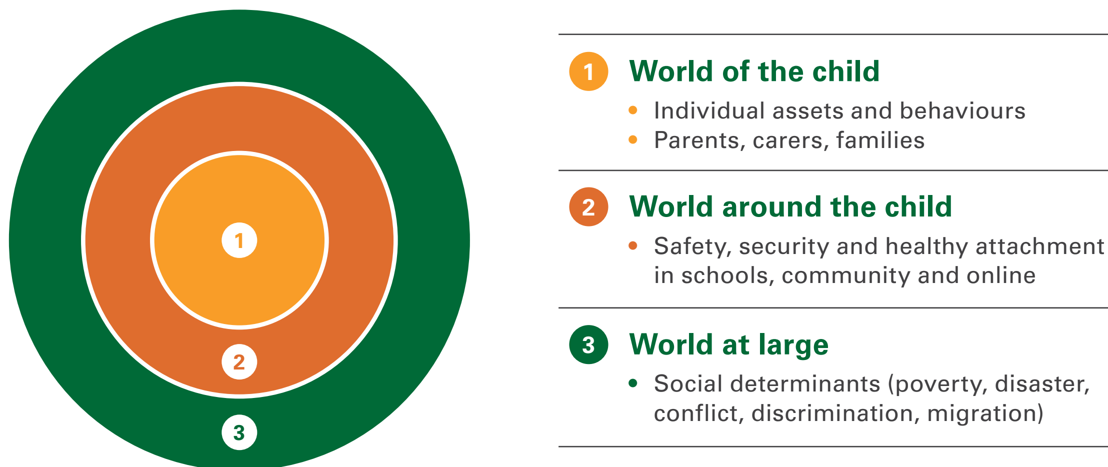
4.2.3 Anxiety

There are a number of research studies that have found a high prevalence of anxiety and depression. For example, research was carried out to determine the prevalence rates and severity of depression, anxiety, and stress among Saudi adolescent boys, using secondary boys' schools in Abha. The research utilized an Arabic version of the 'Depression, Anxiety and Stress Scale' (DASS). The findings showed that 59.4 per cent of the 1,723 male students had at least one of the three disorders: 40.7 per cent of these had at least two disorders; and 22.6 per cent had all three disorders (depression 38.2 per cent, anxiety 48.9 per cent, and stress 35.5 per cent). Another study aimed to estimate childhood anxiety disorders of 468 primary school children from the age of 6 to 12 years. For this, parents completed the Screen for Child Anxiety Related Disorders (SCARED) that showed the prevalence of anxiety disorders in the sample was 42.1 per cent. Of these anxiety disorders, 70.7 per cent exhibited separation anxiety, 32.9 per cent had significant school avoidance, 28.8 per cent showed social anxiety, and 22.2 per cent did not exhibit any anxiety disorder (Al-Gelban, 2007).[16]

4.2.4 Attention-deficit/hyperactivity disorder

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common neurobehavioural disorders in children and adolescents. It is characterized by a pattern of pervasive, persistent and debilitating inattention, overactivity and impulsivity (American Psychiatric Association, Diagnostic Statistical Manual of Mental Disorders, 4th edition [DSM-IV]). A study was conducted to determine the prevalence of ADHD in both government and private primary school children in Saudi Arabia. The total number of participants was 646 (Albatti *et al.,* 2017).[17] Findings showed that the estimated prevalence of ADHD was 3.4 per cent. ADHD manifestations were higher in boys than girls with a ratio of 3 to 1. According to another study of a Saudi sample of 226 children separated by age groups (children aged 4–10 years and adolescents aged 11- 17 years) showed that the overall prevalence of ADHD was 11.3 per cent in children and 8.4 per cent in adolescents.

Figure 5: Spheres of influence for mental health and well-being for children and adolescents



Source: Adapted from UNICEF State of the World's Children 2021.

4.3 Risks, protective factors and determinants of mental health and psychosocial well-being

The UNICEF State of the World's Children 2021 report identifies three spheres of impact that shape well-being and mental health of children and adolescents:

- World of a child: individual assets, carers, parents and family members.
- World around the child: security, safety and healthy attachments in schools, online and in communities.
- World at large: Social and contextual determinants that may include, for example, poverty, disaster, conflict, disclination and migration

4.3.1 World of the child

Attachment

A vital determinant of mental health and well-being is healthy early childhood attachment with parents and other caregivers, and responsive care. Parents' mental health impacts their capacity to provide responsive care. Attachments are the relationships between the parent/caregivers and children that provide children with a sense of protection and safety. This sense of safety aids and fosters the development of emotional and social skills. Attachment starts from early childhood, and it is important across later childhood and adolescence. National-level data describing attachment and the quality of caregiving in the region are very limited.

Individual and family-level risks

Children with disabilities affect their families. This may hinder the family's progress and normal functioning. Saudi Arabia has not conducted an immense amount of research on the psychological effects of raising a child with a disability. This study investigates the psychosocial concerns of disabled parents. In families with disabled children, anxiety and psychophysiological symptoms were present. Families experienced stress due to increased childcare costs, time away from work, and difficulty. (Al Sayed, B., Alaskar, A., & Alonazi, J. (2020).[18]

Diabetes

It is well known that diabetes mellitus (DM) clients have two to three times higher chance of developing psychological disorders, mainly depression, than healthy individuals. A nationwide Saudi Arabian survey reported that the prevalence rate identified was 109.5 per 100,000 children and adolescents (Al-Herbish et al, 2008).[19] Another study was conducted on 148 Type 1 Diabetes (T1D) Saudi children from aged 8–12 years. 53.4 per cent were female and 46.6 per cent were males. More than one-third (34.5 per cent) had diabetes for a duration of more than five years, and 46.6 per cent had episodes of diabetic ketoacidosis (DKA). The most common method of insulin administration was multiple daily injections (81.7 per cent). Depressive symptoms were detected in 27 per cent of children and adolescents, 80 per cent were classified as having mild depression, 12.5 per cent as having moderate depression, and 7.5 per cent as having severe depression (Alaqeel *et al.,* 2021).

Tobacco and drug use

The Saudi government has recognized and acknowledged substance abuse as a public health issue. As a result, many regions have established specialized hospitals to treat substance abuse. There is a high prevalence of smoking, alcohol consumption and drug use among youth in Saudi Arabia. According to published reports between 2007 and 2018, the prevalence of tobacco smoking among adolescents in Saudi Arabia had a wide range from 2.4 per cent to 39.6 per cent. Influence of friends and family negligence were the most commonly reported risk factors for smoking. A total of 400 male high school students were studied, with the average participant age of17.5 years. (Range of ages from 15 to 21 years). Of these, 281 (70.2 per cent) attended public or government schools (from eight separate schools), while 119 (29.8 per cent) attended private or international schools (from three separate schools). Most students in the study (>70 per cent) knew smoking, alcohol and drugs were harmful. However, of the students in the study, 27.8 per cent smoked, 11.5 per cent drank, and 9.0 per cent used drugs. Of those students who used substances, they started smoking before the age 15 years, drinking before the age of 20 years, and using drugs at the age of 14 years. Most of these students who smoked and drank alcohol got their substances on their own, but many students who used drugs got them from friends. The use of these substances seriously affected student performance.

Another study showed that 4.7 per cent of adolescence used a combination of two or more substances. The average length of abuse was 8.8 years. Another study showed that college students are more likely to use substances than high school students, with alcohol and hashish being the most common. The research showed that boredom, fun and escaping problems were the main causes of student drug abuse. Drug use was 18.94 per cent (8.07 per cent male and 10.87 per cent female) in Riyadh high schools, and 24.14 per cent (13.87 per cent male and 10.28 per cent female) in colleges. Drug use was strongly linked to male college students. High school students drank alcohol (44.5 per cent) and used hashish (40.19 per cent) most. Entertainment was the main reason for drinking and using drugs, followed by avoiding problems (Alasqah *et al.,* 2019).[20]

A national cross-sectional survey included 12,121 high school students aged 10–19 years. Logistic regression showed that students who spent more than two hours watching TV, surfing the Internet, or playing video games were more likely to use tobacco, legal and illegal substances than those who spent less than two hours. Men's light and heavy Internet use was linked to smoking. Internet use was excessive only in female smokers. Despite Saudi society's conservatism, findings showed a significant link between tobacco or substance use and media exposure among adolescents. The media's growing influence on adolescents' health risk behaviours in Saudi Arabia should be addressed (AlSayyari *et al.,* 2020).[21]

4.3.2 World around the child

Peer and community risks (peer bullying and violence)

Exposure to bullying is a risk factor to poor mental health, however, there is a shortage of studies related to bullying. Most findings are collected through research studies which are not representative of a whole community. In addition, the term bullying remains unclear to Arab society, making finding data challenging due to the diverse definitions of the word "bullying" across the country.

Table 2: Key findings of studies on bullying

Author	Sample number	Percentage of bullying	Additional information
AlBugami et al., 2009	n=369	56%	Females only • Hail, Makkah and Aseer: 22.3%–23%) • Al Baha and Najran: 23.1%–24.3%) • Tabuk, Aljouf, and Northern Borders: 24.4%–25.8% • Eastern Province and Jizan: 27.8%–30.2% • Qasim and Riyadh: N/A
AlKahtani et al., 2010	n=1,877	31%	
AlMuneef et al., 2013	n=10,156	39%	• ACE-IQ Types of childhood bullying: 1. Hit, kicked and/or pushed: 21.9% 2. (Left out of activities on purpose: 17.5% 3. (Was made fun of with sexual jokes: 15.3% 4. Other ways of bullying: 15.3%
AlEissa et al., 2013	n=16,010	47%	• ICAST-CH • Adolescent students exposed to bullying: 50% • 59% females and 41% males
Buhairan 2014 et.al	n=12,757	25%	• Males: 27% • Females: 23% • Adolescents who were found to have been bullied at school: 25%

Domestic violence

Domestic violence has been rarely researched in Saudi Arabia. According to a United Nations report, almost 4 out of 10 women experience sexual and/or physical violence (UN Women, 2018).[22] The prevalence of lifetime domestic violence was 39.3 per cent overall, including 17.9 per cent for physical violence, 6.9 per cent for sexual violence, and 35.9 per cent for mental abuse.

Child maltreatment

Child abuse occurs in all cultural, ethnic, and socioeconomic groups. Our review indicates that maltreatment of children is still of significant global concern. Child abuse can take many forms, including physical, emotional, verbal and sexual abuse, and neglect. One published report identified the factors that affect discloser of abuse are cultural, and/or related to healthcare and policy barriers. Cultural stigma surrounds reporting child abuse due to a lack of understanding, perception of child abuse as a parental right to discipline a child, misunderstanding of Islamic laws, and not understanding the long- and short-term effects of child abuse (Heron et al, 2021).[23] Healthcare professionals and students of healthcare specialties reported that they do not reporting suspected child maltreatment due to the uncertainty of abuse, lack of knowledge, considering injuries unworthy of reporting, lack of awareness of protocols, prior negative experience after reporting, and lack of strict legal consequences for not reporting. Due to lack of confidence, fear of family breakdown, or lack of awareness that any action can be taken, abused children rarely reported maltreatment to authorities. Institutes should help educate healthcare professionals about child maltreatment and establish mandatory reporting laws. Child abuse affects society and there should be preventive measures in place to eliminate it. Taking action will require community collaboration.

To identify themes, gaps and opportunities for research and capacity building on child maltreatment and protection, the database search for this study returned 6,109 articles. Of these, 160 articles were included in our review. Themes included prevalence, incidence and characteristics of maltreatment, outcomes of maltreatment, attitudes towards child maltreat, awareness of maltreatment, and reporting, accidental injury and death potentially related to child maltreatment and/or neglect, and policies and practices related to child maltreatment. Of the articles included, 87 articles examined Saudi Arabia, 28 the United Arab Emirates, 21 Kuwait, 13 Qatar, 12 Oman, and 11 Bahrain. Based on specific types of abuse, 77 articles examined physical abuse, 54 sexual abuse, and 54 emotional abuse (Neville *et al.,* 2022).[24]

Another study found emotional abuse is the most concealed and frequently overlooked form of child maltreatment. We present findings from an exploratory study of the prevalence and types of emotional abuse among children in Saudi Arabia, as well as their association with other variables. A convenience sample of 60 children aged 12–18 years was recruited from three malls in Jeddah. With their parents' permission, the children completed a specially designed, self-administered questionnaire in confidence. Overall, 90 per cent of participants reported rejecting emotional abuse and 61.7 per cent reported neglect or terrorizing types of abuse. Terrorizing emotional abuse was significantly associated with chronic illness among parents. There was a statistically significant negative correlation between mother-child relationships and neglect and terrorizing types of emotional abuse.

More research on community prevalence, correlation and consequences of child emotional abuse in Saudi Arabia is required (Elarousy *et al.,* 2013).[25] In 2010, the National Family Safety Registry (NFSR) reported 292 documented cases of abuse and neglect (National Family Safety Registry, 2011).[26] Physical abuse, Münchausen syndrome by proxy, or shaken baby syndrome were reported in 70 of the cases. A 2012 cross-sectional study was conducted in secondary schools in five of Saudi Arabia's thirteen major regions. Using multistage stratified sampling, 16,939 adolescents aged 15–19-yearswere invited to participate. Over 80 per cent of the adolescents were raised by both biological parents, and nearly 90 per cent were aged 16–18 years. The prevalence mean of various forms of abuse ranged from 0.10 to 0.65 in the year prior to the 2012 assessment, with sexual abuse being the lowest and psychological abuse the highest. Participants who lived with only their mother or father had higher rates of all types of abuse/exposure, as did those who lived with a biological parent and a stepparent. Girls experienced higher rates of violence, psychological abuse and neglect, while boys had higher rates of sexual abuse (Al-Eissa *et al.,* 2016).[27]

4.3.3 World at large

Stigma is a significant barrier to seeking help for mental health conditions. Misconceptions associated with mental health are common, and an important contributor to poor access to MHPSS. Social/cultural beliefs and media portrayals of mental illnesses limit the understanding of the diagnosis, and result in negative attitudes toward seeking mental health services (Choudhry et al, 2016).[28] These misrepresentations also demotivate professionals from joining mental health careers such as psychology and psychiatry, which perpetuates the workforce shortage in the region.

