The State of the World’s Children 2021

On My Mind: Promoting, protecting and caring for children’s mental health

Published by UNICEF since 1980, The State of the World’s Children report seeks to deepen knowledge and raise awareness of key issues affecting children and advocates for solutions that improve children’s lives.
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On My Mind: Promoting, protecting and caring for children’s mental health
Contents

Acknowledgements .................................................................................................................. 3
Foreword .................................................................................................................................. 9
Key messages .......................................................................................................................... 11

Introduction: A time for leadership on mental health .......................................................... 15
  A challenge ignored ............................................................................................................. 15
  Unheard calls ...................................................................................................................... 17
  A time for leadership ......................................................................................................... 21
  A time for action ................................................................................................................. 21
  About this report ................................................................................................................ 22

Chapter 1: Mental health ......................................................................................................... 26
  Mental health: What it is ..................................................................................................... 27
  Data estimates .................................................................................................................... 30
  Special Section: Stigma ..................................................................................................... 37
  The costs ............................................................................................................................ 39

Perspective Essay: From a mid-night call to a national movement .................................... 46

Chapter 2: The foundation ..................................................................................................... 48
  The framework .................................................................................................................. 48
  Child development ............................................................................................................. 50
  Trauma and stress ............................................................................................................. 54

Chapter 3: Risk and protection .............................................................................................. 58
  Factors that help and harm ............................................................................................... 58

Chapter 4: The world at large ................................................................................................. 76
  Poverty ............................................................................................................................... 76
  Discrimination ................................................................................................................... 79
  Humanitarian crises .......................................................................................................... 85
  The COVID-19 pandemic and mental health ................................................................. 88
  Special Section: Digital technologies and mental health .............................................. 94
  Resilience .......................................................................................................................... 97
  Special Section: The face of ill-treatment ..................................................................... 100

Chapter 5: What is being done ............................................................................................... 103
  Global and national initiatives ......................................................................................... 103
  Making a difference ......................................................................................................... 106
  Data and research ........................................................................................................... 120

Chapter 6: A framework for action ....................................................................................... 123
  Commitment, communication, and action for mental health ....................................... 123
Children around the world have been locked out of classrooms, sequestered in their homes and robbed of the everyday joy of playing with friends – all consequences of the COVID-19 pandemic. Millions more families have been pushed into poverty, unable to make ends meet. Child labour, abuse and gender-based violence are on the rise.

Many children are filled with sadness, hurt or anxiety. Some are wondering where this world is headed and what their place is in it.

Indeed, these are very challenging times for children and young people, and this is the state of their world in 2021. But even absent a pandemic, psychosocial distress and poor mental health afflict far too many children – including millions who, each year, are forced from their homes, scarred by conflict and serious adversity, and deprived of access to schooling, protection and support.

In fact, the COVID-19 pandemic represents merely the tip of the iceberg when it comes to poor mental health outcomes.

It is an iceberg we have been ignoring for far too long, and unless we act, it will continue to have disastrous results for children and societies long after the pandemic is over.

When we ignore the mental health of children, we undercut their capacity to learn, work, build meaningful relationships and contribute to the world. When we ignore the mental health of parents and caregivers, we fail to support them to nurture and care for their children to the best of their ability. And when we ignore mental health issues in our societies, we close off conversation, reinforce stigma and prevent children and caregivers from seeking the help they need.

In the face of this reality, we are too often silent, too often unwilling to embrace the full complexity of what it is to be human. Or, as human rights advocate Lea Labaki, a contributor to this project, puts it: We fail to acknowledge that “psychological distress is not deviant behaviour to be repressed and hidden away, but just a normal aspect of human experience.”

We must be silent no longer.

We must listen to the young people all around the world who are increasingly raising their voices and demanding action.

And we must act.

With this edition of The State of the World’s Children, the first ever to focus on mental health, UNICEF is signalling our determination to listen – and to act.
In recent years, we have worked to help safeguard the mental health and psychosocial well-being of children, adolescents, parents and caregivers in some of the world’s most challenging settings. We have worked, too, to address the sweeping impact of the pandemic on mental health. In 2020, we reached 47.2 million children, adolescents and caregivers with community-based mental health and psychosocial support, including targeted community awareness campaigns in 116 countries – or almost twice as many countries as in 2019.

This engagement will only grow in the years to come, as will our efforts to secure investment for mental health and to tackle the scourges of neglect, abuse and childhood trauma that undermine the mental health of far too many children.

Because we know we all must do more.

Now, with key partners like the World Health Organization, governments, academics and many others, we all must show commitment to leadership and investment to better support mental health.

We all must work to help break the silence around mental health – challenge stigmas, raise mental health literacy and ensure the voices of young people are heard, and especially those with lived experience of mental health challenges.

And we all must commit to action in key areas, like better supporting parents, ensuring schools are kinder and safer places, and – through investment and workforce development – addressing the mental health needs of families in areas like social protection and community care.

Crucially, we all must work to improve data collection, routine monitoring, and research – a key challenge for all of us in the United Nations system. The picture we have of children’s mental health is a partial one, and it is one that is skewed heavily towards the world’s wealthiest countries. That means we know too little of how children and young people in most parts of the world experience mental health. It also means we know too little of the potential strengths and support that diverse communities and cultures may be able to offer children and families.

The challenge we face is immense. It is one that – despite the best efforts of so many, especially the young people who have shared their stories, ideas and passion for change – our global community has barely begun to address. When it comes to mental health, every country is developing.

But if the challenge is great, the rewards of meeting it can be greater still – for every child, for every family and for every community.

We can wait no longer. We cannot fail another generation. The time to act is now.

Henrietta H. Fore

UNICEF Executive Director
Key messages

Around the world, mental health disorders are a significant and often ignored cause of suffering that interfere with children’s and young people’s health and education and their ability to reach their full potential.

➢ It is estimated that more than 13 per cent of adolescents aged 10–19 live with a diagnosed mental disorder as defined by the World Health Organization.
➢ This represents 86 million adolescents aged 15–19 and 80 million adolescents aged 10–14.
➢ 89 million adolescent boys aged 10–19 and 77 million adolescent girls aged 10–19 live with a mental disorder.
➢ Prevalence rates of diagnosed disorders are highest in the Middle East and North Africa, North America and Western Europe regions.
➢ Anxiety and depression make up about 40 per cent of these diagnosed mental disorders; the others include attention deficit/hyperactivity disorder, conduct disorder, intellectual disability, bipolar disorder, eating disorders, autism, schizophrenia and a group of personality disorders.
➢ Children and young people also report psychosocial distress that does not rise to the level of epidemiological disorder but disrupts their lives, health and prospects for the future.
➢ According to research carried out by Gallup for UNICEF’s upcoming Changing Childhood report, a median of 19 per cent of 15- to 24-year-olds in 21 countries self-reported in the first half of 2021 that they often feel depressed or have little interest in doing things.

The cost of inaction is great – in terms of the toll it takes in human lives and on families and communities and financially.

➢ An estimated 45,800 adolescents die from suicide each year, or more than 1 person every 11 minutes.
➢ Suicide is the fifth most prevalent cause of death for adolescents aged 10–19; for adolescent boys and girls aged 15–19, it is the fourth most common cause of death, after road injury, tuberculosis and interpersonal violence. For girls aged 15–19, it is the third most common cause of death, and the fourth for boys in this age group.
➢ New analysis for this report indicates that the annual loss in human capital arising from mental health conditions in children aged 0–19 is US$387.2 billion (purchasing power parity dollars). Of this, US$340.2 billion reflects disorders that include anxiety and depression, and US$47 billion reflects the loss due to suicide.
➢ Of the US$340.2 billion, anxiety disorders account for 26.93 per cent; behavioural disorders 22.63 per cent; and depression 21.87 per cent.

Despite widespread demand for responses that promote, protect and care for children’s mental health, investment remains negligible.

➢ Research carried out by Gallup for UNICEF’s upcoming Changing Childhood report indicates strong demand for action. A median of 83 per cent of young people aged 15–24 in 21 countries believe it is better to address mental health issues by sharing experiences with other people and seeking support than by going it alone.
Despite demand for support, median government expenditure on mental health globally is a mere 2.1 per cent of the median government expenditure on health in general.

In some of the world’s poorest countries, governments spend less than US$1 a person treating mental health conditions.

The number of psychiatrists who specialize in treating children and adolescents was fewer than 0.1 per 100,000 in all but high-income countries, where the figure was 5.5 per 100,000.

Investment in promoting and protecting mental health – as distinct from caring for children facing the greatest challenges – is extremely low.

Lack of investment means workforces – including community-based workers – are not equipped to address mental health issues across multiple sectors, including primary health care, education, social protection and others.

Mental health is widely stigmatized and misunderstood: It is, in fact, a positive state of well-being and a foundation that allows children and young people to build their futures.

Despite growing awareness of the impact of mental health conditions, stigma remains a powerful force. Stigma – whether purposeful or not – blocks children and young people from seeking treatment and limits their opportunities to grow, learn and thrive.

Like physical health, mental health should be thought of as a positive: It underlies the human capacity to think, feel, learn, work, build meaningful relationships and contribute to communities and the world. It is an intrinsic part of individual health and a foundation for healthy communities and nations.

Mental health exists on a continuum that can include periods of well-being and periods of distress, most of which will never evolve into a diagnosable disorder.

Mental health is a basic right and essential for achieving global objectives, including the Sustainable Development Goals.

Risks and protective factors influence mental health at critical developmental moments.

At critical moments of child development, factors based on experience and environment can represent a risk to mental health or can help to protect it. Policy approaches should aim to minimize risk and maximize protective factors.

Risk and protective factors can be organized into three spheres of influence: The world of the child focuses on home and caregiving settings; the world around the child involves safety and security and healthy attachments in preschools, schools and communities; and the world at large includes large-scale social determinants – such as poverty, disaster, conflict and discrimination.

Mental health is tied to critical moments of brain development, which can be affected by factors such as toxic stress triggered by adverse childhood experiences (ACEs), such as physical and emotional abuse, chronic neglect and violence.

Research has shown that exposure to at least four ACEs is strongly associated with sexual risk taking, mental health conditions and alcohol abuse; it is even more strongly associated with problematic drug use and interpersonal and self-directed violence.
Parenting is crucial to laying strong foundations for children’s mental health, but many parents need more support.

- Parenting is foundational to children’s mental health. However, for many caregivers, fulfilling this critical role requires support from parenting programmes, which can include information, guidance, and financial and psychosocial support.
- Many caregivers also need support for their own mental health.
- **Before conception and in early childhood**, risk factors for the child’s mental health include low birthweight, maternal malnutrition, maternal mental health and adolescent parenthood. Globally, 15 per cent of children are born at a low birthweight, while about 15 per cent of girls become mothers before age 18.
- In childhood, risk factors include poor nutrition and violent discipline. Globally, around 29 per cent of children do not have minimum dietary diversity.
- In the world’s least developed countries 83 per cent of children experience violent discipline from caregivers and 22 per cent are in a form of child labour.
- In adolescence, nurturing and supportive parenting remains one of the strongest protectors of mental health.

**Schools and learning environments can provide opportunities to support mental health, but can also expose children to risks, including bullying and excessive exam pressure.**

- Schools can be healthy and inclusive environments where children learn critical skills to bolster their well-being, but also places where children experience bullying, racism, discrimination, peer pressure and stress about academic performance.
- Despite links between early learning opportunities and child development, about 81 per cent of children in the least developed countries do not attend early childhood education.
- Among older children, absence from school or dropping out before finishing is linked to social isolation, which in turn can lead to mental health conditions, including self-harm, suicidal ideation, depression, anxiety and substance use.
- An analysis by RTI for this report indicates that school-based interventions that address anxiety, depression and suicide provide a return on investment of US$21.5 for every US$1 invested over 80 years.

**Socioeconomic and cultural factors in the wider world, as well as humanitarian crises and events like the COVID-19 pandemic, can all harm mental health.**

- The relationship between poverty and mental health is a two-way street. Poverty can lead to mental health conditions, and mental health conditions can lead to poverty. Globally, nearly 20 per cent of children younger than 5 live in extreme poverty.
- Gender norms can impact the mental health of both girls and boys. Girls may face restrictive stereotypes about work, education and family as well as the risk of intimate partner violence; boys may experience pressure to suppress emotions and to experiment with substance use.
Children are far too often on the front lines in humanitarian crises – 415 million in 2018, each exposed to stress and trauma. The impact of such crises can differ from child to child, with some showing resilience and others experiencing extreme and lasting distress.

There are multiple reports of abuse of children in institutions, a high proportion of whom have disabilities, including developmental or mental health disabilities. There is also extensive evidence of the continued use of shackling of developmental and young people with serious mental health conditions, and of the use of coercion and restraint in mental health services.

There is wide concern about the impact of the COVID-19 pandemic on mental health. Research indicates some increases in stress and anxiety among children and adolescents. The mental health of caregivers, especially young mothers, is also a concern.

Interventions across a range of systems and sectors – including in families, communities and schools, and through social protection – can help to promote and protect mental health.

Evaluations of parenting programmes indicate that they help deepen attachments between caregiver and child, reduce harsh parenting practices and improve children’s cognitive development.

In schools, social and emotional learning approaches that include whole-school interventions and specific interventions for at-risk children and young people have proven effective.

Cash transfer programmes can indirectly influence children’s and adolescents’ mental health by increasing school participation, food security and access to health care and social services.

In humanitarian settings, the careful implementation of brief, structured interventions that provide immediate responses to depression, anxiety and post-traumatic stress disorder can bolster children’s and young people’s mental health.

The State of the World’s Children 2021 concludes by calling for commitment, communication and action to promote good mental health for every child, protect vulnerable children and care for children facing the greatest challenges.

Commitment means strengthening leadership to set the sights of a diverse range of partners and stakeholders on clear goals and ensuring investment in solutions and people across a range of sectors.

Communication means breaking the silence surrounding mental health, addressing stigmas, improving mental health literacy, and ensuring children, young people and people with lived experience have a voice.

Action means working to minimize risk factors and maximize protective factors for mental health in key areas of children’s lives, as well as investment and workforce development to:

- Support families, parents and caregivers
- Ensure schools support mental health
- Strengthen and equip multiple systems and workforces to meet complex challenges
- Improve data, research and evidence
Introduction: A time for leadership on mental health

The COVID-19 pandemic has upended our world, creating a global crisis unprecedented in our lifetime. It has created serious concerns about the mental health of children and their families, and it has illustrated in stark terms how events in the wider world can affect the world inside our heads. But the pandemic also offers an opportunity to build back better. We have a historic chance to commit, communicate and take action to promote, protect and care for the mental health of a generation.

Fear. Loneliness. Grief.

As the coronavirus pandemic descended on the world in 2019, these powerful emotions enveloped the lives of many millions of children, young people and families. In the early days especially, many experts feared they would persist, damaging the mental health of a generation.¹

In truth, it will be years before we can really assess the impact of COVID-19 on our mental health.

For even if the potency of the virus fades, the pandemic’s economic and social impact will linger: over the fathers and mothers who thought they had left the worst of times behind them, but are once again struggling to put food in a baby’s bowl; over the boy falling behind in school after months of disrupted learning; and the girl dropping out to work on a farm or in a factory. It will hang over the aspirations and lifetime earnings of a generation whose education has been disrupted.²

Indeed, the risk is that the aftershocks of this pandemic will chip away at the happiness and well-being of children, adolescents and caregivers for years to come – that they will pose a risk to the foundations of mental health.

For if the pandemic has taught us anything, it is that our mental health is profoundly affected by the world around us. Far from being simply a question of what is going on in a person’s mind, the state of each child’s or adolescent’s mental health is profoundly affected by the circumstances of their lives – their experiences with parents and caregivers, the connections they form with friends and their chances to play, learn and grow. Mental health is also a reflection of the ways their lives are influenced by the poverty, conflict, disease and access to opportunities that exist in their worlds.

If these connections were not clear before the pandemic, they certainly are now.

This is the reality that is at the heart of The State of the World’s Children 2021.

A challenge ignored

Indeed, what we have learned is that mental health is positive – an asset: It is about a little girl being able to thrive with the love and support of her family, sharing the ups and downs of daily life. It is about a teenage boy being able to talk and laugh with his friends, supporting them when they are down and being able to turn to them when he is down. It is about a young woman having a sense of purpose in her life and the self-confidence to take on and meet challenges. It is about a mother or father being able to support their child’s emotional health and well-being, bonding and attaching.
The links between mental and physical health and well-being, and the importance of mental health in shaping life outcomes, are increasingly recognized. They are reflected in the connection between mental health and the foundations of a healthy and prosperous world acknowledged in the Sustainable Development Goals. Indeed, that agreement among the nations of the world positioned the promotion and protection of mental health and well-being as key to the global development agenda.

Despite all this, governments and societies are investing far, far too little in promoting, protecting and caring for the mental health of children, young people and their caregivers.

In some of the world’s poorest countries, governments annually spend less $US1 per person on treating mental health. Even in upper-middle-income countries, annual expenditure is still about US$3 per person. Each of these figures falls far short of treating the mental health conditions of children, adolescents and caregivers, especially those facing the greatest mental health challenges. And it means that nearly nothing is left to promote the positive mental health of children and their caregivers.

We pay a high economic price for this neglect – around US$387.2 billion a year, according to calculations for this report by David McDaid and Sara Evans-Lacko of the Department of Health Policy of the London School of Economics and Political Science. That is US$387.2 billion of lost human potential that could be contributed to national economies.

The cost in terms of how it affects real lives, however, is incalculable.

It is there in the families, schools and communities touched by suicide – the fourth leading cause of death among 15- to 19-year-olds. Every year, almost 46,000 children and adolescents between the ages of 10 and 19 end their own lives – about 1 every 11 minutes.

It is there in the daily challenges of the estimated 13 per cent of adolescents living with a mental health condition. For 15- to 19-year-olds, in particular, it can be seen as mental health conditions begin to emerge and contribute to lost years of life and healthy life.

It is there in the voices of young people as they talk about their experiences of depression and anxiety and their significant generalized distress, which may not cross the threshold into disorder. For The State of the World’s Children 2021, UNICEF collaborated with researchers from the Global Early Adolescent Study at the Johns Hopkins Bloomberg School of Public Health to listen to some of those voices (see Box X: Asking Adolescents).

A girl in a discussion group for 15- to-19-year-olds in Jamaica said she believed that everyone goes through periods of low-level depression that stem from the challenge of finding out “who you are as a person”. The problem, she said, is that those feelings can be “boosted or fuelled” by experience in the world.

“I think that it starts there,” she said. “When I think that it becomes serious is when those sorts of feelings or emotions are neglected.”

A girl in the discussion group in Egypt in the same age group was clear about how neglected mental health – or, as she put it, “being tired psychologically” – affects a young person’s future.
“It means that you feel that you are not living life and [are] unable to do anything,” she said. “Even if you are ambitious, you will not be able to achieve your ambitions because you are psychologically totally defeated.”

**Box X. Asking adolescents**

When it comes to mental health, we need to listen to the experiences, concerns and ideas of children and adolescents.

That is why UNICEF teamed up with researchers from the Global Early Adolescent Study at the Johns Hopkins Bloomberg School of Public Health (JHU) to host focus group discussions on mental health and well-being. Support for the project came from the Wellcome Trust.

From February to June 2021, local partners facilitated focus group discussions for adolescents aged 10–14 and 15–19 in Belgium, Chile, China, the Democratic Republic of the Congo, Egypt, Indonesia, Jamaica, Jordan, Kenya, Malawi, Sweden, Switzerland and the United States. The discussions followed a guide developed by UNICEF, JHU and the local partners.

From these discussions, qualitative data were coded using an inductive thematic analysis approach and refined throughout the data analysis process. They are available on request. All sites of the focus group discussions obtained local Institutional Review Board (IRB) approval.

*The State of the World’s Children 2021* includes qualitative data from these discussions and quotes from some of the adolescents who participated in the focus groups. A fuller companion report on the discussions will be released in the future.

**Unheard calls**

Young advocates for mental health, including contributors and advisors to this report, have been brave in calling for mental health to be addressed in different settings across the world. Some have spoken out about their lived experiences with mental health and well-being, the challenges of their friends and peers, and the need for children and adolescents to be able to reach out to get help.

They are not alone. Worldwide, a survey for UNICEF by Gallup shows that large majorities of younger and older people in most countries – typically around four out of five people – believe no one should have to deal with mental health challenges on their own. Instead, they believe, the best solution is to share experiences and seek support.

**Box X. Ready to reach out?**

Young people overwhelmingly believe it is better to seek help from others with mental health issues than to try to deal with them on their own, according to a survey conducted by UNICEF and Gallup in 21 countries in the first half of 2021.
A median of 83 per cent of young people (15 to 24 years old) agreed it was better to deal with mental health problems by sharing experiences with others and seeking support; by contrast, only 15 per cent felt such problems were personal and should be dealt with on one’s own.

Median percentages of people in 21 countries who believe sharing experiences with others and seeking support is the better way to address mental health issues:

<table>
<thead>
<tr>
<th></th>
<th>15- to 24-year-olds</th>
<th>Older adults (40+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing experiences with others and seeking support is the best way to address mental health issues</td>
<td>83</td>
<td>82</td>
</tr>
<tr>
<td>Mental health is a personal matter that people can best work through on their own</td>
<td>15</td>
<td>17</td>
</tr>
</tbody>
</table>


Among the 21 countries, India was the only exception, with 41 per cent of young people supporting the sharing option.

Overall, attitudes differed relatively little between the generations: In the 21 countries, around four out of five older people (40 years and older) also supported the sharing option. However, differences were more marked in some countries: Even though majorities of both younger and older people supported the sharing option in Japan, Germany and Ukraine, there was a gap of at least 14 points between the two age groups. This raises interesting questions as to how else attitudes towards mental health may vary between generations and are evolving over time in different parts of the world.

Full findings from The Changing Childhood Project will be released in a report from UNICEF in November 2021.

Note: As part of the Changing Childhood Project, Gallup interviewed over 20,000 people by telephone in 21 countries between February and June 2021 in two distinct populations – people aged 15–24 and people aged 40 and older. Average margins of error were calculated at 6.7 per cent for the younger age group and 6.4 per cent for the older age group. Full details of the methodology and research methods will be included in the forthcoming *Changing Childhood* report from UNICEF.
Box X. Feeling down?

A median of one in five young people (19 per cent) reported often feeling depressed or having little interest in doing things, according to a survey conducted by UNICEF and Gallup in 21 countries in the first half of 2021. The proportion ranged from almost one in three in Cameroon to as low as one in ten in Ethiopia and Japan.

Percentage of 15- to 24-year-olds reporting often feeling depressed or having little interest in doing things:

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>32</td>
</tr>
<tr>
<td>Mali</td>
<td>31</td>
</tr>
<tr>
<td>Indonesia</td>
<td>29</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>27</td>
</tr>
<tr>
<td>France</td>
<td>24</td>
</tr>
<tr>
<td>Germany</td>
<td>24</td>
</tr>
<tr>
<td>United States</td>
<td>24</td>
</tr>
<tr>
<td>Brazil</td>
<td>22</td>
</tr>
<tr>
<td>Lebanon</td>
<td>21</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>20</td>
</tr>
<tr>
<td>Argentina</td>
<td>19</td>
</tr>
<tr>
<td>Kenya</td>
<td>19</td>
</tr>
<tr>
<td>Peru</td>
<td>16</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>14</td>
</tr>
<tr>
<td>India</td>
<td>14</td>
</tr>
<tr>
<td>Morocco</td>
<td>14</td>
</tr>
<tr>
<td>Nigeria</td>
<td>14</td>
</tr>
<tr>
<td>Ukraine</td>
<td>12</td>
</tr>
<tr>
<td>Spain</td>
<td>11</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>10</td>
</tr>
<tr>
<td>Japan</td>
<td>10</td>
</tr>
</tbody>
</table>

21-country median 19

Source: Changing Childhood [forthcoming].

At a time of great concern over the mental health of young people during the COVID-19 pandemic, the findings provide an interesting insight into young people’s own feelings. It is important to note, however, that these numbers only represent the perceptions of young people themselves, not diagnoses of depression by health professionals. They are also based on just a single question, not the multiple questions used in dedicated mental health research, and so cannot provide satisfactory estimates of prevalence. Finally, there are no comparable pre-pandemic estimates, which means they cannot be read as reflecting the impact of the pandemic on young people’s mental health.

A lack of data gathering and routine monitoring means the picture of young people’s mental health status and needs in most countries is extremely limited. As noted in Chapter 6 of this report, this severely hampers the prioritization of mental health care and the development of policy.

Full findings from The Changing Childhood Project will be released in a report from UNICEF in November 2021.
Note: As part of the Changing Childhood Project, Gallup interviewed over 20,000 people by telephone in 21 countries between February and June 2021 in two distinct populations – people aged 15–24 and people aged 40 and older. Average margins of error were calculated at 6.7 per cent for the younger age group and 6.4 per cent for the older age group. Full details of the methodology and research methods will be included in the forthcoming Changing Childhood report from UNICEF.

And yet, for many millions around the world, there is no one to talk to, nowhere to turn for help.

Why?

Multiple barriers get in the way of promoting, protecting and caring for children’s and adolescent’s mental health. Some of these barriers are systemic, blocks established by a lack of funding, leadership, coordination among sectors and trained workers.

Far too often, our ability to address mental health is stymied by our inability to talk about it. Children, adolescents and caregivers may struggle to find the language they need to talk about how they are feeling. They might fear the harsh words, laughter and abuse engendered by stigmas and misunderstandings around mental health.

High on the long list of misunderstandings is the failure to understand that mental health – just like physical health – is positive. Alex George, a medical doctor and reality television star in the United Kingdom, is well acquainted with suffering related to mental health. His brother lost his life to suicide at the age of 19. He puts it this way: When people describe physical health, they talk about exercise and healthy foods. When they talk about mental health, they mean depression, anxiety and sadness.

“How actually, mental health can be resilience,” he told a British newspaper in February 2021, “It could be happiness, it could be courage.”

The failure to see mental health as a positive often reflects the influence of biomedical thinking, where the focus is on conditions to be diagnosed and medicated. Instead, mental health needs to be understood as a continuum. At any stage of our lives, any one of us may find ourselves at different points on that continuum. We will experience positive mental health – the ability to enjoy life and cope with good and bad days. But we may also encounter periods of serious distress. And some may suffer long-term and disabling mental health conditions.

In a real sense, then, we all have mental health.

And yet, for some, mental health is a luxury or an issue for other people – it is not considered a problem for me or my community. Certainly, culture and contexts shape how mental disorders are experienced, understood and addressed. Far from these different perspectives and understanding being ignored – and they often are – they must instead inform responses to mental health challenges. When that happens it can lead to responses that are more beneficial and acceptable in different societies and that draw on the strengths of those societies. But there are, nonetheless, common and universal aspects to the experience of mental health: As the 2018 Lancet
Commission on global mental health and sustainable development noted, “emotional pain is as fundamental to human experience as physical pain”.

A time for leadership

At the heart of our societies’ failure to respond to the mental health needs of children, adolescents and caregivers is an absence of leadership and commitment. We need commitment, especially financial commitment, from global and national leaders and from a broad range of stakeholders that reflects the important role of social and other determinants in helping to shape mental health outcomes. The implications of such an approach are profound. They demand that we set our sights on a clear shared goal of supporting children and adolescents at crucial moments in their development to minimize risk – and maximize protective – factors.

As well as commitment, we need communication: We need to end stigmas, to break the silence on mental health, and to ensure that young people are heard, especially those with lived experience of mental health conditions. Without their voices being heard and their active participation and engagement, the challenge of developing relevant mental health programmes and initiatives will not be met.

And we need action: We need to better support parents so that they can better support their children; we need schools that meet children’s social and emotional needs; we need to lift mental health out of its ‘silo’ in the health system and address the needs of children, adolescents and caregivers across a range of systems, including parenting, education, primary health care, social protection and humanitarian response; and we need to improve data, research and evidence to better understand the prevalence of mental health conditions and to improve responses.

A time for action

The COVID-19 pandemic has upended our world, creating a global crisis unprecedented in our lifetime. It has created serious concerns about the mental health of children and their families during lockdowns, and it has illustrated in the starkest light how events in the wider world can affect the world inside our heads. It has also highlighted the fragility of support systems for mental health in many countries, and it has – once again – underlined how these hardships fall disproportionately on the most disadvantaged communities.

But the pandemic also offers an opportunity to build back better. As this report sets out, we know about the key role of parents and caregivers in shaping mental health in early childhood; we know too about children’s and adolescents’ need for connection; and we know about the dire impact that poverty, discrimination and marginalization can have on mental health. And while there is still much work to be done in developing responses, we already know the importance of key interventions, such as challenging stigmas, supporting parents, creating caring schools, working across sectors, building robust mental health workforces, and establishing policies that encourage investment and lay a solid foundation for mental health and well-being.

We have a historic chance to commit, communicate and take action to promote, protect and care for the mental health of a generation. We can provide support for a foundation of a generation equipped to pursue their dreams, reach their potential and contribute to the world.
23.09.2021

About this report

*The State of the World’s Children 2021* examines child, adolescent and caregiver mental health. It focuses on the risks and protective factors for mental health and well-being at critical moments in the life course. It aims to increase understanding of the specific needs of children, adolescents and caregivers, and to explore issues around mental health through the perspective of young people themselves. Ultimately, the goal of the report is to highlight a comprehensive approach to *promote* good mental health for every child, *protect* vulnerable children and *care* for children facing the greatest challenges.

**Chapter 1** defines positive mental health as a continuum and describes the detrimental effects of stigma. The chapter outlines the prevalence of mental health conditions and examines their economic cost.

**Chapter 2** outlines a framework for understanding mental health and well-being in the lives of children, focusing on the world of the child, the world around the child and the world at large. It outlines the role of child development in understanding risks and protections for mental health and for building a solid foundation.

**Chapter 3** examines particular risk and protective factors for mental health throughout the course of a life – from before conception through to the second decade, focusing on the importance of nurturing parenting, nutrition, learning environments and peer relationships.

**Chapter 4** turns its attention to the world at large, focusing on the impacts on mental health of poverty, discrimination, humanitarian crises and the COVID-19 pandemic. It also looks at our emerging understanding of resilience.

**Chapter 5** assesses the current state of the response to children’s and young people’s mental health, examining global responses as well as programmes that address parenting, education, social protection, primary health-care systems and humanitarian settings. In addition, the chapter addresses the particular problem of suicide and the importance of data and research.

**Chapter 6** sets out recommendations to *promote* good mental health for every child, *protect* vulnerable children and *care* for children facing the greatest challenges. These recommendations are grounded in three principles: *Communicate, Commit, Act.*
Case study: Lebanon
Put to the Test: A national mental health programme is activated

In 2020, Lebanon put a new national mental health plan to the test.

On 4 August, a powerful explosion devastated the port area of Beirut. At the time, Jad, 9, was at home with his mother.* His father was at work at the port; he returned home with hearing loss and a debilitating back injury.

Though Jad escaped from his home without physical injuries, the experience left him with severe anxiety and an uncontrollable fear of further explosions. He stopped eating, refused to leave his new home and became excessively introverted.

“My father was injured, my mother was upset, and my home was wrecked,” Jad said. “I didn’t know what to do to help.”

Help for Jad arrived with a knock on the door of his temporary residence from Himaya, a non-governmental child protection organization that visited families in the aftermath of the explosion.

Himaya’s work was part of the activation of the Psychosocial Support Response to the Beirut Explosion Disaster that was launched directly after the explosion. The response plan was implemented within the framework of the National Mental Health Programme (NMHP), Lebanon’s first programme to provide a community-based approach to mental health and psychosocial support throughout the country.

