STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SYSTEMS AND SERVICES

for children and adolescents in the East Asia and Pacific region

REGIONAL REPORT 2022

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Foreword

Mental health issues among children and young people are a significant and urgent concern. Before COVID-19, UNICEF estimated that 1 in 7 adolescents aged 10–19 years lived with a diagnosed mental disorder and that suicide was among the top four causes of death amongst this age group in East Asia and the Pacific.

The impact of COVID-19 exacerbated existing mental health issues among children, young people and their caregivers and caused mental health issues for millions more.

Increasing demands for mental health services during the pandemic highlighted the significant service gaps and the extremely limited tailored support for under-18s. This is the result of persistent underspending on mental health; only 2 per cent of health budgets globally is allocated to mental health.

Mental health issues experienced in childhood have long-term impacts, including on health and educational outcomes and earning capacity, with costs to society estimated at $390 billion per year.[i] The combination of the increasing mental health burden and wholly inadequate services for under-18s will have a profound impact on the development of this generation of children – and of countries as a whole – if urgent action is not taken.

However, the pandemic has created an opportunity for action. It has brought mental health into the mainstream, challenging entrenched stigma that had prevented both help-seeking behaviour and political dialogue. Governments in the region have begun to recognize the need to address mental health to mitigate against the impact of the pandemic, including for the learning recovery agenda. Yet, there is little guidance on how to strengthen support for under-18s.

To support governments and partners to increase and target investment and shape systems and programming, UNICEF East Asia and the Pacific Regional Office, with the Burnet Institute, WHO, UNESCO and the Global Social Service Workforce Alliance, collaborated for the development of a regional conceptual framework for strengthening multi-tiered systems and services for children and young people, highlighting the criticality of a multisectoral approach beyond health, informed by their needs and experiences. This framework was applied to four countries with very different contexts – Malaysia, the Philippines, Papua New Guinea and Thailand – providing recommendations for short- and long-term actions to strengthen mental health provision and promotion.

This report calls for a transformational approach for mental health systems and services for children and young people, as well as increased investment, and provides the framework and guidance for this fundamental shift to ensure under-18s have the critical support that they need.

Debora Comini
Regional Director
UNICEF East Asia and the Pacific

i While the impact on children's lives is incalculable, a new analysis by the London School of Economics in the report indicates that the lost contribution to economies due to mental disorders that lead to disability or death among young people is estimated at nearly $390 billion a year.

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Abbreviations

COVID-19	Coronavirus disease 2019
CRC	Convention on the Rights of the Child
EAPRO	East Asia and the Pacific Regional Office (UNICEF)
GBD	Global Burden of Disease
GSHS	Global School-Based Student Health Survey
GSSWA	Global Social Service Workforce Alliance
MHPSS	Mental health and psychosocial support
MICS	Multiple Indicator Cluster Survey
NGO	Non-governmental organization
TAG	Technical advisory group
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Executive summary

The mental health of children and adolescents (aged 0–18 years) is one of the most neglected health issues globally. Before COVID-19, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.[1] In East Asia and the Pacific, almost 1 in 7 boys and 1 in 9 girls aged 10–19 years have a mental disorder, with suicide the third leading cause of death of 15–19-year-olds in this region.[2,3] Additionally, millions more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder but which has significant impacts on their health, development and well-being. Poor mental health can have profound impacts on the health, learning and participation of children and adolescents, limiting opportunities for them to reach their full potential.

Despite this burden, there is a substantial unmet need for mental health and psychosocial support (MHPSS) for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of total health expenditure,[4] despite accounting for 7 per cent of the total burden of disease.[5] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescents is <0.5 per 100,000 population, and there are fewer than two outpatient facilities for child and adolescent mental health per 100,000 population.[4]

To address the mental health and psychosocial well-being of children and adolescents, there is a need for a holistic and tiered approach to MHPSS that includes actions to: promote well-being; prevent poor mental health by addressing risks and enhancing protective factors; and ensure quality and accessible care for those with mental health conditions. This requires the mobilization of all sectors – including health, education, social welfare and justice – as well as engagement with communities, schools, parents, service providers and children and adolescents themselves.