A more recent threat to mental health is **COVID-19.** The pandemic required a public health approach that disrupted and limited social interactions and employment. Therefore, there was an increase in the use of social media and a higher risk of exposure to family conflict and violence that impacted mental health. Economic uncertainties and projected socioeconomic inequalities from the COVID-19 pandemic will have long-term implications. Economic crises may lead to resources being diverted from mental health services, increasing difficulties for accessing mental health services.

Findings in the report entitled Impact of COVID-19 on Saudi Children: Special Focus on Behavioural, Social, and Emotional Aspects show that approximately 30 per cent of children experienced increased irritability and mood swings when compared with the period before the pandemic. Regarding adaptive social behaviours, during the pandemic, 22 per cent of children appeared calmer, and 14 per cent seemed more thoughtful. The study reports increased screen time, less physical activity, and reduced sleep time among children compared with the pre-pandemic period. The COVID-19 pandemic has psychologically affected children. The results highlight the need to reduce this psychological burden by enhancing children's emotional resilience and involving parents in health promotion programmes aimed at mitigating the negative impacts of this public health crisis.

During the pandemic, Saudi Arabia established four psychosocial support platforms to provide free online mental health consultations and launched an awareness campaign to address the mental health and well-being of communities. The country also launched the DA'EM programme, which is a 24/7 web-based well-being and support programme that provides psychological and academic support to healthcare practitioners across Saudi Arabia as well as to all Saudi practitioners who are training abroad on scholarships. The programmes aim to reduce the psychological pressures that health practitioners face from the fight against COVID-19 as well as establish a hotline that provides mental health and psychosocial support for pressing psychological problems.

5. Maternal mental health needs: Outcomes and risks

A woman's life changes dramatically when she becomes pregnant. Having a baby can be an exciting time, but the emotional, hormonal and physical changes that a woman goes through during this process can be difficult and stressful, leaving her feeling sad, anxious, afraid and confused. Most women who go through these emotional changes recover quickly. However, for some women, these feelings do not go away and may worsen.

Women may experience physical, social and psychological difficulties following childbirth. However, the significant consequences of these experiences are rarely addressed. They can range from postpartum depression (PPD) to baby blues, a feeling of sadness that a woman may experience within two weeks of giving birth and that frequently comes with other symptoms such as mood swings and appetite loss.

Unfortunately, most postnatal care is focused on obstetric aspects and infant health, and frequently overlooks mothers' psychological health. Symptoms of depression and, in severe cases, tendencies toward self-harm or even harm to the baby go unnoticed and thus untreated. The consequences of undiagnosed PPD and other conditions affect not only the health of the mother and her infant but also the family dynamic because PPD may affect the ability of the mother to take care of her child.

A study showed that PPD was found in 20.9 per cent of 172 postpartum women. Multivariate regression analysis identified previous depression, difficult life event intervals, and attitudes toward pregnancy as significant risk factors. Jeddah women had a high postpartum depression rate. Thus, we recommend postpartum screening for early intervention and psychosocial support (Alsayed et al.,2021).[29] Working women had lower social functioning than non-workers. Less educated women were more socially functional.

A study conducted at Eastern University Hospital found that 59.68 per cent of patients had probable postpartum depression. Patients with Depression had significantly lower MCS and PCS scores than healthy participants. Smokers have a 21-fold increased risk of depression. Working mothers and patients with a history of depression had a 3.98-fold and 3.6-fold risk of depression and PPD, respectively. Postpartum depression was more likely in women who lived outside Riyadh, had given birth more than twice, and had unwanted pregnancies. The results indicate depression is becoming increasingly prevalent (59.58 per cent). In terms of suicidal thoughts, 6.3 per cent of mothers had these thoughts often, 5.0 per cent sometimes, and 7.9 per cent rarely. Depression symptoms lasted less than a month for 34.78 per cent, 20.72 per cent, and 13.06 per cent, respectively. In terms of timeframe, 30.4 per cent of women developed depression symptoms within a week of giving birth (Almuqbil *et al.,* 2022).[30]

Another study showed that 33.4 per cent of the women reported high-stress levels, and those with no or low income, chronic disease, sleep deprivation, lack of oral hygiene, irregular eating patterns, gestational diabetes, and no family support had significantly higher stress levels. Stress levels are correlated with self-reported oral health issues. Non-brushing, chronic disease, sleep deprivation, gestational diabetes, and gingival redness all predicted stress, according to a multiple linear regression model (Ahmed *et al.,* 2017).[31]

Findings show that PPD is extremely common in Jazan (75.7 per cent). According to the study, 30.4 per cent of the women developed depression symptoms in less than a week after giving birth. The most significant association with PPD was a lack of family support, which increased the risk of PPD significantly. PPD was more likely in mothers who had unexpected pregnancies. Current research has revealed a high prevalence of postpartum depression among mothers in the Jazan region, as well as various risk factors that increase the likelihood of PPD development. Pregnant women must become more aware of PPD and learn how to potentially prevent it or seek support to respond to it (Abdelmola *et al.,* 2023).[32]

6. Overview of legislation, policies, strategies and plans pertaining to MHPSS and the mental health system for children and adolescent

Over the last 30 years, Saudi Arabia has built an extensive hospital-based mental health system, culminating in the passage of a mental health law in 2014. Many WHO international standards are incorporated into this legislation. However, the mechanisms in place to protect the human rights of psychiatric patients are neither sufficiently independent nor robust.

The Saudi government has collaborated with WHO to collect data and create policies for its mental health services (World Health Organization, 2013).[33] Many of the WHO's recommendations in the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) (MI Principles) are incorporated into Saudi Arabia's Mental Health Law (2014).

Figure 6: Evolution of mental health care in Saudi Arabia, 1952–2018

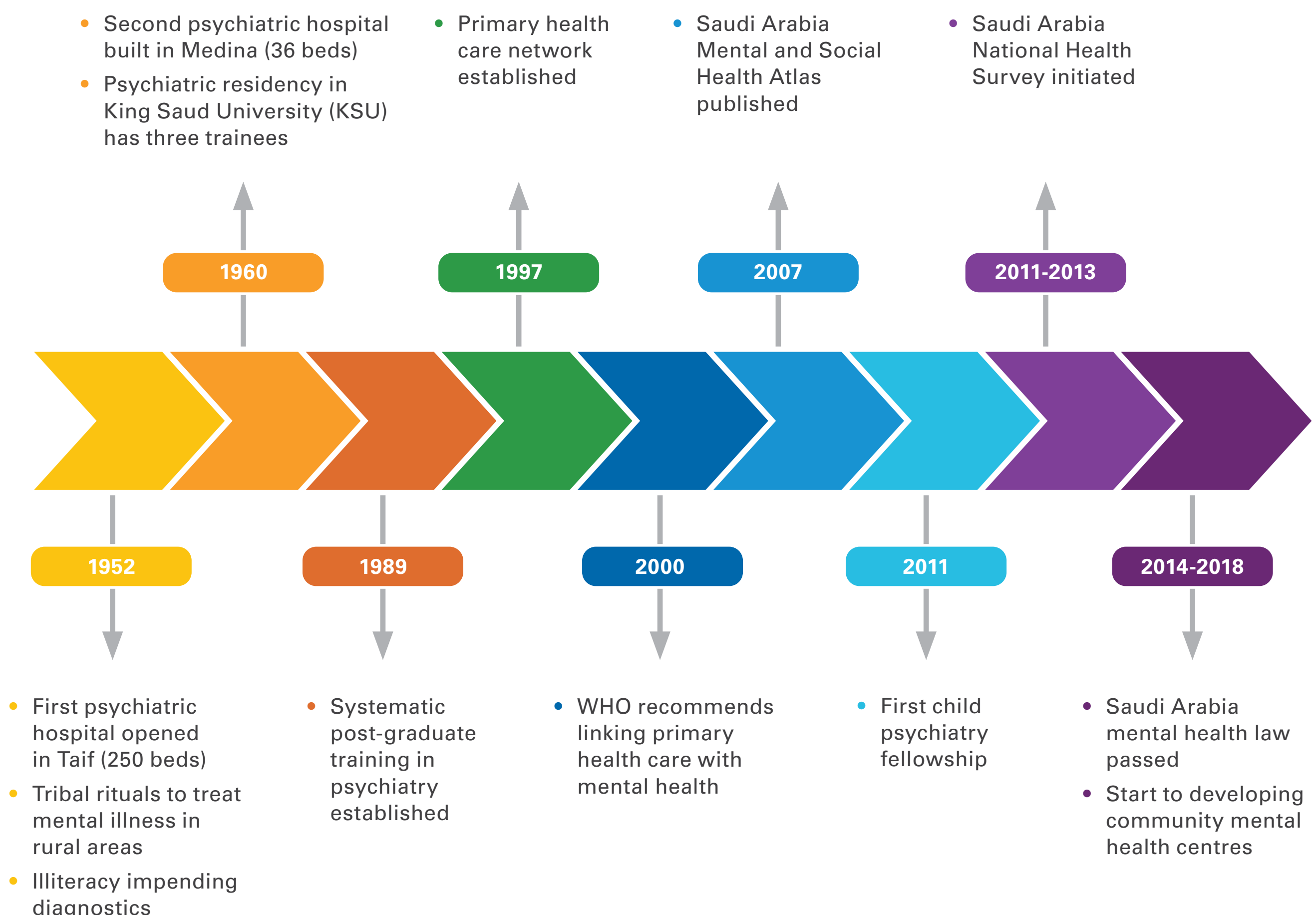


Table 3: MHPSS-related legislation, policies, strategies and plans in Saudi Arabia

<table>
<tr><th>Name of document (policies, strategies and plans)</th><th>Government departments and key stakeholders</th><th>Extent to which document includes specific action for children and adolescents aged 0–19 years and their families</th></tr>
<tr><td>Mental Health Care Law</td><td>Ministry of Health: General Supervisory Board for Mental Health Care</td><td>Includes national mental health policy with specialty programmes for children and adolescents.</td></tr>
<tr><td colspan="3">Summary of key aims/actions:
• Regulate and promote mental health care services for psychiatric patients.
• Safeguard psychiatric patients', their families' and communities' rights and dignity.
• Create a system for interacting with and treating psychiatric patients in mental health treatment facilities.</td></tr>
<tr><td>Executive Regulation of Mental Health Care</td><td>Ministry of Health</td><td>Not applicable</td></tr>
<tr><td colspan="3">Summary of key aims/actions:
Third edition of the mental health care system regulation implements Article 29 by Royal Decree (M/56), 20 September 1435 AH (2)
• Organize and promote mental health care for patients with mentally illnesses.
• Protect the rights and dignity of patients with mental illnesses, their families and society.
• Treat and house patients with mental illnesses who need of psychiatric help.</td></tr>
<tr><td>Policies and procedures for psychological service</td><td>Ministry of Health</td><td>The National Transformation Programme 2020 includes the goal of "ensuring that all children and adolescents have access to mental health services."
The National Mental Health Strategy 2020–2030 has a specific target of "increasing the number of children and adolescents accessing mental health services by 50%."</td></tr>
<tr><td colspan="3">Summary of key aims/actions:
• Organize the practical rules that psychologists use in the service departments of health facilities.
• Establish best practice standards and evidence-based practice guidance for psychologists.
• Develop job descriptions, policies, procedures, detailed guides, and continuing education and training resources for specialists.
Establish standards and a culture of codified practice, as well improve the level of service quality provided by psychologists in health care facilities' service departments.</td></tr>
<tr><td>Health Sector National Transformation Strategy: Saudi Arabia's Vision 2030</td><td>Strategy developed in close collaboration with the Ministry of Health</td><td>Not applicable</td></tr>
<tr><td colspan="3">Summary of key aims/actions:
• Saudi Arabia's Vision 2030 requires the Ministry of Health to implement this strategy.
• Level 2 Strategic Objective is to improve health service.
• Level 3 goals are to improve access, value and prevention of health threats.
• The strategy aims to significantly contribute to Level 2 Strategic Objective 2.2: Promote a healthy environment.</td></tr>
</table>

Name of document (policies, strategies and plans)	Government departments and key stakeholders	Extent to which document includes specific action for children and adolescents aged 0–19 years and their families
The Health Sector Transformation Programme	Programme works closely with the Ministry of Health	Not applicable
Summary of key aims/actions: • The Programme was created for Saudi Arabia's Vision 2030 to promote healthcare development. • The National Transformation Programme's has strategic targets to improve the quality of the health sector's efficiency and risk protection to meet health challenges.		
Saudi Arabian Handbook for Healthcare Guidelines	Ministry of Health	Not applicable
Summary of key aims/actions: Reduce unnecessary variation in practice by involving all relevant groups, such as nurses, physicians, allied health workers, and patients, in the development of health care recommendations based on the best available evidence. One example is the Grading of Recommendations Assessment, Development, and Recommendations (GRADE) approach, which takes a rational approach to decision-making factors.		
Policies and Procedures Guide for Medical Social Service Departments	Ministry of Health	Families and children
Summary of key aims/actions: • Study the social causes of mental health disorders and help create a plan for professional interventions to treat mental disorders. • Assist patients and families with disease-related social issues. • Make planned positive changes in Ministry of Health units (individual, family, local community) to improve social adjustment and well-being.		
Health Care Strategy	Saudi Health Council	Not applicable
Summary of key aims/actions: • Create health information systems, introduce new technologies and implement them in all sectors and health facilities. • Activate the Ministry of Health's role in supervising and monitoring performance, set health policies, and ensure that all population groups receive health services from their respective health authorities. • Promote comprehensive health by ensuring and developing primary health care. • Balance health services geographically and demographically.		
Regulations for Implementing Laws on Mental Health Care	Ministry of Health	Not applicable
Summary of key aims/actions: Department of General Health Social and Mental (G2015 (H1437 Health Mental) 29 (Article of Implementation: the in-issued be shall Regulations These Official documents are published as H. 20/09/1435, H20/09/14/56, ed. On 03/11/1435, no Decr was issued by iss H03/11/1435 in the Gazette. Health and Men's Articles: interpretation Includes Regulations. These workflow rules clarify how mental health facilities implement their forms and procedures.		