Lebanon’s Ministry of Public Health founded the NMHP in 2014 with support from partners that included UNICEF, the World Health Organization (WHO) and the International Medical Corps. Initially the goal was to respond to mental health needs arising from the Syrian crises and the arrival of refugees in Lebanon. However, the NMHP also focused on standardizing mental health and psychosocial support services in community-based platforms throughout Lebanon.

“For too long, this area of well-being has been sidelined as little more than an add-on to other areas of health care,” said Dr. Rabih El Chammay, a psychiatrist and Head of the NMHP. “The NMHP is focused on mainstreaming awareness of mental health, reducing its stigma, and making it part of a holistic national health-care strategy.”

The NMHP oversees a Mental Health and Psychosocial Support Task Force, co-chaired by WHO and UNICEF, that coordinates the work of more than 60 organizations. It also works closely with the Child Protection in Emergencies Working Group and the Psychosocial Support Committee, which work with the task force to provide standardized tools and guidance aimed at harmonizing psychosocial support programming for children, caregivers and communities.

In addition, the NMHP focuses on primary health centres and provides mental health training to nurses, social workers and general health practitioners in hospitals to ensure a basic level of knowledge.
Ultimately, the NMHP ushered in a new era of mental health in Lebanon – one that focused on communities and well-being, rather than only providing medical treatment in hospitals.

“We need to elevate the topic of mental health care from being a luxury for the rich to being a basic, acceptable and human rights-based service available to everyone in the community and close to where they live,” El Chammay said.

The port explosion was not the only event in 2020 that tested the NMHP’s new approach. Indeed, the blast exacerbated already stressful circumstances in Lebanon – circumstances that included a collapsing economy, growing poverty and increasing social and political unrest. In 2020, like the rest of the world, Lebanon was also facing the mental health consequences of the COVID-19 pandemic.

In response to the pandemic, the Government of Lebanon and mental health partners worked together to create a community-based plan to promote mental health, protect against the stresses of the situation and provide mental health support to individuals. The plan involved multiple sectors, including child protection, health, education and communication for development. Efforts included awareness raising through online and digital platforms, emotional support hotlines, national television campaigns and interactive online sessions for adolescents and young people.

For Jad, Lebanon’s new approach to mental health meant that he and his family had readily available access to mental health support – a service that might have eluded them in an earlier time. Jad received occasional visits from a caseworker, and because of COVID restrictions, online talk therapy regularly from Maria Sfeir, a psychologist with Himaya.

Over time, Jad has been able to venture outside his home, despite his recurring fears, and has made “brave progress,” Sfeir said.

* Jad’s family name is being withheld to protect his identity. He was interviewed in Beirut on 9 April 2021.
Box X. #BTSLoveMyself: Ending violence and improving children’s and young people’s self-esteem and well-being

Since BTS formed in 2013, the iconic pop band from the Republic of Korea has become one of the most successful music groups of our time, collecting five No. 1 singles in less than a year, with 38 million Twitter followers and a dedicated global fan base known as the ARMY.

In 2017, BTS and its record label, BIGHIT MUSIC, joined forces with UNICEF to harness the band’s influence to help end violence, abuse and bullying and promote self-esteem and well-being among young people globally. In their role as UNICEF supporters, BTS has addressed world leaders at the annual United Nations General Assembly meeting in New York; released an exclusive music video to support UNICEF’s campaign to encourage love and kindness; and set up booths at their concert venues worldwide with campaign information.

The band has raised US$3.6 million for UNICEF’s work to end violence and reached millions of young people with positive messages of self-love and self-care. The hashtag, #BTSLoveMyself, has generated almost 5 million tweets, according to Twitter, and more than 50 million engagements – such as likes, retweets, replies and comments – covering nearly every country in the world, according to Talkwalker.

From BTS:

“We started LOVE MYSELF as a way to reach young people and help improve their lives and rights. During the process, we also strove to “LOVE MYSELF” ourselves, and we as a team and as individuals grew as well. We hope that many people felt how the love received from others can become the power that allows them to love themselves. We hope that the LOVE MYSELF message can continue to serve to invigorate everyone’s lives. We will be honoured if all seven of us can continue this campaign to return the amazing love that we have received and give people the strength to come closer to LOVE MYSELF. We hope to keep doing what we are doing and voice what we are voicing, so we can help people find happiness and love.”

During the COVID-19 pandemic, the band members’ personal reflections have helped children and young people who have felt isolated, disconnected and frustrated. As 23-year-old Jauharra from the Philippines (@paralumanssi_) said:

“Thank you everyone for today. You have saved a life today. I kinda get teary a bit about how the message hit me when covid started, because it caused me anxiety and stressed myself out. So, thank you.”

In March 2021, BTS and BIGHIT MUSIC renewed its commitment to the LOVE MYSELF campaign, pledging over US$1 million to UNICEF, proceeds from the sale of LOVE MYSELF merchandise and a portion of the LOVE YOURSELF album sales.
Mental health underlies the human capacity to think, feel, learn, work, build meaningful relationships and contribute to communities and the world. It is an intrinsic part of individual health and a foundation for healthy communities and nations.

It is a right that must be promoted and protected.

Globally, far too many children and adolescents live with mental health conditions, including depression, anxiety, and conduct and attention disorders. For children and adolescents with lived experience, a mental health condition is part of life. Care and the opportunity to live a healthy life are essential rights.

However, far too many children and adolescents struggle in silence, stifled by misunderstanding, stigma and a lack of comprehensive initiatives that promote and protect mental health and care for those most in need.

The cost of this silence can be calculated in days, months, years and lives lost. For children and young people, in particular, it can be calculated in lost dreams.

Though mental health conditions exact a toll on children and young people, they also sap societies of human potential. These costs can be calculated in lost human capital, which interferes with the harmony and prosperity of families, communities and nations.

Box X. Mental health: A right and a goal

Mental health is inextricably linked with health – of individuals, communities, nations and economies.

The World Health Organization (WHO) recognized this link in its constitution by defining health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The founding document also affirmed that the “highest attainable standard of health” was a fundamental right and essential for peace and security.¹

Since 1948, when the WHO Constitution went into force, multiple international mechanisms have affirmed the right to mental health and provided structures for protecting it.² In 1991, the United Nations General Assembly affirmed the right to mental health care and underscored the basic rights of people with psychosocial disabilities.³

For children, the 1989 United Nations Convention on the Rights of the Child (CRC) established a framework for understanding the importance of child- and youth-led mental health services.⁴ The CRC calls on Member States to protect the best interests of children and young people and addresses many of the risks to mental health, including discrimination, violence and deprivation of liberty. In particular, the CRC underscores the responsibility
of Member States to ensure the maximum survival and development of children and young people, including access to health care. It calls on Member States to promote physical, psychological and social recovery for children and young people who experience any form of neglect, abuse, degrading treatment or punishment, or armed conflict. It also highlights the rights of children and young people with disabilities to mental health care and a healthy life.

In addition, the Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol, adopted in 2006, signalled a global commitment to the human rights and fundamental freedoms of people with disabilities. The CRPD calls for a move away from a medicalized approach to disability in general and mental health conditions in particular. It also highlights the many ways that social, political and economic factors enhance disparities for people with psychosocial disabilities.

The United Nations has also taken specific efforts to address developmental disabilities. In 2012, the United Nations General Assembly issued a resolution that called for governments to protect the rights of children and families affected by autism spectrum disorder, developmental disorders and associated disabilities. And in 2014, the World Health Assembly called for more multisectoral responses in support of the Comprehensive and Coordinated Efforts for the Management of Autism Spectrum Disorders.

With the adoption of the Sustainable Development Goals (SDGs) in 2015, United Nations Member States recognized mental health as a global public good and a right that countries have an obligation to protect. The SDGs resolution – a blueprint for worldwide peace, prosperity and sustainability – calls for promotion, prevention and treatment approaches to mental health and well-being. It envisions “a world with equitable and universal access to quality education at all levels, to health care and social protection, where physical, mental and social well-being are assured”.

Promoting, protecting and caring for children’s and young people’s mental health plays a role in achieving most of the 17 development goals. In addition to Goal 3 that calls on Member States to “ensure healthy lives and promote well-being for all at all ages,” the SDGs tackle many of the risk factors that threaten children’s and young people’s mental health. Indeed, goals aimed at addressing poverty, inequality, nutrition, education, gender equality, sustainable communities and social justice also play vital roles in mental health for children and young people. In turn, addressing mental health will help Member States achieve these goals.

Mental health: What it is

The term ‘health’ conjures up an image of exercise, nutritious food and a balanced life of work, family and leisure. Put the world ‘mental’ in front of it – mental health – and the image turns dark. In the background lurk multiple misconceptions and a vocabulary that includes words such as dangerous, crazy, possessed and mad. Mental health is considered a problem of thinking too much, and caring for mental health is dismissed as a luxury to be pursued by those with extra time and resources. In many parts of the world, mental health is treated only as a biological or medical problem (see Box X. Medicating childhood).
However, mental health is not disorder or even the absence of disorder. It is positive. It is a state of health.

Indeed, the World Health Organization (WHO), in its founding document, included mental health in its definition of health: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

As a positive, mental health has been described as “a dynamic state of internal equilibrium” that involves the capacity to apply essential social, emotional and cognitive skills to navigate effectively through life and the world. Other definitions link positive mental health with the ability to “enjoy life and deal with the challenges we face.” In general, most definitions touch on emotional, cognitive, functional, social, physical and spiritual capacities.

Often, mental health is linked to well-being – a broad concept that can involve health, economics, nutrition and psychology. In Worlds of Influence: Understanding what shapes child well-being in rich countries, the UNICEF Office of Research – Innocenti pinpointed three categories involved in well-being: good mental well-being, good physical health and skills for life. For children and young people, mental health and well-being is linked to parents and caregivers who are intimately involved in shaping their lives.

A recent framework developed for adolescents in particular identified five domains of well-being: good health with optimum nutrition; connected, positive values and contributing to society; safe and supportive environments; learning, competence, skills, education and employability; agency and resilience.

In many ways, all these frameworks come together to describe positive mental health and well-being. In a general sense, however, mental health and well-being can be understood in three categories:

- Emotional well-being: positive, happy, calm, peaceful, interested in life
- Social well-being: ability to function in the world combined with a personal sense of value and belonging
- Functioning well-being: the capacity to develop skills and knowledge that help a person make positive decisions and respond to life challenges

A continuum
Throughout their lives, children and young people will most likely experience different gradations of positive mental health and well-being. Many will also face gradations of mental health conditions.

Sometimes positive mental health and mental health conditions may exist at the same time. For example, a person with a diagnosed mental health condition can achieve a sense of positive well-being – a sense of mental health – despite distressing or debilitating symptoms. Conversely, a person without a diagnosed mental health condition may experience different levels of mental health throughout life.

As a result, focusing on mental health conditions alone – and relying only on medical interventions – does not describe the diversity of human experience with mental health and can limit efforts to promote and protect mental health while caring for those in need.
Positive mental health

Researchers have established scales designed to measure positive mental health. Some of the indicators measured include self-acceptance, optimism, resilience, positive relations with parents or peers, a sense of purpose in life, and feelings of growth or achievement. Other scales for measuring positive mental health focus on how people see themselves in their public life, including their sense of social acceptance and their integration into a community.

With a focus on positive mental health, it becomes clear that the absence of a mental health condition is not the same thing as mental health. Children and young people without a mental health condition may – and probably will – experience multiple degrees of positive mental health in the course of a lifetime. Based on this model, researchers have concluded that most of the population may have moderate mental health, some may be flourishing and others, languishing. Still others may have a diagnosable mental health condition.

Mental health conditions

Mental health conditions can exist on a continuum. This continuum contains gradations that include mild and temporary distress, manageable conditions that may or may not become chronic, and progressive and severe mental health conditions. In the course of a lifetime, a child may fall somewhere on this continuum.

The continuum can include prevalent mental health conditions such as anxiety, depression, psychosis, and alcohol and drug dependency disorders. Global estimates on the prevalence of mental disorders and the loss of life and loss of healthy life are calculated based on data on disorders, including: depression, anxiety, bipolar, eating, autism spectrum, conduct, substance use, idiopathic intellectual disability, attention deficit/hyperactivity disorder (ADHD) and groups of personality disorders.

It is critical to note, however, that most mental health conditions fall well below the threshold of diagnosis. For example, a young person may describe ‘depression’ or ‘anxiety’ in a particular situation, but only sometimes will those feelings progress so far as to interfere with everyday life or to require a diagnosis and treatment.

Context is key

For children and young people, in particular, understanding mental health means recognizing that the concept itself is entwined with societal and family values, cultural standards, social expectations and developmental capacities. For example, perceptions of acceptable behaviour and appropriate social functioning vary, and they depend on situation, age and culture.

In addition, experiences of adversity and trauma are understood differently in different cultural contexts, affecting understandings of mental health. Similarly, expectations for happiness, personal growth and satisfaction evolve as children age, and they differ from country to country, community to community and, sometimes, family to family. As a result, assessments of mental health need to take into consideration cultural, social, political and environmental contexts.

Box X. Key terms

The State of the World’s Children 2021 report uses the term ‘mental health condition’ to describe a wide range of conditions that can vary in severity from mild and temporary to severe and lifelong. Many of these terms can
be considered stigmatizing and are avoided and replaced by identifications such as ‘person with lived experience’, ‘consumer of mental health services’ or ‘survivor of psychiatry’.

The World Health Organization (WHO) has also used ‘mental health condition in some materials to indicate “mental, neurological and substance use disorders, suicide risk and associated psychosocial, cognitive and intellectual disabilities”.

However, the field of mental health uses multiple terms, some of which have more specific meanings. Some of these terms include:

**Mental health classifications:** Official classifications of mental disorder from publications such as the WHO International Statistical Classification of Diseases and Related Health Problems (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), a handbook from the American Psychiatric Association.

**Mental disorder:** Comprises a range of conditions with different symptoms. WHO has defined mental disorder to include: “anxiety, depression, schizophrenia, and alcohol and drug dependency”.

**Mental health:** Defined by WHO as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community”. For children, the definition of mental health necessarily takes into account age-specific and life-course markers, and includes a positive sense of identity, ability to manage thoughts and emotions, capacity to build relationships and the ability to learn and acquire education.

**Mental health and psychosocial support (MHPSS):** A composite term agreed on by the Inter-agency Standing Committee to “describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder”.

**Psychosocial:** Describes the influence of social factors on mind and behaviour and the interrelation of mind and society in human development.

**Psychosocial disability:** A term used to refer to “all persons who, regardless of their self-identification or diagnosis, experience discrimination and societal barriers based on actual or perceived mental health diagnosis or subjective distress.” The term ‘mental disorder and psychosocial disability’ is used throughout the WHO Mental Health Action Plan 2013–2020. ‘Persons with psychosocial disabilities’ is preferred by international human rights mechanisms and agencies that represent people with disabilities.

**Well-being:** A broad concept connected to multiple fields such as health, economics, nutrition and psychology. In general, it involves emotional, psychological and social elements.

**Biopsychosocial model:** A holistic approach to mental health that takes into account biological, psychological and social determinants.

**Data estimates**

In nearly every corner of the globe, in rich and poor countries, mental health conditions – and the lack of caring responses – remain the cause of significant suffering for children and young people and top cause of death, disease and disability, especially for older adolescents.
One of the ways to measure this human cost is to calculate the prevalence of mental disorders. More than 1.2 billion adolescents aged 10 to 19 lived in the world in 2020. And estimates indicate that more than 13 per cent of them had a mental disorder. This means that an estimated 86 million adolescents 15–19 years old and 80 million 10–14 years old live with a mental disorder (see Figure X). In addition, adolescent boys are slightly more likely to experience mental disorders than girls in both age groups. However, girls are more likely to experience mental health conditions when they are defined as psychological distress, a lack of life satisfaction or a sense of flourishing and happiness, according to a 2021 study of adolescents in 73 countries.

Figure 1.1. Estimates of prevalence of mental disorders globally for girls and boys aged 10–14 and 15–19, 2019

The number of adolescents with mental disorders are rounded to the nearest 1,000; calculations are based on multiple disorders including: depression, anxiety, bipolar, eating, autism spectrum, conduct disorders, substance use disorders, idiopathic intellectual disability, ADHD and groups of personality disorders.

Source: UNICEF analysis based on estimates from the Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Study, 2019

Among adolescents aged 10–19, boys had higher prevalence rates (13.8%) and numbers of mental disorders than girls in the same age group (12.5%). The East Asia and Pacific and South Asia regions had the highest numbers of adolescents with mental disorders. The Middle East and North Africa, North America and Western Europe regions had the highest prevalence rates (see Figure X). The same patterns were observed in two adolescent age groups: 10–14 and 15–19.
Anxiety, depression and other disorders
Among adolescents aged 10–19, anxiety and depression disorders make up about 40 per cent of the mental disorders included in the Global Burden of Disease study by the Institute for Health Metrics and Evaluation (IHME). These conditions include anxiety disorders, ADHD, conduct disorder, depressive disorders, intellectual disability, bipolar disorder, eating disorders, autism, schizophrenia and a group of personality disorders.

Figure 1.3. Among girls and boys aged 10–19 with mental disorders, prevalence of anxiety, depression and other disorders, 2019

Age 10–19, boy and girls
Age 10–19, girls

Note: The sum of the prevalence of individual disorders exceeds 100 per cent due to the co-morbidity between the disorders.
Source: UNICEF analysis based on estimates from the Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Study, 2019

Suicide

Even at one of the healthiest times in the life course, an estimated 45,800 adolescents die from suicide every year, according to the most recent WHO estimates that were available for this report. This is about 1 every 11 minutes. The risk of this tragedy increases as adolescents age (see Figure X).

Worldwide, suicide is the fifth most prevalent cause of death for adolescents aged 10–19. For adolescents aged 15–19, it is the fourth most common cause (see Figure 1.5); and even for younger adolescents, suicide remains in the top 10. For boys aged 15–19, suicide is the fourth leading cause of death after road injury, interpersonal violence and tuberculosis (see Figure 1.6). For girls aged 15–19, suicide is the third leading cause of death after tuberculosis and maternal conditions. However, fewer girls – 5 a year for every 100,000 – die from suicide than boys – 6 a year for every 100,000.

In Eastern Europe and Central Asia, suicide is the number one cause of death for adolescents aged 15–19; in North America, Western Europe, South Asia and Western and Central Africa, it is the second most prevalent cause; in Latin America and the Caribbean, it is the third most common cause of death (see Figure X).
23.09.2021

Figure 1.4. Estimates of suicide as a cause of death, globally, by age and sex, 2019

Adolescents 10–19 total: 45,800

Adolescents 10–14 total: 10,200

Adolescents 15–19 total: 35,600

Note: Results are rounded to the nearest 100; confidence intervals for adolescents aged: 10–19 are 32,641–63,068; 10–14 are 6,517–15,490; 15–19 are 26,124–47,578.

Source: UNICEF analysis based on WHO Global Health Estimates, 2019; global estimates were calculated using population data from the United Nations Population Division World Population Prospects 2019

Figure 1.5. Top five causes of death among adolescent boys and girls aged 15–19 by UNICEF region, 2019

Figure 1.6. Top 10 causes of death for adolescent boys and girls aged 15–19, 2019

Boys and girls aged 15–19

Boys aged 15–19

Girls aged 15–19

Source: UNICEF analysis based on WHO Global Health Estimates, 2019; global estimates were calculated using population data from the United Nations Population Division World Population Prospects 2019
Box X. A caution about data

There are plenty of reasons to be wary about the data estimates on mental health and particularly what they say about suicide and self-harm. Historically, suicide has been considered under-reported. As a result, the quality and availability of the data about suicide is considered poor. For example, in the World Health Organization suicide estimates, only 80 Member States had good-quality vital registration data that could be used to estimate suicide rates.

In addition, suicide can be a sensitive subject. Indeed, the causes of under-reporting are likely linked to stigma about suicide in many cultures and families. In some countries, suicidal behaviour is illegal, which can also lead to under-reporting and misclassification. Registering suicide in national records can involve medical and legal authorities, and procedures can vary. Often, suicides are misclassified as deaths of undetermined intent, unknown cause or as accidents. For children and adolescents in particular, suicides are more likely to be recorded as undetermined or accidental not only because of the assumptions about the developmental stage of the individual, but also to avoid the social stigma for families whose child has died.

Assessing data on any mental health condition can be complex. In most of the world, data are not available; they are not collected or analysed; and they are not used to develop effective policies and programmes or allocate resources. In low- and middle-income countries and areas (LMICs), mental health data about children and adolescents cover about 2 per cent of the population. This makes calculating the global burden of disease due to mental disorders particularly difficult because nearly 90 per cent of the world’s 1.2 billion adolescents live in LMICs.

In the countries where data are collected, methods differ and often the data cannot be compared. As a result, most of the reporting on the prevalence of mental disorders, especially in LMICs, are modelled estimates based on little hard data.

Good data on the prevalence of mental health conditions – and the risk and protective factors – are essential for designing and implementing appropriate policies and programmes to protect children. They are also needed to accurately allocate the resources to assist adolescents in need of support.

Generating good data cannot be accomplished without investment. Although the global cost to address mental health conditions is expected to top US$6 trillion by 2020, investment in research remains stuck at about US$3.7 billion a year, based on calculations between 2015 and 2019. That means only about US$0.50 cents a person a year. And only 33 per cent of this figure is spent on research about mental health and young people.

In addition, only 2.4% of this research funding is spent in LMICs, where 84 per cent of the world population lives.
Special Section: Stigma

Despite growing awareness about the effect of mental health conditions on lives and communities, stigmas about mental health remain a powerful force impeding efforts to promote mental health and protect vulnerable children and young people.\(^{50}\)

The discriminatory effects of stigma – whether purposeful or not – have blocked children and young people from seeking treatment and limited their opportunities to grow, learn and thrive.\(^{51}\) Indeed, children and young people with mental conditions, when they speak out, say the rejection, misunderstanding and discrimination associated with stigmas about mental health can be more disadvantageous than the condition itself.

In the focus group discussions held in conjunction with Johns Hopkins University (JHU) Global Early Adolescent Study and 13 partner organizations from around the world, the adolescent participants confirmed that stigma about mental health can impede them from seeking help. They spoke about their concern that they would face harsh judgement from family, friends, school officials and their communities if they disclosed their struggle with mental health. The concern was particularly strong for boys, who felt inhibited from sharing their feelings about mental health because of masculine gender norms.

The result of these fears was silence about mental health problems.

As an adolescent girl from Sweden said in a discussion for young people aged 15–19: “With stress and mental illness, for many it’s a very anxious subject. And you don’t really want to talk about it ... Society has kind of made it into a big thing, that it's supposed to be something negative.”

In Kenya, a boy in the same age group said: “When he knows that he has a problem, but he is not willing to share with anyone ... that thing will eat him up.”

Or a girl in the discussion for ages 10–14 in Egypt said: “We have people, if they see someone going to the psychologist, they would say that he or she is crazy.”

Stigma about mental health stems from a combination of factors such as ignorance, prejudice and discrimination.\(^{52}\) As described by Sir Graham Thornicroft, co-chair of the newly established *Lancet* Commission on stigma and discrimination, stigma is a problem of knowledge, attitude and behaviour.

The force of stigma on mental health starts early in a child’s life. By age 6, children recognize everyday derogatory terms associated with mental conditions, such as crazy or mad.\(^ {53}\) By age 10, children are familiar with cultural stereotypes that denigrate people with mental health conditions. Studies have shown that, although knowledge about mental health conditions increased with age, knowledge did not always mean with acceptance.

Gender also plays a role in children’s understanding of mental health. Studies have shown that males are more likely to be stigmatized and to perpetuate stigmas than females.\(^ {54}\) For example, a study of ethnically diverse young adolescents in the United States of America showed that boys were more likely than girls to stigmatize someone with a mental condition and distance themselves socially from the person.\(^ {55}\)
Children do not learn to stigmatize mental health conditions on their own; many mirror behaviours they see in the world around them. For example, a cross-sectional study of 566 secondary school teachers in South India found that nearly 70 per cent believed that depression was weakness, not sickness, and that it was unpredictable but not dangerous.\textsuperscript{56}

The field of mental health itself has perpetuated stigma. Indeed, the history of psychiatry includes examples of professionals pathologizing socially or politically unacceptable behaviour and placing individuals, against their will, in asylums and prison-like hospitals.\textsuperscript{57}

**Risks: Individual and structural**

The influences of stigma on mental health can be complex. In general terms, however, stigma can influence individuals and social structures.\textsuperscript{58} With either category – individual or social – stigma can be intentional or not.

For individuals, stigma, when internalized, can shape a child’s self-esteem, actions, emotions and coping strategies. For adolescents, in particular, stigma can also cause feelings of shame, social rejection and fear of not fitting in. It can also impact their sense of identity, with implications for their success in school and in life.\textsuperscript{59}

One of the most harmful effects of stigma is that it can interfere with an individual’s desire to seek help.\textsuperscript{60} Stigma can even prevent children and young people from disclosing their symptoms to the people closest to them. Instead, many young people decide to handle their mental health struggles alone.\textsuperscript{61}

Stigma can work bi-directionally; it can instigate mental health conditions and exacerbate them. Stigma can combine with other stresses, such as discrimination based on race, gender, disability, sexual orientation or personal history, to drive poor mental health. For example, children and adolescents associated with armed groups often face stigma when they try to return to their communities, which often aggravates already fragile mental health.\textsuperscript{52} Conversely, chronic social stress and stigma – such as bullying and perceived parental rejection – are linked to higher prevalence of mental health conditions for children and young people who are lesbian, gay, bisexual, transgender, queer/questioning or other (LGBTQ+).\textsuperscript{63}

Stigma also can be structural as it influences laws, policies, attitudes and cultural norms, and as it violates human rights.\textsuperscript{64} Examples include laws and policies that limit the freedoms of people with mental health conditions and media depictions that perpetuate stereotypes. Unintentional consequences include an extreme lack of development assistance for mental health interventions, limited research on mental health, and restricted insurance payments for treatment.

\textbf{[GWA quote]}

Mental health care is health care. As someone who suffers with generalized anxiety disorder and who’s been hospitalized to be treated for this disorder, I know how life-changing good mental health care is. I’ve also experienced first-hand how harmful and dangerous stigma around mental health can be. This needs to end. It’s past time for us to come together and break this stigma so that every person—without regard to their wealth,
their gender, their race, or where they live—can safely seek out and receive the medical care they need for their mental health.

*Alyssa Milano is an American actress, author, producer, host, activist and humanitarian. She was appointed a UNICEF Goodwill Ambassador in 2003.*

The costs

The human costs of ignoring mental health can be devastating for individuals, families and communities. However, the financial costs of not addressing mental health conditions — the costs of inaction — are also destructive.

For *The State of the World’s Children 2021*, David McDaid and Sara Evans-Lacko of the Department of Health Policy of the London School of Economics and Political Science estimated the global cost of mental health conditions for children and adolescents aged 0–19. The estimate is based on the value of lost mental capital — or cognitive and emotional resources — that children and young people would contribute to economies if they were not thwarted by mental health conditions.

McDaid and Evans-Lacko started with estimates of the burden of disease attributable to mental health expressed in disability-adjusted life years (DALYs). One DALY represents the loss of a year of healthy living caused by disability or premature death. The researchers then assigned a monetary value to each disability-free year based on the average output each person contributes in an economy. One DALY is therefore equivalent to a country’s gross domestic product (GDP) per capita, expressed in purchasing power parity (PPP) terms. This formulation allows comparisons to be made globally.

Using this methodology, McDaid and Evans-Lacko estimated that the annual loss in human capital because of mental health conditions is US$340.2 billion (PPP dollars). The conditions that account for most of this cost include *(see Figure X)*:

- Anxiety disorders: 26.93 per cent
- Behavioural disorders: 22.63 per cent
- Depression: 21.87 per cent

In addition, the loss caused by intentional self-harm is US$47 billion. Together, the total adds up to US$387.2 billion in lost human capital *(see Figure X)*.
23.09.2021

Figure 1.7. Cost of mental disorders based on country-specific GDP per capita adjusted for PPP, in US$ millions


Figure 1.8. Lost human capital from mental disorders by UNICEF region based on country-specific value of DALYs, in US$ millions (PPP)

- East Asia and the Pacific: US$74,680
- Eastern Europe and Central Asia: US$21,878
- Eastern and Southern Africa: US$10,535
- Latin America and the Caribbean: US$30,612
- Middle East and North Africa: US$27,687
- North America: US$68,705
- South Asia: US$41,501
- Western and Central Africa: US$6,948
- Western Europe: US$57,640


These estimates attribute greater economic cost to poor mental health in more productive economies. However, it is important to remember that the epidemiological burden of children’s and adolescents’ mental health conditions exists disproportionately in the least developed countries. This is a matter of demographics because children and young people in poor countries make up a larger share of the population than in rich countries.

McDaid and Evans-Lacko therefore offer an alternative approach to estimating the global cost of mental health conditions for children that places the same value on disability everywhere in the world. In this formulation,
one DALY is assigned a monetary cost of US$16,951 – the average income per person at a global level expressed in PPP terms. Using this approach, the global cost of lost human capital is estimated at US$393.2 billion (PPP), and the loss incurred by self-harm rises to US$57.7 billion, resulting in a total of US$451 billion a year in lost human potential.

To make matters worse, the cost of mental health conditions, excluding self-harm, is expected to climb. If the prevalence does not change, the global cost of lost human potential (based on global costing of DALYs) will jump to US$420 billion by 2040.

Though staggering, these estimates likely do not reflect the full economic toll of mental health conditions. Since the calculations are based on years of life lost to disability or death, they do not fully represent the economic and fiscal burdens that child and adolescent mental health conditions place on health, education, welfare and criminal justice systems, for example.

These strains can be significant. In Brazil, for example, a study of children aged 6–14 in Sao Paolo and Porto Alegre estimated that the costs to health and social service sectors and parents were 2.2 times greater for a child with a mental health condition than a child without. A study in Great Britain demonstrated that the overall cost to public services was 15 times greater for children and young people with mental health conditions than those without.

The cost of mental health is felt not just by economies, but also by individuals and their families. Mental health conditions in childhood also have financial implications for the individuals affected – often into middle age.

In Sweden, for example, male military conscripts diagnosed with mental health conditions at age 19 had higher levels of unemployment over the next 20 years. And data from the British National Child Development Study found that 50-year-olds who had experienced childhood mental health conditions had family incomes that were 28 per cent less than peers who did not.

The costs are not only financial. In New Zealand, for example, a study that followed a cohort of 7-year-olds found that the children with the most severe conduct problems experienced worse life outcomes 18 years later. These adverse outcomes included: an 11-fold risk of being arrested or convicted; a greater chance of being a teenage parent; increased chance of being on welfare; a risk of being unemployed for more than 12 months; and a greater incidence of attempting suicide.

In Brazil, data from more than 5,000 children in Pelotas showed that children with conduct problems at age 11 had a 38 per cent higher risk of not being in employment, education or training (NEET) by the time they were at least aged 22. 69 They also had a 92 per cent greater risk for criminal behaviour, a 39 per cent greater risk for hazardous alcohol use and a 32 per cent greater risk for harmful use of illegal substances.

**Return on investment**

The research on the cost of inaction presents losses to human capital incurred because of mental health conditions. However, there are also financial benefits to acting – to investing in efforts to promote and protect mental health in children and young people.
United for Global Mental Health estimates that depression and anxiety in all population groups costs the world about US$2.5 trillion a year in lost economic productivity, a cost that is expected to rise. Companies that invest in their employees’ mental health have four times the retention rate and, on average, receive a US$5 return for every US$1 invested in well-being.

The benefits are not only financial, however. Promoting, preventing and caring for mental health provides returns on investment for individuals that are reaped in realized potential – in increased participation in communities, schools, workplaces and families.

For adolescents aged 10–19, evidence indicates that investment in school-based interventions can be effective and cost-effective. For The State of the World’s Children 2021, researchers from RTI International reviewed evidence on intervention packages that were universal in scope – addressing all the students in the school – as well as packages that were more targeted to the needs of students at risk. The programmes addressed universal prevention of anxiety and depression, universal prevention of suicide and targeted prevention of depression in high-risk adolescents. Their analysis used a Markov model that included data from the 36 countries that represent 80 per cent of the global burden of these adolescent mental disorders in 2017.

The results of the analysis indicated that school-based interventions that address anxiety, depression and suicide provide a return on investment of US$21.5 for every US$1 invested over 80 years. The greatest return on investment was in lower-middle-income countries, which showed a return of US$88.7 on every dollar invested. Upper-middle-income countries showed a return of US$85.8; low-income countries, US$67.6; and high-income countries, US$16.3. There were no meaningful differences in the results based on age or sex of the adolescents (see Figure X).

Figure 1.9. Return on investment in school-based adolescent mental health interventions, in US$


Though few studies exist in low-income countries, a scattering of economic evaluations on the return on investment indicate a potential pay-off for investing in preventing mental health conditions, self-harm and
suicide. New research on programmes that effectively reduce the prevalence of mental health conditions can provide models for calculating the return on investment for protecting and promoting mental health.

One such study investigated the return on investment of KiVA, a research and evidence-based programme developed at a university in Finland. The goal of the programme was to prevent bullying, a known risk for mental health conditions. KiVA is based on a model of prevention, intervention and monitoring, and it focuses on strengthening students’ empathy and self-efficacy and fostering anti-bullying attitudes in the classroom. In England, the programme has been delivered by teachers to children aged 7–11.

Based on KiVA’s previous success and estimates of the long-term costs of bullying, researchers estimated that in the United Kingdom, implementation of the programme could offer a short-term return of US$1.58 for every US$1 invested. The long-term return on investment jumped to US$7.52 for every US$1 invested.

Though more research is necessary, especially in low- and middle-income countries (LMICs), these kinds of research models indicate that investing in efforts to promote and protect mental health can be financially cost-effective. Even more importantly, investment in efforts to protect and promote mental health can save children and young people from the short-term suffering of mental health conditions and the long-term life consequences.

Case study: Peru
Community-based Mental Health Care

At age 14, Andre* considers himself open-minded and able to adapt to new circumstances. About two years ago, however, his mother, Roxana, received a distressed phone call from Andre’s school.

“He was under a desk, crying, and saying that he didn’t want to keep living,” Roxana said.

Roxana knew her son needed help. But she and Andre live in the northern outskirts of Lima, where they share a small room in an aunt’s house. The hospitals and private clinics were too far away – or too expensive. However, a visit to a local health centre provided them with public health insurance and a referral to the Community Mental Health Centre in Carabayllo, a 10-minute bus ride from their home.

The Community Mental Health Centre is housed in a repurposed municipal stadium and staffed by a multidisciplinary team that includes psychiatrists, psychologists, nurses, a social worker and pharmacy staff. The centre provides services aimed at preventing mental health conditions and specialized care for people with moderate to severe mental health conditions, including children and adolescents.

At the community centre, the professionals diagnosed Andre with anxiety and depression linked, in part, to his parents’ separation. He was prescribed an antidepressant and referred to a psychologist, psychiatrist and social worker for therapy.
“We made an integrated plan to help him understand and manage what he’s going through,” psychologist Yesica Chambilla said. “We provided him with tools to make his own changes.”

The mental health centre also provided guidance to Roxana, who plays an active role in her son’s care.

The integrated plan is part of Peru’s community-based mental health care model. The model focuses on offering services at the primary health-care level, close to where people live, and where they can access their communities’ network of support.

The community-based model was instituted in response to a gap between the need and the availability of mental health services in Peru. In 2013, Peru’s Ministry of Health estimated that one in five people had mental health conditions. The ministry also estimated that only one in five of those people received the care they needed. At the time, mental health care in Peru was concentrated in three hospitals in Lima.

Inspired by the need and supported by advocacy from the Ombudsperson’s Office – an oversight body that protects people’s rights and monitors the delivery of public services73 – the Government of Peru instituted a series of reforms to expand community-based care that included adding mental health-care coverage to the national health insurance scheme and establishing a mental health results-based budget programme74 that helped boost public spending. In 2019, Peru passed a new national mental health law.75

As a result of these actions, the country’s network of community-based mental health care centres increased in number from 22 in 2015 to 203 in 2021. The centres are complemented by 30 specialized units in general hospitals and 48 halfway houses.76 The COVID-19 pandemic put these advances to the test.

According to an online survey conducted by the Ministry of Health and UNICEF in 2020, a third of children and adolescents in Peru experienced socioemotional difficulties during the pandemic.77 The 106-day national lockdown from 16 March to 30 June 2020 left many adults, including Roxana, temporarily unemployed. Children and adolescents, including Andre, were confined at home. The demand for mental health services increased.

In response, the Ministry of Health, with UNICEF’s support, released specific guidance for adolescent health care in the context of COVID-19 in 2020 and technical guidelines for comprehensive mental health care of adolescents in 2021.78 With support from UNICEF and CEDAPP, a non-governmental organization that provides psychosocial services, Peru’s Ministry of Health piloted a free mental health hotline for adolescents and their families. From December 2020 to April 2021, the hotline reached 821 individuals struggling with anxiety, depression and family problems; 48 per cent were adolescents.

“Looking ahead, there are two important challenges,” said Dr. Yuri Cutipé, Executive Director, Mental Health, Ministry of Health. “One, continuing to expand community-based services while ensuring the same quality across the country; and two, developing specific programmes for vulnerable populations as a part of a multisectoral approach.”

For Andre, the lockdown was stressful, but he was able to speak regularly with his psychologist by phone. He also spent more time with his mother, whom he usually only saw late at night after she returned home from her job on the other side of Lima.
“I made up for lost time with my son,” Roxana said.

More than a year after his first visit to the centre, Andre is coming off his medication and experiencing positive changes.

“Before coming, things were really bad,” Andre said. “I felt sick and didn’t want to eat. Now I feel much better, and I don’t want to give up.”

*Andre and Roxana are pseudonyms used to protect their identities. They were interviewed in Lima in June 2021.*
Perspective Essay: From a mid-night call to a national movement

By Ali Amirkafi

Suddenly finding yourself in a new environment with a different culture, not being able to cope with new lessons, failing exams one after the other, and seeking solace from drugs.

This was the state my friend found himself in when he called me at 2 a.m., disappointed, empty of hope and his voice trembling; this call was his last step before self-harm.

I was shocked and worried. With loads of adrenaline in my blood, I used everything I had in mind to hear him out and reassure him that he was truly valuable to us and to his family, and I managed to save him from immediate danger. But was it the best possible way? Or were we just lucky?

Just as it happened to my friend, the mental health issues of youth, especially students, do not get enough attention; the issues are not detected in time, and the necessary actions are not taken properly. If you look around, or think back on your days as a student, you will definitely find that friend who needed proper help.

Although my friend’s story is tragic, his 2 a.m. phone call changed his life; it also changed mine. It motivated me to become part of a super-talented team of students who organized Beyond Our Thoughts (BOT), a national, student-led campaign that addresses mental health issues – especially depression – among university students.

On a cold winter’s day, the group of friends who formed BOT came together in a room in the basement of our university to make a leap – not a step – towards addressing the mental health issues of students and young people just like my friend. We felt we were not only responsible for helping our peers, but also responsible for increasing mental health awareness and educating university officials so they could take necessary actions. The idea for BOT grew. Our mental health initiative was not only implemented at our university, but by working with many others throughout Iran, it also became a national movement aimed at highlighting the mental health issues of youth.

As students, we were committed to combining scientific evidence with the knowledge we had from our peers with lived experience – our friends who had made late-night calls! We ourselves wanted to learn more, share our knowledge and reach out to others who needed help.

Above all, the experience with BOT taught us that youth have the power to make big changes.

Numerous obstacles can get in the way of reaching great goals and BOT was not immune to them. Students encounter stigma surrounding mental health problems; they face extreme pressure to succeed academically; there is a lack of access to professional mental health centres; and there is ‘downward drift’, a cascade of negative events that can damage our mental health drastically.

As students shared some of their concerns with BOT, there were serious challenges that we youth alone could not address. There are challenges that decision-makers and people in power need to tackle. These include:
23.09.2021

- Equip students, teachers, professors and academic leaders with greater capacity to respond to students who struggle with their mental health.

- Integrate psychological first aid into academic curricula.

- Make sure to establish more professional mental health centres on university and school campuses.

BOT has helped students like my friend become aware of the threats to their mental well-being and pointed out ways to prevent the risks. As a result of the BOT campaign, my friend is more aware of his mental health condition and is also able to help others, to keep them away from the dangers he has experienced. He – and all of us with BOT – know what advocacy efforts need to be taken in order to make significant changes.

My friend’s mental health has improved dramatically, and he is now seeking professional help. But what about your friends and loved ones? Could all of us be that lucky?

Ali Amirkafi is a medical student who was born in a desert city in the Islamic Republic of Iran. He is concerned with the mental health of the people around him and tries to help them improve it.
Chapter 2: The foundation

Children’s and young people’s mental health is forged by experiences and environments. It is moulded in the worlds of parents and caregivers, of communities and schools, and of poverty, conflict and disease. At critical moments of child development, these experiences and environments can harm mental health. Or they can be shaped to promote and protect it.

The foundation of lifelong mental health is established in the earliest moments of a child’s life.

Starting from before conception and extending into early adulthood, a complex interplay of biology, experience and environment shape children’s and young people’s development and their mental health. Throughout the course of childhood and adolescence, this complex dynamic constructs the psychological, emotional, social, cognitive and behavioural foundation on which children and young people build their mental health and their lives.

As a result, the critical developmental moments that occur in childhood and adolescence offer singular opportunities to promote and protect mental health.

The framework

Multiple factors shape children’s and young people’s mental health. And multiple frameworks explain how these influences interact to cultivate mental health.

The State of the World’s Children framework emphasizes the importance of socio-ecological influences on mental health and the vital importance of experience and environment as they impact critical phases of child development: the start, the perinatal period, early childhood, middle childhood and adolescence.

Socio-ecological influences

The framework for understanding children’s and young people’s mental health in The State of the World’s Children 2021 is built on existing frameworks. In particular, it relies on: Urie Bronfenbrenner’s ecological system theory;¹ the framework outlined in Innocenti Report Card 16: Worlds of Influence – Understanding what shapes child well-being in rich countries;² and the life-course approach to the social determinants of mental health developed by WHO.³

The report framework is organized into three spheres of influence: the world of the child, the world around the child and the world at large.

From the start of life through adolescence, primary influences on mental health exist in the world of the child – the world of mothers, fathers and caregivers. In the world of the child, adequate nutrition, stable and safe homes, knowledgeable and engaged caregivers, and caring and enriching environments are essential.

As a child’s world widens, the spheres of influence include the world around the child. In addition to the ingredients for mental health fostered in the world of the child, the world around the child must include safety and security – in person and online – and healthy attachments in preschools, schools and communities.
The third primary sphere of influence, the world at large, plays a critical role in shaping mental health. The world at large includes large-scale social determinants – such as poverty, disaster, conflict, discrimination, migration and pandemics – that intrude on the lives of children and young people. The world at large plays a role in the lives of mothers, fathers and caregivers, and as children grow into adolescents and adults, the world at large begins to have a direct influence on their mental health and futures.

**Case study: Sierra Leone**

**Caring for the Caregiver**

Mbalu Turay knew immediately that Kankay Suma was experiencing significant stress.

As a trained counsellor, community health worker and facilitator of the local Mother’s Support Group (MSG), Mbalu saw the signs as soon as she first met the pregnant mother of three.

“I can look at the mothers in the MSG meetings and immediately recognize someone going through a hard time,” Mbalu said.

Kankay was, indeed, “going through a hard time.” Kankay lives outside town in a rural part of Kambia district in Sierra Leone, a country with high maternal and neonatal mortality rates and a fragile and under-staffed health system.

Personally, Kankay struggled with the 30-minute walk to collect water from a borehole and the task of gathering firewood from the bush. She was isolated from neighbours. And she was experiencing complications with her pregnancy.

Using the skills she learned from Caring for the Caregiver (CFC) training, Mbalu gained Kankay’s trust and was able to provide emotional support. She also linked Kankay to a community health supervisor who made the connection to essential medical and community services.

In the weeks after the two women met, Mbalu visited Kankay and her family daily. She counselled Kankay, listened to her concerns, bolstered her confidence and provided practical tips on managing stress.

“In our community, when someone is exhibiting signs of sadness, others may chastise them for it,” Mbalu said. “However, thanks to the CFC programme, [many of us] are now aware that it’s better to be kind and sympathetic to those who are feeling down.”

CFC is a training programme that equips frontline workers, including community health workers such as Mbalu, with the knowledge and skills they need to support the emotional well-being of caregivers – the mothers, fathers and others who provide primary care for newborns and young children.

The training is founded on a seemingly simple concept: To provide the best start in life, it is essential to care for the caregivers who care for children. And it is essential to focus on vulnerable caregivers, including adolescent parents. At its core, CFC recognizes that caregivers’ mental health and emotional well-being is the foundation
that allows them to nurture and care for their children. This nurturing care, in turn, builds a child’s lifelong mental health.

CFC training builds frontline workers’ interpersonal and counselling skills and offers a package of materials and activities that can be used to strengthen caregivers’ confidence, emotional well-being and ability to connect and support their young children. CFC trains professional and community health workers so they can help caregivers develop strategies for coping with challenges and stress that arise in daily life. The workers are also trained to help caregivers find support and services if needed.

These were the skills that Mbalu put to use when she first met Kankay. And even after Kankay gave birth to her son Mark, Mbalu continued to visit the family, providing support to mother, father, baby and siblings.

"Mbalu wrapped her arms around me and took me to a hospital for the first time in my life,” Kankay said. “She showed me what it means to take care of myself and my family.”

“I am grateful to Mbalu for [the services] she brought to us,” Kankay added. “Because one has helped keep us alive and the other has reminded us we are worthy of being happy.”

Child development

These three spheres of influence provide a framework for understanding the context of children’s and young people’s lives, and they shape an individual’s mental health throughout the course of their early lives. Within these contexts, however, the process of cultivating mental health is also tied to critical moments in child development – critical moments at the start, during the perinatal period, in early childhood, childhood and adolescence. At these critical moments, children’s and adolescent’s brains develop as part of a dynamic interaction between their genes, experiences and the environment in which they live; they develop in response to a combination of biological and psychosocial determinants.

At the start

This interaction begins before conception and affects genetic, biological and development processes. For example, evidence indicates that the cells involved in reproduction can be altered through an epigenetic process that is influenced by psychosocial distress, toxicants and drug exposure. These altered cells can influence how genes are expressed in a mother, and the alterations can be passed on to the child.

In the womb, the process of neurodevelopment begins, and nervous systems are formed. By the end of the fetal period, the parts of the brain that process complex information are connected and the basic cellular blueprint is in place.

After a baby is born, the brain continues to build at a remarkable speed, forming more than 1 million neural connections a second. At this time, the brain’s capacity to change is at its greatest level; it is a time of increased neuroplasticity, when connections in the brain are constantly being wired and rewired and strengthened. As the
baby’s brain develops, neural connections build on each other, becoming increasingly more complex in structure and function as they set a pattern for future behaviour, capacity to learn and mental health.

During these critical perinatal and newborn moments, neurodevelopment – and brain plasticity – can be altered. Positive experiences and environments can promote brain development; negative ones become risk factors. In the perinatal period and in early childhood, the experiences and environments that affect brain development are mostly connected to the world of a child’s home and caregivers. Much of the research on child development and mental health focuses on maternal influences. However, as fathers in many parts of the world take on greater caregiving responsibilities, research has begun to examine paternal influence and establish links to children’s and young people’s mental health.

First decade
In the early moments of the first decade, brain plasticity is strong and neurodevelopment rapid. In early childhood, children learn the sensory, motor, cognitive, language and socioemotional skills that will help them think, solve problems, communicate, express and perceive emotions, and form relationships. From newborn to about age 3, children learn to show affection and express joy, displeasure, and distress towards strangers. They respond to others’ distress, seek attention, and protest when frustrated. For example, from age 4 to age 8, children start to learn how to play with others, form friendships and recognize, express and control emotions.

Throughout the first decade, mothers, fathers and other caregivers remain the defining influence. However, in middle childhood, the world widens. Learning environments begin to influence children’s development of transferable skills and their physical and mental health.

Second decade
Once overlooked as a phase to be suffered through on the way to adulthood, adolescence is now acknowledged as a period of profound biological, neurological and social transitions. It is also increasingly recognized as a critical moment for unlocking human potential and securing lifelong mental health. During adolescence, dynamic neurological transitions take place in regions of the brain that affect social perception and cognition. Nerve cells begin to transmit information faster and more effectively from region to region, allowing for complex mental processes. In addition, structural changes occur in the parts of the brain that affect memory, socioemotional ability and executive functions such as impulse control and cognitive flexibility.

These neurological transitions often continue into a young person’s early 20s.

In addition to neurological changes, puberty is also a defining transition in adolescence. Typically, puberty occurs between ages 8 and 12 for girls, and 9 and 14 for boys. Though limited, evidence suggests that sexual maturation, hormone-related mood swings and changes in body composition and appearance can acutely affect adolescent mental health.

Early onset of puberty carries particular risks for mental health. While risks overlap, for boys it is associated with externalizing, antisocial behaviours. For boys and girls, early physical maturity is associated with early sexual
initiation, delinquency and substance use. For girls, early onset of puberty, is linked to anxiety, depression and eating disorders.\textsuperscript{17}

Puberty also coincides with the onset of mental health conditions, though the link between the two is not well understood.\textsuperscript{18} However, the timing of puberty may play a role.

In adolescence, social roles also transition. At age 10, children often live with parents or caregivers, most attend school and often have few, if any, adult obligations. By age 19, some remain in education or training, though others live on their own and are employed in formal or informal work. Some are parents. By age 24, it is not uncommon for young people to have transitioned into employment, life partnerships and parenthood.

These transitions mean new relationships with family and community and greater direct exposure to social determinants that can impact mental health, learning and acquisition of transferable skills. In adolescence, caregivers remain a vital touchstone for mental health. However, influences on mental health are no longer only centred on parents, caregivers and homes; peers, schools and community take on greater roles in young people’s lives.\textsuperscript{19} As a result, social determinants such as poverty, conflict, gender norms, technology and labour have a greater influence on the way young people learn and work, where they live, and their relationships with family, friends and community.

Though the social determinants of mental health play a role throughout the life course, in adolescence they can become direct risks and lead to diminished opportunities for education, training and employment.

**Box X. Connecting the critical moments**
The critical moments of development do not happen in isolation; they are linked by critical issues in child development, including attachment, developmental cascades, cumulative risks and biological embedding.

**Attachment**
Attachment refers to a psychobiological principle that drives an emotional relationship with a mother, father or caregiver who can provide a child with a sense of safety and protection.\textsuperscript{20} Attachment occurs when a child feels safe and secure enough to venture out and explore the world.\textsuperscript{21}

When attachment is positive, responsive and caring, the child develops a model on which to build sense of self, identity and a baseline for other relationships.\textsuperscript{22} The connection that comes from strong attachment fosters the child’s ability to develop skills such as curiosity, emotion regulation, empathy and reciprocity in relationships.\textsuperscript{23}

Though attachment exists throughout the course of a child’s development, it changes over time. From 6 to 9 months old, children finalize their attachment to a primary caregiver.\textsuperscript{24} In middle childhood, attachment with a caregiver no longer needs to be immediate or physical. At this point, a child can spend more time away from a caregiver, though the relationship remains central, especially in times of distress.\textsuperscript{25}

In adolescence, secure attachments are recreated with peers. However, a child’s attachment to parents and caregivers remains essential, though it often mutates in response to a growing need for independence and autonomy.\textsuperscript{26}
Attachment between caregiver and newborn can be particularly difficult for adolescent parents. Adolescent pregnancy can negatively impact development of the emotional and cognitive capacities required to foster healthy attachment with a newborn. In addition, the attachment needs of newborns can conflict with an adolescent parent’s own evolving need for autonomy. Adolescent parenthood also commonly coexists with risks, including poverty and a lack of prenatal care and social support, all of which compounds the difficulty of establishing secure attachment between parent and child.

**Developmental cascades**

From newborn to adolescence, positive and negative experiences and environments can have a cascading effect on a child’s or young person’s development. In the early stages of development, positive experiences such as nurturing caregiving and optimum nutrition initiate a cascade of positive development. Conversely, negative experiences — neglect, abuse and persistent extreme stress — increase exposure to other risks.

Exposure in early childhood to risks such as neglect and violence can emerge later in life as difficulties in school, trouble with peers and alcohol misuse. A high dose of exposure to adverse experiences can have consequences that affect cognitive development, physical and mental health, educational achievement and professional success.

**Cumulative risk**

The consequences of negative and positive experiences and environments are also cumulative. In early childhood, research shows that the more different risk factors a child faces and the more often the child is exposed to them, the greater the chance of cognitive, social and emotional conditions later in life.

A landmark study in 1979 calculated that a child who experienced zero or one risk factor had a 2 per cent chance of having a mental health condition later in life. The possibility of facing mental health conditions increased with each exposure, reaching 20 per cent for a child exposed to four risks in early childhood.

In addition to having a cumulative effect, risk factors also cluster, indicating that some adverse experiences may also point to the existence of others. For example, a child experiencing difficulty at home may also face troubles at school. Clusters of risk are particularly pronounced for children who live in poverty or who come from ethnic minority or immigrant communities.

**Biological embedding**

Research also indicates that exposure to risk factors during early periods of rapid brain development can alter a child’s physiology and gene expression — they become biologically embedded. These changes can either help or hinder resilience and vulnerability in the face of trauma. Negative experiences and environments that alter biology or brain development — such as neglect, stress, violence and poverty — can weaken resilience and increase vulnerability. Conversely, positive experiences can bolster resilience.

A ground-breaking 2001 study of children who had lived in Romanian orphanages for more than eight months in their first year of life illustrated how adversity can alter a child chemically. The study showed that, six years
after adoption, children from the orphanages still had higher levels of cortisol (a hormone released in response to stress) than other children.

**Early deprivations: A life-course effect**

In recent decades, multiple researchers have observed the development of children who have experienced extreme deprivation in Romanian institutions. Studies have followed children who were adopted by families in the United Kingdom. The results have highlighted the profound and lasting impact of early deprivations on mental health, despite subsequent years in well-resourced and supportive families.

The studies have shown strong association between the length of time spent in the institution with symptoms of mental health conditions at age 6; these conditions included inattention and overactivity, autism spectrum disorders and disinhibited social engagement – an attachment disorder. In adolescence and early adulthood, the children who experienced the deprivations longer were at greater risk of mental health conditions such as anxiety and depression. The children who experienced the greatest deprivations were also more likely to have low rates of success with school and work.

**Trauma and stress**

From the start and through the first and second decades of life, stress and trauma are also critical determinants of children’s and young people’s development and mental health. Stress and trauma present mental health risks whenever they occur. However, when they occur early in life, stress and trauma can activate responses with biological and mental health consequences that can last a lifetime.

**Toxic stress**

Stress occurs in different degrees throughout a child’s life, from the womb into adolescence. In small doses, stress is essential for healthy brain development and mental health; in extreme doses, however, it is toxic.

The National Scientific Council on the Developing Child has identified a widely accepted framework that includes three levels of stress: positive, tolerable and toxic. Positive stress is moderate, short lived and part of daily life. It is activated when a child receives an immunization or meets a new caregiver. Tolerable stress is more intense, but short lived, allowing time for the brain to recover.

Biologically, stress increases the heart rate and blood pressure and causes the release of hormones, including cortisol. With positive and tolerable stress, the effect on the brain is moderated by the attention of a loving caregiver who can comfort and soothe the child. These are the adults who can create safe environments despite outside threats, and help children recover from difficult experiences.

In contrast, damage caused by toxic stress can last a lifetime.

Toxic stress is characterized as a strong, frequent or prolonged activation of a person’s stress management systems. Toxic stress in childhood occurs in the absence of a loving adult who can provide safety and comfort. In critical prenatal and postnatal periods, toxic stress can interfere with brain development. It can limit neural connections in regions of the brain involved in reasoning, learning, memory, decision-making, behaviour regulation and impulse control. It also overproduces connections in the regions involved in responses to fear,
anxiety and impulse control, which can lead to overreaction and the inability to accurately interpret threats. Toxic stress can also diminish the release and regulation of cortisol, which can lead to impairments in the brain’s memory and mood-related functions.

Research indicates that even in the prenatal period, exposure to maternal stress can influence a child’s later stress response.

**Adverse childhood experiences**

In childhood, experiences that lead to toxic stress include physical and emotional abuse, chronic neglect and violence. These dangers, grouped together, are often categorized as adverse childhood experiences (ACEs).

In general, ACEs are defined as persistent, frequent and intense “sources of stress that children may suffer early in life.” Typically, the term is used to describe adverse events in early childhood, but the age range can include newborns up to 17-year-olds.

Though the definition of ACE has mutated over time, it now includes abuse, neglect and household dysfunction, including caregiver mental illness, substance abuse and interpersonal violence. The term ACE also includes experiences that occur outside the boundaries of home and family. These experiences can include violence in the surrounding community, the experience of living in unsafe neighbourhoods, homelessness, bullying, discrimination based on race or ethnicity, and income insecurity.

The WHO definition reflects this broader approach. It refers to ACEs as “multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence.”

The toxic stress associated with ACEs can lead to impairments in physical and mental health, social development and educational attainment. Across the life course, ACEs correlate with rates of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement, time out of work and premature death.

ACEs are also tragically common, and as they add up, the harm grows.

In the United States, for example, more than two thirds of the population reports having experienced at least one ACE and a quarter have experienced three or more. In a meta-study of research in 17 countries that included Canada, China, Latvia, Montenegro, New Zealand, the United Kingdom and the United States, exposure to at least four ACEs was strongly associated with sexual risk taking, mental health conditions and alcohol abuse; it was even more strongly associated with problematic drug use and interpersonal and self-directed violence.

Exposure to intimate partner violence in the home can also present mental health risks for children and young people. For example, a study of children’s reactions to intimate partner violence in Cambodia, Malawi and Nigeria showed that a quarter to a third of children had witnessed intimate partner violence in their homes, and that for many of them, the experience increased the risk of mental distress.
Conflicts and social and political insecurity can also create traumatic experiences for children and young people. Some of these traumas come from the direct experience of war or violence; other risks to mental health arise from the destruction to families and communities, including the loss of a loved one and the breakdown of services such as schools and health care.

In adolescence, as roles in families and societies change, new traumas can enter young people’s lives, including child marriage, interpersonal violence, gender-based violence and intimate partner violence.

**Case study: Kenya**

**Call for Help: An open line for protecting children**

In a protected booth, carefully separated from her co-workers, Barbra Sillingi listens intently before speaking calmly into her telephone headset.

As a counsellor in the Nairobi offices of Childline Kenya, a national helpline for children that addresses mental health and violence against children, ‘listen to them’ is her mission and her passion.

“When a child comes to you and tells you something, we should not ignore them,” Sillingi said. “We should listen to their voice, listen to what they are saying because they also have feelings. They also need to be loved.”

Since March 2020, when the first case of COVID-19 was officially confirmed, Sillingi has had to listen twice as hard as the number of weekly calls has more than doubled. In May 2020, there were more than 1,200 calls to Childline Kenya, up from fewer than 500 in May 2019.

“The increase in calls could be attributed to the fact that children spent a lot of time at home during the COVID period and were not going to school,” said Beatrice Muema, Head of Helpline Operations at Childline Kenya. “Because of that, you find more children were vulnerable to sexual abuse, neglect and also physical abuse.”

COVID-19 placed significant strain on children in Kenya. Many struggled to cope with the restrictions on movement designed to help curb the spread of the coronavirus. As a result, some faced increased dangers, especially during school closures. For many children, COVID restrictions, school closures and the rise in risk left them in need of someone who could really listen.

“Children go through a lot of stresses and mostly parents do not understand,” Sillingi said.

Throughout the pandemic, Barbra Sillingi has offered counselling to every one of her callers and has referred some cases to local authorities for intervention.

“I love what I do,” she said. “It’s just a passion that I have.”

Childline Kenya was set up in 2004 with support from the Government of Kenya, UNICEF and other partners. The free 24-hour emergency service allows anyone across the country to anonymously report child abuse and other child protection concerns by calling the free helpline number 116 or visiting Childlinekenya.co.ke. It offers one-on-one counselling and connects children with support services in their communities.
Childline Kenya also works with the Department of Children’s Services to intervene when children are in danger and, when possible, place them with other family members.

UNICEF provides funding for counsellors and equipment and training for staff members. During the COVID-19 pandemic, the organization funded a one-third increase in the number of counsellors to meet increased demand. UNICEF also is working with the Department of Children Services to ensure a gradual increase in public financing for operation.

“While there were restrictions on movement and children were out of school, this was one of the few channels for children and adults to report incidents of abuse, but also for children to express themselves,” said Bernard Njue Kiura, UNICEF Kenya Child Protection Specialist.

UNICEF also helped Childline Kenya to set up remote working, allowing counsellors to securely take calls from their homes. UNICEF also got the word out through a nationwide public awareness campaign, ‘Spot it, Stop it’, that encouraged children in need to call the free 116 helpline.

“Since COVID-19, people here in Kenya are more open about discussing mental health issues: from Government, to service providers, to communities, to children,” Kiura said. “The capacity to speak about it has increased.”
Chapter 3: Risk and protection

Since many of the factors that shape mental health – for better and for worse – are not biological, they can be changed. To do so, it is essential to identify and understand these factors. For children, nurturing care from and for parents and caregivers really matters. So, too, do safe and engaging learning environments, where children can develop soft skills and resilience. And, as children enter their adolescent years, peer relationships can shape lifelong norms and attitudes.

At critical moments of child development, factors based on experience and environment present potential risks to mental health. When risks occur early and in the extreme, their negative effects influence neurodevelopment, mental health, well-being, learning and futures.

These risks can occur in the world of the child, the world around the child and in the world at large. Since these factors are not biological but based on experience and environment, many can be modified. As a result, identifying some of the most common risk factors can help to formulate programmes and policies that promote and protect mental health.

Factors that help and harm

Though researchers have gathered much knowledge in recent years, systematic methods for identifying common risks to mental health are limited. Globally, data are scarce and even identifying, gathering and tracking information can be complicated by the diversity of cultural experiences and understandings about mental health.

However, it is clear that risk factors – also known as risk markers – do not portend poor mental health. Indeed, there is rarely a direct line of causation between risk factor and mental health condition. Instead, these factors work through a probabilistic chain to increase the possibility of risk – a chain modulated by length of exposure (the dosage), context and timing.¹

In addition, the effect of risk and protective factors varies depending on the child and his or her social, economic and environmental circumstances.² For example, an experience, event or environment that harms one child’s mental health may not have the same effect on another’s.

To make matters more complex, some environments can introduce risk and protective factors depending on the circumstances. For example, schools can bolster mental health by providing empowering learning opportunities and a platform for critical mental health services. They can promote and protect mental health. However, schools can also be a risk factor – places where children and young people are faced with violence, bullies, stress and abusive learning environments.

Despite the complexities, there are critical factors that have a profound influence on mental health throughout the life course. This chapter of The State of the World’s Children 2021 report focuses on three domains that are particularly relevant in the world of the child and the world around the child: parenting, learning environments and peer relationships.
In addition to examining the data and research, this chapter also presents the thoughts of adolescents who discussed mental health in discussion groups directed by Johns Hopkins University (JHU).

**Box X. A life-course approach to prevalent mental health risks**

Since many of the factors that contribute to mental health conditions can be modified, it is essential to understand the distribution of common risks in order to better develop and implement interventions that promote and protect mental health. Unfortunately, interpreting the prevalence of risk factors in global, regional and local populations can be difficult because standardized information is not always available across different contexts.