Name of document (policies, strategies and plans)	Government departments and key stakeholders	Extent to which document includes specific action for children and adolescents aged 0–19 years and their families
Early childhood and care and development (ECCD)	Ministry of Health (MOH) and Ministry of Education (MOE)	Depending on a child's abilities, MOE laid the foundation for students' physical, social, emotional and intellectual development that occurs between the ages of 3 and 8 years. MOH is responsible for ECCD services. These services include health, nutrition, education, and social and emotional support.
Summary of key aims/actions: • These policies address young learners' special needs, improve performance and prepare them for higher education. • In the Ministry's Organizational Guide, Applyet Resolution No. (511) dated 2-9-1440 states: "The general objective of the work of the Early Childhood General Administration of the Agency for Public Education is on working to provide this support."		
Preschool services for children with disabilities	Ministry of Education	Services included for children with disabilities who are under the age of six years, making services available in nurseries and preschools throughout Saudi Arabia in government and private kindergartens.
Summary of key aims/actions: Dedicated to providing a decent life for all citizens and residents, highlighting the efforts to preserve the rights of people with disabilities and ensuring that they can lead dignified lives by improving the services provided for them.		
Social services for children with disabilities	Ministry of Human Resources and Social Development (MHRSD)	Families with preschool-aged children with disabilities can apply for financial aid online.
Summary of key aims/actions: • Monthly financial benefits are provided to preschool-aged children with disabilities and their families registered with MHRSD. • Families caring for one or more preschool-aged children with disabilities entrusted to the Ministry's Agency for Social Welfare and Development receive financial and social assistance.		
Social Welfare System	Ministry of Human Resources and Social Development (MHRSD)	The social protection system was created using carefully considered strategies to achieve a healthy society. It is the result of MHRSD efforts to stabilize citizens, improve quality of life, overcome risks, and work to maintain economic, social and psychological support.
Summary of key aims/actions: • Develop preventive programmes to improve support for individuals and society in all categories to meet various needs. • Develop care and rehabilitation programmes for those in need of long-term assistance to achieve a stable, balanced and equal community.		

Name of document (policies, strategies and plans)	Government departments and key stakeholders	Extent to which document includes specific action for children and adolescents aged 0–19 years and their families
Law of Protection from Abuse in Saudi Arabia	Ministry of Practical Social Development	Not applicable
Summary of key aims/actions: On 21 September 2013, the Minister of Social Affairs issued Royal Decree No. M/52 establishing the Law of Protection from Abuse		
Protecting children from juvenile employment	Ministry of Human Resources and Social Development (MHRSD)	MHRSD are not authorizing the employment or work of persons between 13 and 15 years
Summary of key aims/actions: Employing a minor under the age of 15 years is prohibited, and minors under the age of 15 years are prohibited from entering the workplace.		
Regulations for the Child Protection System	Ministry of Human Resources and Social Development (MHRSD)	A child is in all cases is a priority for protection, care and relief.
Summary of key aims/actions: • Publication date: 21 September 2022 • The relevant bodies prioritize child housing, assistance, psychological, social, health and security. • Children are prioritized in emergencies.		
Rehabilitation and Social Guidance Agency	Ministry of Human Resources and Social Development (MHRSD)	The Rehabilitation and Social Guidance Agency provides care, rehabilitation and empowerment for people with disabilities, orphans, elderly people, abused women and children so that they may be healthy and be compensated for their deprivation.
Summary of key aims/actions: • Establish the family as a key component of society to foster cohesion and stability, and support families, which will lay the groundwork for the empowerment plan's success, expand families' options, and strengthen their capacity to manage their own affairs and well-being. • Provide guidance, social rehabilitation care, family counselling and social counselling. • Develop policies, regulations, systems and programmes for family guidance. • Develop and monitor the implementation of work criteria in support centres/facilities. • Work to increase family awareness, and, in collaboration with the government, private and non-profit sectors, address the problems and cases that need to be addressed.		
Department of Family Protection	Ministry of Human Resources and Social Development (MHRSD)	On 01/03/1425 AH, Ministerial Resolution No. 1/10771/SH established the Domestic Violence Protection Department. Family protection units have been established across Saudi Arabia under Royal Order No. 48539/B dated 08/12/1429 AH, which are specialized in responding to domestic violence.
Summary of key aims/actions: Domestic violence reports are received across Saudi Arabia through the Domestic Violence Reporting Centre. The centre employs trained and highly qualified psychologists and social workers to provide confidential advice to callers at the number 1919, available 24 hours a day, seven days a week.		

Name of document (policies, strategies and plans)	Government departments and key stakeholders	Extent to which document includes specific action for children and adolescents aged 0–19 years and their families
Protocol for Suicide Risk Assessment and Management	Ministry of Health (MOH)	Not applicable
Summary of key aims/actions: • Assessment and management in MOH facilities. • The Patient Safety Screener will be used in primary health care facilities, general facilities and specialty hospitals for mental health care. All three screening questions to be asked exactly as worded by the patient’s language.		
Saudi Vision 2030	Government	Society and families
Summary of key aims/actions: • The Quality-of-Life Programme is one of the Saudi Vision 2030 Realization Programmes. It was launched in the middle of 2018 with the strategic goal of improving the lifestyles and liveability of individuals, families and communities. • The Saudi Vision 2030 supports establishing a healthy lifestyle for children.		
Manual of Medical Social Work Policies and Procedures	Ministry of Health	Based on quality standards and indicators, social services are provided to patients and their families.
Summary of key aims/actions: • The General Directorate of Mental and Social Health recently released this manual. • Qualified and trained health specialists use its goals in medical, health and rehabilitation institutions for preventive, curative and developmental purposes, and work closely with other health and medical fields.		
Practitioner's Clinical Practice Guidelines for Family Nurses	Ministry of Health	Not applicable
Summary of key aims/actions: • To achieve the Vision 2030, the healthcare system must focus on disease prevention rather than treatment. • The manual is for increasing nurses' importance, encouraging them to focus on primary care, and providing guidance for specialized nursing curriculum-based primary care nursing. • The manual supports collaboration with the Education Department, improving Saudi Commission for Health Specialties (SCFHS) collaboration on nursing certification and nurse practitioner approval. • ANPs form lasting partnerships with their patients to achieve health goals.		

6.1 Overview of mental health system

6.1.1 Governance

The Ministry of Health (MOH) is the main government body responsible for mental health policy, planning, and service delivery. It has a dedicated Mental Health Department, which is responsible for developing and implementing mental health policies and programmes, and works with other government agencies, such as the Ministry of Education and the Ministry of Social Affairs, to provide mental health services.

6.1.2 Structure of the system

The mental health system in Saudi Arabia is divided into three levels:

- **Primary care level:** This level provides basic mental health services, such as screening, diagnosis, and treatment of mild to moderate mental disorders. Primary care services are provided by general practitioners and nurses at primary health care (PHC) centres.

- **Secondary care level:** This level provides specialized mental health services, such as inpatient care, psychotherapy and rehabilitation. Secondary care services are provided by psychiatric hospitals and specialized clinics.

- **Tertiary care level:** This level provides the highest level of mental health care, and includes research and training. Tertiary care services are provided by a few specialized centres in the country.

6.1.3 National Center for Mental Health Promotion

The Honorable Council of Ministers Decision No. 685 dated 1440/27/11 established the National Center for Mental Health Promotion to create national programmes that contribute to promoting mental health, creating a better life for community members, promoting positive participation, and supporting groups that are most vulnerable to mental disorders. One of the centre's initiatives is to build capacity to practice effective parenting skills in order to improve knowledge about children's physical, mental, psychological and social needs.

6.1.4 Inclusion in the unified Health Card programme or national health insurance

Mental health services are included in the Unified Health Card programme, which provides free health care to all citizens and residents of Saudi Arabia. However, there are some restrictions on the availability of mental health services under the programme. For example, inpatient care is only available for severe mental disorders, and psychotherapy is only available for a limited number of sessions.

6.1.5 Linkages with other sectors

The mental health system in Saudi Arabia is linked with other sectors, such as school health, child protection and criminal justice. For example, MOH works with the Ministry of Education to provide mental health education in schools. MOH also works with the Ministry of Social Affairs to provide mental health services to children and families in need of protection, and works with the Ministry of Interior to provide mental health services to people in the criminal justice system.

The National Committee for Mental Health and Addiction Treatment

Based on the recommendation of the Council held on 04/28/1429 AH on the issue of coordinating psychological services, His Excellency the Minister of Health, Chairman of the Council No. 84/87990 dated 11/19/1429 AH, issued a decision to form the committee. In addition, based on the decision of the Saudi Health Council in its fifty-first meeting held on 11/24/1431 AH on the issue of merging the Advisory Council for the Development of Mental The 18/02/1431 AH Decision No. 0784/345468 was issued to discuss means of cooperation and integration in the provision and implementation of psychological services, as well as to develop unified implementation strategies and attain the desired standards for these services in Saudi Arabia. Then, Resolution No. 0784/345468 was issued on 10/22/1433 AH to name the committee the National Committee for Mental Health and Addiction Treatment.

National Health Committee to deal with cases of violence and abuse

Based on the decision of the Saudi Health Council in its thirty-second meeting on 11/22/1428 AH, which included the formation of an executive committee for the national programme for family safety, His Excellency the Minister of Health, Chairman of the Council No. 18053/84, dated 02/30/1429 AH, issued a decision to form an executive committee to supervise the implementation of mechanisms dealing with cases of child abuse, and then the committee was reconfigured. The most recent reconfiguration decision was made on 06/07/1437 AH.

MOH initiatives and projects concerning children’s and women's health

MOH relies on a strategic plan representing its future vision in order to implement its health initiatives and projects. This plan considers the equitable distribution of medical projects to all parts of Saudi Arabia in accordance with unified and well-known criteria, such as hospitals, health centres, and specialized centres. This is part of the MOH goal of deploying all medical specialists throughout the country's regions.

National Programme for Developmental and Behavioural Disorders

Several Developmental and Behavioural Disorders Clinics and Centres, as well as Early Diagnosis Clinics, are located throughout Saudi Arabia's provinces and cities, and are overseen by MOH.

Comprehensive Health Guidance Initiative: Primary Mental Care Programme

In the Primary Mental Care Programme of the Comprehensive Health Guidance Initiative, physical and mental health are inextricably linked, as physical health can best be realized through mental health. Chronic diseases, such as diabetes, hypertension, asthma and others, can only be controlled by preventing their occurrence, and treating anxiety or depression to improve mental stability can mitigate the impact of the elevation of cortisol and adrenaline levels in a patient's body. As a result, providing comprehensive mental health services at primary health care centres by physicians helps to achieve successful treatment.

6.2 Maternal and child health care

The Saudi Health Care Law (available only in Arabic only) guarantees comprehensive, integrated health care to all residents in a fair and accessible manner. In addition, MOH operates an integrated network of healthcare services that covers the entire country. MOH, in collaboration with district councils, determines the locations, levels and need for services based on the geographical and demographic patterns of diseases prevalent in the region, and provides free health care services to citizens in its medical facilities in accordance with the National Transformation Programme in the health sector, which works to meet the sector's needs.

The National Center for Mental Health Promotion was established under the Honorable Council of Ministers Decision No. 685 dated 1440/27/11. Its mission is to develop and implement national programmes aimed at enhancing mental health, fostering a better quality of life for community members, encouraging positive engagement, and providing support to those who are most susceptible to mental health challenges. As part of its initiatives, the National Center for Mental Health Promotion focuses on enhancing parenting skills to better understand the physical, mental, psychological and social needs of children, thereby promoting effective and responsible parenting.

MOH pays close attention to Article 4 of the Saudi Health Care Law (available only in Arabic) on maternal and child health, as well as immunization programmes, by providing vital educational information and health services in its health facilities' maternity and child care sections. The goal is to achieve maximum satisfaction among the target groups and their families. These educational guidelines and services help families live happier and safer lives. These guidelines also emphasize the significance of reproductive health, specifically safe pregnancy and childbirth to ensure the health of both the mother and child. Maternal and child health care services include:

- Premarital screening examination is for couples who are about to marry to determine if they have any hereditary blood diseases or infectious diseases. It aims to provide medical advice to couples if there is a possibility of transmitting these diseases to each other or their future children. and gives the engaged couple options and alternatives to help them plan a healthy family.

- Periodic maternal screenings for early breast cancer detection are also provided, along with providing information on the locations of early breast cancer screening clinics.

- Information on services such as calculating the best time to get pregnant, the breastfeeding cycle, and an approximate due date calculator to ensure an easy pregnancy free of complications and healthy children.

MOH created the Mother and Child Health Passport System to address the health of both mother and child. It keeps track of their medical history, monitors and follows up on their health status, and orders any necessary tests and analyses. All of this is then documented in the passport, which is used in health centres as the first reference for mothers' and child health services. The passport aims to provide integrated health care, healthy pregnancies, happy families, and healthy childhoods.

Furthermore, MOH has implemented the Fertilization, Embryo and Infertility Treatment Units Law (Arabic only), which consists of 41 articles divided into six chapters. Decree Royal No. 11/21/1424H, M/76, was issued, approving this law.

Platforms have also been developed to address specific issues:

The Women's Health Awareness Platform addresses important topics including:

1. Female Reproductive Health
2. Women's Health Before Pregnancy
3. Women's Health During Pregnancy
4. Delivery
5. Women's Health After Delivery

The Child Health Awareness Platform addresses:

1. Newborn Health
2. Premature Babies
3. Child Nutrition
4. Vaccinations
5. Child Safety
6. Children's Dental Care
7. School Health

6.2.1 Child Rights in Saudi Arabia

Saudi Arabia's efforts in childcare relate to protecting children from abuse, ensuring effective means of child healthcare, including vaccinations, school health and childhood cancer facilities, while also guaranteeing child safety, education and protection from inappropriate internet content, while simultaneously empowering children in the cyber world. Efforts are also dedicated to protecting children from child labour, ensuring the right to quality orphan care and to initiatives and services provided by the Ministries of Health, Education, Human Resources and Social Development.

6.2.2 Ministry of Education

Early childhood development and care

The Ministry of Education laid the groundwork for students' physical, social, emotional and intellectual development between the ages of 3 and 8 years old, depending on the child's abilities at each stage. Policies address young learners' special needs, and aim to improve performance and prepare students for higher education. In the Ministry's Organizational Guide, Cabinet Resolution No. (511) dated 2-9-1440 stated:
"The general objective of the work of the Early Childhood General Administration of the Agency for Public Education is based on working to provide services for children and adolescents with disabilities and special needs, Preschool programmes, and Social services.

Rights of people with disabilities

Dedicated to providing a decent life for all citizens and residents, Saudi Arabia highlights efforts to preserve the rights of people with disabilities, ensuring that they can lead dignified lives by improving the services provided. The country emphasizes the legal framework related to the basic law of governance, protection from harm, social care, rehabilitation centres, health care and equality in education for people with disabilities.
It also highlights employment initiatives, mobility and transportation, facilities and parking, sign language support, housing, and mobile services for people with disabilities, as well as information about the King Salman Award for Disability Research.

Early care services for preschool-age children with disabilities

Throughout Saudi Arabia, services are available for children, including disabled children under the age of six, in nurseries and preschools in both government and private kindergartens. The Ministry of Education provides free grants for special education schools and private special education programmes that meet specific standards and requirements at kindergarten, primary, intermediate and secondary levels.

Preschool programmes

Saudi Arabia has made significant efforts to incorporate disabled children into preschool programmes. The Ministry of Education established the foundations for students' physical, social, emotional and intellectual development in the early stages of childhood, between the ages of 3 and 8 years, including children with disabilities. The child's abilities at each stage determine the child's progress.

Special care and education

Preschool-aged children with special needs and their families have the support of the government, which is working to ensure they have access to appropriate educational opportunities and services.

Social services

Monthly financial benefits are provided to preschool-aged children with disabilities and their families registered with the Ministry of Human Resources and Social Development. Preschool-aged disabled families can apply for financial aid online. Families caring for one or more preschool-aged disabled child entrusted to the Ministry's Agency for Social Welfare and Development receive financial and social assistance. Related services include:

1. Disability assessment
2. Issuance of disability certificate
3. Enrolment as needed for private day care
4. Financial aid for people with disabilities
5. Subsidy services for certain medical devices

6.2.3 Ministry of Human Resources and Social Development

Social Welfare Systems

The social protection system was created using carefully considered strategies achieve a healthy and possible society. It is the result of Ministry of Human Resources and Social Development efforts to stabilize citizens, improve their quality of life, overcome risks, and work to maintain economic, social and psychological support. Saudi Arabia also focuses on developing preventive programmes to improve support for individuals and society in all categories to meet their various needs, as well as providing care and rehabilitation programmes for those in need of long-term assistance in order to achieve a stable, balanced and equal community.

The Law of Protection from Abuse

Abuse is defined as any form of exploitation: physical, psychological, or sexual mistreatment, or the threat of such mistreatment, committed by one person against another that exceeds the powers and responsibilities conferred by guardianship, dependency, sponsorship, trusteeship, or livelihood relationships. The term "abuse" shall include an individual's failure to perform his duties or responsibilities in providing basic needs for a family member or another individual for whom he is legally responsible.

On 21 September 2013, the Minister of Social Affairs issued Royal Decree No. M/52 establishing the Law of Protection from Abuse, with the following goals:

1. Ensure protection from all forms of abuse
2. Provide assistance, treatment and shelter, as well as social, psychological and health care
3. Take necessary legal procedures to hold the violator accountable
4. Raise societal awareness of the concept of abuse and its implications
5. Address undesirable social behaviour that indicates the presence of an environment that encourages the occurrence of abuse
6. Implement scientifically based procedures to address abuse
7. Protect children from juvenile employment
8. Follow the Regulations for the Child Protection System: Publication date: 21 September 2022

6.2.4 Department of Family Protection

On 20/04/2004, Ministerial Resolution No. 1/10771/SH established the Domestic Violence Protection Department, which is an organization in charge of stopping domestic violence, including any exploitation, physical, psychological or sexual mistreatment of another person or the threat of such mistreatment, when it goes beyond the authority and duties derived from guardianship, dependency, sponsorship, trusteeship, or livelihood relationships.

Furthermore, family protection units have been established across Saudi Arabia under Royal Order No. 48539/B dated 06/12/2008 which are specialized in responding to domestic violence. Domestic violence reports are received across Saudi Arabia through the Domestic Violence Reporting Centre. The centre also employs trained and highly qualified psychologists and social workers to provide confidential advice to callers at the 1919 hotline, available 24 hours a day, seven days a week.

6.2.5 Rehabilitation and Social Guidance Agency

The objective of the Rehabilitation and Social Guidance Agency is to establish the family as a key component of society to foster cohesion and stability and to transform families' participation to help lay the groundwork for empowering agency's success. This will expand the families' options, and strengthen their capacities to manage their own affairs and well-being.

The agency is responsible for providing families in Saudi Arabia with guidance, rehabilitation care, family counselling, and social counselling. It develops policies, regulations, systems and programmes for family guidance; monitors the implementation of work criteria in its centres; works to increase family awareness; and, in collaboration with the government, private and non-profit sectors, addresses the challenges that families may face.

In addition, the agency provides care, rehabilitation and empowerment for people with disabilities, orphans, elderly people, women how are abused, and children so that they may attain a healthy upbringing and be compensated for their deprivation.

6.2.6 Saudi Vision 2030

Saudi Arabia launched Vision 2030 in April 2016 with three major axes:

- a vibrant society,
- a thriving economy, and
- an ambitious nation.

Vision 2030 established 96 strategic goals and 13 programmes to achieve those goals.

A vibrant society axis aims to create a productive and strong society by enabling families to fulfil their roles and responsibilities in establishing the best social and health care systems possible. The vision emphasizes the importance of physical activity, developing one's health, and improving one's lifestyle (Saudi Vision, 2030).[34]

The Quality of Life Programme is one of the Saudi Vision 2030 Realization Programmes. It was launched in the middle of 2018 with the strategic goal of improving the lifestyle and liveability of individuals, families and communities. In light of the Saudi Vision 2030, this includes support for establishing a healthy lifestyle for children.

Services

Table 4: Six key enablers and initiatives of the Vision Realization Office

Key enablers	Initiatives
Private sector participation	• Increase private involvement by facilitating ownership or management of MOH hospitals. • Activity support localization of pharmaceutical and medical devices leveraging MOH procurement.
e-Health	• Provide digital tools (apps) for patient services, prevention, connected care and workforce efficiency. • Accelerate the information technology infrastructure build-up at MOH to reach 100% deployment by 2020.
Workforce	• Enhance the quality and quantity of the workforce through increased capacity, improved licensing criteria and improvement to make the profession attractive. • Establish a National Health Care Workforce Planning Unit to coordinate actions across key stakeholders.
Healthcare financing	• Establish a value-based provider payment system. • Set up National Health Insurance with a gradual rollout.
Corporatization	• Split MOH to corporatize delivery, creating independent provider networks with operational autonomy. • Create local clusters that bring providers together, ultimately forming accountable care organizations.
Governance	• Strengthen the MOH mandate to lead sector reform with strong oversight over regulatory agencies (“super-regulator”) and transform the role of MOH to be more strategic. • Create a range of new development and regulatory bodies at arm’s length from the MOH.

6.2.7 Ministry of Health

Information and services

MOH has launched a strategic plan for the health sector as part of the Saudi Vision 2030. The strategy focuses on three key elements that need to be improved. The first two components are concern for citizens' health and enhancement of their quality of life. The third component emphasizes the improvement of service quality. This third component emphasizes quality services that add value to the health sector by containing and reducing costs for citizens, as well as directing more investment toward the health sector.

MOH has also identified a set of indicators to measure health sector development, such as the number of health care employees, infant mortality rate, and average life expectancy of citizens.

Health care services

Saudi Arabia improved access to health care services by increasing the percentage of specialized consultations provided within four weeks from 38 per cent to 84 per cent, and increased the percentage of urban and rural communities with access to basic health care services in their communities from 78 per cent in 2016 to 85.7 per cent in 2020.

Health care legislation

Saudi Arabia's health law aims to provide comprehensive health care for all people in a fair and accessible manner. MOH offers a wide range of medical services throughout the country. Health care in government medical facilities is provided free to citizens and is based on a new health strategy that addresses the needs of the health sector.

Healthy Schools Programme

The impact of the school environment on children's mental health can be either negative or positive. The absence of structured mental health programmes within educational institutions underscores a serious demand to build and establish such programmes.

In an effort to improve students' health in line with WHO's global standards, policies and procedures, MOH, through the Public Health Agency, has implemented the Healthy Schools Programme (WHO).

This documents Healthy Schools: Scientific Evidence and Healthy Schools Guidelines, as well as providing a Self-Evaluation Form and the Final Evaluation Form. Both are available for download. A “Healthy School” is defined as one in which all members of the school community – students, parents, faculty and administrators – collaborate to improve the health of the student body. In addition to adopting all existing measures and a set of basic programmes of school health education, the Healthy School Programme takes measures to promote the health of students alongside the educational process through an integrated partnership between MOH and the Ministry of Education.

In accordance with the National Transformation Programme (NTP) 2020 and Saudi Vision 2030, MOH has recently developed a more comprehensive approach that focuses on students in physical, psychological, social and religious aspects.

School-Based Health Awareness Programme

The School-Based Health Awareness Programme focuses on a variety of awareness-raising activities and initiatives aimed at improving health knowledge, promoting behavioural attitudes and enhancing healthy behaviours in the school community. It also aims to increase students' awareness of health issues by introducing students to relevant health issues and helping them develop self-control with the aim of developing healthy habits in the school community.

Programme Components

GCC/International days:

- GCC Adolescent and Youth Health Day
- World Diabetes Day
- Breast Cancer Awareness Month
- World No Tobacco Day

Awareness visits:

- Oral health
- Adolescent health and healthy marriage
- Communicable diseases and their prevention
- Mental health and video game addiction (internet gaming disorder)
- Physical activity and obesity control

Awareness programmes:

- Healthy food awareness.
- Healthy sleep awareness

School-based obesity control (Rashaqa)

A school-based obesity control effort, which is a collaboration between the MOH and the Ministry of Education, is in place in a limited number of schools at various educational levels. This effort focusses on raising awareness, creating a supportive environment, enacting laws and regulations governing a healthy diet and physical activity, and combating childhood obesity.

By the end of 2020, the goal was to reduce the prevalence of childhood and adolescent obesity in a subset of schools by 5 per cent and to improve students' nutritional habits and increase students' physical activity. Overweight and obese students should receive preventative and therapeutic services. Students at all educational levels (primary, intermediate, and secondary) from selected schools across the country were involved in this effort.

Community Empowerment Initiative

The Community Empowerment initiative began in April 2018 and is ongoing. MOH launched the Community Empowerment Initiative with the intention of empowering community members in the process of health promotion by giving them leadership roles in identifying the health issues faced in the district, prioritizing, making decisions and collaborating with the district healthcare centre to enhance the role of primary health care. This aims to promote the concept of self-care among community members, in accordance with the Saudi Vision 2030 initiatives.