To fill this gap in the research, a team of experts from Universidade Federal do Rio Grande do Sul in Brazil examined standardized data from the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and the Global School-based Student Health Survey (GSHS) to estimate the prevalence of factors linked to mental health outcomes in the countries covered by the surveys. The team extracted more than 50 possible factors that have data available in 47 to 146 countries, depending on factor. From the indicators mapped in the three surveys, the researchers listed 23 factors in the perinatal, early childhood, childhood and adolescent periods of a child’s first two decades. The selection was initially based on the existence of systematic reviews or meta-analyses that described an association between exposure to the factor and subsequent onset of any mental health outcomes. These factors were also subjected to a review by experts in the field.

**Figure X: Factors across the life course that affect mental health**

<table>
<thead>
<tr>
<th>Perinatal</th>
<th>1. Maternal age under 18 at birth of a child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Low birthweight</td>
</tr>
<tr>
<td>Early childhood</td>
<td>3. Lack of minimum acceptable diet of five or more of eight food groups</td>
</tr>
<tr>
<td></td>
<td>4. Lack of preschool enrolment</td>
</tr>
<tr>
<td></td>
<td>5. Lack of playthings, including toys, home-made, manufactured, household objects</td>
</tr>
<tr>
<td>Childhood</td>
<td>6. Lack of primary school attendance</td>
</tr>
<tr>
<td></td>
<td>7. Violent discipline</td>
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<tr>
<td></td>
<td>8. Child labour</td>
</tr>
<tr>
<td></td>
<td>9. Orphanhood</td>
</tr>
<tr>
<td>Adolescence</td>
<td>10. No close friends</td>
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<tr>
<td></td>
<td>11. Bullying</td>
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<tr>
<td></td>
<td>12. Lack of physical activity</td>
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<td></td>
<td>13. Sedentary behaviour</td>
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<tr>
<td></td>
<td>14. Overweight</td>
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<tr>
<td></td>
<td>15. Underweight</td>
</tr>
<tr>
<td></td>
<td>16. Heavy alcohol use</td>
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<tr>
<td></td>
<td>17. Marijuana use</td>
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<tr>
<td></td>
<td>18. Lack of secondary school attendance</td>
</tr>
<tr>
<td></td>
<td>19. Not in education, employment or training (NEET)</td>
</tr>
<tr>
<td></td>
<td>20. Child marriage</td>
</tr>
<tr>
<td></td>
<td>21. Intimate partner violence – sexual</td>
</tr>
<tr>
<td></td>
<td>22. Intimate partner violence – physical</td>
</tr>
<tr>
<td></td>
<td>23. Intimate partner violence – psychological</td>
</tr>
</tbody>
</table>
Though these 23 factors are neither causal nor exhaustive – and only include indicators available in the three surveys mined for information – the research offers insight into some of the most common risk factors and points in the direction of first steps towards promoting and protecting mental health.

**Parenting**
The role of parenting is foundational to children’s mental health. It is linked to mothers, fathers and caregivers who can provide nutrition, safety, stimulation and protection for their children and adolescents.

The influence of parenting begins before conception with the mental health, nutrition, and social and economic circumstances of mothers, fathers and caregivers. In early childhood, parents and caregivers are the primary influence on the world of the child. They can create a world that encourages attachment and provides nutrition, protection, engaged stimulation and early learning opportunities.

In childhood, even as the world around the child takes on greater importance, mothers, fathers and other caregivers remain the defining influence. In addition to nutrition and protection, the essentials of engaged parenting also include play and access to learning opportunities, including pre-primary and primary school.

In adolescence, the world expands for many children, introducing new risks and protective factors to mental health. Some of these risks exist in the world at large and stem from large-scale social determinants such as poverty, conflicts and pandemics (see Chapter 4). However, the world of the child and the world around the child also remain critical protective forces in adolescents’ lives. And though adolescence is a time when young people reach outside their homes to seek meaning and community, nurturing and supportive parenting remains one of the strongest protections against mental health conditions in adolescence.

**Risks**
Engaged parenting does not happen on its own. And toxic caregiving environments – for example, those that include intimate partner violence – can be a risk to mental health. Indeed, building the foundation for lifelong mental health requires mothers, fathers and caregivers who have access to safe homes, nutritious foods, learning opportunities, comprehensive health care and mental health care, and the support of family-friendly policies. These essential tools equip parents and caregivers with the resources they need to fortify their mental health. Equipped with these tools, they can then provide nurturing care and construct a solid foundation for their children’s mental health.

When mothers, fathers and caregivers do not have the tools they need to provide health, nutrition, safety and caring homes, mental health risks can arise.

**Box X. Big changes start small**
At least £16.13 billion a year. It’s an alarming price tag – about US$22 billion a year.

In England, it is the cost of not investing in the mental health, well-being and healthy development of children under age 5. It is the amount spent on problems that could have been avoided by action in early childhood – problems stemming from antisocial behaviour, long-term mental and physical health conditions and criminality.

It is the cost of lost opportunity for a nation and for its children.
To put the number in perspective, £16.13 billion is nearly five times the amount England spends on early education and childcare entitlements.

The figure was calculated by the London School of Economics for *Big Changes Start Small*, a June 2021 report by the Royal Foundation Centre for Early Childhood.

Though £16.13 billion a year is a lot, the report argues that it is only a fraction of what is lost when we do not invest in young children, their families and caregivers. For example, it does not include losses to productivity and individual earnings that occur when children do not reach their optimal level of development.

And according to the Royal Foundation report, nearly a third of 5-year-olds do not reach a good level of development. In addition, children from disadvantaged circumstances are 4.6 months behind their peers by the time they start school.

The Royal Foundation makes six main recommendations for reducing this £16.13 billion a year in losses:

1. Raise awareness about the impact of the early years on individuals and nations
2. Build mentally healthier and more nurturing society
3. Create communities of support
4. Strengthen the workforce that supports families and young children
5. Collect and use more data to better care for children, families and caregivers
6. Support long-term changes that drive holistic and preventative early childhood support

The Royal Foundation report also makes a clear link between this essential work and its effect on mental health. In her foreword, Catherine, the Duchess of Cambridge, writes that her interest in early childhood started with adults. As she talked to people who were rebuilding their lives from challenges that often originated with mental health conditions, she was struck by how often they talked about the relationship between their mental health and early childhood experiences.

For her, there is a clear connection between our early years as children and our future selves. And the report calls for a focus not just on children’s physical needs, but also on their emotional and social needs.

Achieving this focus may be hard, she writes, but big changes start small.

*At the start*

Before conception and in the perinatal period, many risks emerge that can affect mental health. Some of the risks linked to the role of parenting include low birthweight, maternal malnutrition, maternal mental health and adolescent parenthood.

Globally, 15 per cent of children are born at a low birthweight, which is a risk for attention, conduct and social disorders. The effects of low birthweight can extend into adulthood with a connection to higher levels of anxiety, depression, shyness and lower social function. In addition, multiple risks exist for adolescent mothers and their children. About 15 per cent of girls become mothers before age 18.
Understanding why these factors occur and how they are linked to mental health hinges on the critical role of parents and caregivers. Low birthweight, for example, can have multiple causes, but it can also be connected to a mother’s use of alcohol, nicotine and drugs during pregnancy. Programmes that help pregnant women stop smoking and reduce alcohol use have also led to lower incidents of low birthweight and mental health risks.

Before and during pregnancy, maternal malnutrition can also create risks to a child’s mental health. Globally, 9 per cent of women are underweight and 30 per cent experience anaemia. During pregnancy, malnutrition – which includes undernutrition, overnutrition and obesity – can impair placental transfer of nutrients from mother to fetus. In addition, malnutrition can influence a woman’s own mental health during pregnancy, which in turn can affect her child’s mental health.

Mental health conditions are a risk for far too many women during pregnancy, with potential effects on the health and well-being of mother and child. Most of the studies that link maternal and child mental health focus on depression and anxiety – conditions that affect many millions of women around the world. For example, a 2020 study concluded that antenatal depression was common all over the world, but it is neither well investigated nor comprehensively treated.

The physical effects of antenatal maternal depression can include low birthweight, preterm birth and complications with pregnancy. Antenatal depression is also linked to developmental, emotional and attachment problems in children, with effects that can be long term. For example, a mother’s depressive, anxious and stress symptoms in pregnancy can be a predictor of mental health challenges for her child from childhood into adolescence.

Much of the research on mental health conditions focuses on women. However, evidence is emerging about the relationship between a father’s mental health and that of his child. According to a 2016 study, about 8 per cent of fathers experience depression in the antenatal period. Paternal depression has been recorded both antenatally and postnatally and is often associated with stress and poor health. Though the interconnection between maternal and paternal mood remains unclear, research consistently shows a small to medium impact of paternal depression on children, independent of their exposure to maternal depression.

For adolescent parents, multiple disadvantages can have lasting influence on their children’s mental health. Adolescent motherhood, in particular, presents risks for newborns such as preterm birth and low birthweight – both linked to mental health conditions later in life. In addition, adolescent pregnancy has implications for the mother’s nutrition, mental health and potential success in education and the workforce.

Promoting health and well-being and protecting vulnerable adolescents – whether they are parents or not – builds a foundation for pre-conception health and the healthy development of the next generation. For adolescent parents, early support can bolster healthy fetal development and early childhood development, and ultimately influence the trajectory of a child’s life.
First decade

Though parenting can help build a basic foundation starting even before birth, the first decade offers ample opportunity to build a child’s mental health. However, critical risks related to the role of parenting continue to emerge and include a lack of complete nutrition and the absence of toys and the opportunity to play and learn.

The risks are not uncommon. Globally, far too many children do not receive the standard nutritional requirements for a child in the early years of development: foods from five of eight essential food groups. The high prevalence of children aged 6–23 months who do not have minimum dietary diversity – 29 per cent globally – indicates the potential scope of the challenge that lack of nutrition presents for mental health.\(^{20}\)

For newborns, food insecurity is linked to attachment, mental and cognitive conditions. From about age 3 to about age 5, lack of complete nutrition can be linked to incidences of aggressive behaviour, anxious and depressed mood, attention deficits and hyperactivity.\(^ {21}\)

In addition to nutrition, risks in the first decade can be marked by the absence of books and playthings in a child’s life, including household or found objects such as sticks or rocks. And again, the prevalence is high. In the world’s least developed countries, 50 per cent of children younger than age 5 do not have playthings at home and 98 per cent do not have books.\(^ {22}\)

As a marker of child development, the toy or plaything itself is not the main factor. Rather, it can be an indicator of the care in a child’s home, the importance of engaged interaction with parents and caregivers, and the role of play as a critical part of early learning.\(^ {23}\)

Other risks to mental health that are linked to parenting include violent discipline and child labour, and here too, the prevalence is significant. In the world’s least developed countries, 83 per cent of children experience violent discipline from caregivers.\(^ {24}\) In addition, about 22 per cent of children in least developed countries are in a form of child labour.

Second decade

Relationships with parents and caregivers remain central to development and mental health in adolescence. Researchers have identified living without an engaged caregiver as a common risk factor associated with mental health conditions in adolescence. Lack of caregiving in adolescence occurs for multiple reasons, including death and migration. A study of children in China whose parents migrated away from home for work, for example, showed increased risk of depression, anxiety, suicidal ideation, conduct disorder and substance use in their children.\(^ {25}\) For children and adolescents facing the death of a caregiver, even brief bereavement interventions can prevent traumatic grief and lower the risk of mental health conditions.\(^ {26}\)

Throughout adolescence, nurturing and supportive parenting remains one of the strongest protectors of mental health. Research from the United States indicates that maternal care in adolescence is associated with lower odds of depression and eating and behavioural disorders. Paternal care is linked to lower social phobia and alcohol abuse; parents who communicate with their adolescents and keep track of their activities are also protecting their mental health.
However, the style of parenting may need to evolve as children grow into adolescents. Overbearing parenting can be a problem. For example, controlling an adolescent’s agency in the world is associated with greater social anxiety and alcohol abuse but lower levels of ADHD. Conversely, disengaging from parents or caregivers early, or premature autonomy, comes with high levels of health and behaviour risks linked to poor well-being.27

Though the focus of studies is usually parenting style or interpersonal connection, family settings also provide other opportunities to protect adolescents’ mental health. In particular, physical activity, diet and substance use often mirror parents’ expectations and practices. As a result, providing caregivers support that addresses these risks in their own lives may also foster healthy mental health habits in adolescents.

**Box X. Nutrition, physical activity and body weight**

Nutrition is a foundation of lifelong mental health; however, malnutrition and food insecurity can also become risks. Though mental health risks linked to nutrition often focus on the perinatal period, nutrition remains a risk and protective factor well into adolescence.

Lack of complete nutrition is linked to mental health risks such as low birthweight; conversely, nutrition can also be a powerful protective factor. For example, nutrition interventions that provide mothers with oral supplements – including vitamin A, calcium, zinc, along with nutrition education and antimalarial medication – have led to reductions in the risk of low birthweight.28

After the birth of a child, breastfeeding is a critical protective factor, with physical and psychological benefits for babies and mothers. Initiating breastfeeding within an hour after birth is proven to have benefits, including reduced mortality and morbidity from infectious diseases, and even improved intelligence.29 Breastfeeding is also an important part of nurturing care and an opportunity for mother and child to bond, which can establish a newborn’s sense of attachment and comfort.30

Despite these benefits, initiating breastfeeding within the first hour after birth occurs in only 48 per cent of births, and only 44 per cent of babies under 6 months old are exclusively breastfed.31

In adolescence, food insecurity is associated with mental health conditions that include anxiety, depression, attempted suicide and substance abuse.32 Studies have also linked food insecurity to serious mental health conditions in adulthood.33

Globally, the challenge of malnutrition remains troubling. For children younger than age 5, 22 per cent are stunted, or are too short for their age; 7 per cent are moderately and severely wasted – too thin for their height; and 6 per cent are moderately and severely overweight.34 Of children aged 5–19, 11 per cent are thin and severely thin, and 18 per cent are overweight and obese.35

In adolescence, overweight and obesity can become particular risks with links to anxiety and depression. In addition, lack of physical activity becomes a risk marker for mental health conditions. These risks may become increasingly common as the proportion of children and students who are overweight and do not get enough physical activity increases.36 Indeed, available data indicate that, among adolescents aged 11–17 who attend school, 78 per cent of males and 85 per cent of females do not get enough physical activity.37
Sedentary behaviours and screen time are also linked to a lack of sleep – another risk related to mental health. While adolescents are estimated to need around nine hours of sleep a night, many fall far short. This problem appears to be chronic worldwide. Sleepiness is the most obvious consequence of sleep deprivation. But sleep deprivation also has long-term consequences for physical health and healthy brain development. For example, evidence in recent years has linked insufficient and poor-quality sleep with the onset of a range of mental health conditions, including depression, anxiety, suicidality and impaired judgement. One study of adolescents aged 14–18 in the United States showed that, for each hour of sleep lost, the odds of feeling sad and hopeless rose by 38 per cent.

Like any parent, the pandemic left me feeling anxious. I’ve been worrying about how my own kids are doing, about my family’s health and about how we’re all going to get through this. Luckily, I’m able to shield my kids from most of my worries. But, that’s not the case for so many families. Far too many children are suffering because their parents are suffering, wondering how they’re going to make it through another day. To do better for kids, we need to do better for parents’ mental health. When we support parents and caregivers, we support children and young people.


Adolescent participants in the focus group discussions directed by JHU strongly agreed that family has a profound effect on their mental health and well-being. In 13 countries across the globe, these young people agreed on a common collection of risks that they deal with in their daily lives: lack of support or understanding; fighting or conflicts within their family; challenges communicating with parents and caregivers; lack of parental attention and experience of neglect.

In Jordan, for example, a girl in the discussion for 10- to 14-year-olds said: “There are many parents who do not care for their daughters. They tell her, ‘You came by mistake, we do not want you, and you are not our daughter’. The girl [comes to] hate herself and regrets that she came into this world.”

Some of the other less common risk factors arose in many of the discussions, including parental control, parental pressure, financial instability, traditional thinking about gender roles, the value of education and mental health.

As a girl in the 10–14 age group in Belgium said: “They tell you what to do and what to say, what not to say. What you have to wear. Or they force you to become a lawyer, which you really don’t want to be, because, I don’t know, maybe you want to work in a hair salon.”
23.09.2021

In the discussion group of adolescents aged 15–19, a girl in Indonesia said: “They tell me that I am their child, they are my parents, therefore I have to understand that as their child, I have to behave like a child should, which is to obey the parents.”

In Kenya, a boy in the discussion for 15- to 19-year-olds made the connection between poverty, family pressure and education: “For some, they may see that if they continue going to school then they will be overburdening their parents. They may sooner or later get involved in crime like theft and also begin abusing drugs to reduce the stress.”

Some common risks arose in particular countries. For example, in Belgium, China and Switzerland, adolescents spoke about the pressure they feel from their parents and caregivers to succeed academically. In Chile and Jamaica, they described family criticism, particularly targeted towards girls, as a detriment to mental health. In Kenya and Malawi, participants focused on mental health risks related to financial instability and verbal, physical and sexual abuse. In Egypt and Jordan, adolescent participants discussed verbal and physical abuse, and emphasized the control families wielded over them. For girls, this control also extended to male siblings.

In some countries, adolescents talked about the way stigmas in their societies and within their families could be a risk – sometimes, a life-threatening risk. Stigmas about sexual behaviours, unplanned pregnancy, substance use, body image and poverty were discussed as particular risks. Stigmas about sexual violence were a particular topic of conversation among girls in Egypt and Jordan, who said that the experience of such violence exposed them to rejection by family members and communities.

In Jordan, a girl in the 10–14 age group explained: “It is possible that she will be beaten by her family and be afraid of them and [take her life] so they will not punish her and … because she feels that she is the reason for degrading her family.”

**Protective factors**

From before conception and into adolescence, measures to promote mental health and protect the most vulnerable focus on providing care for caregivers and encouraging engaged parenting.

The Nurturing Care Framework is one of the most widely recognized tools for encouraging engaged parenting in the early years of a child’s life.\(^{43}\) Established by UNICEF, the World Bank Group, WHO, the Early Childhood Development Action Network (EDAN) and the Partnership for Maternal, Newborn & Child Health, the framework identifies five categories essential to nurturing care and healthy development: good health, adequate nutrition, responsive caregiving, security and safety, and opportunities for early learning.\(^{44}\) Recently, understandings of the framework have been expanded to address preconception through adolescence.\(^{45}\) The expanded framework focuses on promoting resilience and securing health development throughout the life course, mitigating the consequences of risks and bolstering human capital.

Equipping parents and caregivers also requires directly addressing *their* mental health (*see Box X. Care for the Caregiver*). For example, providing mental health support as part of antenatal care can limit maternal mental health conditions. A review of 13 trials showed that psychosocial interventions delivered by community health
workers in LMICs reduced antenatal maternal depression. The benefits to the children included better interaction with mothers and improved growth and cognitive development.\textsuperscript{46}

In particular, interventions that combine nutrition and interactive caregiving have bolstered children’s cognitive development. In Jamaica, for example, children with stunted growth were visited by a community health worker as part of a nutrition programme. The community health workers encouraged mothers and caregivers to engage interactively with their children – to play with them. The result was a significant impact on cognitive development, with ripple effects for employment 20 years after the intervention.\textsuperscript{47}

Consistent attention to the basic building blocks of lifelong mental health is essential throughout a child’s first decade, especially for at-risk children, and nurturing care remains critical to a child’s mental health.

Engaged parenting also remains a critical protective factor for mental health in adolescence. In this developmental period of transitions, positive parenting can foster adolescents’ capacity for resilience in the face of adversity and have long-lasting effects on health and education.\textsuperscript{48} Across diverse cultural contexts, warm relationships between caregivers and children can lead to positive outcomes, including higher self-esteem, reduced stress, better mental health and fewer psychological and behaviour problems.\textsuperscript{49}

Evidence indicates that programmes which provide information and support for parents and caregivers of adolescents can improve adolescent outcomes. In particular, effective programmes increase parents’ and caregivers’ understanding of early and late adolescent development, and sexual development; improve attitudes about parenting; and provide opportunities to gain new parenting skills and strategies.\textsuperscript{50}

Recent guidance from UNICEF indicates that effective programmes for parents and caregivers have the following characteristics: They draw on adolescents’ strengths; are gender responsive; include adolescent participation; take into account differences in abilities; and are evidence based.\textsuperscript{51} The content of successful programmes focus on:

- Warmth, love and affection
- Adolescent development
- Respectful communication
- Positive discipline
- Safe environments
- Provision of basic needs
- Caregivers’ and parents’ mental health

Box X: Medication and children
Psychotropic drugs are increasingly used to treat conditions like attention deficit/hyperactivity disorder (ADHD) and depression.\textsuperscript{52} Data are scarce and cover mostly high-income countries, but they indicate notable growth in the use of medication.

For example, from 2005 to 2012, prescription rates for antidepressants for children younger than 19 are estimated to have increased 60.5 per cent in Denmark, 49.2 per cent in Germany, 17.6 per cent in the Netherlands, 54.4 per cent in the United Kingdom and 26.1 per cent in the United States. From 2008 to 2016,
the rate rose 78.3 per cent in New Zealand. However, there is evidence that some of these rises may now be slowing.

To an extent, these increases reflect the reality that mental health services are more available in many countries, and that more children and young people are using them. But that only explains part of the picture, and it does not address a number of the debates that accompany the use of such drugs in childhood.

Among these debates is the concern that drugs are being overprescribed – albeit, not everywhere. In many parts of the world, necessary treatments and skilled staff are lacking, meaning children who might benefit from medication go without.

Concerns about medication have been taken up by the Committee on the Rights of the Child. In 2015, the committee warned about the overuse of drugs for ADHD “despite growing evidence of the harmful effects of these drugs.” The committee drew a clear link between overuse of such drugs and overdiagnosis.

ADHD has gained particular attention. There is emerging evidence of ADHD overdiagnosis in children and adolescents in some countries; in contrast, diagnosis remains less common in countries where culturally adapted and validated screening tools remain limited. Numerous factors are at work with overdiagnosis, such as clinicians’ reliance on subjective judgements rather than diagnostic criteria. The result can be higher rates of diagnosis among boys compared with girls, and among children who are younger than average in their classroom or peer group.

However, there is a bigger issue at play: Overly biomedical approaches to mental health interventions can fail to address the social determinants that impact the mental health of many children, such as poverty, inequality, violence and adverse childhood experiences. And they may also fail to reflect the need to ground mental health care upon the ways that individual cultures understand mental distress, healing, and recovery.

From a medical perspective too, there is criticism of what some see as an overexpansion of diagnostic categories in the absence of a solid scientific basis. And there are concerns that an over-reliance on medications may obscure the advantages of non-medical approaches, including approaches that focus on promoting and protecting mental health, rather than treating conditions.

Medications can play an important role in treating mental health conditions. But far more research is needed to understand their unique impacts on children and adolescents experiencing rapid cognitive, social and neural development; the effects of drugs on young people may be very different from those seen in adults. The use of drugs also needs to be understood in the context of a broad biopsychosocial approach to mental health that holistically addresses the needs of each child. Children, adolescents and their families should have access to a range of medical, therapeutic, and other interventions and should be supported to make informed choices that are in the best interest of the child.

**Learning**

Opportunities for early learning is one of the main principles of the Nurturing Care Framework, but the importance of inclusive education and learning environments persists beyond early childhood and into adolescence.
23.09.2021

Risks

In early childhood, a lack of preschool enrolment can indicate risk for mental health outcomes. As a marker of mental health, preschool enrolment can be tied to the importance of early learning and responsive interaction between child and caregiver. In early childhood, responsive interaction that comes from playing, singing, talking and reading books serves a critical neurological function – it stimulates neural connections in the brain at a vital time of early childhood brain development. Research has shown that interactive stimulation from a caring adult can boost social and emotional development.

Despite links between early learning opportunities and child development, about 81 per cent of children in the least developed countries do not attend early childhood education.64

The risks continue into adolescence as young people pursue transitions from schools, to training and the world of work.

In 2019, nearly 200 million adolescents and young people of secondary school age were out of school.65 According to figures from the UNESCO Institute for Statistics (UIS), the out-of-school rate for primary school-aged children was 9 per cent for girls and 7 per cent for boys; for lower secondary school, the rate was 15 per cent for boys and girls; and for upper secondary school, the rate was 35 per cent for boys and girls.66

In addition, 12 per cent of boys and 22 per cent of girls aged 15-19 were not in education, employment or training (NEET).67 Globally, women were twice as likely as men to not be in education, employment or training, with some regions posting higher disparities.68 Those who were employed often had unstable or informal jobs with no guarantee of economic stability. Of the 429 million young workers around the world, 13 per cent lived in extreme poverty, defined as living on less than US$1.90 a day; 17 per cent lived in moderate poverty, or US$3.20 a day.69

Absence from school or dropping out before finishing is linked to social isolation, which in turn can lead to mental health conditions, including self-harm, suicidal ideation, depression, anxiety and substance use.70 The effect is also bi-directional. For example, some studies show that substance use and disruptive behaviour disorders can be a risk for absenteeism and drop-out rates.71

The barriers to employment and economic stability alter historic transitions into adult roles and are linked to risks for mental health conditions.72 For example, a Mexico City study published in 2012 indicated that young people who do not work or who are not in some form of education or training were more likely to experience mental health conditions. In addition, they were also more likely to abuse substances, including drugs and alcohol, and were at greater risk for suicide.73

Tragically, sometimes the risks associated with learning come from the environment. This was a theme expressed in the discussion groups directed by JHU. In some of the discussions, schools were associated with sexual and gender-based violence.

As a girl in the discussion group for 15- to 19-year-olds in Egypt said: “The teachers harass girls even in primary or preparatory school. He touches her in ways, and she is unable to talk, because if she does, he will fail her and if she tells her people, they will say, ‘You are wrong, no teacher would do that’.”
For others, school environments highlighted disadvantages caused by poverty and presented opportunities for bullying. A boy in the group for older adolescents in Malawi explained:

“At school, there are rules that everyone should dress up completely ... you need a good shoe. You find that at your home they cannot provide that for you, and you are putting on ‘crocs’. Others ... they get that croc and start throwing it at each other: “Look at this!” And the whole class starts laughing at you. It is so painful for us young people ... it is so terrible.”

Protective factors
Despite the risks that learning environments sometimes introduce, schools can and do serve as platforms for multifaceted health and mental health in countries around the world. In addition, they are among the most important settings for promoting emotional and social skills, and an avenue for reaching a significant number of adolescents who experience mental health conditions.74

In early childhood, childcare and pre-primary programmes have reported significant successes, showing positive associations with cognitive and socioemotional skills.75 Pre-primary education can bolster collaboration with parents, foster intellectual and social-emotional development and establish healthy behaviours.76 Many of the benefits last into adulthood.77 However, the quality of a programme remains critical to its success. And the interventions with the most success include individualized attention, a variety of play materials, interactive reading and organized classrooms.

In adolescence, safe, predictable and supportive learning environments can foster resilience.78 Learning opportunities that provide transferable skills – also known as soft or socioemotional skills – can help young people become agile, adaptive learners and citizens equipped to navigate personal, academic, social and economic challenges.79

In addition to the benefits of learning to mental health, schools provide a critical platform to promote and protect children’s and young people’s mental health and reach children in need of care. In countries at all income levels, evidence shows that school-based interventions are linked to mental health benefits.80 In LMICs, mental health interventions in schools have been linked with improved self-esteem and emotional regulation, reduced anxiety and depression, and overall better well-being. Many interventions combine mental health promotion with other categories of support, including sexuality education and physical fitness. Some focus on developing social, emotional, problem-solving and coping skills; and others target specific vulnerable populations, including children affected by HIV/AIDS or war.81

Whole-school approaches to social and emotional learning (SEL),82 in particular, have provided students with the knowledge, attitudes and skills they need to understand and manage emotions, set and achieve goals, show empathy, maintain positive relationships and make responsible decisions.83 Global evidence shows that SEL and whole-school approaches improve students’ emotional well-being, social functioning and academic performance.84 They are also linked to reduced risk of depression, anxiety and stress, and have proven effective in limiting substance misuse, antisocial behaviour, and risky health and sexual practices.
Within a whole-school approach, multicomponent interventions have proven particularly effective. An examination of school-based mental health initiatives, published in 2020, indicated that interventions focused on a single concern were only marginally effective. However, a tiered approach showed better results when it provided: universal interventions for the whole school aimed at preventing emotional and behavioural disorders; selected interventions for a small group of at-risk students; and individual, targeted interventions for students struggling with emotional and behavioural disorders. 

Though evidence shows that SEL interventions can work, many challenges exist to effectively offer them in schools worldwide. Successful implementation requires an understanding of the particular context in which the intervention is used. And questions must be addressed such as: What are the concerns of the school? What is the cultural context?
Case study: Ireland
Mindout: Social and emotional learning for adolescent well-being

Like most of his classmates at Gonzaga College, a secondary school in Dublin County, Jude* wants to do well in school. However, the pressure can be overwhelming.

“Some of us do need to gain perspective,” Jude, 17, said. “I have seen some people having panic attacks before exams; there definitely is a sense of pressure.”

And it is not just academic pressure. Far too often, adolescents face peer pressure, social stigma and restrictive stereotypes – all of which can take a toll on mental health. Indeed, as Ireland was developing a National Youth Strategy in 2015, young people identified mental health as one of the top three issues.

Mindout, an evidence-based universal social and emotional learning (SEL) programme, offers an opportunity to address some of the mental health and well-being concerns that are important to young people in Ireland.

As part of Ireland’s Health Service Executive, Mindout is offered to 15- to 18-year-olds in schools and youth settings. It is also integrated into the Social Personal and Health Education (SPHE) curriculum, which is a mandatory part of school curricula.

Mindout features 13 sessions based on a structured manual for teachers. The intervention uses interactive teaching strategies to engage students and focuses on helping participants with essential social and emotional skills, including: self-awareness, self-management, social awareness, relationship management and responsible decision-making.

An evaluation of Mindout in 32 disadvantaged schools indicated that, when the programme was implemented well, it produced improvements in participants’ social and emotional skills and a reduction in stress and depression.

At Gonzaga College, Jude’s school, Aryn Penn teaches SPHE and was trained in Mindout. The programme helped her become more empathetic to the struggles of her students, she said.

“It really allowed me to see the schooling experience through the lens of well-being, whereas so often we are fixated on achievement,” Penn said.

For the students, Mindout taught some simple skills, such as how to be a good listener, recognize ways to access support and reach out to peers in need.

“The more I witnessed the value the students took from it, the more I was able to reflect on my own experience as a teacher and reframe that in terms of helping young people at this vulnerable time in their lives, rather than just focusing on homework and exams,” Penn said.

For Jude, Mindout has helped him to foster his communication skills, develop self-acceptance and acquire coping strategies, he said.
“I think the course does bring up some really useful stuff,” he said. “There is stuff that you realize you know deep down, but it did help to go over them. You realize when you are under stress that you should be using these techniques.”

* Jude’s family name is being withheld to protect his identity. He was interviewed in Dublin.

**Peer relationships**

In adolescence, the multiple transitions that occur in children’s lives introduce new risks and sometimes increase exposure to persistent ones. In particular, the role of peers in adolescents’ lives grows, bringing with it both risk and protective factors.

In adolescence, peers begin to provide a sense of identity beyond the walls of their family life. Peers help adolescents navigate social networks and understand their role in relation to their communities. In the early years of adolescence, children look to peers for behavioural and social cues and approval. Ultimately, association with a group of peers confers status at a time when adolescents are sensitive to social exclusion. Over time, adolescents can begin to conform to the norms practised by their peer group.

**Risks**

The growing importance of peer relationships in adolescence also introduces two main risk factors to mental health: bullying and a lack of friendships.89

Bullying – online and in person – and peer victimization become more common in adolescence, with effects on mental health.90 These kinds of toxic relationships have been associated with tobacco, alcohol and drug use. They are also linked to lower academic achievement, loneliness, obesity and overweight. At least one meta-analysis found convincing evidence for a causal relationship between being bullied and anxiety, depression, poor general and mental health, non-suicidal self-injury, suicide attempts and suicidal ideation.91

Children and young people with disabilities can face a ‘double disadvantage’ with bullying, especially in school settings.92 Research based on longitudinal data from the Millennium Cohort Study and the Longitudinal Study of Young People in England indicated that children and young people with disabilities have a greater risk of being bullied in learning environments, and that the bullying is directly related to disability rather than other stigmatizing factors. As a result of the increased risk of bullying, the adverse mental health consequences that come from bullying can also increase.

**What young people say**

Bullying – whether it is in the form of ‘traditional’ bullying or cyberbullying – was the predominant concern for the adolescents who participated in the discussion groups directed by JHU.

For example, a girl in a discussion group in Indonesia talked about being mocked for being “too short and skinny”.

“I was being bullied by my friends,” she said. And the experience hurt her and her friendships.
“Once I felt hurt and I got disappointed, it really made me feel indifferent towards them,” she said.

Many focus group participants described a lack of trust within peer relationships. As a result of this lack of trust, many refrained from relying on friends when they faced mental health conditions. As a girl in the discussion group for 15- to 19-year-olds said: “I don’t like to confide in friends because they can expose your secrets, so I keep things to myself and this increases my suffering.”

Participants also talked about the negative influence of ‘bad’ friends and the power of peer pressure when it comes to engaging in drug and alcohol use, sexual activity, violence, bullying and stealing. A boy in the discussion among older adolescents in Malawi provided this example: “For instance, maybe the group you are chatting with smokes marijuana and you don’t smoke. Eventually you are going to start smoking so that you could conform to the group’s way of living ... If you don’t participate then you will not belong to that group. So you force yourself and find that you have started bad behaviour.”

However, adolescents in the group discussions – both boys and girls – also talked about the importance of strong friendships in their lives and the ways in which social isolation caused distress. Many said that their peers were a powerful source of protection for their mental health. For many, peers were the primary source of support.

“If you don’t have a good relationship with your parents, well, then maybe you, you might turn to friends, or maybe siblings who are of an equal age because they maybe can understand [you] better,” said a girl in the older age group in Sweden.

**Substance use**

Substance use – alcohol and marijuana, in particular – are among the more common mental health risk factors for adolescents. The most recent figures indicate that 36 per cent of boys and 17 per cent of girls aged 15–19 have had at least one alcoholic drink in the last year. In part, the risk is associated with the effect of substance use on an adolescent’s developing brain. Indeed, substance use may affect patterns of neurodevelopment at a time when regions involving understanding of emotion, reward, planning and consequences are being developed.

Many factors influence adolescents’ substance use. Peers can be a main source of enticement to substance use, but they can also be a deterrent. Ultimately though, family and community norms also play a major role in whether an adolescent uses alcohol and marijuana.

**Protective factors**

Just as peers can be a source of toxic relationships and bullying, they can also be positive factors that support mental health.

For example, adolescents are less likely to engage in risky behaviours – such as drugs, alcohol or cigarette use – if their peers discourage them. At the same time, if encouraged by their peers, adolescents are more likely to become involved in positive activities such as volunteering.
In general, adolescents with close friendships report greater levels of happiness. They also report a stronger sense of self-worth and say they are able to find support in times of duress. As adolescents move into secondary school, maintaining a strong friendship helps them adapt and can lead to fewer conduct and academic challenges.

Box X. Violence and mental health
Tragically, every year, over a billion children aged 12–17 are estimated to be exposed to interpersonal violence with mental health consequences that include depression, anxiety, suicide and behaviour and social problems.

Multiple forms of violence often co-occur in the same family, and children’s exposure to both violent discipline and violence against their mothers increases their risk of violence in adulthood, either as victims or as perpetrators.

Therefore, preventing exposure to violence in childhood is essential to promoting mental health. This can be easier said than done. However, evidence points to critical entry points for interventions.

For example, identifying pregnant women at risk of intimate partner violence, including pregnant adolescents and screening for postnatal depression has effectively identified mothers and children at risk. Responding with gender-sensitive caregiver support for new and young parents can both promote early childhood development and prevent violence against children and women.

Health services also offer a critical entry point to identify children and their caregivers who may be experiencing or perpetrating violence. Indeed, the World Health Organization (WHO) strongly recommends that health-care providers consider exposure to violence when assessing children’s health, especially when facing conditions that may be caused or complicated by maltreatment. By intervening, appropriate care can be provided and referrals made to support services – action that can prevent future harm.
Chapter 4: The world at large

The world at large imprints on mental health. Poverty undermines physical and mental health and can expose children to violence and trauma; discrimination can expose children to disadvantage, prejudice, and social exclusion; and humanitarian crises and pandemics — like COVID-19 — can lead to extreme and lasting distress. Resilience helps children better cope such stresses. Counter to what many people think, resilience can be cultivated.

In addition to the world of the child and the world around the child, the world at large is a critical influence on children’s and young people’s mental health — for better or worse.

As a sphere of influence on mental health, the world at large involves multiple kinds of events and social determinants that shape children’s lives. Catastrophic events such as disasters, conflicts or global health emergencies can strike at any time. Social determinants, such as poverty and discrimination, can also intrude on a child’s development, often as a direct influence on children and adolescents, as well as on their caregivers, communities and schools. The influence of the world at large on children’s and young people’s mental health is not the same for every child. Indeed, different children and young people can experience risk and protective factors in many different ways depending on their circumstances, personal experiences and cultural context. As a result, nuanced responses that recognize the importance of culture and context are essential for protecting and promoting mental health and caring for vulnerable children.

This chapter focuses on key social determinants of mental health: poverty and discrimination. It also looks at the effect humanitarian crises — including COVID-19 — have on children and young people. Finally, the chapter examines resilience and how it can provide a pathway to promote and protect mental health.

Poverty

Poverty is a critical social determinant of mental health that shapes the lives of far too many children and their caregivers.

According to a 2020 report, 356 million children — 17.5 per cent — live in extreme poverty, which is defined as existing on less than US$1.90 a day. Globally, nearly 20 per cent of children younger than 5 live in extreme poverty. Poverty is not just about a lack of money — it is multidimensional, involving deprivations in education, health, food, water and sanitation. By this measurement, 644 million children live in multidimensional poverty.

Effects

The association between poverty and mental health is both well established and complex.

On average, a child from a poor family faces worse life outcomes than a child from a wealthier family — outcomes such as poor physical and mental health, less success with education and work, and a prevalence of risky behaviours and delinquency. In addition, poverty increases the likelihood that children and young people will be exposed to risks, including violence, trauma, social exclusion, disease, and food and water insecurity.
Much of the research on poverty and mental health focuses on *correlational links and causal links*. However, the relationship can also be a two-way street: Poverty can lead to mental health conditions; and mental health conditions can lead to poverty. For example, poverty can harm children’s and young people’s mental health by exposing them to risks such as extreme stress, violence and trauma. Conversely, research also shows that children and young people with mental health conditions can drift into poverty, propelled by increased healthcare costs, reduced productivity, lack of employment, and stigma that denies them participation in treatment and community.

*A ripple effect* 
Poverty can also have multiple effects that compound with continued exposure and ripple throughout a child’s or young person’s life.

In the earliest moments, one of the primary influences of poverty on children’s mental health is its effect on caregivers. The stress of poverty can interfere with caregivers’ capacity to consistently provide positive parenting, a key ingredient of brain development and mental health.

Research, for example, has linked the daily stresses of poverty to maternal depression, which in turn can hinder mother-newborn interactions. The stress of poverty is also linked to punishing or neglectful parenting. In the first years of life, this kind of parenting can create anxiety, depression and behavioural conditions. Poverty – and the resulting parental distress – is also linked to ACEs, including child abuse and sexual abuse.

The amount of exposure to poverty also matters. Indeed, the longer a child lives in poverty, the greater the risks to mental health. In the United Kingdom Millennium Cohort Study, for example, researchers showed that, for children who lived in poverty early in life, the risk to their mental health conditions grew as they aged from 3 years old to 11 years old. In addition, their mothers reported more psychological distress, which also increased as their children aged. Similarly, a Danish study associated early intermittent household poverty with conduct problems, psychosocial problems and stress in early adolescence.

When the stresses associated with poverty accumulate without the protection of a caring adult, cognitive development can be impaired. As a result, children from disadvantaged families face risks to memory, executive function and the capacity for delayed gratification – functions that, when impaired, can harm mental health.

*Hopes and dreams* 
Poverty can also have a profound psychological impact on children’s and adolescents’ capacity to seek opportunity and realize their dreams.

In discussion groups directed by JHU, adolescents spoke eloquently about how poverty affects their lives and mental health. They said poverty forced them to drop out of school, led them towards crime and prostitution, increased their drug and alcohol use, and contributed to child marriage and early pregnancy. Ultimately, they said, it contributed to stress, sadness, hopelessness and suicide.

Research has shown that children and young people formulate their world view based on their experiences of stress and deprivation. For children in poverty, the view can be constricted by limited dreams and few goals – and ultimately, a loss of hope.
Poverty – and relief from poverty – can impact children’s expectations for themselves and their parents’ aspirations for them. In Ethiopia, Young Lives – an international study of poverty and children – showed that children’s aspirations – shared by their parents – were linked to poverty. In the study, 84 per cent of children in the highest income levels aimed to attend university, but only 67 per cent of children in the lowest levels shared the aspiration. The study also found that aspirations were a reliable predictor of educational attainment.

Living in poverty also affected long-term decision-making. Studies have demonstrated that deprivation focuses young people’s attention on their immediate needs, leading to short-sighted, impatient and risk-averse decisions.

Access to opportunity can also have an impact on children’s and young people’s mental health and behaviour. Among adolescent members of under-represented minority groups in the United States, for example, cigarette and alcohol use rose after the reversal of a social policy that offered many of them a path to university. Similarly, a programme in the United States that offered immigration benefits to undocumented Hispanic adults aged 19–50 was linked to a decrease in psychological distress.

Income inequality also works on individual psychology with damaging effects to mental health. The most common association is between income inequality and depression. Though the findings are mixed, the connection may be fostered by status anxiety, or feelings of defeat and shame arising from comparisons between social groups. Another theory is that income inequality erodes social trust and social interactions, promoting isolation, alienation and loneliness. Though most of the studies on income inequality and mental health involved adults, some focused on the risk in adolescence, a critical moment of development when trust and group membership are essential elements of self-identity (see Chapter 2).

Response
The complex relationship between poverty and mental ill health demands complex and multisectoral responses that protect and promote good mental health.

Cash transfer programmes, for example, have shown promising results for educational attainment, use of health-care services, food security and child labour. For example, an unconditional cash transfer programme in Kenya reduced depressive symptoms in young people aged 15–24, with the biggest drop in young men aged 20–24.

In Rwanda, Sugira Muryango (Strengthen the Family) demonstrated success with a multisectoral approach that combined an early childhood development programme with an existing social protection programme. Among the goals of the programme was to reduce violence in the home and increase fathers’ engagement in play and caregiving.

As part of the intervention, trained community-based lay workers visited homes in extreme poverty to provide parents and caregivers – male and female – coaching in nurturing care, emotion regulation and problem-solving. The result was improved caregiving practices, including engaged parent-child interactions, responsive care and better nutrition. In addition, intimate partner violence and harsh discipline decreased and instances of anxiety and depression in caregivers were reduced.
Discrimination

Discrimination is also widely recognized as a risk to mental health, though the connection can be complex. Understanding it is complicated by the intersectionality of the different kinds of discrimination that children and young people experience — discrimination that can be based on gender, race, socioeconomic status, sexual orientation or disability.

For example, gender can overlap with race, ethnicity, socioeconomic status or sexual identity to exacerbate experiences of stigma and discrimination. Or experiences of racial discrimination can vary based on gender. Though the research is mixed and dependent on context, evidence indicates that these risk factors often occur together with aggravating effects on mental health and well-being. Recognizing the intersectionality of different kinds of discrimination can help highlight interlocking disadvantages that affect the experience of discrimination and mental health.

Gender

Though forms of discrimination often intersect, researchers have also delved into the ways different forms of discrimination influence mental health. For example, gender inequalities and harmful social norms based on gender can define roles and responsibilities that limit opportunity, restrict behaviour, and constrain expectations and self-expression — all of which can affect mental health. Gender inequality, in most societies, puts girls at a disadvantage. However, gender norms can influence the mental health of all. Gender norms are entrenched beliefs or expectations about behaviour or individual expression in society. They vary from society to society, community to community, and sometimes, household to household. They can determine how one is treated and the power, opportunity and resources a person can or cannot have.

Though the effects of gender norms on a child’s development can begin even before birth, they can become more restrictive and entrenched as children grow into adolescence and adulthood.

For girls in particular, gender norms can become more restrictive in adolescence, hindering independence, movement and education. Child marriage, gender-based violence, and family and cultural expectations can significantly limit opportunity and self-determination. In later adolescence, restrictive stereotypes about work, education and family can get in the way of a young woman’s fledgling ambitions and prospects. In addition, violence against women, including intimate partner violence, can harm health and mental health.

For example, 5 per cent of girls globally are married by age 15 and 19 per cent are married by age 19. According to 2018 data, 16 per cent of girls experience intimate partner violence.

Boys also face restrictive gender roles. Harmful concepts of masculinity can hamper boys’ ability to express emotions or seek support. These constructs of masculinity can also place pressure on boys to take risks, experiment with substance use and engage in violence.

These risks often cross socioecological spheres of influence and exist in the world of the child, the world around the child and the world at large. For example, child marriage and interpersonal violence often stem from gender stereotypes and cultural norms — powerful social determinants of mental health — but they are also tied to family and community behaviours and expectations.
Gender differences in mental health also begin to emerge in adolescence, and gender divides emerge in diagnoses of mental health conditions. Internalizing disorders such as anxiety and depression are more commonly diagnosed in girls, while boys are more likely to experience substance abuse and violence. Although girls and boys often manifest mental distress differently, before puberty, the risk for depression, though small, is equal. Starting around age 12, girls are more likely to be diagnosed with depression than boys.

The gender divide in reported psychological distress and life satisfaction – and in instances of depression and anxiety disorders – can be complex to unpack. A 2021 study of adolescent mental health and well-being found that girls report less life satisfaction and more psychological distress than boys in countries around the world. However, the gap between boys and girls by these measures is larger in high-income countries such as Finland and Sweden than in some lower-income countries. The authors of the report indicate that the wider gap may be the result of stress from new and conflicting gender expectations and the frustration girls face when confronting discrimination and other barriers as they seek to achieve in arenas newly open to them.

Box X. What young people say
In the 13 countries where JHU directed focus group discussions, adolescents talked about how gender norms affected their mental health. Boys and girls had different concerns.

Girls frequently discussed the impact of restrictive norms on their well-being. Prominent themes included the role of societal pressure on body image. These restrictive norms were different in different contexts.

In Egypt and Jordan, for example, girls talked about families that valued and trusted sons more than daughters. They spoke about limited mobility and freedom, and judgement that follows even the most limited interaction with boys. They also expressed concerns about child marriage and early pregnancy.

A girl in the discussion group for 15- to 19-year-olds in Jordan said that she feels “depressed because I see my friends in secondary school and I am in something else.” For her, family was the root of the problem because “they don’t give us our freedom to do what we want, and they say no to everything we want. They say, ‘because you are girls this does not suit you’.”

A girl in the 15- to 19-year-old discussion group in Malawi said families often expect girls to take on most of the household chores, often leaving school. “They say, ‘there is a boy, so a girl will not have any benefit in [the] future,’” she said. “So they make the girl do all the household chores at home and the boys do nothing.”

However, social norms also mean that it is more acceptable for girls to seek help than boys for mental health conditions.

In all 13 countries, boys and girls discussed the impact of harmful gender norms regarding masculinity. They said that boys experienced pressure to be strong, unemotional, invulnerable and able to handle issues on their own. The result of this pressure was linked less to emotional challenges and more to behaviours, including violence, aggression, substance use and risky sexual activity. Some boys also talked about pressure to provide for their families and the lure of crime to fulfil this perceived obligation.
“Girls have the opportunity to speak to their peers and their parents and express how they feel inside, and boys have to hold it in,” said a boy in the 15- to 19-year-old group in Jamaica.

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<tr>
<th>Case study: Bangladesh</th>
<th>Empowerment and Independence: In pursuit of adolescent-friendly mental health</th>
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<tr>
<td>By age 17, Alia* had already experienced significant loss and instability in her life.</td>
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<td>When she was 9, her mother died, and her father remarried. When she was 16, her father died, leaving Alia to care for her younger sister.</td>
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<td>Determined to continue her studies, Alia worked as a household helper. And she found guidance and information at a local Adolescent Friendly Health Services (AFHS) centre in the Mirpur neighbourhood of Dhaka.</td>
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<td>Her dream – and the dream of her dying mother – was that she would be able to live an independent life.</td>
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<td>“The AFHS programme taught me how to speak, to address my struggles, reach out,” Alia said. “No matter how grave the crisis seems, by sharing, anything can be resolved given the proper attention.”</td>
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<td>The AFHS programme was founded by the Directorate General of Family Planning and UNICEF with the support of Bangladesh Association for Prevention of Septic Abortion, Bangladesh (BAPSA). Throughout Bangladesh, AFHS functions at scale with support from the country’s Ministry of Health &amp; Family Welfare, with about 1,240 programmes run through health facilities. In Dhaka, UNICEF and BAPSA provide support for six AFHS programmes, though others are supported by non-governmental organizations in Dhaka and throughout Bangladesh.</td>
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<td>AFHS is a wide-reaching programme with multiple focuses. For adolescents aged 10–19, the programme provides information on menstrual and reproductive health and puberty. In addition, it offers psychosocial support and individual and group counselling. The programme also includes recreational and cultural activities and vocational training in fields such as computers and photography.</td>
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<td>In districts throughout Bangladesh, the AFHS programmes usually reach between 2,000 and 3,000 adolescents a month.</td>
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<td>“We assure adolescents, this is a safe space to speak easy,” said Mahamudul Hassan, a counsellor at an AFHS centre in Dhaka. “All your queries will be resolved, maintaining utmost confidentiality.”</td>
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<td>During the COVID-19 pandemic, the AFHS programme was able to adapt to social distancing guidelines by offering sessions on rooftops, in fields, in outdoor courtyards and over phone and video.</td>
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<td>“From prolonged isolation, disruption of social practices with friends and community, adolescents suffered from depression and fatigue,” said Mou Juliet, an AFHS counsellor. “Providing counselling helped them to cope, interact better with their families and motivate them through such grave times.”</td>
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AFHS also reaches out to parents and communities to raise awareness about adolescent sexual and reproductive health and mental health – breaking down silence and misinformation.

“Receiving counselling from the programme, my daughter achieved skills needed to tackle issues which hinder her psychological well-being,” said Minu Alam, whose daughter, Sharmin Akhter Eti, 19, is a peer educator at the AFHS centre in the Azimpur part of Dhaka.

“She even can consult and clear up many confusions and misinformation of mine or many others like me.”

Indeed, peer educators – male and female – play a vital role in the AFHS programmes as they reach out to other adolescents at the centres and interact with members of their families and communities. For 18-year-old Mohammad Shohan, becoming a peer educator has helped him gain the trust of his family members, whom he can help with information, guidance and support.

“The AFHS programme has helped to break through the social taboos that ... we carry around about adolescent development,” Mohammad said. “This generated confidence within me ..., made me confident to talk about these issues.”

Now that Alia has completed her Secondary School Certificate examination, she is also volunteering as a peer educator.

And she has already accomplished a significant goal: She and her 15-year-old sister, Shima, live independently – on their own, together.

* Alia’s family name is being withheld to protect her identity. She was interviewed in Dhaka in April 2021.

**Race**

The effect of racism on the mental health of children and young people is profound, entrenched and widespread. The link can often be explained by the increased stress, stigma and discrimination that children and young people face in their daily lives.

In general, racism exposes children and young people to discrimination, disadvantage, prejudice, stereotyping, microaggressions and social exclusion based on race or ethnicity. Racism devalues, disempowers, and can be a powerful force for denying resources or opportunities. Whether felt directly or indirectly, racism significantly harms children’s mental health and well-being.

Research suggests that racism affects mental health in multiple ways: It interferes with children’s and adolescents’ school performance, harms cognitive functioning, limits access to health care and damages self-esteem. It can lead to symptoms of poor sleep, loneliness, depression, anxiety or distress, and increase rates of substance use or delinquency. Experiences of racism can cause a ripple effect through families and communities, transmitting trauma from caregiver to child, for instance. And racial discrimination may aggravate the stigmatization of mental illness.
Though the amount of exposure to racism may change in the course of a person’s life, during sensitive periods of development, racism may have an even greater influence on a child’s mental health, and younger children appear particularly vulnerable. Over time, chronic stress from persistent racism can increase the risks of future mental health conditions.

Racism can also impact the diagnosis of mental health conditions. For example, in the United States, white children are more likely to receive ADHD diagnoses; however, Black and Hispanic children are more likely to be perceived as having disruptive behavioural disorder, resulting in very different care trajectories.

The bottom line is this: For many children and young people, tackling racism and the roots of discrimination is essential to safeguarding mental health.

Disability
Far from being a homogenous group, children and young people with disabilities have a wide range of intersecting identities based on race, gender identity, language, religion, ethnicity or socioeconomic status, among others.

And far too often, they face discrimination based on these multiple and intersecting identities.

For children and young people with psychosocial disabilities, discrimination can come from multiple spheres of influence. They deal with discrimination from peers and in the world around them. They are also often victims of pervasive practices such as segregation from other children and young people, overmedicalization and institutionalization. Institutions can also present risks of violence and abuse.

Addressing these forms of discrimination demands a human rights model that recognizes the complexity of intersecting forms of discrimination and addresses individual situations on a case-by-case basis, taking into account the best interest of the child and his or her views.

Lesbian, gay, bisexual, transgender, queer/questioning and other (LGBTQ+)
Children and young people of diverse sexual orientation and gender identity confront significant and intersecting forms of discrimination that create barriers to opportunity and expose them to violence.

The result can be greater risk to their mental health.

A 2020 report based on the Millennium Cohort study in the United Kingdom, for example, showed that LGBTQ+ 14-year-olds were five times more likely to have depressive symptoms and experience self-harm compared to their heterosexual peers. Bullying, victimization, physical inactivity, food restriction, poor body image and substance use were also more common. In addition, these 14-year-olds expressed lower life satisfaction and self-esteem and said they were less connected with caregivers.

The risks are not just in the United Kingdom. A meta-analysis of mental health for LGBTQ+ young people showed elevated rates of suicide attempts, anxiety and depression. The instances of depression, in particular, were linked to bullying, family rejection, hate crimes, internalized oppression, stress of concealing and managing one’s stigmatized identity, and maladaptive coping. In addition, LGBTQ+ young people, especially males, are
also at greater risk of school-based victimization, which can impact academics, health and development. Young people who identify as non-binary can experience worse mental health outcomes, less social support and be at greater risk of abuse and victimization.

**Indigenous groups**

Indigenous groups around the world also face discrimination-based risks to mental health. In New Zealand, for example, suicide and depression have been linked to experiences of racial discrimination among Maori young people. In Australia, aboriginal children who experienced racism in school showed increased risk for emotional and behavioural conditions. In Sweden, a survey of Sami indigenous children revealed decreasing senses of well-being with age.

More generally, a 2018 systematic review of studies from 30 countries and territories found that many indigenous adult populations have elevated rates of suicide, compared to the non-indigenous populations. In Taiwan and Alaska, some indigenous groups had suicide rates up to seven times that of the non-indigenous populations, while the highest disparities were seen in Brazil and Canada, where rates were 20 times higher among indigenous groups compared with the non-indigenous populations.

**Response**

Addressing mental health conditions that arise from intersecting forms of discrimination most often starts with understanding the complexity of the issues and responding in a way that helps dismantle the discrimination.

For example, addressing gender norms can be a source of engagement and empowerment for adolescents and young people, and a powerful tool for promoting mental health. A 2019 review of efforts to decrease gender inequalities indicated a link between the programmes and improvements in health among children and young people up to age 24. The study linked 10 of the programmes with the potential to change gender norms. These 10 programmes shared four factors: collaboration across sectors; collaboration with multiple kinds of stakeholders; diversified implementation; and a focus on social participation and empowerment.

Mental health challenges can also be addressed by increasing a young person’s sense of belonging to and appreciation of a minority group. For example, studies show that indigenous people in Canada can build resilience based on revitalizing a connection to traditional language, culture and stories, and engaging in activism for indigenous issues.

For children and young people with psychosocial disabilities, efforts that target self-esteem and self-stigma have also helped address discrimination. With these efforts, caregivers’ optimism and faith in a child’s abilities have also served as a protective measure against self-stigma.

Mental health-care systems also have to be aware of the intersectionality of discrimination and the effect it can have on individuals. Recent guidelines for providing anti-racist mental health care, for example, call on practitioners to: raise their own awareness about discrimination, microaggressions, racial profiling and their potential impact on mental health; make culturally complex assessments of an individual’s needs; prescribe medication only as a last resort; and establish an individualized, culturally appropriate approach to treatment that addresses issues related to racism.
Humanitarian crises

In 2021, nearly 235 million people around the globe needed humanitarian assistance in response to crises such as war, disaster, displacement and disease. Children were far too often on the front lines – 415 million in 2018, each of them exposed to stress and trauma.

The impact of humanitarian crises on children’s and young people’s mental health involves a complex mix of risks, and the effect of these risks can differ from child to child. For example, some children will have a reaction that affects their mental health and functioning in ways that are normative, despite substantial exposure to violence. Others may experience extreme and lasting distress.

Complex conditions

When children and families are thrust into humanitarian crises, they bring with them histories of care and protection, insecurity and trauma. As a result, focusing on a single traumatic event – war, displacement or disaster – can mask the spectrum of experiences that shape their mental health.

Poverty, for example, is a common experience for children and young people in humanitarian crises. For some, poverty has plagued most of their lives. For others, displacement and crises have plunged their families into new experiences of deprivation.

Crisis can mean that school is disrupted, family members depart, others move in, and children are orphaned or separated from primary caregivers. These changes introduce new stresses and exacerbate existing stresses such as family violence and economic hardship. In settings established to address humanitarian crises such as refugee camps and neighbourhood resettlements, disruptions to routines add up quickly, adding stress and hardship to already difficult circumstances.

Age and phase of development can also alter how a child or young person reacts in times of stress. For example, a systematic review of children from birth to age 6 who were exposed to war identified symptoms of post-traumatic stress disorder (PTSD), depression, sleep problems, disturbed play, and psychosomatic symptoms such as stomachaches. For adolescents, PTSD, depression, aggression, anxiety and sleep conditions were prevalent.

The specific characteristics of a child’s or adolescent’s experience with crisis can have different consequences. Losing a loved one, experiencing injury, witnessing a traumatic event or directly experiencing trauma can each result in different outcomes. In addition, experiences can accumulate, compounding the impact on mental health. The result is a dose effect: the greater the exposure, the greater the risk to mental health. Indeed, chronic exposure to conflict has been associated with higher levels of mental health and psychosocial conditions.

In addition, children with a history of mental health and psychosocial conditions often experience an escalation of symptoms when exposed to crises or fragile contexts. For example, exposure to disasters has been linked to the exacerbation of anxiety disorders and the development of phobias, panic disorder, separation anxiety and generalized anxiety.
The direct effects of conflict can harm children’s and young people’s mental health and well-being. However, conflict also inflicts indirect effects, including the breakdown of services and systems such as health care, education, and water and sanitation. Many of these effects linger for generations with long-term implications for mental health. It is therefore essential to also focus on mental health interventions in efforts to build back better in the aftermath of conflicts or crises.

**Box X. Mental health and migrant children**

For an 18-year-old from Ethiopia, the memories of his migration journey still hurt.

“\textit{I will never forget what I have experienced in my journey,}” he said. “\textit{Words are inadequate to explain how much I was sad and lonely.}”

Globally, nearly 41 million migrants are younger than age 20. They migrate for multiple reasons: Some migrate to seek opportunities, others want to reunite with family members and others are escaping violence and persecution. Regardless of their reasons for leaving home, many find that the experience profoundly impacts their mental health and well-being.

In the Horn of Africa, where the 18-year-old was interviewed in 2019, most children and young people who migrate stay within the region. Their experiences are complex, consisting of positive and negative impacts on their well-being, as illustrated in \textit{Reimagining Migration Responses: Learning from children and young people who move in the Horn of Africa}, published in 2021 by the UNICEF Office of Research – Innocenti.

The report was based on surveys of migrant children and young people aged 14–24 in internally displaced person camps, refugee camps, and border and urban areas. It highlighted that, for many migrant children and young people, the experience can cause serious stress, anxiety and trauma at critical moments of child development.

In addition to the challenges of the journey, migrant children and young people reported regular exposure to extreme stressors in both their communities of origin and destinations, including persistent legal and material disadvantages and social and financial exclusion.

The migrant children and young people interviewed in the study reported strong feelings of anxiety, isolation, and fear of exploitation and abuse. They described dissolution of community and family support networks during transit, disruptions to their education, persistent feelings of limited autonomy and a lack of viable future career options. They also experienced stigmatization, marginalization and neglect – factors that not only prompted their initial decisions to leave home, but also persisted as barriers to integration in the host communities where they settled.

However, the narratives of children and young people also show their resilience, ability to adapt to uncertainty and sense of purpose as they pursue aspirations for a better future through migration.

**Case study: Mexico**

\textbf{Making Sense of Sadness: Protecting the mental health of unaccompanied migrant children}
When she arrived at the shelter, María’s first feelings were of sadness.* The shelter was not her desired destination. And the route that brought her there was lined with sorrows.

In November 2020, Hurricane Eta ripped through her native Honduras, killing her parents. Now an orphan, María, 16, decided to leave home in search of family in the United States.

María’s hopes came to a halt when she was detained by immigration officials near the border of Guatemala and Mexico. From there she was transferred to Albergue Temporal para Niñas y Adolescentes Migrantes Separados o No Acompañados, a temporary shelter for unaccompanied migrant girls.

The 29-bed shelter in Tapachula is funded by the Government of Mexico, operated with support from UNICEF and managed by the local municipality. It offers the basics of food, safety and a bed, and provides psychosocial support as shelter officials assess whether it is possible to unite the girls with family members. During their stay, which officially can last up to 45 days, the girls are required to remain in the shelter.

“Research has shown that children experience stress when they are limited to one space, when they are locked up,” said Adriana Arce, the UNICEF Field Office Manager in Tapachula. “They have also experienced stress in transit when migrating from one country to another. These situations generate stress and anxiety and may pose challenges to their mental health.”

In addition to the challenges on their routes, many of the girls who arrive at the shelter have fled dangers at home, said Montserrat García Lozano, Director of the shelter. Some had experienced abuse, gang violence and human trafficking. Like María, some of the girls had migrated on their own, forced from home by natural disasters and the effects of climate change. Far too many arrive at the shelter carrying experiences that, without the support of a caring adult, can lead to toxic stress – a significant risk to their development and mental health.

UNICEF provides support to Albergue Temporal para Niñas y Adolescentes Migrantes Separados o No Acompañados to strengthen its programme that provides holistic care and child-centred attention. Resilience building and life skills development, as well as implementation of psychosocial activities through recreation and sports, are part of the intervention.

“Their rights, resilience, self-esteem and the power to lead their lives travel with them,” said Ana Cecilia Carvajal, who monitors psychosocial support carried out by UNICEF partners in the field. “We want to provide them with support and to remind them of their worth and to help them think positively.”