Table 5: Non-profit organizations engaged with mental health

Name	Aim/Goal
Children with Disabilities Association	The goal of the Children with Disabilities Association is to provide highly professional medical, rehabilitation and educational services in line with the highest international standards. Source: https://dca.org.sa/
Saudi Attention-deficit/hyperactivity disorder (in Arab إشراق or AFTA)	AFTA Society is a non-profit organization that aims to enhance the life of individuals and aid families who are affected by attention-deficit/hyperactivity disorder (ADHD – or "AFTA" in Arabic) in Saudi Arabia by providing comprehensive specialized services. The society was founded in June 2004 and received its charitable status as the ADHD Society in September 2008. The society has three branches: Riyadh, Al Khobar and Jeddah. Source: https://adhd.org.sa/en/
Charitable Society of Autism Families	The Charitable Society of Autism Families is a non-profit organization founded in 2009. It aims to advance the autism sector in Saudi Arabia by bringing together autism families to share experiences led by multidisciplinary expertise in counselling services, awareness campaigns, initiating programmes and courses, and social initiatives. Source: https://www.saf.org.sa/
Child Care Association	The mission of the association is to support and empower families and workers in the field of childhood development, as well as to raise community awareness about developing children's abilities. Source: https://www.childcare.org.sa/
The King Salman Center for Disability Research	The King Salman Center for Disability Research is a non-profit organization based in Riyadh. It conducts and funds laboratory and field research on all aspects and ages of disability. Source: https://www.kscdr.org.sa/en
Sanad Children's Cancer Support Association	Sanad Charitable Association is registered with the Ministry of Human Resources and Social Development and is a non-profit charitable organization. Its mission is to provide financial or in-kind resources to children's cancer centres in Saudi Arabia, as well as social and shelter services for patients and their families in need after conducting field research. The association also prepares education and training programmes for patients and their families about childhood cancer and how to deal with it. Source: https://sanad.org.sa/
Saudi Association for Patients with Schizophrenia (Ehtiwa)	Under the supervision of the National Center for the Development of the Non-Profit Sector of the MOH, the association is in charge of implementing programmes that strive to improve the quality of life for schizophrenic patients and their families through effective partnerships, professional work teams, a distinguished controlled system, and supportive environments. Source: https://www.ssca.org.sa/
Cyber Kids Association	The goal of the Cyber Kids Association is to contribute to raising the level of awareness of children and their families about cyber risks and threats, as well as cyberbullying, by developing protection and safety skills for children. The association contributes to training children about safe Internet use, and provides advice and guidance in cybersecurity for children. Source: https://cyberkids.org.sa/

Name	Aim/Goal
Al-Muhaidib Social Foundation	Al Muhaidib Social Foundation is an institution concerned with early childhood in social, pedagogical and educational contexts by initiating and supporting programmes that target early childhood in collaboration with the private and government sectors. One of the initiatives is the Mental Health Initiative, which is considered to be one of the first of its kind in Saudi Arabia to specialize in the child mental health care field. The Suleiman Saleh Olayan Foundation, the Al-Muhaidib Foundation, Dr. Lamees Suleiman Al-Sulaim, and Alfaisal University are participating in the initiative. They signed a cooperation agreement to offer a two-year diploma to qualify recipients to address mental disorders in children and to contribute to promoting healthy children, youth and families in all facets of life. Source: https://www.amsf.org/en/article/Index.aspx
Childhood Committee	The vision of the Childhood Committee is to see children enjoying a supportive environment and to help establish values that preserve their rights and realize their full potential. Its mission is to work with families and stakeholders through preparing programmes, policies and legislation, and following up on their implementation to create a supportive environment that responds to children's needs and expands their options. The committee’s objectives are to raise the level of community awareness of children's rights and to protect children from all forms of violence, abuse and harm by securing safety in their surroundings, on the Internet. This includes cyber violence, abuse and harm.

6.3 Current MHPSS service integration into primary health care facilities

Table 6: Current MHPSS integration into primary health care facilities

Tier of MHPSS action	Type of MHPSS services	Integration status of MHPSS services into primary health care
Responsive care	Early identification, screening, and diagnosis of mental health conditions	MOH has launched several initiatives to treat mental health conditions. These initiatives include the Comprehensive Health Counselling Initiative (Primary Mental Care Programme), which targets early detection of depression and anxiety among primary health care centre clients to provide comprehensive primary psychological services.
	Psychological first aid and emergency care	The integration of primary first aid and emergency care of mental health within primary health care in Saudi Arabia is a relatively new development. However, there is growing recognition of the importance of providing this type of care for people who have experienced a traumatic event or are suffering from other mental health care conditions.
	Provision of care and management of psychosocial support (including the treatment plans and the psychosocial interventions)	The “Qareboon” App aims to offer mental text counselling supervised by specialized staff. It also offers an integrated library that contains information on mental health, with the latest modern methods, such as text materials, infographics, and video content.
	Referral mechanism for specialized services	A referral system has been established to connect people identified as having mental health conditions with specialized mental health care providers. This system ensures that people who need help can get it quickly and easily.
	Referral mechanism with other sectors	In the education sector, schools can have a system in place for referring students who are struggling with mental health problems to the appropriate health care providers. This could involve a school counsellor, a social worker, or a mental health therapist. In the social welfare sector, social workers can refer clients who are experiencing mental health problems to mental health providers. This could involve a community mental health centre, a hospital, or a private therapist. In the criminal justice system, judges and probation officers can refer offenders who are struggling with mental health problems to mental health providers. This could involve a treatment programme, a halfway house, or a residential treatment facility.
	Multidisciplinary care model	There is a new multidisciplinary care model for mental health in primary health care in Saudi Arabia. This model was developed by MOH in collaboration with WHO. The model includes a team of healthcare professionals from different disciplines, including general practitioners, nurses, psychologists, social workers and psychiatrists. The team works together to provide comprehensive mental health care to patients.

Tier of MHPSS action	Type of MHPSS services	Integration status of MHPSS services into primary health care
Responsive care	Health information system for registering cases and mental health indicators	MOH in Saudi Arabia is developing a health information system to register cases and mental health indicators. The system will be used to collect data on mental health conditions, treatments, and outcomes. This data will be used to improve the quality of mental health care in Saudi Arabia.
Preventive care	Building individual assets and interpersonal skills programmes	Not established
	Positive parenting care programmes	Not established
	Addressing the risk factors by identification, screening, intervention and referral, especially for substance use and violence	Several developmental and behavioural disorders clinics and centres, as well as early diagnosis clinics, are located throughout Saudi Arabia's and are overseen by MOH.
	Safe and enabling learning environment	Not established
Promotion of mental health care	Stigma reduction campaigns	MOH has changed the name of Primary Psychological Clinics in primary health care centres to Comprehensive Guidance Clinics to increase use of these services and prevent making visits clinics uncomfortable or stigmatizing.
	Awareness-raising programmes to improve community mental health literacy	To raise awareness and provide information, the Institution of Psychiatric Awareness Platform addresses various important topics including insomnia, mental health promotion, stress, depression, bipolar disorder, obsessive-compulsive disorder and schizophrenia.
	Family, child and adolescent participation	Measures are being taken to assist patients and families with disease-related social issues, making planned positive changes in its units (individual, family, local community) to improve social adjustment and well-being.
	Linkage and coordination with other sectors	In partnership between MOH and the Ministry of Education, the School Health Programme launched "Attention Groups", a primary health care development initiative in the Assistant Agency for Primary Healthcare.
	Policy and legislation	The mental healthcare law incorporates a number of international health standards promoted by WHO.

MOH is responsible for the provision of mental health and psychosocial support (MHPSS), and primary health care services in Saudi Arabia. These are closely linked and are often provided through primary health care facilities, in which workers are trained to identify and refer people with mental health problems as needed to secondary and tertiary care facilities. To support mental health responses that require specialized treatment beyond what can be provided by primary health care facilities, Saudi Arabia has a number of mental health hospitals and clinics.

The MOH has a number of initiatives to improve MHPSS and primary health care. These initiatives include:

- Development of a national mental health strategy
- Training of PHC workers in MHPSS
- The establishment of a network of mental health hotlines
- The promotion of mental health awareness

The MOH is also working to improve access to MHPSS services in rural areas of Saudi Arabia.

The following are some of the challenges to providing MHPSS and PHC in Saudi Arabia:

- The stigma associated with mental illness
- The lack of trained MHPSS providers
- The lack of access to MHPSS services in rural areas

Despite these challenges, there has been significant progress in the provision of MHPSS and PHC in Saudi Arabia in recent years. The MOH is committed to further improving these services in order to improve the mental health of the Saudi population.

In addition to MOH, there are a number of NGOs that provide MHPSS services in Saudi Arabia. These include the King Salman Center for Mental Health and the National Society for Mental Health.

Key informant interviews with sector stakeholders

Informant interviews were conducted to explore child and adolescent mental health needs and programmes, as well as to better understand ongoing challenges, and sectoral roles and responsibilities to meet the goal of strengthening the mental health system. Key informant interviews covered the following topics:

- Mental health needs (outcome, risks, and population) of children, adolescents, and mothers
- Current MHPSS services
- Linkages and existing referral mechanisms
- Current challenges and barriers for integrating MHPSS into primary health care
- Priority mental health needs
- Referrals and linkages with other sectors
- Feasibility and delivery of mental health services in primary health care facilities

Table 7: Key informant interviews with sector stakeholders

Priority mental health needs Requirements for mental health care: outcomes, risks, and population **Outcomes:** *Brief description of priority mental health conditions for children, adolescents, mothers* **Risks:** *Brief description of the key risks or determinants of mental health* **Population:** *Brief description of the populations that are highest priority for mental health*	**Challenges Shortage in specialized staff,** as well as insufficient representation of mental health sub-specialties among MHPSS staff members (insufficient number of psychiatrists, a shortage of clinical psychologists, and other subspecialties). **Limited comprehensive awareness and coordinated educational approaches** to mental health promotion and prevention in communities as well as among healthcare workers and educators. **Absence of awareness regarding the definition of mental health of children and adolescents,** which has an effect on the significance of child mental health as well as the significance of services provided in a variety of sectors. **Gaps programmes reaching marginalized locations.** According to the data provided by the stakeholders, the majority of the services offered to children are protocols for dealing with child abuse and domestic violence. **Limited availability and accessibility** of community-based, child- and adolescent-friendly, family-centred, and multidisciplinary care for mental health conditions (particularly outside of specialized tertiary and institutional settings). **Delay in early detection programmes in schools,** weakness in school health programmes, and absence of multisectoral standards of screening and early diagnosis. **Significant gap in prevention and promotion,** especially in life skills development for children and adolescents, as well as for parents; and in the provision of family services. **Lack of awareness and management in both the health and educational sectors** **Shortage of mental health professionals, limited workforce capacity, limited time for provision of services and consultations** (from a system perspective). **Risks associated with misdiagnosis and inappropriate treatments.** S**hortage of training, resources and financial planning** in the establishment of programmes and access to care. **Populations at risk:** • Children (aged >10 years) • Adolescents (aged 10–18 years) • Maternal mental health (pregnant and postpartum women) • Marginalized children and adolescents (rural and outreach areas).

Referrals and linkages with other sectors	Absence of standard tool for referral mechanisms between sectors. No clear referral policies that are commonly recognized. No organized referral systems, with all undertaken in an unplanned manner. Health insurance companies are currently working to streamline referral processes in the private sector. The National Health Insurance and Health Service Procurement Programme focuses on the strategic purchase of health care services, the evaluation of health cost-based risks, and the facilitation of the restructuring of Saudi Arabia's healthcare provider network.
Feasibility and delivery	According to the information provided by the stakeholders, the majority of MHPSS services are provided to children and adolescents in school, not as an official programme but rather as individual efforts, and most of them are educational programmes and recreational activities. Need to develop models and guidelines for children adolescents, and maternal health in different sectors. In primary health care clinics and community centres, there is a lack of wellness and mental health programmes that address issues such as stress management, social and emotional learning awareness, and parenting programmes. Establish supportive supervision programmes and performance indicators to monitor the MHPSS integration for children and adolescents. Limited rehabilitation and specialized hospitals for psychiatric paediatric admissions. Lack of systemic linkages between sectors. There is a need for a cross-sectoral approach.

6.4 Challenges and recommendations for strengthening integration of MHPSS services in primary health care

6.4.1 Legislation, policy, strategy, budget, and financing

Status according to the SNMHS: In terms of budgeting at MOH, 4 per cent goes to mental health and 96 per cent goes to other healthcare sectors. Current mental health services are in a total of 99 public mental health clinics, 27 mental health hospitals, 38 rehabilitation centres for patients with intellectual and physical disabilities, under the Ministry of Social Affairs, 69 day care units for people with mild and moderate intellectual disability having behavioural problems, 5 active consumer organizations and NGOs, and 5 community-based psychiatric inpatient units. These services provide a total of 0.41 beds per 100,000 population. The percentage of MOH mental health outpatient facilities are 21 per cent for children and women and 79 per cent for general patients.

There is a gap in prevention and promotion programmes that aim to enhance the life skills and resilience of children and adolescents, as well as their parents and families. Life skills are essential for coping with stress, managing emotions, communicating effectively, making decisions, solving problems, and developing positive relationships. These skills can help prevent or reduce the risk of developing mental disorders, as well as improve the outcomes of treatment. However, there is a lack of evidence-based programmes that can teach these skills to children and adolescents in different settings, such as schools, communities and homes.

Another challenge is the risk of misdiagnosis and inappropriate treatments that may harm the children and adolescents with mental health issues. Due to the shortage of qualified professionals, some children and adolescents may receive inaccurate or incomplete assessments, and/or be prescribed medications or therapies that are not suitable for their age or condition. This may lead to adverse effects on their physical and mental health, as well as their social and academic performance.

In addition, there are shortages of training, resources and financial planning for the development and implementation of effective programmes and policies for child and adolescent mental health. Financial planning is important for allocating adequate funds for the establishment and sustainability of programmes and policies that can improve the mental health system in Saudi Arabia. The stakeholders interviewed have agreed on four root causes that results in the proposed financial burden, and there are doubts about the feasibility of providing psychological care within primary health care. This doubt is mainly due to the absence of indicators for need and the lack of quantitative evidence, and therefore, no basis for localized of funding. This leads to a lack of conviction of decision-makers. Moreover, most of funder do not consider mental health as a priority when compared with other health care sectors. Consequently, there is not sufficient funding for these programmes, or there are attempts to limit spending.

Another challenge is the lack of knowledge about the economic cost of primary psychological care compared to other services. The focus has been on the immediate needs for treatment and rehabilitation rather than on prevention of mental health disorders. In many cases, treatment and rehabilitation, which are significantly more expensive than prevention, could have been avoided. Given the difficulties faced by the systems (governance, workforce, service-delivery, etc.) distributing resources differently and in a coordinated effort would help to improve responses to complex issues.

Recommendations for legislation, policy, strategy, budget and financing

According to the stakeholders interviewed, it is crucial to prioritize raising awareness among health leaders about the importance of mental health and its long-term economic impact. Additionally, a comprehensive understanding of the economic costs associated with mental health care at all levels within Saudi Arabia is essential. There is a need to encourage spending efficiently by taking into account the current workforce and services, thereby maximizing the benefits derived from the available infrastructure and personnel. This can be done by the implementation of economic modelling to support an investment case for mental health, and also to help accurately identify costs to provide MHPSS services, which could be compared to the costs of not providing MHPSS.