The temporary shelter consists of two floors with a small outdoor eating area and a garden. The dorm rooms and a classroom are on the top floor. The first floor houses staff offices and a room for babies. In March 2021, when María was there, 18 other girls and four babies lived in the shelter. Sitting in the classroom, with sunshine pouring through the windows, María told her story and shared her experience at Albergue Temporal para Niñas y Adolescentes Migrantes Separados o No Acompañado. When she speaks, she is confident and looks directly into the eyes of adults and peers.
During her stay, María has made it a priority to attend the classes and has learned how to manage her stress and regulate her emotions, she said. She has gained an appreciation of her rights. Though she has struggled with sadness, her faith also helps her to remain hopeful and focused on her future, she said.

“Sometimes you can learn a lot even if you don’t know why God brought you to a place,” she said.

* María is a pseudonym used for her protection. She was interviewed in March 2021 at the Albergue Temporal para Niñas y Adolescentes Migrantes Separados o No Acompañados.

The COVID-19 pandemic and mental health

Children may have been largely spared the worst physical effects of COVID-19, but it has still upended their lives, and created real concern for their mental health and well-being.

Globally, at least one in seven children have been directly affected by lockdowns. More than 1.6 billion children have suffered some loss of education, with at least 463 million unable to access remote learning. In July 2021 – more than 18 months into the crisis – UNICEF estimated that two out of five children in Eastern and Southern Africa were out of school because of the pandemic. For children, the closures have translated into a loss of the comforting routine of school, sports, recreation and friends and opportunities for social and emotional development.

“You don’t realize it but staying at home locked in, it’s really not the same when you study,” said a girl in Switzerland who participated in the focus group discussions organized by JHU for 15- to-19-year-olds. “Even if you tell yourself that you will study, well the social part has a huge impact on us, and I find that changes our mood a lot.”

Her experience was echoed by a boy in the United States who said: “I don’t feel like I’m benefiting from this [on-line schooling] at all. It’s just a struggle even wanting to do work.”

While many children and adolescents have been able to rely on families to make up some of the loss in education and learning, school closures have put a great deal of extra pressure on caregivers, in turn affecting their mental health and well-being.

The pandemic has dealt an additional blow to children who rely on support for specific mental health challenges. According to WHO, mental health services for children and adolescents were disrupted in more than two thirds of 130 countries surveyed, while school mental health services were disrupted in almost four out of five countries.

And then there are the longer-term impacts. After years of progress, the pandemic triggered a sharp uptick in the number of children who live in monetary poverty. According to forecasts by UNICEF and Save the Children, the number of children living below their country’s national poverty line is estimated to have risen by up to 142 million in 2020, meaning nearly two out of five children worldwide are poor.
Economic uncertainty and loss of learning is likely to lead to a rise in early marriage, with up to 10 million more girls forecast to be at risk of becoming child brides over the next decade. Malnutrition has worsened, too, with warnings that an additional 9.3 million children may be suffering from wasting by the end of 2022. And at least 1.5 million children are estimated to have lost parents or live-in grandparents, leaving them at higher risk of abuse and institutionalization.

In addition, the pandemic has raised particular mental health concerns for some vulnerable groups in countries with a history of conflict and forced displacement.

In Colombia, for example, a longitudinal study reported that, early in the pandemic, there was a significant decline in maternal mental health among internally displaced people, reflecting increases in anxiety, depression and parenting stress. In six conflict-affected countries, interviews by World Vision and War Child Holland indicated that 57 per cent of children felt a need for MHPSS because of the pandemic and lockdowns. This figure reached 70 per cent among refugee and displaced children.

**Mental health concerns**

It will take many years for these risks to play themselves out in terms of the mental health of children, adolescents and caregivers. Assessing the scale of the impact will be very challenging.

This is true even when it comes to the shorter-term question of how the pandemic has directly affected mental health. This question has generated an enormous amount of speculation, media coverage and academic studies. But, as this report repeatedly points out, data collection on, and routine monitoring of, child and adolescent mental health falls far short of what is needed. As a result, it is difficult to compare children’s and young people’s mental health before the pandemic with their mental health after the pandemic started. Studies have also tended to rely on self-reporting by children or their parents, not diagnostic assessments by qualified professionals.

These difficulties need to be acknowledged upfront.

Bearing this in mind, what do studies say about the pandemic’s impact on children’s and adolescent’s mental health? UNICEF’s Office of Research – Innocenti carried out a rapid review of papers, most of which came from a few countries, particularly China, Italy and the United States, and were focused mainly on adolescents. The report, *Life in Lockdown: Child and adolescent mental health and well-being in the time of COVID-19*, is expected to be published in 2021.

Overall, the review indicates that the pandemic did fuel some increases in depression, although in most studies these symptoms were only mild to moderate. There were increases, too, in irritation and anger among children as well as anxiety. For example, in a study early in 2020, more than a third of Chinese adolescents reported symptoms of anxiety well above what would be expected in this age group.

These feelings of anxiety and depression where echoed in the focus group discussions.

“When I think about everyone that has died because of the disease, it makes me sad and when I learn the number of cases is increasing, it makes me stressed,” said a boy in the discussion for adolescents.
aged 10–14 in the Democratic Republic of the Congo. In Egypt, a girl in the same age group said, “It made us have fear for all our family and friends. I am not only afraid for myself but also [for] all those that surround me.”

Not all children were affected equally.

Children and adolescents who faced the greatest mental health risks came from disadvantaged families, had pre-existing mental health conditions or a history of ACEs. There was also a difference in response between boys and girls; girls were at greater risk of depressive symptoms, anxiety and behaviour issues, and boys were at greater risk of substance abuse.98

In Malawi, a boy in the JHU focus group discussions for adolescents aged 16–19 said that “young people have gone wild drinking beer because of frequent changes in opening dates for schools.” A girl in the group for younger adolescents said that “a lot of people got pregnant and … a lot of people have dropped out of school.”

Less noticed, but worth noting, is that the pandemic may have improved life satisfaction for some children and families by relieving them of school pressure or allowing them to spend more time together. A study in China, for example, indicated that about a fifth of students reported being more satisfied with life during the school closures.99 In Italy, about half of parents reported positive changes in their relationship with their children.100

Indeed, family – including positive parenting, and being able to talk to parents and other family members – was a key protective factor for many children, providing much-needed support and bolstering resilience. Other factors included physical activity, feeling connected to friends, maintaining daily routines, and – for some young people – civic engagement (see Box X. The COVID Effect).101

Finding resilience

In addition to the Life in Lockdown report, a number of other studies have surveyed research from around the world. One of the most widely reported is a meta-study in JAMA Pediatrics, released in August 2021, that pulled together results from 29 studies worldwide, covering around 80,000 children and adolescents under 18.102 According to the study, rates of clinically significant generalized depression and anxiety doubled over the course of the pandemic, with one in four youth experiencing depression and one in five anxiety. The meta-study notes higher rates of anxiety and depression among girls and young women, and higher rates of depression (but not anxiety) among older children. Among other factors, this latter finding may reflect the impact of social isolation on an age group that relies heavily on socializing with peers.

Other studies have focused on the mental health of the general population but have provided some insights relevant to child, adolescent and caregiver mental health. For example, a forthcoming review of high-quality studies from The Lancet’s COVID-19 Commission Mental Health Task Force. This study raises important concerns around caregiver mental health, noting that young women – including those aged between 18–24 and young mothers with children under 5 – appear to have suffered the greatest declines in mental health.
Generally, however, the study sounds a relatively optimistic note, concluding that, overall psychological distress increased in the early months of the pandemic but had mostly returned to pre-pandemic levels by mid-2020. “We were surprised by how well many people weathered the pandemic’s psychological challenges,” the study authors wrote. “People are more resilient than they themselves realize.”

**BOX. The COVID effect?**

Studies so far indicate that the main areas in which the pandemic has affected the mental health of children and adolescents are:

**Stress and anxiety:** Both have increased, reflecting fear of infection, uncertainty over lockdowns and school closures, and the challenge of adjusting to the new normal. There was no strong evidence of increases in post-traumatic stress disorders (PTSD).

**Depression and suicidal behaviour:** There were moderate increases in depressive symptoms and sadness, especially among older adolescents. Evidence so far does not indicate a rise in suicide rates.

**Behaviour problems:** Lockdown fuelled an increase in anger, negativity, irritability and inattention, particularly among children with attention deficit/hyperactivity disorder (ADHD) and autism. Parents also reported that younger children became clingy and adolescents experienced more conduct problems and disruptive behaviours.

**Alcohol and substance use:** Limited studies indicate that adolescents, especially boys and young men, drank more and abused other substances as a coping mechanism to deal with the pandemic and other mental health issues.

**Lifestyle changes:** Lockdowns and school closures meant less exercise, more screen time and disrupted sleep – all of which are associated to some extent with lower quality of life and increased psychological distress.

**Positive mental health:** There is evidence that some children enjoyed improved life satisfaction during pandemic lockdowns because they were able to spend more quality time with family members and enjoyed a break from school and exams.


**Photo Essay: China**

**Locked Down: Keeping busy in difficult times**

In February 2020, as part of the effort to control the spread of the COVID-19 virus, China’s schools asked adolescents to stay home.

There was no going to school, no social events, nothing. The start of the spring semester was postponed. For Xiaoyu, who was in Grade 11 at the time of the shutdown, postponing school did not sound all bad – at first.
“When I first learned the news about the postponing of spring semester, I was happy about the extended holiday,” Xiaoyu said at the time. “But now I just want to go back to school.”

Xiaoyu kept herself busy by taking online review classes, participating in Q&As with teachers, playing online games with friends and keeping up with the news on the pandemic. She also spent time texting her friends.

“I miss my friends,” she said. “We sometimes talk about the outbreak and when school will start. Staying at home for such a long time is so boring."

Efforts were made to keep adolescents engaged and active, despite the lockdown. For example, tips on coping with stress and anxiety during the pandemic were created by UNICEF and the China Communist Youth League, which has about 81 million members. The tips were distributed on official digital channels. A video outreach was launched to encourage exercise during the lockdown, an effort supported by social media partners and UNICEF.

For some adolescents in China, boredom was not the only problem. A national online survey in February 2020, supported by UNICEF, indicated that 26 per cent of respondents reported feeling worried about the virus and its effect on their education, families and communities. In addition, about a third of respondents reported feeling scared or anxious. About 21 per cent said they were afraid of dying and 22 per cent reported feelings of loneliness.

In May 2020, as China was opening up again, a follow-up survey showed a reduction in the number of adolescents who reported feelings of fear and anxiety. However, 11 per cent of respondents said they needed mental health counselling services. As the pandemic continues in China – and around the world – this call for services can be a reminder of the importance of protecting adolescents’ mental health in difficult times.

Photo captions:

Xiaoyu takes online classes while her mother works remotely in the background. (photo 4)

During a break from classes, Xiaoyu plays a video game with a friend. (photo 5)

Exercise was encouraged and Xiaoyu responds by doing situps at home. (photo 6)

At the very least, lockdown is boring, despite Xiaoyu’s efforts to make staying home productive. For other adolescents, lockdown created feelings of fear and anxiety. (photo 8)
Case study: Philippines

Young Heroes: Building a better world, one click at a time

Daniel Delfin used to think that only superheroes could change the world. A shy and serious 21-year-old engineering student in Cebu, Daniel saw himself as a spectator of life and spent all his time studying, socializing and looking after his pet rabbit.

“I don’t believe in youth engagement and participation,” he used to say.

Then the COVID-19 pandemic disrupted his comfortable routine.

Forced to stay home by a community quarantine mandate, Daniel turned to social media, only to find himself disgusted by most of the content. He was bothered by the deluge of angry posts from his friends calling out the Government, using bad names and hurling expletives.

Late one night, when he could no longer stand the negativity, he decided to deactivate his social media account. But before he could hit deactivate, a call for volunteers for the Young House Heroes Initiative (YHHI) caught his attention. The first thought that came to his mind was, “Am I doing good service to my country?” Before he could answer his own question, Daniel signed up as a volunteer.

“It was my first time to join this kind of volunteer programme,” he said.

Led by the Council for the Welfare of Children, UNICEF Philippines and the Positive Youth Development Network, YHHI has provided a place for young people to express concerns during the COVID-19 pandemic. YHHI tackles critical COVID-19-related issues affecting them, including lack of participation and engagement, and mental health issues. The programme also provides sexual and reproductive health information for adolescents, and addresses child protection. At the heart of the programme is a youth-led wellness chatline.

Daniel is one of 241 young volunteers – dubbed as heroes – whom YHII trained to conduct mental health assessment calls and provide referrals to service providers. As a volunteer, Daniel reaches out to strangers to ask them how they are coping during the pandemic. He offers them emotional support by listening to their stories and engaging with them. Since he started with YHHI, Daniel has provided support to 55 young people. But as much as he has touched their lives, they have also given Daniel hope for the future.

“I was very afraid at first, but I’ve learned to love the project because I have an opportunity to help my fellow youth,” he said. “I gained confidence after passing difficult exams and assessments.”

For his hard work, dedication, compassion and warm personality, Daniel was recognized as one of the best YHII volunteers. He has even signed up to do more: He has since become a YHHI facilitator and creates social media content as an advocate for the programme.
Daniel continues to encourage young people to take action, do what they love, pursue their dreams and help their communities.

“YHHI encouraged me to be a better version of myself, even beyond my own expectations,” Daniel said.

“Now, I believe that the youth can contribute to building a better Philippines if we act now,” he added. “I believe that as young people, we can help each other and our communities get through this crisis.”

**Special Section: Digital technologies and mental health**

The COVID-19 pandemic brought home, as never before, the ways in which digital technologies are now intertwined in many children’s lives. For many families around the world, smartphones, tablets and laptops provided children and young people with a vital connection to school, friends and family during the long weeks of lockdown, as well as much-needed distraction and entertainment.

For many other families, the absence of digital access was never more acutely felt. As schools closed around the world, more than 90 per cent of education ministries implemented remote learning. But lack of access to televisions and digital tools meant that one in three schoolchildren were unable to access this learning.

Overwhelmingly, these children came from the poorest families. There is also evidence of a gender divide when it comes to digital skills, with girls in some countries behind boys in their information communication technology (ICT) skills.

The pandemic has underlined the positive role that digital technologies can play in children’s lives – and the high price paid in terms of lost educational and economic opportunity by the estimated 2.2 billion children and young people under the age of 25 with limited or no internet access. Despite this positive aspect of technology, many parents, teachers, and even children and young people themselves remain concerned over the impact of digital technologies on young minds.

How justified are these concerns? Two key issues, social media and screen time, can help illustrate some of the broader themes in this research.

While social media is often popularly portrayed as a key cause of anxiety and depression among children and young people, the research paints a much more nuanced picture. Overall, there is now a substantial body of research indicating only a very small association – which may be either positive or negative – between social media use and mental health, including depression, anxiety and well-being. The small size of the associations has made it difficult to separate cause from effect – in other words, does social media make young people depressed or are depressed young people more likely to use social media? In addition, some young people who are lonely and isolated or feeling depressed and anxious may turn to social media and the online world to find friends and support or communities that help meet their needs.

With screen time, there is only limited evidence of a strong association with poor mental health outcomes. For example, a major review of reviews in the United Kingdom found ‘moderately strong evidence’ for an
association between higher rates of screen time (including television watching) with ‘higher depressive symptoms’, but only weak or no evidence for anxiety and behaviour problems.\textsuperscript{110}

For many researchers, however, in an age when digital technologies have become so integrated into so many young peoples’ lives – in how they communicate, learn, socialize, play and, in some cases, earn – focusing narrowly on screen time is a distraction from much bigger questions. It is becoming increasingly hard to disentangle offline experiences from those online.\textsuperscript{111} As more of the world becomes digitally connected in the years to come, this phenomenon is likely only to grow. Against that backdrop, we need to think about digital technologies in the much broader contexts of the child’s overall life and situation.

With screen time, for example, it is more useful for parents to consider what children are doing in front of screens – rather than how long they are spending in front of them – and to think about how screen time fits into children’s overall time use. According to Sonia Livingstone of the London School of Economics, “what matters is not so much how many hours children spend with screens but whether that takes too much time away from sleeping, playing, talking and being physically active.”\textsuperscript{112}

As \textit{The State of the World’s Children 2017: Children in a digital world} noted, it is also essential to consider the overall contexts of the child’s life: As children’s offline and online worlds are now inextricably connected, vulnerability in one typically equates to vulnerability in the other.\textsuperscript{113} Or, as journalist Nathanial Popper neatly summed up in \textit{The New York Times}: “The phone is just a mirror that reveals the problems a child would have even without the other.”\textsuperscript{114}

\textbf{What young people say}

Adolescents have plenty to say about digital technology and mental health. In the focus group discussions directed by JHU, participants described how digital technology was both helpful and harmful to well-being.

As a boy in the discussion group for 15- to 19-year-olds in Switzerland said: “I look at it as an instrument, like a knife; it depends on what you do with it.”

Interestingly, there were large geographical differences in the amount of discussion focused on digital technology: In low-income settings, the topic was much less likely to arise than in middle- and high-income settings.

Among the many participants who did discuss digital technology, a common concern was impact of social media on self-esteem. Many described constantly comparing themselves to the ‘perfect’ images posted online. Another theme was an inability to control the amount of time they spent on social media or online gaming. Several adolescents also discussed their sometimes crippling need for validation online.

Many adolescents in the discussion groups also talked about cyber-violence and the damaging impact of receiving hurtful comments online. As a girl in the discussion group for adolescents aged 15–19 in China said: “There are very few people who encourage you ... For keyboard warriors who speak without thinking, only one word may hurt others.”
At the same time, focus group participants also described the way digital technology helped their mental health. Adolescents around the world said that access to the internet could facilitate exposure to new ideas and different types of friends – to help them leave their ‘bubble’.

Many adolescents also said that sharing their feelings anonymously was a powerful coping strategy, especially in places where stigma is strong. Girls were more likely to use this coping strategy compared with boys, who were more likely to manage distress with online gaming.

As a girl in the discussion for 15- to 19-year-olds in Jordan said about sharing feelings online: “When you don’t trust anyone, you find someone.”

**Digital technology in mental health**

Digital technology is also becoming an important part of mental health and psychosocial support services. It can be: a way to educate and disseminate information; an aid in screening and diagnosing; a conduit to treatment and care; and a tool for training and supervising mental health-care workers. Digital technology may also be useful for tracking human trends in behaviour, which can help accurately formulate interventions. In addition, it has the potential to bolster the global mental health-care workforce and help equitably provide mental health services in places where they are currently scarce.

Digital interventions are used for mental health and psychosocial support responses in multiple formats, including websites, games, apps, robotics, virtual reality and mobile messaging. A systematic review of digital interventions indicated that young people are likely to respond when the service is convenient, self-paced and anonymous, and when it has minimal text and offers opportunities to connect with peers.

Among the promising digital interventions in use is EMPOWER, a digital training platform led by Harvard’s Global Mental Health Lab. The goal of the programme is to build a global mental health workforce and bridge the divide between the need and the lack of high-quality, evidence-based services in many parts of the world.

EMPOWER uses digital technology to train and provide real-time guidance for community health workers, including nurses, social workers and midwives. It also uses digital platforms to remotely track the effects of mental health-care interventions.

EMPOWER was piloted in India in conjunction with an established mental health-care organization, and in 2021, efforts were underway to launch the programme in the United States. EMPOWER is also developing content on parenting, a key approach to building the foundation of mental health in children and young people.

In addition to capacity-building, digital technology is also being used to provide treatment. For example, computerized cognitive behavioural therapy (c-CBT) can be moderately effective for treating depression and anxiety in young people aged 10–24, particularly when coupled with in-person components to encourage adherence.

One innovative approach to c-CBT is Smart, Positive, Active, Realistic X-factor thoughts (SPARX), a computer game developed in New Zealand for young people. The goal of the game is to restore balance to a world consumed by gloomy, negative and automatic thoughts. In it, players follow an avatar through a fantasy world...
of tasks that incorporate c-CBT skills, including relaxation, emotion regulation and mental restructuring of thoughts and assumptions. A 2017 study that tested a version of the programme and was held before final secondary school exams indicated that SPARX reduced depression symptoms short term. However, 18 months after the study, there was no sustained effect. SPARX is funded by the New Zealand Ministry of Health and the game is available for free throughout New Zealand.

In 2020, SPARX was included as part of a study aimed at determining if smartphone apps were an effective way to address students’ depression.

**Box X. Climate change and mental health**

Young people have come to the forefront in calling for urgent action on climate change. In the words of young Swedish activist Greta Thunberg – who describes her own Asperger’s Syndrome as a superpower – “We deserve a safe future. And we demand a safe future. Is that really too much to ask?”

Climate change and, more broadly, environmental degradation, will profoundly impact young people’s futures. But there is also concern about whether their mental health and emotional well-being will also be affected.

At one level, the concern about the role of climate change on mental health is related to evidence that young people feel distress over the prospect of living in a world of rising temperatures and climate unpredictability. But threats to mental health and well-being also stem from the consequences of climate change, including extreme weather events such as floods and heatwaves, rising food insecurity, water insecurity and conflicts. In essence, these dangers expose young people to significantly stressful experiences and, indirectly, harm their physical health and community well-being.

There are other links between environmental conditions and mental health. For example, growing evidence indicates that air pollution harms children’s developing brains, and that exposure during childhood and adolescence to pollutants such as nitrogen oxides – often found in urban streets – are linked to mental disorders in late adolescence.

Concrete urban living may result in other costs to mental health too, since access to green spaces is known to benefit children’s mental health and to reduce stress, especially for children from low-income families.

**Resilience**

Since at least World War II, researchers have examined the ways calamity impacts the human ability to adapt and recover. They have asked: Why is it that one child might successfully navigate terrible hardship while another continues to struggle? What makes a child or young person resilient in the face of adversity?

Recently, the response to this question has evolved dramatically, with significant implications for how we protect and promote children’s and young people’s mental health.

Where once researchers – and mental health practitioners – focused on individual characteristics, they now see a complex combination of systems that come together to foster a child’s or young person’s resilience.
Theories about the process vary and methods to foster resilience remain under construction. However, evidence shows that resilience is fundamental to mental health; it is not the goal, but the means to foster mental health.\textsuperscript{130}

**Definition**

In the past, research on resilience focused on individual resilience, implying a personal responsibility for overcoming adversity.\textsuperscript{131} The definition of resilience favoured individualism and the ability to bounce back.

In recent years, a new wave of research seeks to understand resilience as a process that results from the intersection of multiple and complex systems that can change depending on context.\textsuperscript{132} Some of these systems are found in the world of the child and are related to biological functions such as children’s neurobiological stress-regulation, immune systems or family relationships;\textsuperscript{133} others are part of the world around the child, including their schools and community resources; and others are part of the world at large – the world of social, political and economic determinants.\textsuperscript{134}

Ultimately though, resilience definitions have shifted from a focus on individual characteristics to an approach that examines the effect of culture, context and resources.

In a cross-cultural study of resilience published in 2007, Michael Ungar and colleagues interviewed 89 young people at 14 sites in 11 countries. The analysis of the interviews showed that mental health outcomes associated with resilience depended on individual, relational, community, cultural and contextual factors. The authors concluded that resilience requires the ability to navigate seven tensions:\textsuperscript{135}

1. Access to material resources: finances, education, health care, employment, and the basics of food, clothing and shelter
2. Relationships: healthy interactions with peers, family members and adults in the community
3. Identity: a personal and collective sense of purpose; self-appraisal of strengths and weaknesses; aspirations; beliefs, including religious beliefs, and values
4. Power and control: experience of caring for the self and others and the ability to effect change in one’s social and physical environment
5. Cultural adherence: adhering to local, global or cultural practices, values and beliefs
6. Social justice: finding a meaningful role in community and social equality
7. Cohesion: balancing personal interests with a sense of responsibility to the greater good

The data showed that, though the tensions were global, individuals navigated them differently in different contexts and cultures.\textsuperscript{136} No single way was more effective than another.

In a 2008 study, Ungar argued that resilience occurs amid significant exposure to adversity and is:

“The capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided and experienced in culturally meaningful ways.”\textsuperscript{137}
Protective and promotive factors

An updated understanding of resilience requires an updated understanding of what protects children and young people against risks to mental health. It requires a multidimensional understanding of the promotive and protective factors and processes that build resilience.¹³⁸

Evidence has shown that multiple factors combine to bolster resilience and mental health.¹³⁹ For example, a review of studies with indigenous young people in Alaska, Canada, Greenland and Norway found that a mixture of involvement in social and community activities – especially those that cultivated a connection to culture – fostered mental health.¹⁴⁰ These activities led to greater self-esteem and self-confidence, which were also protective influences on mental health.

Even for children whose lives are infused with multiple adversities and trauma, these factors can be a force for resilience. A study of street children in Haiti, for example, showed that despite significant adversity, the children were able to develop strategies for resilience.¹⁴¹ These strategies involved figuring out how to access the little social support available to them from non-governmental organizations and other institutions, perhaps bolstering their sense of agency and hope. In addition, they built a social network of other street children, which offered a community and an identity on which to build resilience.

In Pakistan, a study of young people in the Kalasha community – a religious, ethnic and linguistic minority – highlighted the importance of cultural practices as a source of resilience in the face of pressures, including social changes in the community.¹⁴²

Cultivating resilience

Unfortunately, the research makes clear that there is no magic formula for cultivating resilience – no one-size-fits-all intervention. Resilience is built over time and throughout the life course. However, some themes point to key elements for action. They include:

The importance of supporting the needs and well-being of parents and caregivers

Though multiple efforts exist to promote good parenting, it is also essential to support parents and their needs and well-being.¹⁴³ Or, as resilience expert Suniya S. Luthar says: “If we want a child to function well, tend to the person who’s tending to the child.”¹⁴⁴

Support schools as protective, inclusive environments for child learning and development

Schools are foundations for children. When they are safe, stimulating and nurturing, they serve as essential learning environments and opportunities to build resilience in children and young people. As with parents, if we want schools to serve an important psychosocial function, it is essential to also tend to the educators who tend to the child.

Adopt a multisystem, multidisciplinary approach to equitably providing services that bolster resilience

Fostering resilience in children and young people requires interventions that provide learning, recreation, employment and social opportunities that address social marginalization, racial discrimination and poverty – that minimize risks and maximize protective factors in everyday environments.

Understand and tailor interventions to multiple diverse contexts
Understanding of the pathways that lead to resilience in LMICs lags in comparison to what is known about high-income countries. Interventions and impact evaluations in these settings are essential to recognizing the unique qualities required in diverse cultural settings with specific values and concepts of mental health, needs and resources.

Special Section: The face of ill-treatment

A girl is chained by her family and fed medications by force; a boy flees an orphanage only to be forced to return, tied to a bed frame without a mattress and injected with drugs; a young man is handcuffed in a juvenile court and made to feel “like a chained dog.”

These are just a few of the many faces of the ill-treatment inflicted on children and young people. Data on the extent of ill-treatment are scarce, but evidence indicates it is widespread. It exists in criminal justice systems, mental health services, health-care institutions, private homes, religious organizations and orphanages, among other settings. In countries rich and poor, children and young people are deprived of their human rights and subjected to detention and treatment that, in many cases, can undermine their mental health or aggravating an existing condition.

Mental distress in such settings may be interpreted as a reflection of underlying mental health issues, although it can often be a response to ill-treatment itself. For example, children in institutions may be unable to form the necessary connections or secure attachments with caregivers, and this neglect can lead to behaviours like headbanging, which can result in the use of restraints. In juvenile detention facilities, seclusion and restraint can retraumatize already vulnerable children and young people. This trauma may, in turn, be misattributed to mental ill health. In any setting, restraints can exacerbate psychological harm and place the child at an increased risk for suicide, self-harm, mental illness and developmental delays.

Institutional care

Institutions are often loosely defined, but many are characterized by separation from a parent or caregiver, structural neglect, and the absence of a nurturing and stimulating environment. These institutions are of particular concern for mental health. Estimates vary widely, but it is likely that at least 2.7 million – and perhaps as many as 5.4 million – children live in various forms of institutional care. There is evidence from around the world that a high proportion of them have disabilities, including developmental or mental health disabilities.

There are multiple reports of abuse of children in institutions.

In Serbia, a United Nations Special Rapporteur reported a “lack of oversight and enforceable regulations on the use of physical restraints.” In a Ukrainian orphanage, Disability Rights International, a non-governmental organization (NGO), interviewed one boy who said: “After I escaped and they brought me back, they undressed me, put me on a mattress-less steel bed, tied me to the bed and gave me shots of psychotropic drugs.” In Guatemala, the NGO reported that in one private institution, “all children with disabilities were tied to chairs, regardless of their disability or degree of mobility.” In another, four adolescents lay on mats with their hands restrained behind them.
There is a similarly worrying picture when children and young people are deprived of liberty, whether their liberty is deprived because of immigration status, as part of criminal justice procedures, or because of health or family situations. Deprivation of liberty can also produce or compound mental health conditions.

Focusing on institutions tells only part of the story. There is also extensive evidence of ill-treatment in homes, prayer camps and religious institutions. In Indonesia, for example, about 14 per cent of people with serious mental health conditions are estimated to have been shackled. Often, people are left without adequate shelter, food, water, or regard for their personal hygiene or safety.

In countries with very few options for care for children with the greatest mental health challenges, families may turn to a range of faith-based institutions, often reflecting local beliefs, stigmas and superstitions. Again, ill-treatment is not uncommon. In prayer camps in Ghana, former United Nations Special Rapporteur on Torture, Juan Méndez, saw children and adults with mental or neurological disabilities shackled to floors, walls or trees, and forced to fast for extended periods, reportedly to deter escape or aggressive behaviour.

The roots of such ill-treatment are complex. They reflect the powerful impact of stigma and the harsh reality that most families in most countries cannot access mental health services.

**Mental health services**

But even in countries with established mental health services, there are real reasons for concern over the treatment of children and young people. There is extensive evidence of the continued use of coercion and restraint in mental health services. Such services may take an overly medicalized approach to mental health conditions, relying on top-down treatment and failing to respect the role of the individual in their own recovery. Far too often they perpetuate stereotypes of people with mental ill health as dangerous. But, as human rights advocates Dainius Pūras and Julia Hannah have noted, “people with psychosocial disabilities are much more likely to be victims of violence than perpetrators.”

**What can be done**

Globally, treating children and young people with mental health conditions demands a profound cultural change. Children and young people with mental health conditions must not only be treated as patients, but as individuals with rights – individuals who, in accordance with their evolving capacities, can play an active role in their care through direct or supported decision-making. Mental health legislation based on the rights of individuals with mental health conditions is essential. In addition, communication, advocacy and collaboration is required with community leaders, including faith healers.

Unfortunately, to date, few countries have established frameworks to meet these goals and the goals set out by the Convention on the Rights of Persons with Disabilities.

**Change is possible**
In many countries, progress is underway to address the discrimination and violation of basic rights that occur far too often in mental health settings. Good practices exist around the globe in community mental health centres, crisis response services, hospitals and other settings.

For example, Centros de Atenção Psicossocial (CAPS) in the Brasilândia region of São Paulo offers community-based mental health centres that act as a substitute for psychiatric hospitals. Some of the CAPS facilities are tailored to the needs of children and adolescents and provide continuous community-based mental health care and support, including crisis intervention. The CAPS approach is based on the principles of freedom first and deinstitutionalization.

Unfortunately, success has not always endured. And providing community-based interventions requires a significant shift in attitude and practice. In parts of the world with few resources, these changes will be challenging.
Chapter 5: What is being done

The good news is that evidence-based efforts are underway to promote and protect mental health and care for children and young people most in need. And there are nascent initiatives aimed at collecting data and research to make this work increasingly effective and efficient. The bad news is that much, much more needs to be done.

In countries around the world, children and young people face risks to their mental health. For some, these risks are in the world of the child and the world around the child—in homes, relationships, schools and communities. For others, the greatest risks come from the world at large, from social determinants such as poverty, conflict and disaster.

Though much more is needed, critical efforts are underway to make a difference in the mental health of children and young people. Some successful efforts focus on risks that arise in the world of the child by supporting parents and caregivers as they provide foundations of support for children and adolescents. Other efforts stem from the world around the child and include school-based interventions.

However, the world at large also imprints on the mental health of children and young people. Addressing these issues requires significant changes in social sectors—it requires tackling issues such as poverty, discrimination, exclusion and conflict.

Global and national initiatives

In the past decade, global mental health advocates have come together to promote initiatives that raise awareness and address children’s and young people’s mental health. Some of these initiatives have been forged by researchers and specialists; others have been led by international organizations. Still others have been led by communities, families and young people.

Global initiatives

WHO has made significant contributions in the past decades, including with the WHO Comprehensive Mental Health Action Plan (MHAP). Established in 2013, the MHAP features four objectives—with targets and indicators—that can guide countries: effective leadership and governance; comprehensive and integrated provision of services in communities; implementation strategies for promotion and prevention; and strengthened information systems, evidence and research. In 2019, the MHAP was extended to 2030, to align with the timeline for the Sustainable Development Goals.

In addition, WHO has also issued guidance on interventions for the prevention and management of priority mental health, neurological and substance use disorders such as depression, suicide and behavioural disorders. The Mental Health Gap Action Programme (mhGAP) aims to increase the financial and workforce resources dedicated to mental health and provide guidance on interventions that can reach more people. It presents interventions that can be adapted to national and local situations, especially in LMICs.

WHO has also focused on tackling critical social determinants of mental health and addressing human rights injustices associated with mental health services. In 2021, WHO issued a series of guidance materials for
23.09.2021

countries on providing people-centred, community-based mental health services that address human rights issues and critical social determinants of mental health such as violence, discrimination, poverty and exclusion.⁵

Adolescent mental health has also been a focus for global action.

In 2016, WHO published the *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation* to provide national governments with an approach to dealing specifically with adolescent health risks, including mental health risks.⁶ And in 2020, WHO produced the first guidance of Helping Adolescents Thrive (HAT), an initiative aimed at providing programmatic materials to support adolescent mental health.⁷ In 2021, UNICEF and WHO added an Adolescents Thrive Toolkit, which offers guidance on addressing mental health in the health, social services, education and justice sectors.⁸ A comic book was also launched for teachers working with adolescents aged 10–14.⁹

Outside the health sector, work is also underway to address risks to mental health. For example, the Nurturing Care for Early Childhood Development Framework (*see Chapter 2*) was pioneered by UNICEF, WHO and the World Bank Group to address early developmental challenges.¹⁰ It has also played a guiding role in promoting mental health initiatives for parents, caregivers and children. In addition, UNICEF has provided parenting guidance aimed at parents of adolescents and initiatives that support caregivers.

**National initiatives**

Despite many promising global efforts, national responses to children’s and young people’s mental health challenges remain uneven and inequitable. In wealthy countries, children and young people are more likely to receive interventions to treat mental health conditions than in poor countries, where the largest populations of children and young people live. Even in countries where policies and programmes are in place, implementation can be haphazard; and programmes, where available, remain inequitable, small in scope, ineffectually implemented and not based in evidence. Significant gaps exist not only in policies and programmes, but also in the data and research required to form comprehensive and effective responses.

A review for UNICEF of data from the WHO Mental Health in Development (MIND) project – an online database of country and international resources – showed that most countries do not have specific child and adolescent mental health policies. At best, they have generic guidelines. From the information provided in the database, it is also difficult to tell what treatment, prevention and promotion programmes have been effectively implemented and are successfully responding to the needs of children and young people.

According to the 2020 WHO *Mental Health Atlas*, 68 per cent of WHO Member States reported having at least two functioning national, multisectoral mental health promotion and prevention programmes.¹¹ Of the 420 prevention and promotion programmes reported by 148 countries, 18 per cent focused on mental health awareness or stigma reduction, 17 per cent were school-based and 15 per cent addressed suicide. The other categories included early childhood development, parental/maternal mental health, work-related mental health and mental health and psychosocial support as part of disaster preparedness and disaster risk reduction.

There were also wide gaps in data collection. Only 31 per cent of Member States compiled public sector data on mental health and only 40 per cent compiled mental health data as part of general health statistics.
The 2020 Mental Health Atlas did not focus specifically on children and adolescents, but where it did, the overall picture was bleak. The atlas found that only 53 per cent of 90 countries that responded to WHO’s questions had a plan or strategy on child or adolescent mental health. In the countries that responded, the median number of child and adolescent inpatient facilities was less than 0.5 per 100,000 and there were fewer than two outpatient facilities per 100,000 population. In addition, the number of psychiatrists with a speciality in treating children and adolescents was fewer than 0.1 per 100,000 in all but high-income countries, where the figure was 5.5 per 100,000.

Investment

Wide gaps also exist between mental health needs and mental health funding.

Though recent data collection has been hampered by limited response in many low income countries, WHO indicates that, in some of the world’s poorest countries, governments spend less than US$1 a person on treating mental health. In upper middle-income countries, expenditure is around US$3 a person.

According to the 2020 Mental Health Atlas, median government expenditure on mental health globally was 2.1 per cent of the median government expenditure on health in general – a figure based on data from 2018. Though few low- and lower-middle income countries responded to data collection requests, the variation was vast. In low-income countries, median government spending on mental health per capita was US$0.08; in lower middle-income countries it was US$0.37; in upper middle-income countries, it was US$3.29; and in high-income countries, US$52.73.

The 2020 atlas indicated that, especially in poor countries, individuals and families often bear the financial burden of mental health care. In 85 per cent of countries globally, individuals are fully insured or pay at least 20 per cent of the cost of mental health services. However, the out-of-pocket costs were larger in Africa, where 41 per cent of individuals pay mostly or entirely out of pocket for mental health services. In contrast, in Europe, where nearly all individuals (98 per cent) were insured for all of the costs, the out of pocket costs were up to 20 per cent.

More than 70 per cent of public expenditure on mental health went to mental hospitals in lower- and upper-middle income countries compared with less than 40 per cent in high-income countries.

International development assistance for mental health is also scarce. From 2006 to 2016, the amount was far less than 1 per cent of development assistance for health in general. Development assistance for children and adolescents in developing countries is even more meagre. Indeed, a 2018 study found that, between 2007 and 2015, US$190.3 million in development assistance was devoted to child and adolescent mental health – about 0.1 per cent of the assistance to health in general. Though the percentages fluctuated over the time period, assistance dedicated to the mental health of children and adolescents made up 10 per cent of all assistance for mental health in 2007, but rose to 14 per cent in 2015. In addition, most international development assistance focused on reaching children and adolescents in humanitarian settings.
Box X. Barriers

As the review for UNICEF shows, international conventions, development agendas and a range of interventions have fallen far short of establishing a comprehensive global approach to promoting and protecting mental health and caring for children and young people with mental health conditions. In part, significant barriers have impeded progress. Five of the most prominent and destructive barriers are:

**Stigma:** One of the most prevalent barriers to promoting and protecting mental health and treating ill health is the stigma associated with it. Stigma, and the discrimination that accompanies it, prevents children, young people and caregivers from seeking treatment and participating fully in their families, schools and communities. It blocks them from living life to the fullest. Whether intentional or not, stigma fosters misconceptions about mental health and hinders research, funding and commitment to addressing the mental health needs of children and young people. It limits efforts to fully understand the emotional and psychosocial worlds of children and adolescents. In some cases, stigma can lead to gross violations of the rights of children and young people with psychosocial disabilities.

**Lack of coordination between sectors:** A focus on mental health conditions that seeks remedy in a single sector presents significant barriers. Coordination between multiple sectors such as health, education, early childhood development, child protection and social protection is required to address the complex needs that occur across the mental health continuum and throughout the life course.

**Inadequate financial resources:** Only a tiny fraction of government and international development spending is available to address mental health needs. This needs to change. In the course of a lifetime, most children and young people will fall at some point on the mental health continuum, requiring promotion and protection services. Some will need treatment for mental health conditions.

**Inadequate human resources:** For the most part, the human resources dedicated to mental health are inadequate. When human resources are available, they are largely focused on treatment of mental health conditions. Mental health promotion and protection are ignored. More specialists in mental health are essential, but so too is the need to increase general knowledge about mental health across multiple professional fields to provide critical promotion and protection services.

**Human rights violations:** Children and young people who use mental health services are far too often subjected to discrimination, prejudice, abuse, social exclusion and segregation. In some cases, children are unlawfully or arbitrarily institutionalized, overmedicated and denied autonomy, will and preferences. Overcoming the attitudes and practices that marginalize mental health and people with psychosocial disabilities is essential to developing the kinds of mental health services called for by the Human Rights Council – community-based, people-centred services that do not lead to overmedicalization and inappropriate treatment.

**Making a difference**

Despite significant gaps, evidence-based programmes and policies have been implemented and tested to promote and protect mental health and care for the most vulnerable children and young people. Many of these efforts are integrated into established parenting, education, social protection, health-care and humanitarian responses. And many can reach across traditional boundaries to involve multiple sectors.
Parenting shapes the world of the child throughout the first two decades of life, providing a source of healthy attachment and acting as a buffer against the kinds of trauma that can lead to toxic stress. However, for many caregivers, fulfilling this critical role requires support from parenting programmes.

In line with the recommendations from the Nurturing Care Framework, many parenting programmes guide caregivers on how to provide complete nutrition, interact responsively with a child and engage in interactive stimulation and learning activities at home. Increasingly, programmes have begun focusing on providing caregivers the support they need to care for children and adolescents (see Box X: Care for the Caregiver).

Evaluations of parenting programmes indicate that they help deepen attachments between caregiver and child, reduce harsh parenting practices and improve children’s cognitive development. For example, one analysis found that 88 per cent of interventions in LMICs led to positive outcomes, including improvements in parenting behaviours, family functioning, and children’s and young people’s mental health. In addition, parenting programmes have also effectively engaged lay workers and trained professionals from complementary fields, a critical component of scaling up these programmes in low-income settings.

Parenting for Lifelong Health

Though many of the most evidence-based parenting programmes come from high-income countries, there are notable efforts underway in LMICs. Parenting for Lifelong Health (PLH), for example, offers a package of evidence-based, cost-effective and home-based parenting programmes that rely on local lay workers.

PLH was officially launched in 2013 by partners including WHO and UNICEF. It features four packages of age-appropriate interactions grounded in evidence about child development issues such as attachment, cognitive development, behaviour management, social learning and problem solving.

The effectiveness of PLH has been tested in four age groups, with successful outcomes in attention, socioemotional development and caregiver sensitivity. The interventions have also led to reductions in conduct problems and harsh parenting. Some have also reduced instances of mental health conditions for caregivers.

For adolescents, the interventions have not improved mental health outcomes specifically, but have reduced family violence, depression in caregivers and use of alcohol and drugs. They have also led to improvements in family finances.

PLH was started in South Africa, but plans are underway to reach more than 500,000 families by the end of 2022. More than 25 LMICs are involved in sub-Saharan Africa, Eastern Europe, South and Southeast Asia and the Caribbean.

Care for Child Development

As a landmark early childhood development intervention, Care for Child Development (CCD) has led the way for other evidence-based parenting programmes. CCD started in the 1990s to promote early learning and responsive caregiving, pillars of the Nurturing Care Framework.
In general, CCD interventions are embedded in education, health and social protection services and delivered at home or in community clinics, mostly by trained community health workers. CCD interventions have encouraged caregivers to use household items or homemade toys to stimulate children’s motor, social, cognitive and language skills, effectively using play to strengthen parenting skills.

The programme has been adapted and implemented in at least 23 countries. Evaluations have pointed to improvements in parenting practices and interactions between caregivers and children. CCD has also increased children’s cognitive, language and motor development. In Pakistan, a randomized trial showed that, up to four years after the intervention, children in the CCD programme had higher cognitive, language, motor and socioemotional skills than the other children tested.

**Education**

As children grow, their environment expands to the world around them. As this occurs, schools, teachers and peers become central sources of learning and socializing; they influence emotional, behavioural and moral development.

Schools can – and often are – healthy and inclusive environments where children learn critical skills that bolster their well-being and prepare them for the future. But schools are also places where children experience bullying, racism, discrimination, peer pressure and stress about academic performance. As a result, learning environments are critical platforms where cost-effective and culturally acceptable interventions can encourage inclusion and promote and protect mental health. In addition, school interventions can reach children and young people most in need of care, those who might otherwise not have access to mental health services.

In recent decades, SEL frameworks have formed the backbone of many school initiatives, offering an effective approach to mental health promotion and protection. Systemic approaches to SEL involve interventions that respond to the developmental and cultural needs of children, young people, families and communities. When well executed, these universal SEL initiatives can equip children and young people with essential cognitive, behavioural and emotional competencies that help them succeed academically, manage life’s challenges and maintain positive interactions with others.

Evaluations of SEL programmes have shown positive academic, social and behavioural outcomes. SEL approaches that include whole-school interventions and specific interventions for at-risk children and young people have proven particularly effective. For example, a whole-school approach might include initiatives such as girls’ clubs, green spaces or gender-sexuality alliances that are combined with specific interventions to address mental health risks such as smoking, bullying and adolescent pregnancy. However, research has shown that, regardless of approach, success requires quality implementation and resources and support from teachers, families, schools and communities.

**SEHER**

Strengthening Evidence Base on school-based intErventions for pRomoting adolescent health (SEHER) in Bihar, India is an example of a whole-school, multicomponent mental health promotion programme that has operated on a large scale and has been tested. It features activities for all students while also offering individualized
counselling for students in need. It operates in conjunction with a life-skills training programme integrated into classrooms.\textsuperscript{41}

Evaluations showed that the programme succeeded by creating a positive school atmosphere that featured strong, nurturing relationships between teachers and students and fostered a sense of belonging among students.\textsuperscript{42} The result was lower rates of depression, bullying and violence. Interestingly, SEHER improved students’ attitudes towards gender equity, depression, bullying and violence when the intervention was delivered by a counsellor. In contrast, when the intervention was delivered by teachers, there was little effect.\textsuperscript{43}

**Positive Action**

Like SEHER, Positive Action is also considered a model of a whole-school mental health intervention based on robust research.\textsuperscript{44} The initiative has been in operation since 1977 and implemented in more than 16,000 schools, predominantly in the United States. It has been proven to be effective and cost-effective.\textsuperscript{45}

Grounded in positive psychology, Positive Action encourages children and adolescents to develop positive thoughts that lead to positive behaviours and result in feelings of self-worth. The interventions are tailored to distinct age groups of children starting at age 5 and continuing until age 18.\textsuperscript{46}

Evaluations of Positive Action programmes have shown improvements in students’ behaviour and academic success.\textsuperscript{47} For example, a study of 1,170 students aged 8–14 in 14 low-income schools in Chicago demonstrated small but significant reductions in disruptive behaviours, violence, bullying, depression and anxiety over a six-year period. The study also indicated that students had a greater sense of satisfaction with life, that their academic achievement improved, and substance use decreased.\textsuperscript{48} Studies also showed that the more access students had to Positive Action, the better the results.\textsuperscript{49}

**Social protection**

The influence of the world at large on mental health demands interventions that tackle some of the social determinants that affect the lives of children and young people. Though they do not necessarily target mental health, social protection interventions have provided critical pathways to addressing the risk factors associated with poverty.\textsuperscript{50}

In general, social protection interventions aim to prevent child poverty, protect children from its effects and promote economic opportunities that can counteract the power imbalances that sustain poverty and vulnerability.\textsuperscript{51} Often these interventions are integrated into health and education sectors and include methods such as cash transfers, tax credits, social insurance, social services and job support.

Cash transfer programmes, in particular, can indirectly influence children’s and adolescent’s mental health by increasing school participation, food security and access to health care and social services. Cash transfers have also led to a reduction in common mental health risks such as poor physical health and intimate partner violence.\textsuperscript{52} In younger children, cash transfers have also positively impacted cognitive and behavioural development.\textsuperscript{53}

Direct influences are also possible. For example, recent research showed that conditional cash transfer programmes reduced suicide by 18 per cent in Indonesia and 3.4–7.9 per cent in Brazil.\textsuperscript{54} The effect was
particularly strong among women. In Malawi, unconditional cash transfers were associated with a 15 per cent reduction in depressive symptoms in young people aged 15–22, results that were also more pronounced for females.\textsuperscript{55}

**Ujana Salama**
Increasingly, social protection programmes are being delivered in tandem with social services.\textsuperscript{56} In the United Republic of Tanzania, for example, Ujana Salama (Safe Youth) combined a cash transfer programme for adolescents aged 14–19 with in-person training, mentoring, grants and health services. Evaluation of the programme indicated that it led to a reduction in depressive symptoms.\textsuperscript{57} After a year, male and female adolescents exhibited more positive mental health and self-esteem and demonstrated greater knowledge about sexual and reproductive health and HIV. Studies of the programme also indicated decreases in sexual violence and increases in school attendance among girls.

**Bridges and Bridges Plus**
In Uganda, economic interventions that also featured financial life-skills training led to improvements in physical and mental health, financial stability and food security for young adolescents who had been orphaned by HIV/AIDS.\textsuperscript{58}

The programmes, Bridges and Bridges Plus, provided savings incentives to be used for learning, financial literacy workshops and peer mentoring. The programmes were provided to adolescents in grades 5 or 6 and lasted for about two years.

A study of 1,383 adolescents in the programmes indicated that Bridges and Bridges Plus improved self-rated mental health. Immediately after the intervention, the programmes reduced depressive symptoms and hopelessness. Adolescents in the Bridges Plus programme – which had a higher level of savings incentives – seemed to maintain lower levels of hopelessness longer.

**Case study: Spain**
**Journey to Mental Health: A culturally sensitive approach to mental health care for migrant young people**

As Dr. Francisco Collazos sees it, the migrants and unaccompanied migrant children and young people he works with as a psychiatrist are much more than a diagnosis. And much more than a psychiatric response is required to promote and protect their mental health.

“Our commitment obliges us to seek alternatives that are equitable, culturally competent and adjusted to the particular needs of each population group we serve,” said Collazos, a psychiatrist and founder of the Transcultural Mental Health Programme for Unaccompanied Migrant Children and Young Migrants at Hospital Vall d’Hebron in Barcelona. “This commitment to cultural competence is what governs us.”

Cultural competence is the guiding principle for the Transcultural Mental Health Programme, which reaches out to children and young people, some of whom are in Spain’s child protection system and others who live on the streets. For many, their circumstances and life experiences are complicated and difficult.
According to Dr. Collazos, many of them faced challenges even before they began their migration journeys, including marginalization in the country of origin and violence at home, such as physical violence, abuse and neglect. Far too many also faced violence and hardship during transit.

Once they arrive at a destination, many experience anxiety and frustration over their status as migrants in Spain. Some also struggle under the pressure of family expectations and the difficulty of finding work and sending remittances to their country of origin. Some struggle with substance abuse.

In addition, migrant children and young people often have to deal with social exclusion and the challenge of navigating a new language and culture.

Founded in 2001 at the Hospital Vall d’Hebron, the Transcultural Mental Health Programme embraces this complex interplay of risks to migrant children’s and young people’s mental health in order to respond effectively. The programme engages professionals from non-governmental organizations (NGOs) and trains community mental health agents and mental health professionals using a specially designed course on culturally aware assessment and multidisciplinary assistance.

Take the current partnership with Superacciò, an NGO that reaches out to young migrants who live on the streets in Barcelona. In particular, its Spaai project offers a multidisciplinary approach to addressing the challenges of refugee and migrant children with interventions that include education, sports, social integration and mental health support. At the core of the mental health interventions is a recognition that a young person’s cultural background is an integral part of their mental health.

With the support of the Spanish National Committee for UNICEF and local and regional authorities, the Transcultural Mental Health Programme of the Hospital Vall d’Hebron is expected to expand and become integrated into the child protection system in Catalonia.

“Culture is considered a risk factor and a protective factor,” said Abdallah Denial Kandil, a community health agent who works with Collazos on the Transcultural Mental Health Programme. “Before this programme, there was just interpretation services. The transcultural approach is much more than that; it is an integrative model of working with fantastic results.”

For Collazos, the success of the programme can be seen in many of the young people he has worked with over the years. In particular, he recalls a young Moroccan immigrant who had struggled with substance abuse, homelessness and had run-ins with the police and immigration authorities before finding his way to Superacciò.

The young man remains active with Superacciò as a volunteer, even as he tries to find work and handle the demands of his mother in Morocco who needs financial assistance from him.

Collazos has also encountered surprises: “Children and young migrants accept me despite the stigma associated with mental health and psychiatrists,” he said. “I feel I become a fundamental piece in their balance.”
Primary health-care systems

Access to mental health promotion, prevention and care remains out of reach for far too many children and young people. Shortages of services and mental health professionals mean that children and young people miss out on the support they need. Sometimes, when services do exist, the low quality and stigmas associated with mental health care keep them away.69

Increasing access to mental health services requires meeting children and young people where they are, such as in homes and schools. Primary health-care providers, especially in community-based settings, also can offer a critical platform to promote and protect mental health and provide care for children and young people at risk.

The important role of primary health in mental health was recognized in the WHO MHAP, which recommends the integration of mental health care and treatment into primary health care as a way to shift away from attitudes that associate mental health with specialized and medical approaches.60 Other efforts include the PRogramme for Improving Mental health care (PRIME) and the National Institute of Mental Health’s Scale-Up Hubs.61 Both efforts focus on examining the community context, engaging specially trained community health workers and establishing services that meet particular community needs. Unfortunately, too often efforts to integrate mental health in primary care settings do not focus on the specific needs of children and young people.

Thinking Healthy Programme

The Thinking Health Programme has been reaching out to mothers to address perinatal depression in Pakistan since 2007.62

The programme integrates mental health into a primary health platform. It was initially delivered by an established corps of community-based primary health-care workers called Lady Health Workers, but it now involves trained community members.63

The programme is based in cognitive behavioural therapy (CBT) and includes four-weekly sessions for women in their final month of pregnancy, three sessions in the month after birth and monthly sessions for the next nine months.64

Early evaluations of the Thinking Healthy Programme showed that it decreased incidence of depression by half. In addition, mothers in the programme reported more engaged stimulation with their child and greater subsequent use of contraception. The babies in the study were less likely to have episodes of diarrhoea and more likely to have received immunizations.65 A follow-up study seven years later showed a 17 per cent reduction in depression among the mothers in the programme. Mothers also showed greater time and financial investments in their children.66

Based on its success, the Thinking Healthy Programme was incorporated into Pakistan’s National Programme for Non-Communicable Diseases and Mental Health, included in the country’s universal health care package and featured in the President’s Plan to Promote Mental Health of Pakistanis. In addition, the programme was included in the WHO’s Mental Health Gap Action Programme (mhGAP) intervention guide and has been implemented in other countries such as Bangladesh, Bolivia, India, Nigeria, Peru67 and Viet Nam.68 Pilots are underway in China and in a mobile application in Kenya.69
Headspace
One of the longer-running initiatives for young people is headspace, a system of primary health-care centres for young people aged 12 to 25 in Australia.70

Headspace integrates mental health into interventions that also provide vocational support and address physical and sexual health and alcohol and drug use.71 The intervention also offers online, phone and text messaging services. In addition, headspace reaches out to primary and secondary schools with tools to help teachers and parents support students with mental health conditions. Some of the centres offer specialized mental health services that care for young people with complex conditions, including psychosis.

Participation by adolescents and young people is a critical component of headspace, and they take part in decisions about their own care and serve as advisors to the development, strategy and operational planning of headspace. In addition, headspace reaches out to communities historically less likely to seek mental health services such as young people from Aboriginal and Torres Strait Islander and LBGTQ+ communities.

Since headspace was first started by Australia’s National Youth Mental Health Foundation, it has grown from 10 centres to a national network of 110 centres. Evaluations have highlighted positive mental health outcomes for adolescents and young people. However, challenges include long waiting lists for services and staffing shortages.72 Funding modalities can also mean that some of the services aimed at providing holistic responses suffer.

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Case study: Sri Lanka
Befriending: A community-based response to mental health in the aftermath of conflict

When Sugarna Kanagratnam arrived in Tellipalai on her scooter, the children in the small town in Northern Sri Lanka greeted her with hugs.

They trusted her and enjoyed the art, drama and storytelling she brought into their lives – activities aimed at helping them open up and address their fears and anxieties.

“This is a place with a troubled history, but I’ve been happy working with children here,” said Kanagratnam, a mental health counsellor.

Kanagratnam works with Shanthiham, a mental health and psychosocial support (MHPSS) organization focused on post-conflict areas in the Northern and Eastern parts of Sri Lanka. Over 10 years ago, for nearly three decades, the area was the epicentre of an armed conflict that inflicted death, injury and protracted displacement in camps on children and families.

In the aftermath, families and children have struggled to start a new way of life. For some, the past displacement, return and resettlement have taken a toll on family and community structures, leaving children and young people at risk for violence and neglect.
On top of these struggles, families that were once displaced face stigma associated with being ‘camp people’ as they try to build new homes and lives.

Kanagratnam’s work in Tellipalai was part of Shanthiham’s community-based MHPSS initiative in the Jaffna region in Northern Sri Lanka that was active from 2017 to 2019.

As part of the initiative, Kanagratnam and other counsellors assessed MHPSS needs in towns and villages, communicated with local leaders about the importance of mental health, established referral mechanisms and provided community outreach programmes on topics that included parenting and youth leadership. To date, the programme has served over 8,000 beneficiaries and handled 180 counselling cases. In addition, the organization helped establish Child Well-being Core Groups of community members who used their local connections to identify children and adolescents in need of MHPSS services.

Central to all these activities was the ‘befrienders’ – volunteers aged 19–26 who identified psychosocial needs and issues in their neighbourhoods and provided support. The volunteers were nominated by local leaders and received training and field experience. Once ready, the volunteers:

- Assisted people who needed counselling support by arranging group meetings to discuss critical issues.
- Used their involvement in the community to identify individuals and families in need of MHPSS and refer them to professional service providers.
- Reached out to children and young people who were out of school or at risk of dropping out and encouraged them to continue their education.

This community-based approach to MHPSS allowed counsellors, befrienders and members of the Child Well-Being Core Groups to earn the community’s trust. By involving community members, a town or village was able to increase access to services and raise concerns to local authorities.

The befrienders, in particular, created a strong sense of ownership within communities, which allowed the programme to evolve with the needs and context of each distinct village. They also helped break through the social stigma associated with seeking psychosocial support.

After the conclusion of the programme, the befrienders have remained trusted and influential resources in their communities. Overall, the MHPSS programme has continued to serve as a bridge between the aftermath of conflict and a brighter future.

As member of a Child Well-Being Core Group, Baheerathi Jegatheeswaran – a former head of Palai Veemankaamam village – said she plans to continue the efforts underway to improve the mental health and well-being of members of her community.

“I learned the usefulness of having a core group in a village and understood how it helped the community,” she said. “I will take this experience wherever I go and try to set up more core groups.”
Humanitarian settings

As a result of the many complex factors that arise in humanitarian crises, effective responses require a nuanced understanding of context and a multi-layered reaction. Researchers are increasingly able to establish evidence-based approaches and evaluate their efficacy, despite the complexity of crisis situations. Research-based, effective interventions include focused psychosocial support in humanitarian settings, family- and community-based programmes, and education- or training-centred models.

In addition, these responses also look beyond the immediate crisis to foster children’s and young people’s lifelong mental health and build systems that can continue to address needs.

Focused interventions: Advancing Adolescents

When carefully implemented, brief, structured interventions that provide immediate responses to depression, anxiety and PTSD have been able to bolster children’s and young people’s mental health. One example is Advancing Adolescents, which was part of a humanitarian response to the conflict in the Middle East region led by UNICEF, Mercy Corps, Save the Children and World Vision. It was launched in 2014 and was part of the No Lost Generation effort in the region.

In Jordan, Advancing Adolescents has offered structured group activities for adolescents aged 12–18 from Syrian refugee and Jordanian host communities. The group activities were based on a psychosocial care approach that emphasized social interaction and encouraged participation. The activities were run by trained adult facilitators and included fitness, arts and skills-training classes.

Evaluations of the programme included self-reporting on mental health conditions and biological measurements of cortisol concentrations, a physical marker of stress. The results showed that the programme successfully relieved stress, insecurity and distress, particularly for the adolescents who had experienced the most trauma.

Activities to bolster adolescent mental health continue in Jordan with support from UNICEF. Using a psychosocial care approach that emphasizes social interactions, activities have helped adolescents gain transferrable skills such as the ability to work in teams, make decisions, and cope and respond resiliently in times of stress.

Social and community support: Youth Readiness Intervention

Other interventions have focused on support for reintegration in the aftermath of crisis. For a group of former child soldiers in Sierra Leone, for example, the effects of the trauma continued even 15 years after the end of hostilities. And nearly half of the former child soldiers in a long-term study still experienced anxiety and depression above a threshold that could interfere with their full capacity to function in the world. About 28 per cent of the group experienced PTSD at a level that exceeded this threshold.

The former child soldiers who fared the best benefited from strong family and community connection. They also faced less stigma about having been a child soldier. The young people who had the greatest difficulties had faced the most violent experiences of trauma as child soldiers and had not reintegrated into family or peer groups. These young people were at an increased risk for anxiety, depression, PTSD, attempted suicide and involvement with police.
23.09.2021

Education and training
The long-term study of child soldiers in Sierra Leone indicated that participation in education and training were enduring protective factors for mental health. However, participation in learning opportunities can be difficult as mental health conditions following trauma can complicate interactions with peers, teachers and supervisors. In response to these challenges, researchers involved in the Sierra Leone study developed an evidence-based intervention to address mental health conditions that impede life success and functioning. The programme, Youth Readiness Intervention, integrated elements of CBT, mindfulness and interpersonal group therapy to improve young people’s interpersonal relationships, emotion regulation and levels of distress. After 10–12 sessions of the intervention, the young people were provided a subsidized learning experience at an alternative school for impoverished young people.

An evaluation of the Youth Readiness Intervention showed that the participants were six times more likely to persevere in school than students not in the intervention. Indeed, the programme boosted educational engagement, attendance and behaviour.

As a next step, the Youth Readiness Intervention will be incorporated into a youth entrepreneurship training programme in Sierra Leone and studied to determine if similar successes will occur. Early results indicate improvements in both anxiety and depression and in labour market returns that, over time, may lead to greater economic self-sufficiency for young people affected by war.

Build back better
Mental health services are a critical part of humanitarian responses. But increasingly, it is also clear that they need to be central to recovery after crisis and disaster risk reduction efforts.

WHO has advocated for efforts to build stronger mental health service systems in the aftermath of emergencies such as conflicts and disasters. Where the response to emergencies includes mental health care for affected populations, opportunity exists to engage in efforts that can continue for years to come. Response to emergencies can also provide a chance to advocate for better mental health resources at a time when local and world leaders are paying attention.

In addition, there is a growing call for mental health services to be integrated into disaster risk reduction efforts and research indicates that much more is needed for effective integration. Linking mental health and disaster risk reduction can mean communities – and humanitarian responses – that are more resilient, better prepared, and better able to respond to mental health needs.