One of the key recommendations is to allocate a separate and sustainable budget for mental health services, which would ensure adequate funding and resources for the development and implementation of effective interventions.

Another recommendation is to have a clear and coherent plan for the service delivery pathway, as well as establishing benchmarking indicators to monitor and evaluate the quality and outcomes of the services.

All programmes and policies should be tailored to the specific needs and context of local populations, taking into account the cultural, religious and social factors that influence mental health. Additionally, the mental health of children and adolescents should be given priority and attention in national policies, strategies and plans, as well as in other relevant sectors. Along with mental health, these should include topics such as nutrition, sexual and reproductive health, violence and injury prevention, and psychosocial support related to the health and well-being of this vulnerable group. Finally, it is essential to have a national mental health act that covers all aspects of mental health promotion, prevention, treatment and protection of children's and adolescents' rights, as well as the integration of MHPSS services for children and adolescents in the general health system.

To effectively address mental health challenges, it is imperative to embark on a multifaceted approach. This involves determining the extent of the problem and developing comprehensive statistical data on mental health issues, emphasizing a broader perspective. There is a need for economic studies, which includes identifying existing facilities and the services they provide. The existing work force needs to be supported and expanded. One example is that there is a psychologist in every primary health care centre. But this requires a high cost. As an alternative model, to benefit from primary care doctors, why not train the medical staff by training them regarding mental health to be able to provide mental health services to children and pregnant women, along with guidance on referral to more specialized services if needed. This requires further research to advocate for political commitment and funding, and which would also inform policy decisions (data to identify the mental health burden and needs of children and adolescents, and economic modelling).

6.4.2 Service feasibility and delivery

Based on the stakeholder interviews, most of the MHPSS interventions are delivered in schools, but are not part of an official programme or policy. MHPSS services depend on the individual initiatives of teachers or counsellors, and mostly consist of educational and recreational activities that do not address the specific needs of children and adolescents with mental health conditions.

Therefore, there is a need to develop evidence-based models and guidelines for MHPSS services for children, adolescents and maternal health in different sectors, including education, health, social welfare and justice. These models and guidelines should be based on a comprehensive assessment of the needs, gaps and resources in each sector, as well as how they can work together, and should follow a life-course approach that considers the developmental stages and transitions of children and adolescents.

Another challenge is the uneven distribution and accessibility of mental health services across the country. Most of the existing services are concentrated in urban areas, while rural and remote areas suffer from a lack of resources and facilities. Most of the services are focused on responding to cases of child abuse and domestic violence, which are important but not sufficient to address the broader spectrum of mental health issues that children and adolescents may face. There is a need for more community-based, child- and adolescent-friendly, family-centred, and multidisciplinary services that can provide prevention, early detection, intervention and follow-up for various mental health conditions.

There is a lack of preventive and promotive MHPSS programmes (e.g., early childhood development, nutrition, postnatal care, etc.) in primary health care clinics and community centres, where most children and adolescents access health services. These settings could offer opportunities to implement wellness and mental health programmes that address common issues such as stress management, social and emotional learning awareness, and parenting skills. These programmes could facilitate the early identification and referral of children and adolescents with mental health problems to specialized services.

To ensure the quality and sustainability of MHPSS services for children and adolescents, it is also essential to establish supportive supervision programmes and performance indicators to monitor the integration of MHPSS in different sectors. These mechanisms should provide regular feedback, coaching, mentoring and training to the staff involved in MHPSS service delivery, as well as evaluate the outcomes and impacts of the interventions.

Moreover, there is a limited availability of rehabilitation and specialized hospitals for psychiatric paediatric admissions in Saudi Arabia. This poses a challenge for the treatment of children and adolescents with severe mental disorders who require inpatient care. There is a need to increase the number and capacity of these facilities, as well as to ensure that they follow international standards of care and human rights principles.

Finally, there is a lack of systemic linkages between sectors that provide MHPSS services for children and adolescents. This results in fragmentation, duplication, or gaps in service delivery, as well as poor coordination and communication among different actors. There is a need for a cross-sectoral approach that fosters collaboration and referral mechanisms among different stakeholders, such as government agencies, NGOs, community-based organizations, religious leaders, families, and service users. There is also a need for more resources, such as equipment, materials, space, transportation, etc., to support the delivery of quality services.

Recommendations for feasibility and delivery

One of the main challenges of the mental health system in Saudi Arabia is the lack of standardized protocols and procedures for identifying, diagnosing and treating children and adolescents with mental health issues across different sectors. Therefore, it is essential to develop and implement clear and consistent guidelines for referral within and between sectors, such as health, education, social services and justice. This can be done by linking the Ministry of Education to MOH, such that a teacher can refer, after the approval of the parents, when there are any challenges or problems in school that may require specialized attention at a centre for developmental and behavioural disorders. In addition, effective communication should be present to link the ministries of labour, education, and health in all areas related to children. Providing a card for each child, in which all the child’s health information is kept in an electronic health record or application, would ensure that every child and adolescent has the right to receive appropriate and timely care for mental health needs.

The stakeholders interviewed suggested implementing a mandatory annual examination service for children to check on their well-being including looking out for any developmental/behavioural or psychological issues. This type of evaluation currently depends on the family and their awareness, but a more standardized regular screening that is accompanied by the availability of care and support could help with preventative services rather than solely calling on responsive services and treatment.

There is dominant focus in health care on diagnosis and treatment rather than prevention and promotion. To shift from disease response to promotion of health and wellness is recommended. This provides a holistic and comprehensive approach to mental health that considers the biological, psychological, social and spiritual dimensions of well-being. However, to do this requires improving the quality of services provided by primary health care clinics, as well as increasing the community's trust and satisfaction with these services. It would also require being more systemic in linking sectors and stakeholders that can contribute to enhancing mental health outcomes for children and adolescents in Saudi Arabia.

The stakeholders noted that the enhancement of mental health services necessitates the implementation of a comprehensive family doctor programme, ensuring mandatory annual examinations for children. It also involves training doctors in primary health to detect psychological disorders and emphasizes preventive programmes within ministries. These efforts should be directed toward equitable service distribution, public awareness campaigns about available services, and clarification of access procedures.

Advocating for flexibility in the health insurance market to alleviate financial burdens on families seeking mental health services is crucial. Initiatives such as establishing national programmes for short breaks and integrating mental health centres with primary care programmes would contribute to an overarching strategy aimed at improving overall well-being.

6.4.3 Referral system and linkage with other sectors

One of the main challenges that the mental health system in Saudi Arabia faces is the lack of a standardized referral mechanisms between different sectors, such as primary health care, social services, education and justice. This means that there is no consistent way of identifying, assessing, and transferring patients who need specialized mental health care or support from other sectors. As a result, there are only individual efforts within each sector, which may not be coordinated or effective. Moreover, there are no clear referral policies that are commonly recognized and followed by all stakeholders. The referral systems that exist unplanned and informal, which can lead to delays, gaps and/or duplication of services. This affects the quality and accessibility of mental health care and the integration of mental health into other sectors.

Recommendations for referral system and linkage with other sectors:

The first recommendation is to develop and implement a standard tool for referral mechanisms between different sectors, based on the best practices and evidence from other countries. This tool should include clear guidelines and criteria for identifying, assessing and transferring patients who need mental health care or support from other sectors. It should also specify the roles and responsibilities of each sector in the referral process, as well as the procedures and documentation required. The tool should be widely disseminated and used by all stakeholders involved in the referral process.

The second recommendation is to establish clear referral policies that are agreed upon and adhered to by all stakeholders, including the roles and responsibilities of each sector, the criteria and procedures for referral, and the follow-up and feedback mechanisms. These policies should be based on the standard tool for the referral mechanism, but also take into account the local context and needs of each sector. The policies should be formally endorsed by the relevant authorities and communicated to all staff members involved in the referral process. The policies should also be regularly reviewed and updated to ensure their relevance and effectiveness.

The third recommendation is to strengthen the coordination and communication between different sectors, through regular meetings, joint trainings, shared databases and referral networks. These activities should aim to foster mutual understanding, trust and collaboration among different sectors in providing mental health care and support to patients. They should also facilitate the exchange of information, feedback and referrals among different sectors. The coordination and communication should be supported by a designated focal point or coordinator in each sector who is responsible for overseeing and facilitating the referral process.

The fourth recommendation is to enhance the capacity and awareness of each sector on mental health issues, through education, training, supervision and support. These interventions should aim to increase the knowledge, skills and attitudes of staff members in each sector on how to identify, assess, refer and follow-up patients who need mental health care or support from other sectors. They should also provide them with the necessary resources, tools and guidance to perform their roles effectively. The education, training, supervision and support should be tailored to the specific needs and characteristics of each sector.

The fifth recommendation is to evaluate and monitor the referral systems and their outcomes, through data collection, analysis, and reporting. These activities should aim to measure the performance, quality, efficiency, effectiveness, impact and satisfaction of the referral systems among different sectors. They should also identify the strengths, weaknesses, opportunities and challenges of the referral system and provide recommendations for improvement. The data collection, analysis and reporting should be done using standardized indicators, tools, methods and formats.

Another challenge is the limited capacity and resources of the education sector to address the mental health needs of a large population of students. To overcome this challenge, it is recommended to strengthen the preventive and promotional actions in academic settings, such as raising awareness, providing counselling and support, and fostering a positive school climate. Moreover, it is recommended to establish effective collaboration and coordination between the education sector and the primary health care clinics/facilities, so that students with mental health issues can be identified early and referred to the appropriate services.

6.4.4 Governance and coordination

Recommendation in governance and coordination

One of the main challenges is the delay in implementing early detection programmes in schools, which are crucial for identifying and addressing mental health problems at an early stage. The school health programme is weak and does not include standardized screening and diagnosis tools for mental health issues. There is also a lack of collaboration and coordination between the health and education sectors, which hinders the referral and integration of services for children and adolescents with mental health needs.

Effective governance plays a role in the success of any project. However, the current issue is that different sectors and institutions lack a shared vision resulting in a lack of coherence and impacting the outcomes. It is crucial to establish a vision, which is seen as a priority, and an achievable goal. Therefore, outcomes and outputs are not as impactful as they should be due to the low connection between entities.

The shard vision is critical. After having a shared vision, the framework can be developed. This is a high priority and is feasible. There is an existing national framework for mental health, coordination and planning, if we have a clear vision and a clear framework, the will serve to create local strategic plans.

To ensure accountability, it is essential to map out stakeholders involved in healthcare services, especially as roles within the health sector continue to evolve. One significant concern revolves around defining the age limit for child health services accurately and addressing the discrepancy between how children under the age 18 years are defined in comparison to how children are defined by MOH, which is age 14 years and younger.

To address this, efforts are already underway to restructure primary care services with an emphasis on children through 18 years of life. The aim is to integrate health promotion and mental health prevention into existing programmes. The challenge lies in aligning sectors to ensure a comprehensive and unified approach towards workforce development. This becomes more critical, within the context of health sector transformation programmes that aim to redesign governance structures and enhance integrated care, giving special attention to expanding mental health services within primary care settings.

As part of this transformation, capacity building plays a role by involving professionals, including health counsellors, psychologists and social workers. The primary objective is to ensure that mental health services are provided fairly and address the requirements of individuals. There is a requirement to determine a national goal for MHPSS that follows a multisectoral strategy and enhanced coordination (multisectoral committee, taskforce, etc.)

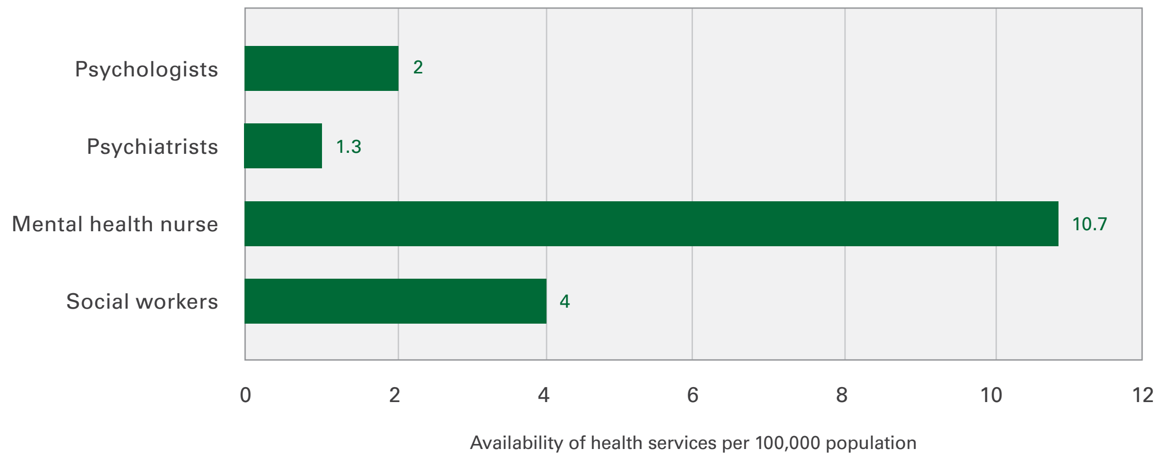
The main objectives related to Vision 2030 are:

1. Increase accessibility to care
2. Implement measures to improve the quality of services
3. Increase KPIs
4. Reducing road traffic accidents and injuries

6.4.5 Workforce

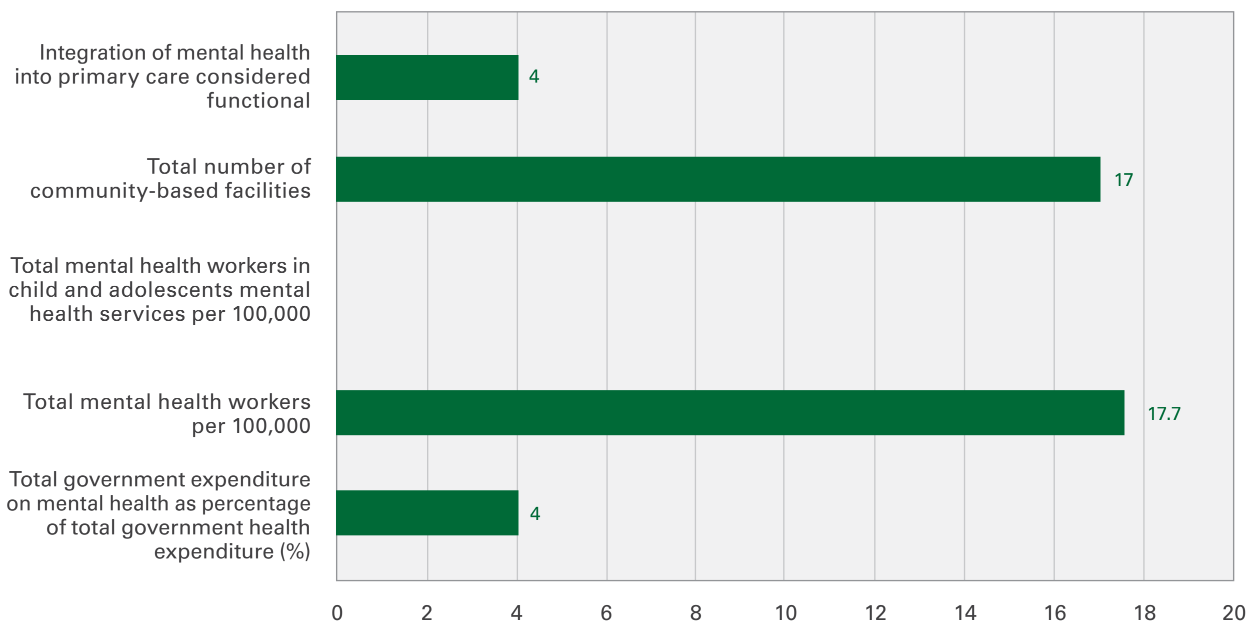
One of the main challenges facing the mental health system in Saudi Arabia is the shortage of specialized staff who can provide adequate and quality care for children and adolescents with mental health needs. There is a lack of representation of different mental health subspecialties among the mental health and psychosocial support (MHPSS) staff members, such as psychiatrists, clinical psychologists, social workers, counsellors, and others. This leads to a limited range of services and interventions that can address the diverse and complex needs of the young population.

Figure 7: Availability of mental health services



Source: World Health Organization, 2018a;[35] World Health Organization Regional Office for the Eastern Mediterranean, 2019; World Health Organization Regional Office for Europe, 2019.

Figure 8: Overview of mental health care service delivery



Source: WHO Mental Health Atlas 2020.

Furthermore, the overburdened workforce suffers from high turnover rates, lack of training, absence of social support, low motivation and burnout. These factors affect the quality, accessibility, and effectiveness of mental health services.

In addition, the workforce faces difficulties in building their capacity, managing their time, and consulting with other stakeholders. There is a need for more training and supervision programmes, as well as more collaboration and coordination among different sectors and levels of care. These challenges hinder the ability of the mental health system to meet the complex and evolving needs of the population. There is a need for more training opportunities for MHPSS staff members to update their knowledge and skills on the latest evidence-based practices for child and adolescent mental health. Moreover, non-specialist providers are currently not trained and have limited capacity to deliver on MHPSS. It might be good opportunity to also train family doctors, nurses, midwives in delivering some of the MHPSS interventions, building their capacity to address mental health at the primary health care level.

Recommendations for the workforce

The first recommendation for the workforce is that priority should be given to increasing the amount and quality of collaborative training that occurs between the various stakeholders in the field of child and adolescent mental health, such as psychiatrists, psychologists, social workers, educators, religious leaders and family members. Moreover, clear roles should be assigned to them based on their skills and competency, and according to the role they play in MHPSS services. This would help to foster a common understanding of the needs and challenges, as well as to provide support for sharing best practices and resources.

Second, a multidisciplinary approach should be adopted in each sector involved in the provision of mental health services for children and adolescents, such as health, education, social welfare, and justice. This would help to facilitate the implementation process of policies and programmes, as well as to ensure a comprehensive and integrated care for this population.

Finally, the mental health knowledge and competency of various primary, secondary and tertiary care providers should be enhanced through continuous education and training, as well as through regular supervision and feedback. Developing programmes for continuous development of the workforce, according to flexible strategies that are compatible with the needs of society, represented by children, adolescents, women, and all members of society would improve skills and confidence in identifying, assessing, treating and referring children and adolescents with mental health problems. It would also cultivate professional relationships among these service providers, in order to improve patient outcomes.

This can be supported by fostering collaboration with the relevant authorities, such as MOH, Ministry of Education, universities, NGOs, training institutions, which is essential for community-focused training, development and tailored support to address specific community needs. This involves attracting individuals with specialized expertise to contribute to the workforce. Financial support is pivotal in overcoming workforce obstacles; facilitating the availability of more centres and specialists across locations, especially in schools, where having specialists can ensure ongoing support and follow-ups for students; and preventing mental health issues from escalating. Another recommendation is to train non-specialist providers, as not all of the cases require specialist review and can be addressed at a lower level of care within communities, which will also help address the stigma and promote help-seeking behaviour.

6.4.6 Engagement of the community and other stakeholders

Stigma is a major barrier to mental health care in Saudi Arabia. It is important to destigmatize mental health so that people feel comfortable seeking help. This can be done through education, awareness campaigns, and by changing the way that mental health is portrayed in the media. In addition, there is a lack of awareness about mental health problems in Saudi Arabia. This lack of awareness can make it difficult for people to understand the signs and symptoms of mental health problems, and it can also make it difficult for them to know where to get help.

Cultural factors also pose challenges to engagement in mental health care. For example, some people may view mental health problems as a sign of weakness or a punishment. This can make it difficult for people to talk about their mental health problems or to seek help. There are limited facilities available for mental health care in Saudi Arabia. This can make it difficult for people to access the care they need.

Another challenge is the limited awareness and education about mental health issues among the general public, as well as among healthcare workers and educators. Many people do not have a clear understanding of how mental health impacts children and adolescents, and how it affects their development, well-being and functioning. There is also a lack of coordinated and comprehensive approaches to promote mental health and well-being, and prevent mental disorders in various settings, such as schools, communities and families. This results in low recognition of mental health problems, stigma and discrimination, and barriers to seeking and accessing help.

The stigma and mistrust associated with psychiatric services in Saudi Arabia leads to low utilization and accessibility of mental health care. To change this perspective, it is recommended to shift the provision of psychiatric services from hospitals to primary health care mental health clinics, which are more accessible, affordable and acceptable for the community. Additionally, it is recommended to increase the number of beds in inpatient mental health services, especially for children and adolescents who require intensive care. Furthermore, it is recommended to enhance the integration and linkage of programmes and sectors that deal with mental health issues, such as education, social services, justice and religious institutions.

Recommendations for engagement of the community and other stakeholders

There are several things that can be done to engage the community and other stakeholders in mental health in Saudi Arabia. It is important to raise awareness about mental health problems and to challenge the stigma associated with mental health care. This can be done through public education campaigns, training for health care providers and other initiatives.

Involving community leaders is an integral component of the strategy, as community leaders can play a key role in promoting mental health. They can help to raise awareness about mental health problems to reduce stigma and to advocate for better mental health services. Moreover, individuals with mental health problems need to be empowered to seek help. This can be done by providing them with information about mental health services, by removing the barriers to accessing care, and by providing them with support. Finally, partnerships between different stakeholders, such as government agencies, NGOs and community organizations, can be effective in promoting mental health and well-being. These partnerships can help to pool resources, share expertise and develop effective strategies for engaging the community.

6.4.7 Data, health information, research, monitoring and evaluation

Data, health information, research, monitoring and evaluation are essential components of a comprehensive mental health system. However, in Saudi Arabia, these components face several challenges that hinder the development and improvement of mental health services and outcomes.

There is a significant gap in the availability and quality of data on mental health in Saudi Arabia. This is attributed to various factors, such as the social stigma and cultural barriers that prevent people from seeking help for mental health issues, the shortage of qualified mental health professionals who can collect and analyse data, and the insufficient allocation of resources for mental health research.

Health information is not easily accessible to people who need it, especially those who live in remote or rural areas. This can be caused by various factors, such as the low level of awareness and knowledge of mental health resources among the general public and health care providers, the high cost of mental health services that makes them unaffordable for many people, and the inadequate transportation infrastructure that limits the access to mental health facilities.

There is scarcity of research on mental health in Saudi Arabia, especially on the prevalence, causes and treatment of mental disorders. This is due to various factors, such as the lack of funding and incentives for mental health research, the lack of trained and experienced researchers who can conduct and publish high-quality research, and the lack of ethical guidelines and approval mechanisms for mental health research.

In addition, the monitoring and evaluation of mental health programmes in Saudi Arabia is not always effective or consistent. This is due to various factors, such as the lack of clear and measurable goals and objectives for mental health programmes, the lack of data and indicators to measure the impact and effectiveness of mental health programmes, and the lack of resources and capacity for monitoring and evaluation activities.

Recommendations for data, health information, research, monitoring and evaluation

To improve the availability and quality of data on mental health in Saudi Arabia, there is a need to increase the awareness and reduce the stigma of mental health issues among the population, to train more mental health professionals who can collect and analyse data, and to allocate more resources for mental health research. There is also a need to raise the level of awareness and knowledge of mental health resources among the public and health care providers, to subsidize or provide free mental health services to those who cannot afford them, and to improve the transportation infrastructure that connects people to mental health facilities.

In order to promote research on mental health in Saudi Arabia, there is a need to provide more funding and incentives for mental health research, to train and support more researchers who can conduct and publish high-quality research, and to establish ethical guidelines and approval mechanisms for mental health research. Moreover, there is a need to define clear and measurable goals and objectives for mental health programmes, to collect and use data and indicators to measure the impact and effectiveness of mental health programmes, and to provide more resources and capacity for monitoring and evaluation activities.

Some services have been launched to screen for neurodevelopmental disorders and provide early detection and referral. For example, MOH has established clinics in primary health care settings that can screen and refer patients to appropriate services. The Ministry of the Interior has also implemented early autism screening through Modified Checklist for Autism in Toddlers MCHAT and referral to Security Forces Hospital. Data analysis teams have been established in each sector and subsector to improve the analysis, reporting and intersectoral sharing of data on mental health indicators and outcomes.

Research capabilities should be developed at the regional level to conduct, report on and expand research on adolescents, including sensitive topics like sexuality, gender identity, suicide and self-harm. Such research can inform evidence-based policies and interventions for this vulnerable group.

In addition, emerging digital technologies should be identified and leveraged to address the health needs of children and adolescents both within and across borders. These technologies can offer innovative solutions for access, quality and affordability of mental health care. However, users should also be equipped with the skills necessary to prevent and/or manage potential harm from online risks or misuse.

Finally, coordination at administrative and implementation levels should be improved, especially in referral systems. Standardized referral procedures and tools should be provided to ensure smooth and timely transitions between different levels of care and sectors. Feedback, monitoring and evaluation mechanisms between stakeholders should be increased in effectiveness. These mechanisms can enhance accountability, learning and improvement of mental health services and systems.

7. Conclusion and final recommendations

In conclusion, the mental health landscape in Saudi Arabia faces several challenges, including a shortage of specialized staff, limited awareness, uneven service distribution, weak school health programmes, and risk of misdiagnosis that can lead to over-diagnosis of mental health conditions due to inaccurate screening, or incorrect diagnosis of mental disorders due to lack of trained staff. Financial constraints and a lack of prioritization contribute to the complexity of the issue.

To address these challenges, prioritizing mental health awareness among health leaders and understanding the economic and social impacts are crucial. Recommendations highlighted the need for a holistic strategy that, based on data and supported by effective policies, includes allocating a separate budget, training of primary care doctors to provide mental health care, and developing clear service delivery planning. Children and adolescents' mental health should be a priority in national policies, and a comprehensive mental health act is essential for integration.

In addition, the challenges in the delivery and feasibility of mental health services for children and adolescents in Saudi Arabia are multifaceted. They include the lack of standardized protocols, limited preventive and promotive programmes, insufficient collaboration between sectors, stigma, and a disease-oriented approach. To address these challenges, clear and consistent guidelines for identification, diagnosis and treatment should be developed, fostering communication between ministries, particularly education and health. Strengthening preventive actions in academic settings and implementing mandatory annual examinations for children can enhance early identification and intervention.

Governance and coordination challenges in Saudi Arabia's mental health system revolve around the lack of a shared vision among different sectors, impacting the effectiveness of outcomes. To address this, establishing a clear and shared vision is crucial, followed by the development of a national framework for mental health coordination and planning.

Aligned with Vision 2030, the main objectives include ensuring access to care, improving service quality, increasing key performance indicators, and reducing road traffic injuries. These objectives form a comprehensive strategy for the transformation of mental health services within the primary care setting, aligning with broader healthcare sector transformation programmes.

Workforce challenges in Saudi Arabia's mental health system, including shortages, lack of diversity, high turnover rates and burnout, significantly impact service quality and accessibility. Prioritizing collaborative training among various stakeholders, adopting a multidisciplinary approach in different sectors, and enhancing the knowledge and competency of primary, secondary and tertiary care providers are crucial steps. Continuous education, regular supervision and feedback are recommended to improve skills and confidence in identifying, assessing, treating and referring children and adolescents with mental health problems.