Box X. Preventing suicide
Suicide destroys lives, and the trauma can travel far beyond the victim’s own family to affect friends, schoolmates and communities. These ripples can, in turn, lead to the loss of other young lives: Clusters of suicide and suicidal behaviour are much more common among young people than among adults. In the past, these typically occurred in settings like schools, universities and detention centres. But, increasingly, there is concern that coverage and discussion of suicide on social media may create clusters among victims bound only by their digital connections.
Suicide is often linked to self-harm, when individuals deliberately harm themselves by, for example, taking excessive doses of paracetamol or poison, cutting themselves, or jumping from high buildings. It can often be difficult to determine the meaning behind such acts: Was the young person deliberately seeking to end their own life or trying to temporarily escape an unbearable feeling or situation? Some young people are at greater risk than others. While suicide rates are typically higher for boys and young men (see Chapter 1), among young adolescents, girls are much more likely than boys to self-harm, which is a risk factor for suicide. Similarly, adolescents who identify as LGBTQ+ are a particular risk group: Data from the United States, for example, indicate that the proportion of LGBTQ+ individuals who died by suicide among 12- to 14-year-olds was three times higher than among 25- to 29-year-olds. And a 2016 study of students in the United States showed that lesbian, gay or bisexual 14- to 18-year-olds were almost three times more likely to have seriously contemplated suicide than their straight-identifying peers. Despite rising social acceptance in much of the world, there is evidence that today’s LGBTQ+ young people are more likely to have attempted suicide than LGBTQ+ young people in previous generations.

The higher risk of suicide clustering among the young, coupled with the reality that many suicides are preventable, underlines the importance of suicide prevention. There is no single solution, and the risk can only ever be reduced – not eliminated – but there is clear evidence from around the world that much can be done to save young lives.

An important first step may be the development of a national suicide prevention strategy. As of 2018, 40 countries had such strategies, which typically target actions across a range of sectors, such as health, education, social protection and the law. Approaches can include research and data collection to establish the scale of the problem, better understand risk and protective factors, and identify high-risk groups; restrictions around the means of suicide; guidelines for media reporting of suicide; building social and emotional skills of adolescents; reducing stigma; and providing special training for health workers, teachers, police and others.

Research indicates that such strategies help reduce suicide rates, and that they may be particularly impactful among younger age groups. WHO’s Live Life Implementation Guide, released in June 2021, offers countries strategies, examples and resources for enacting evidence-based programmes to address suicide.

Limiting access to lethal methods is an important step in all suicide prevention, but especially for young people, who may be more likely to act impulsively. There is a common misconception that people who seek to lose their lives to suicide will find a way, no matter what. But this greatly misunderstands the path that a young person may take from thinking about suicide – ideation – to planning and then acting on it. The suicidal crisis that leads to action may be caused by feelings of extreme pain or hopelessness, but such feelings may pass, at least for a time. If a young person can be prevented from killing themselves during such a crisis, there is a strong possibility they will not attempt suicide again.

Social media and traditional media can play an important role for adolescents during these crises – sometimes the role is protective and other times it can be harmful. As a result, providing local resources online and implementing protocols to monitor web content for harmful materials is key. An example of this kind of effort is StigmaWatch, a programme that promotes responsible reporting of mental health and suicide in Australia.
Clearly, there are limits to the extent to which means can be restricted, especially in countries where hanging or jumping from a height are widely used methods of suicide.\textsuperscript{100} Still, much can be done. For example, limiting access to guns helped lower suicide rates in Australia, Canada and New Zealand, while in Sri Lanka restrictions on the sale of highly toxic pesticides were linked to a sharp fall in suicides at around the turn of the century.\textsuperscript{101}

Schools must also be part of the response. Whole-of-school approaches may normalize the idea for students that it is okay to ask for help. There is also a role for training ‘gatekeepers’ – adults and young people with the skills to spot warning signs – such as mood and behavioural changes, hopelessness and withdrawal – and who can provide guidance on how to seek help.\textsuperscript{102} Schools can also play a role in building socioemotional skills such as problem solving and stress management.\textsuperscript{103} The design of the programme matters – for example, in Europe, studies indicate that the Youth Aware of Mental Health (YAM) programme succeeds in lowering rates of suicide ideation and attempts.\textsuperscript{104}

We still know far too little about what drives young people to kill themselves or to self-harm. Research is hampered by many issues, including vague and inconsistent terminology, an absence of widely used and standardized measures,\textsuperscript{105} stigma, and the under-reporting and misclassification of suicide deaths – a particularly acute issue with suicides among young people, where officials and medical figures may try to protect a family that has lost a child to suicide.\textsuperscript{106} Much more work is needed too on identifying children at greatest risk, understanding the particular factors that distinguish young people who just think about suicide from those who attempt it, and the effectiveness of prevention strategies.\textsuperscript{107}

\[GWA\text{\,quote}\]

I have lost friends to mental illness and watched them drown in an inky pit of darkness. I have also seen friends blossom and navigate their way towards the light with professional help and a loving, attentive support system. A mind filled with shame cannot grow and that is why I believe that deconstructing stigma, making mental health support accessible and building structures to support people, in particular vulnerable and marginalized groups, is essential. Queerness in particular should not mean guilt, it should not mean other. We must check up on each other, stand up for each other and banish shame from our vocabulary.

\textit{Arlo Parks} is a BRIT Award and Mercury Award winning singer, songwriter and poet from London. In her world, words are as useful as photographs. Luscious, expressive vignettes pepper the poetic lyrics in her sweet, ruminative indie pop songs. She’s inspired by an eclectic mix of artists from Radiohead to Portishead, and Sufjan Stevens to Solange.
Case study: Kazakhstan

Reaching New Heights: A proactive approach to preventing suicide

At home, Dina* has plenty of interests. The 14-year-old plants trees, cares for the garden and dances to K-pop videos in the living room.

At school, things are more difficult, and interacting with peers, stressful.

“They are not like me,” Dina said. “We do not share the same interests.”

Recently, however, Dina has addressed her feelings of stress and anxiety with the help of Bakhytkul Seitkhanova, an educational psychologist.

“[Seitkhanova] taught me to express my thoughts openly,” Dina said. “I feel now that I should never give up.”

Dina was paired with Seitkhanova in 2020 after an assessment conducted as part of the Adolescent Mental Health Promotion and Suicide Prevention Programme (AMHSP), a pivotal school- and health-care-based adolescent mental health awareness and suicide prevention programme in Kazakhstan.

“She was too private,” said Seitkhanova, who works at Dina’s school. “She had problems in her family. I worked with her once a week for two months. I now continue to work with her twice a month.”

AMHSP was founded in 2015 in response to a grave public health concern in Kazakhstan: suicide among young people. Since then, the programme has delivered significant results.

An evaluation of AMHSP from 2015 to 2017 in Kyzylorda, where Dina lives and attends school, showed a 36.1 per cent decrease in suicidal ideation among young people, 80.6 per cent decrease in anxiety, 56.1 per cent decrease in depression and 65 per cent decrease in stress.

In addition to providing critical help to students, AMHSP has also raised awareness about the importance of mental health for school personnel. For Zhaniya Bissenova, an educational psychologist with 15 years of experience, AMHSP changed how she views her work at the 204 School in Kazaly, a town in the Kyzylorda region.

“I realized that children who need help send signals,” Bissenova said. “I feel more confident as a professional,” she added. “I am not afraid; I act more firmly.”

AMHSP was developed with partners, including UNICEF, as an intervention for school and public health professionals. The goal of the programme is to identify adolescents at risk of mental health conditions such as suicide and provide them with psychosocial support.

In addition, AMHSP also focused on reducing stigma associated with mental health – stigma that can keep young people from seeking help. One of the primary ways the programme addressed stigma was to reach out to parents.
In the region of Kyzylorda, for example, adolescents were only allowed to participate in mental health screenings with parental or caregiver consent. Therefore, AMHSP also focused on helping school and health-care workers reach parents with information. As a result of the programme, the number of parents who refused to give permission for mental health screenings dropped to 5 per cent from 2015 to 2016 and to 1 per cent by 2017. In a sign of strong support from the highest levels of government, the Kazakhstan Prime Minister featured AMHSP in the country’s National Action Plan for 2015–2020, and in 2015, implementation of AMHSP began in the Kyzylorda region with support from partners, including: the country’s National Centre for Mental Health; the ministries of health, education and science, and internal affairs (police); and the regional health and education departments. In 2016, implementation began in the Mangistau region.

Overall, Kazakhstan is on a path to making mental health – especially for children and young people – a primary national concern. The Government of Kazakhstan is embracing AMHSP as a centrepiece of adolescent mental health services and has increased financing for mental health services by 25 per cent.

However, the success of these efforts will ultimately be measured by improvements in the lives of children and young people.

Dina, for one, is on her way.

“No matter the difficulties, you need to go forward,” Dina said. “And by overcoming difficulties, you will reach heights.”

* Dina is a pseudonym being used at her request to protect her identity. She was interviewed in May 2021 while walking through mulberry trees on a main street in Kyzylorda.

**Data and research**

Despite promising approaches, effectively responding to children’s and young people’s mental health challenges requires accurate data and robust research. In most of the world, data are not available; they are not collected, analysed or used to develop effective policies and programmes or to allocate resources. Indeed, a lack of national data and research can hide children’s and young people’s mental health challenges, making it difficult to advocate for services and respond effectively.  

Particularly in LMICs, where 90 per cent of the world’s 1.2 million adolescents live, data and research are scarce. In these countries, available data on adolescents’ mental health cover about 2 per cent of the population. In the countries where data are collected, methods differ and often the data cannot be compared. As a result, most of the data on the prevalence of mental health conditions and associated risk factors, especially in LMICs, are modelled estimates.

Using modelled estimates offers a glimpse into the prevalence and burden of mental health conditions in the lives of children and young people. It allows children’s and young people’s mental health conditions to be counted in places where they might otherwise go unnoticed. However, modelled estimates can only offer a general understanding of the situation. Weaknesses and omissions in modelled data can become magnified when used on a large scale.
Part of the data and research problem is a lack of funding. In 2019, investment in mental health research amounted to about 50 cents per person per year, given a population of 7.7 billion, and stark inequalities mean that only 2.4 per cent of this funding is spent in LMICs. Only 33 per cent of the total spent on mental health research involves adolescents.

**Improvements**

Efforts to improve understanding and evidence-based responses are underway around the world. But there are challenges.

Collecting data requires definitions of mental health conditions that can be applied in different settings and different cultural contexts. Indeed, context can determine how mental health conditions present and how the symptoms are interpreted. In addition, it is essential to capture information on experiences that do not necessarily meet the definitions of diagnosable disorders — experiences that may point to anxiety or depression, for example.

In recent years, however, tackling these challenges and improving collection and management of mental health data has become a major focus of research and development organizations. For example, UNICEF, WHO and other key partners have embarked on Measurement of Mental Health Among Adolescents at the Population Level (MMAP), a robust and methodological approach to collecting and managing mental health data for adolescents in LMICs.

When complete, MMAP will provide a culturally sensitive suite of tools to capture and validate data on symptoms of anxiety, depression, functional impairment, suicidal thoughts and behaviours, and psychosocial support. MMAP also provides a tool for researchers to proactively detect mental health conditions and enable lay community workers to refer adolescents to the support they may need.

Another collaborative effort is the Common Measures in Mental Health Science Governance Board (CMB). Founded in 2019 by the National Institute of Mental Health and the Wellcome Trust, CMB has outlined a core list of research questionnaires aimed at improving data collection and research on mental health. In collaboration with academic and institutional partners such as WHO, UNICEF is using MMAP to adapt and evaluate these common measures for use in LMICs.

Research efforts are also underway to make critical links between mental health and some of the social determinants that put children and young people at risk. For example, CHANCES-6, a project of the Care Policy and Evaluation Centre at the London School of Economics, has engaged in a large-scale research programme investigating the links between poverty, mental health and life chances for young people from economically deprived backgrounds. The programme was underway from 2018 to 2021 in Brazil, Colombia, Liberia, Malawi, Mexico and South Africa. Their methods focused on examining the impact of cash transfer programmes on mental health and the impact of mental health programmes on poverty.

The UNICEF Office of Research – Innocenti has embarked on research efforts that will identify evidence gaps and systematically review and synthesize available evidence on children’s and young people’s mental health in LMICs. The work will also include efforts to clarify critical concepts, definitions and measurement approaches.
for children’s and young people’s mental health as a first step towards developing mental health indicators that can be measured and monitored.
Chapter 6: A framework for action

We may not have all the answers, but we know enough to get to work. To promote and protect mental health for every child and care for children facing the greatest challenges, we need commitment backed by investment; communication that breaks the silence and breaks down stigmas and barriers to change; and action that minimizes risk factors and maximizes protective factors in key areas of children’s and adolescents’ lives, especially the family and school.

This report has set out the mental health challenges facing children and adolescents and their families. It has shown that these challenges are global – from the poorest village to the wealthiest city, children and their families are suffering pain and distress. At an age and stage of life when children and young people should be laying strong foundations for lifelong mental health, they are instead facing challenges and experiences that can only undermine those foundations. The cost for us all is incalculable.

It does not have to be this way. And it should not be this way.

Our priorities are – or should be – clear. We may not have all the answers, but we know enough to be able to act now to promote good mental health for every child, protect vulnerable children, and care for children facing the greatest challenges.

This report sets out a framework to help the international community, governments, schools and other stakeholders do just that, grounded in three core principles: Commitment from leaders, backed by investment; Communication to break down stigmas and open conversations on mental health; and Action to strengthen the capacity of health, education, social protection and other workforces, to better support families, schools and communities, and to greatly improve data and research.

Commitment, communication, and action for mental health

To Commit means strengthening leadership to set the sights of a diverse range of partners and stakeholders on clear goals and ensuring investment in solutions and people across a range of sectors.

Strengthen global leadership and partnerships. Supporting the mental health of children, adolescents and caregivers is a global challenge – and a global opportunity: Laying strong mental health foundations in childhood offers unique possibilities for lifelong returns and the prevention of the onset of mental health conditions. That is why mental health demands a global response. Building on existing efforts, stronger global leadership is needed to align stakeholders around clear goals and set priorities; to develop financing models that can help bridge the investment gap; to develop partnerships to share knowledge and experience – globally, regionally and nationally – on delivering services, building capacity, gathering data and evidence, and providing mental health and psychosocial support (MHPSS) in crisis and emergency settings; and crucially, to monitor and evaluate progress.
Invest in supporting mental health. Mental health is woefully underfunded: Many governments spend only a few cents per capita directly on mental health, and allocations from international development assistance are meagre. Most spending goes into psychiatric services, meaning that almost nothing is spent on mental health prevention or promotion.

In recent years, there has been considerable focus on, as well as support for, setting specific targets for mental health in health budgets – typically at least 5 per cent in low- and middle-income countries (LMICs) and at least 10 per cent in high-income countries.¹ The median government expenditure on treatment is 2.1 per cent.² There has been similar support for an increase in global funding for services to $1 billion by 2023.³ Such additional funding is essential if we are to increase access to quality mental health care.

But investment is needed across sectors, not just in health, to support a strong focus on workforce development in health, education and social protection systems. Clear targets need to be set, and new and innovative sources of funding and investment need to be identified to meet those targets. This is true not just at the national level: Funding by international agencies and donors must target mental health needs, not just through spending on health systems and services but also in areas like education and social protection, where important progress is possible in promoting and protecting mental health.

A guiding principle for all investment – global, regional and national – is that it must be in line with rights-based approaches that take account of the needs of people with lived experiences and comply with international human rights instruments.

To Communicate means tackling stigmas around mental health, opening conversations and improving mental health literacy. It means amplifying the global conversation on mental health to raise awareness and mobilize all stakeholders to take action and facilitate learning. It also means ensuring children, young people and people with lived experience are part of the conversation, that they have a voice and can meaningfully engage in the development of mental health responses.

Break the silence, end stigma. Misconceptions about mental health fuel stigma and discrimination and prevent children and young people from seeking support and participating fully in their families, schools and communities. A simple message: It is not just okay to talk about mental health – it is essential. Governments and other stakeholders, including the media, should work to break down stigmas around mental health and promote a message of inclusiveness: We are all on the mental health continuum, and – so long as adequate support and opportunities are available – living with a mental health condition or psychosocial disability need not be an obstacle to living a happy and healthy life. Tackling stigma also means promoting mental health literacy – supporting children, adolescents and caregivers to better understand how to promote positive mental health, how to recognize signs of distress in themselves and in others, and how to seek help when they most need it.

Ensure young people have a say. Young people are gradually raising their voices and sharing concerns about their mental health and well-being. Continued support is needed to provide all young people, especially those with lived experience of mental health conditions, with the means for active and meaningful engagement. This can be done through, for example, investment in community youth groups, co-creation of peer-to-peer initiatives and training programmes. Ensuring that children and young people have a voice can help mental
health services – as well as mental health promotion and protection efforts – to better reflect the varying and evolving needs and concerns of children, young people and caregivers throughout their lives.

**Box X. Monitoring mental health**

Routine monitoring of mental health and mental health-care provision is seriously lacking in low- and middle-income countries (LMICs) and especially for child and adolescent mental health. As a result, there is a real lack of high-quality information to measure the need for, and provision of, mental health care and services. This is hampering the prioritization of mental health care and the development of policy at all levels. It is also undermining efforts to increase investment and financing for mental health services.

Governments, donors, non-governmental organizations and multilaterals need a consensus-based set of core indicators for routine monitoring of mental health across sectors. But while this need is easy to describe, identifying these indicators is more complicated. For example, what might such a set look like – which indicators are essential to routinely monitor and which are less so? What is the best balance to strike between indicators that are important (i.e., those that really need to be collected over the next 10 years and are likely to shape policy and practice) versus those that are feasible (i.e., those that LMICs could be reasonably expected to begin monitoring over the next 10 years)? And can indicators that meet the need for global monitoring also meet needs as they are perceived at the regional, national and local levels?

Developing such a set of indicators is a challenge that requires extensive consultations and research. An initial step in this process was taken by a team of researchers led by Mark Jordans, Director of Research and Development at War Child, who took into account the views of nearly 50 relevant global experts as part of a rapid prioritization exercise to generate and prioritize a list of possible core indicators (involving two rounds of scoring on predetermined criteria, resulting in mean priority scores for each of the 38 generated indicators).

The top-rated indicators were diverse and multisectoral, reflecting the need to address mental health challenges broadly. Overall, they were clustered around three domains. First, those related to the availability of mental health services, ranging from inpatient beds to prevention, promotion and treatment services in schools and health care. Second, those related to the frequency and pervasiveness of mental health problems, including prevalence rates of disorders, especially suicidality. Third, those related to coverage, such as the degree to which children and adolescents receive services at school, primary health care, or through social welfare and child protection referrals.

Categories for data disaggregation were also prioritized by the experts. The top-ranked categories reflected a mix of priorities between socio-demographic groups (e.g., gender, age, rural/urban residents) and specific groups of children and adolescents who need to be clearly represented in data collection in order to highlight particular vulnerabilities. Most prominently, these included children and adolescents who are detained or incarcerated; refugees and the internally displaced; those living with disabilities; and children and adolescents experiencing homelessness.

This prioritization exercise contributes to developing a framework to help fill the data gap around child and adolescent mental health and across all relevant sectors. A couple of limitations are worth noting: Firstly, it drew heavily on a previous prioritization exercise that was not specifically focused on child and adolescent mental...
health, and secondly, the range of experts who participated in the consultations may not sufficiently represent all sectors involved in child and adolescent mental health care. Nevertheless, it is hoped that the exercise will help inform the work of a range of key partners and stakeholders, including the World Health Organization, UNICEF and many others, as we work together to develop and prioritize relevant indicators in the years to come.

**To Act** means working to minimize the risk factors and maximize the protective factors for mental health in key areas of children’s and adolescents’ lives, especially the family and school. More broadly, it also means investment and workforce development across some key sectors and systems, including mental health services and social protection, and the development of strong data collection and research.

**Support families, parents and caregivers.** The family is fundamental in a child’s life. Parents and caregivers are the first attachment figures, playing a vital role in shaping the home environment and the child’s socioemotional development. Supporting parents and caregivers is essential to building child and adolescent well-being and to reducing and preventing violence against children. Stable relations at home can help protect children against toxic stress and promote resilience and overall well-being.

- **Promote responsive caregiving and nurturing connections.** Parenting programmes need to be scaled up, with a focus on social and emotional learning (SEL) to support families and children to develop positive attachments and to create a positive home environment in which children can thrive. Family-responsive care services must be present at the community level, amplifying access and acceptability. Targeted support must be designed for families and children at particular risk, such as those facing violence and toxic stress in the home.

- **Help parents support their children’s health and well-being.** Mental health and well-being are not about the absence of disorder; they are positive states that enable children to navigate effectively through life. Parents and caregivers need support to engage with their children throughout the child’s and adolescent’s life to foster their social, emotional, physical and cognitive development. Training programmes and counselling should share knowledge on health, nutrition and child development, and stimulate learning within the home. Support for parents should also include family-friendly policies, such as paid parental leave; breastfeeding support; available and accessible high-quality childcare and child benefits.

- **Care for caregivers’ mental health.** Many parents struggle to cope with multiple stressors, which can have serious consequences for their own health and well-being and, in turn, that of their children. Mental health programmes must prioritize caregivers, providing support to manage chronic stress and conflict, and to enhance coping strategies.

- **Give parents training to respond to children’s mental health challenges.** Skills training for parents can improve the developmental, behavioural and familial outcomes for children and adolescents facing mental health challenges. Investments must be made to scale up family-centred approaches, including those designed to be delivered by non-specialists. These approaches can play a vital role in improving communication, engagement, daily living skills and caregiver coping strategies.

**Ensure schools support mental health.** Schools play a unique and vital role in the lives of children and adolescents. Violence and bullying – both by teachers and other students – as well as excessive pressure to succeed can undermine children’s mental health; on the other hand, a warm school environment and positive relationships between students and between students and teachers can bolster it.
• **Invest in a whole-of-school approach to mental health.** A holistic approach means moving beyond focusing only on the curriculum to consider all the ways in which schools affect children’s development and well-being. It should seek to encourage a positive and warm school climate that makes children feel safe and connected, and that empowers them to express opinions, support other students, and seek help when they need it. It should provide regular mental health and psychosocial well-being training for teachers and other personnel and for children, adolescents and families. It should tailor its approach to reflect the constantly evolving needs and capacities of all children and adolescents, and the special needs of children from disadvantaged groups and from different socio-cultural backgrounds.

• **Strengthen teachers’ knowledge and socioemotional competencies.** Teachers are core to ensuring children and adolescents learn and thrive in school. Teachers and other school personnel need support to build their capacity so that they, in turn, can help children and adolescents learn about mental health and develop healthy habits, and so that they can recognize students in need of additional support. For teachers, these skills are imperative not only for their own personal well-being but also to improve student learning. Teaching can be an extremely stressful profession, particularly in low-resource, crisis and conflict-affected contexts. Teachers’ stress not only has negative consequences for the teachers themselves but also results in lower achievements for students and higher costs for education.

• **Prevent suicide.** Schools should be a crucial partner in preventing suicide – a leading cause of death among adolescents. Specialized training for teachers and peers (as well as parents, school counsellors, social and health workers) can help ensure that at-risk children are identified and provided with support. But the task cannot be left to schools alone. National suicide prevention programmes can play an important role in supporting efforts to, for example, restrict access to the means of suicide, encourage responsible media reporting, and identify and remove harmful content on social media.

**Strengthen and equip multiple systems and workforces to meet complex challenges.** The focus for mental health programming and services needs to broaden to take advantage of opportunities to promote, protect and care for mental health not just in health services, but in areas like social protection and community care. But, for this to happen effectively and sustainably, child- and family-focused workforces and relevant systems need to be strengthened both to deliver services across systems and settings, and to ensure that the needs and human rights of every child are upheld.

• **Integrate mental health services into social protection and community care systems.** To reach children and young people without access, services need to be provided not just through health systems but across a wide range of sectors and delivery platforms, including education, social protection and community care.

Children and young people who experience disadvantages and risk because of differing family contexts, violence, neglect and abuse need dedicated attention and programmes that are accessible and tailored to meet their needs. Community-based interventions are particularly positioned to identify and support at-risk children who require specialized care. These interventions include child protection and gender-based violence case-management – services that raise awareness of mental health needs and resources and that promote inclusion and participation of vulnerable children and families within community life.

For women and girls, including those who are survivors of gender-based violence, service providers such as local women’s organizations are a crucial source of psychosocial support. Mental health services can also be
integrated into community care, and there should be a strong focus on task sharing, particularly in low-income settings.

For these efforts to work, community workers need training and ongoing support and supervision to build their knowledge and skills. Community interventions should also create collective opportunities for healing after crises.

- **Provide MHPSS interventions in humanitarian and fragile settings.** Children and adolescents are among the most vulnerable groups in humanitarian settings. Responses in those settings must be context specific and multi-layered. MHPSS interventions should be scaled up to provide children the necessary means and resources to cope with anxiety and severe forms of distress. Specialized care for the most vulnerable populations should be offered, with more intentional focus on young mothers, victims of gender-based violence, and children associated with armed groups. Support is also needed to integrate children back into everyday life in the aftermath of severe distress or traumatic experiences.

- **Respect child rights in mental health services.** Many children endure human rights violations in mental health services, facing coercive practices such as institutionalization, forced treatment and restraint that can have a lasting negative impact. Child rights must be respected in the design and provision of mental health services, with service users treated not as patients but as individuals with rights. Care should be person-centred and recovery-oriented and grounded in respect for human rights. Clear commitments are needed to provide services that are free of coercion and that respect supported decision-making, which must be underpinned by long-term strategies to, for example, provide adequate community-based crisis-response services and extensive workforce development.

- **Address gender inequalities in mental health programming.** Mental health programmes must actively seek to redress gender inequalities by assessing and addressing the needs of women, girls, boys, men and non-binary individuals through data collection, wide consultation and participation, and monitoring. Gender-based barriers to accessing mental health care should be removed. Investment is needed to address gender-based violence, gender-role stereotyping and discrimination against women and girls. Programmes focusing on adolescent girls’ psychosocial support, particularly that of adolescent mothers, must be scaled up.

**Improve data, research and evidence.** Data on the mental health of children, adolescents and caregivers are sadly lacking, especially in LMICs, where most of the world’s adolescents live. Lack of data and evidence renders children with mental health conditions invisible and is a major obstacle to policy development and planning. Progress on mental health is also hampered by lack of research and inadequate investment in implementation research.

- **Strengthen research.** Research into mental health happens overwhelmingly in high-income countries and focuses mainly on adults, not adolescents, even though adolescence is the peak period for the onset of most mental health conditions. Greater investment is needed in research on children and adolescents, which should be cross-culturally applicable, adaptable to local realities and capable of capturing diverse experiences and realities. Qualitative research can help close critical gaps in evidence generation and provide a solid account of children’s and adolescents’ well-being.

- ** Routinely monitor mental health.** There is a serious lack of routine monitoring on mental health-related issues in most countries, but especially in LMICs. A determined effort is needed to develop a consensus-based set of core indicators around child, adolescent and caregiver mental health, covering the prevalence
of mental health conditions, the provision of mental health care, and the extent of efforts to promote mental health and to protect at-risk children and adolescents (see Box X. Monitoring mental health).

- Support implementation research and science. The successful implementation of health policies and interventions, especially in the area of non-communicable diseases, is often hampered by a lack of understanding of conditions on the ground. In response, there needs to be increased investment in implementation science, which investigates how a range of factors can impede or accelerate the implementation of policies and interventions. Insights generated by such research is crucial to turning ideas into action.
Chapter 1: Mental health

10 Ibid., p. 3.
11 Ibid., p. 16.
23.09.2021

22 Barry, ‘Addressing the Determinants of Positive Mental Health’.
30 WHO, Social Determinants of Mental Health, p. 13.
34 OCHA, Good Health and Well-Being, p. 35.
41 UNICEF analysis based on estimates from the IHME Global Burden of Disease Study, 2019.
47 Erskine et al., ‘The Global Coverage of Prevalence Data for Mental Disorders in Children and Adolescents’.
23.09.2021


52 Ibid.


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66 This figure was calculated for UNICEF by McDaid, David, and Sara Evans-Lacko, ‘The Case for Investing in the Mental Health and Well-being of Children’, background paper for *The State of the World’s Children 2021*, United Nations Children’s Fund, November 2020, p. 3. It was calculated using estimates of mental disorder in the Global Burden of Disease (GBD) 2019 study to estimate potential economic value of adverse impacts of poor mental health globally. Authors of the background paper assumed that a monetary value could be attached to DALY burdens associated with poor mental health over a year. DALY weights for different conditions accounted for the relative severity of different disorders and the direct cost of premature mortality for some conditions such as eating disorders and self-harm. To compare, each disability-free year was calculated as equivalent to GDP per capita expressed in (PPP) adjusted international dollars. The DALY due to mental health conditions was valued in two ways: 1. DALYs due to mental health conditions for people aged 0–19 in all countries were valued at a fixed PPP adjusted international dollar rate of US$16,951, the World Bank estimate for GDP per capita worldwide in 2019; 2. Global costs were estimated using World Bank country-specific GDP per capita in 2019. The prevalence of mental health conditions and DALY data for each country are taken from the GBD 2019 study and cover all mental health conditions excluding dementia, alcohol and substance abuse disorders. In addition, the cost of DALY loss due to intentional self-harm for young people until age 19 was also calculated.

67 Note: UNICEF countries and regions are: East Asia and Pacific: Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Democratic People’s Republic of Korea, Fiji, Indonesia, Japan, Kiribati, Lao People’s Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Myanmar, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Thailand, Timor-Leste, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam; Europe and Central Asia: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Romania, Russian Federation, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, Uzbekistan; Western Europe: Andorra, Austria, Belgium, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Holy See, Hungary, Iceland,
Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom; Latin America and Caribbean: Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, British Virgin Islands, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos Islands, Uruguay, Venezuela (Bolivarian Republic of); Middle East and North Africa: Algeria, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, State of Palestine, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen; North America: Canada, United States; South Asia: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka; Sub-Saharan Africa: Eastern and Southern Africa, West and Central Africa; Eastern and Southern Africa: Angola, Botswana, Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, Somalia, South Africa, South Sudan, Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe; West and Central Africa: Benin, Burkina Faso, Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d’Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Togo.

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Chapter 3: Risk and Protection


As part of the State of the World’s Children 2021, Claudia Buchweitz, Arthur Caye and Christian Kieling of the Universidade Federal do Rio Grande do Sul in Brazil investigated risk factors related to mental health across the life course. They examined data from three main sources: Demographic and Health Surveys (DHS), which are supported by the United States Agency for International Development; Multiple Indicator Cluster Surveys (MICS) from UNICEF; and the Global School-based Student Health Survey (GSHS), which consists of self-reported data from schools on students aged 13–17 years. The survey is supported by WHO in collaboration with UNICEF; United Nations Educational, Scientific and Cultural Organization (UNESCO); and the Joint United Nations Programme on HIV and AIDS (UNAIDS); with technical assistance from the U.S. Centers for Disease Control and Prevention (CDC). Since the surveys do not specifically collect data on mental health, the researchers examined DHS, MICS, GSHS questionnaires, datasets and variable definitions to assemble a list of life course-specific factors potentially linked to mental health in childhood and adolescence. These data and information were examined for feasibility of analysis and factors were included if data were available for at least 10 countries. The result was a selection of more than 50 factors divided into perinatal, early childhood, childhood and adolescence periods. Next was a rapid review of the literature linking exposure to each factor with mental health outcomes. A PICO scheme was used for the rapid review, focusing on exposure to risk factors prior to the onset of a mental health condition. An AMSTAR2 appraisal tool was used to assess the quality of the literature. In addition, a consultation with a group of experts was also conducted to narrow the list of factors to the most essential for mental health, based on a life-course perspective. In total, the rapid review retrieved 2,237 abstracts for screening; 805 full-text systematic reviews were assessed and 140 were included in the final results. Data on indicators were available for a minimum of 47 countries (intimate partner violence against women) and a maximum of 147 countries (low birthweight). The median was 69. Data from half the factors were collected after 2015 and the median year of collection was 2014.

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146


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