Improving coordination, standardized referral procedures and feedback mechanisms between stakeholders will enhance accountability, learning and the overall effectiveness of mental health services and systems. The development of regional research capabilities can address sensitive topics and inform evidence-based policies for children's and adolescents' mental health.

Following is a list of key recommendations that can be undertaken in each sector, and coordinated among sectors:

1. Ministry of Health

In collaboration with training institutions, professional associations and other key sectors (such as education), MOH should undertake further scoping of the primary-care-level MHPSS workforce to define core cadres and roles, and identify required competencies to support workforce planning and development. This should include strengthening training of primary-level non-specialist providers in MHPSS.

2. Financing for MHPSS

Develop a comprehensive understanding of the economic costs associated with psychological care at all levels within Saudi Arabia, encouraging efficient spending by implementing economic modelling to support an investment case for mental health, accurately identifying costs for MHPSS. Undertake efforts toward equitable service distribution and public awareness campaigns, work toward clarifying access procedures, consider national programmes for short breaks, and integrate mental health centres with primary care programmes to improve overall well-being.

3. Ministry of Education

It is recommended that the Ministry of Education implement mandatory annual examination services for children, covering developmental, behavioural and psychological aspects.

To enhance social welfare in the context of mental health and suicide prevention for youth, it is recommended to implement community-based and school-based support programmes, ensuring accessibility to mental health services and affordable treatments. Family counselling and support, crisis intervention services, and specialized training for healthcare professionals play crucial roles. Collaborations with NGOs and community organizations, public awareness campaigns to reduce stigma, and ongoing research for evidence-based interventions are essential. By creating a comprehensive and integrated approach, these recommendations aim to address the multifaceted challenges and risk factors faced by youth, fostering a supportive environment for mental well-being.

4. Strengthening referral mechanisms across sectors

Developing and implementing a standard tool for referral mechanisms between different sectors, and incorporating best practices and evidence from other countries with strengthen referral mechanisms across sectors. The formulation of clear guidelines and criteria for identifying, assessing and transferring patients needing mental health care or support across sectors with preidentified roles and responsibilities of each sector is required. There also needs to be efforts toward establishing effective collaboration and coordination between the educational sector and primary health care clinics/facilities for early identification and referral of students with mental health issues.

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Appendix 1

CONSULTATION WORKSHOP OBJECTIVES, PARTICIPANTS AND AGENDA

ESTABLISHING THE FOUNDATION FOR INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN PRIMARY HEALTH CARE FOR CHILDREN, ADOLESCENTS, AND PREGNANT/POSTPARTUM WOMEN IN SAUDI ARABIA

Participant information and consent form

Objectives:

- **Knowledge Sharing:** Present key findings from a comprehensive desk-based review on MHPSS literature, data, and research.
- **Gap Prioritization:** Collaboratively prioritize main gaps in MHPSS service delivery and develop action plans.
- **Challenge Resolution:** Identify and prioritize implementation challenges at the PHC level and devise action plans.
- **Mechanism Exploration:** Explore existing mechanisms for MHPSS service delivery in primary healthcare, analyze challenges, establish linkages, and unearth improvement opportunities through interactive discussions.

Participants:

- Ministry of health (policymakers, stakeholders) at National and Regional levels.
- Ministry of education (policymakers, stakeholders) at National and Regional levels.
- Ministry of Human Resources and Social Development (policymakers, stakeholders) at National and Regional levels
- Family Affairs Council
- Saudi Commission for Health Specialties
- Ministry of Interior
- Saudi Arabian Ministry of Justice
- Ministry of Culture
- General Sport Authority
- National Transformation Program
- Saudi Health Council
- Human Right Commission
- UNICEF Office
- National Family Safety Program
- Professionals and advocates for the health of children and adolescents
- Non-profit Organizations

Workshop Agenda

<table>
<tr><th>Time</th><th>Activity</th><th>Speakers</th></tr>
<tr><td colspan="3">Session 1</td></tr>
<tr><td rowspan="2">9:00-9:30</td><td>Welcoming remarks</td><td>Dr. Abdulhameed Alhabib
Dr. Maimoonah Alkalil
Mr. Eltayeb Adam</td></tr>
<tr><td>Presentation:
Section A:
• Definitions of mental health and psychosocial well-being and common mental health conditions and risk factors).
• Definitions and scope of MHPSS for children and adolescents, and maternal mental health The rationale for delivery through PHC and definition of the PHC system (including multisectoral linkages).
• Project overview & Desk Report findings.
Section B:
• Project overview: Overview of project objectives, approach and expected outputs.</td><td>Ms. Marwah Albuhaisi
Ms. Munirah Alassaf</td></tr>
<tr><td colspan="3">Session 2</td></tr>
<tr><td>9:30 – 10:00</td><td>Break attendants into groups:
Task 1: Systems-Strengthening Topics Exploration
• Form small groups with mixed-sector participants.
• Assign each group one of the following topics: workforce, governance and coordination, financing, participation, or service delivery (models, guidelines, standards).
• Conduct a problem tree analysis to identify and explore current challenges related to the assigned topic.
Task 2: Prioritizing Gaps and Feasibility Assessment
• Within each group, prioritize identified gaps as either 'very high' (critical) or 'lower' (less critical).
• Assess the feasibility of addressing these gaps, categorizing them as 'highly feasible' (achievable in the short term) or 'unlikely to be feasible' (not achievable in the short term).
• Visually represent your findings using sticky notes on a flip chart for discussion and planning.
These tasks guide participants through the process of identifying, prioritizing, and assessing the feasibility of addressing challenges within specific systems-strengthening topics related to mental health and psychosocial support at the Primary Healthcare (PHC) level.</td><td>Ms. Marwah Albuhaisi
Ms. Munirah Alassaf</td></tr>
<tr><td>10:00 – 10:30</td><td colspan="2">Feedback and Discussion</td></tr>
<tr><td colspan="3">Break (20 minutes)</td></tr>
</table>

Time	Activity	Speakers
Session 3		
10:50 – 11:30	**Group Activity 2: Action plan (60 minutes)** In groups, participants will address the identified gaps or challenges, starting with the most critical and proceeding to the less critical ones. It's important to note that due to time constraints, not all gaps may be addressed. Therefore, each group will focus on their top three priority issues. For each priority, the group will engage in discussions and collaborate to create a detailed action plan. Worksheets will be provided to assist in this process.	Ms. Marwah Albuhaisi Ms. Munirah Alassaf
11:30 – 11:45	Feedback and Discussion	
11:45 – 12:00	Questions	

Appendix 2

INTERVIEW GUIDE (DRAFT)

ESTABLISHING THE FOUNDATIONS FOR INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) IN PRIMARY HEALTH CARE TARGETING CHILDREN AND ADOLESCENTS IN THE MIDDLE EAST AND NORTH AFRICA REGION

Key informant interview

Interviewer ID:		Date (dd/mm/yy):	
Start time:		End time:	
Participant ID:		Sector / organization:	
Current designation / role of participant:			
Age of participant		Gender of participant:	
Consent obtained?	YES / NO		

Thank you very much for agreeing to participate in this interview.

Today we will be asking for your views and opinions about how to integrate mental health and psychosocial support services (MHPSS) for children, adolescents and pregnant / postpartum women within the primary health care system in [country name]. This will include questions about your thoughts on the mental health needs of children and adolescents, and maternal mental health, what role your sector currently plays in delivery of support services, and the challenges and opportunities to improve the delivery of MHPSS in primary care.

'Mental health and psychosocial well-being' is a positive state in which children and adolescents are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn, and have a positive sense of self and identity.

'Mental health conditions' is a broad term that encompasses the continuum of mild psychological distress through to mental disorders, that may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, common mental health conditions include: difficulties with behaviour, learning or socialisation; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, psychosis, bipolar disorder, eating disorders, substance use disorders, conduct disorder, attention

By MHPSS we mean any services or supports to diagnose and treat mental health conditions, to prevent poor mental health, and to promote mental health and psychosocial well-being.

The session today will take approximately 60-90 minutes.

Participating in this project is voluntary. You do not have to answer any question that I ask you, and we can stop the interview at any time. If you don't want to answer a question or would like to stop the interview you do not have to give a reason. If you wish to withdraw from the project after our discussion, please contact the study team and the information that you shared will be destroyed.

With your permission I will be taking notes and recording today's interview, to make sure we gather all your ideas. Everything you say will remain confidential. Your responses will not be shared with your manager or employer, and they will not affect your role or employment.

What we learn from this interview will be compiled with the responses from other interviews. A summary of the key findings will be shared with government representatives, and UN agencies in this country, and in Middle East and Northern Africa region. They will also be used to develop recommendations to improve the delivery of mental health support services in [country name] and the region. No personal information identifying you or your organisation or employer will be included in any reports or other documents.

Please confirm the participant's consent to continue the interview, and consent to have the interview recorded.

Theme	Questions
Mental health needs of children and adolescents	**I would like to start by asking what you think the main mental health needs or problems are of children and adolescents in [YOUR COUNTRY]?** • Children (<10 years) • Adolescents (10-18 years) • Pregnant and postpartum women (maternal mental health) • Are there particular groups who have worse mental health than others, or are at increased risk? Why? (eg girls v boys, pregnant adolescents, refugees, migrants,) • Are they any systems in place to collect and report data on mental health needs (eg surveillance systems). Can you describe these?
Current MHPSS provided through primary health care	**I would like to ask you about the different mental health and psychosocial support services that are currently provided through primary health care.** • What types of services are provided and what mental health needs do they address? o Children o Adolescents 10-19 o Maternal mental health • Who provides these services (which types of health care providers)? • How are they provided (are they standalone mental health services (such as community mental health clinics) or integrated with other services, (such as general outpatient clinics, maternal and child health, nutrition programs, outreach services, school-based services)? • Who utilizes these services? • Who funds the services? Are fees charged? Are any services subsidized? • Are there any services that are specifically for children and adolescents? • Are there any population groups that face additional barriers to access (rural families, refugees or displaced populations, migrant families)? • How is data about mental health services collected and reported (and who is this reported to?) Some **examples** could include: • Screening, early identification and diagnosis • Triaging and assessment • Treatment and management of mental health conditions (including developmental disorders) • Continuity of care / multi-disciplinary case management • Mental health facilities / residential care • Screening and management of risk factors (exposure to violence, abuse, neglect, bullying, substance use, etc) • Parenting support • Linkages with schools or communities for mental health promotion **What are the existing linkages and referral mechanisms with secondary and tertiary-level care, including specialist mental health services? How could these be strengthened?**

Theme	Questions

Current barriers and enablers	**I would like to ask you about the current challenges delivering or integrating MHPSS into primary health care**
	• What is **currently being done well** to address the mental health of children, adolescents and maternal mental health through primary health care?
	• What do you think could be improved or strengthened?
	• What are the gaps (what specific areas of mental health and well-being or services aren't being addressed)?
	• What are the main challenges delivering MHPSS through primary health care?
	
	Some **prompts** could include:
	• Access to clinical guidelines, protocols, tools, job aids
	• Workforce (availability, training, skills, supervision)
	• Referral mechanisms
	• Workload pressure / integrating into other services
	• Financial and other resources
	• Lack of medical supplies for mental health
	• Low care-seeking / stigma
	• Lack of data / health information systems
	• Can you explain the social norms or attitudes towards mental health, stigma, care-seeking behaviour?
	  o How do these norms impact on service providers and quality of care?
	  o How do these norms impact on the community and care-seeking behaviour?

How could MHPSS be strengthened	**Are there any mental health and psychosocial supports or services that you think could be provided through primary health care that are not currently being provided? Can you describe these? (ie what services could be integrated into primary health care?)** Some **prompts** could include: • Additional services to identify or screen for mental health conditions • Management (including multi-disciplinary support and case-management) • Services to identify and address risk factors (violence, bullying, substance use) • Parenting programs and support • Outreach, community-based, school-based services Which of these would be the highest priority in your opinion? How could these be delivered? • Integrated with existing services (if so, which ones)? • Establishing new services / programs specifically for mental health? • Community-outreach or school-based? • Linkages with communities and community-based organisations • Who (which providers) should be engaged in delivering these?

Theme	Questions
Considerations for implementation	**Reflecting on the challenges you have already described, and some of the gaps / priorities, what would be needed to support MHPSS through primary health care?** Some **examples** could include: • What policy or legislative changes are needed (eg parental consent for adolescents)? • What is needed to support planning and coordination (between government departments, different levels of health care, between health services)? • What additional guidelines, protocols, standards, job aids are needed? • What infrastructure or facility environment changes are needed? • What workforce supports are required (numbers, training and capacity building,, skills mix, supervision)? • Financial resources? • Data and information (eg health information systems, surveillance, further research)? • What service-delivery approaches are needed to reach children, adolescents and pregnant women / new mothers? • Improved community engagement / care-seeking
Linkages with other sectors	**What are the existing linkages and referral mechanisms between primary health care and other supports / sectors (schools, social welfare, NGOs)?** • How are mental health referrals to primary health care from schools, child protection, NGO or other services currently managed? What are the challenges? • What referrals are made by primary health care to other MHPSS supports (eg child protection, special education, social protection, etc)? What are the challenges? • Are there any examples of coordinated programs or services provided by primary health care and other sectors to address mental health and well-being? For example: o School-based screening, counselling, support o Multi-disciplinary case management of those with mental health conditions o Multi-disciplinary case management for children or families at increased risk **What role could other sectors (social welfare, social protection, child protection education) have in supporting community-based mental health for children, adolescents and their families?** **What would be needed to strengthen these linkages and coordination?**
Any other issues?	**Are there any other comments or suggestions you would like to raise that we have not yet covered today?** I will go over a summary of what we have discussed, if you would like to add or change anything you have said please let me know.

unicef

World Health
Organization

وزارة الصحة
Ministry of Health

مجلس شؤون الأسرة
FAMILY AFFAIRS COUNCIL

Burnet
reach for the many