To support the urgent need to strengthen MHPSS systems and services for children and young people in the region, especially in the wake of COVID-19 that has had a profound impact on mental health, UNICEF embarked on a research initiative to identify how MHPSS can be most effectively implemented. Supported by the Regional Technical Advisory Group (TAG) composed of UNICEF, UNESCO, WHO and the Global Social Service Workforce Alliance (GSSWA), this initiative included the development of a regional framework that sets out: a tiered and multisectoral package of MHPSS services to meet the specific needs of children and adolescents; the role of key sectors – health, education, social welfare and justice – in the delivery of this package; and the legislative, policy, institutional and capacity building steps required to ensure a multisectoral mental health system.

Key to this research initiative was the application of this conceptual framework in four countries in the region – Malaysia, Papua New Guinea, the Philippines and Thailand – to explore how MHPSS could be implemented across diverse contexts.

This report sets out the regional framework and the key lessons learned from the application of this framework in the four countries and provides recommendations for the region to strengthen MHPSS for children and adolescents and for UNICEF's engagement in mental health.

In addition to specific recommendations to strengthen the multisectoral mental health system, overarching recommendations to improve the implementation of MHPSS for children and adolescents in East Asia and the Pacific include:

1. At national level, mental health legislation and national mental health policies should be strengthened to more clearly articulate the specific MHPSS actions and protections for children and adolescents. They should also detail a multisectoral plan (and coordination structure) for implementation of MHPSS, including cross-sectoral performance indicators. This should be based

on a collective vision for the provision of MHPSS services for children and adolescents. Sufficient allocation of public resources for MHPSS to all relevant sectors (not only health), as well as ensuring effective expenditure, is critical to enable legislation and policies to be implemented.

2. Governments should establish or strengthen a national multisectoral committee (or similar body) for child and adolescent mental health with responsibility for coordinating planning and implementation. At subnational level (provincial or district level), governments should establish or strengthen the role of mental health subcommittees and provide capacity building of subnational leadership and local government to improve awareness of mental health and support the development of local multisectoral implementation plans, resource allocation and coordination.
3. Ministries of health, in consultation with other sectors and technical partners, should strengthen national, standardized protocols for child and adolescent health across agencies, including:
    a. Validated screening tools and guidance on use;
    b. Referral procedures;
    c. Non-specialist management;
    d. Case management of children and adolescents engaged in the child protection and justice sectors; and
    e. National quality service standards for child and adolescent mental health services across sectors.
4. Governments should include mental health services (including outpatient services) within universal health coverage and national insurance schemes and increase public resource allocation for mental health across the tiers of care, prevention and promotion. To support this, ministries of health should consider including mental health as a primary programme, and a minimum-services package (based on the regional framework) should be defined and costed, with budget allocation and responsibility clearly defined across key sectors. Governments should also consider establishing a national cross-sectoral body or cross-sectoral committee on MHPSS within the department or bureau of budget to support coordinated and comprehensive budget requests that align with national MHPSS goals
5. Ministries of health and social welfare should prioritize the integration of MHPSS into primary and community-level services for children and adolescents in their families, including through primary healthcare and community-based approaches to child protection and support for families.
6. Governments, with support from professional associations, training institutions and development partners, should strengthen the multisectoral MHPSS workforce through:
    a. Further in-depth mapping to identify key roles across sectors against the MHPSS priority actions and the required competencies and inter-sectoral training needs to support these roles;
    b. Development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for key providers across sectors;
    c. Integration of child and adolescent development and mental health into the pre-service training of health professionals, the social service workforce, justice sector workers, teachers and other school-based staff, in alignment with the roles and responsibilities with respect to MHPSS;
    d. Strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers), social service workers, the justice sector, teachers and education staff, that is competency-based and aligned with expected MHPSS roles;
    e. Training provided to relevant ministry-level staff from the health, education, social welfare and justice sectors to support planning and development of the workforce, as well as broader MHPSS programmes;
    f. Expansion of the number of posts at national and subnational levels; and
    g. Improved supervision and support for MHPSS providers across sectors, including establishing provider support networks and multidisciplinary teams, improved remuneration, job security and career pathways, and attention to the mental health needs of providers themselves;

7. Governments, in consultation with academic and development partners, should improve the collection, use and accessibility of data at national and subnational levels – including data and mechanisms to identify mental health needs, support planning and implementation and track progress. This should include strengthening data linkage and sharing across agencies in conjunction with privacy laws to protect children and adolescents. In addition to greater investment in mental health research, national information systems (health, education, child protection and justice) should be strengthened to include a minimum set of child and adolescent MHPSS-related indicators harmonized across sectors, while national suicide surveillance systems should be established.
8. Governments, development partners and non-governmental organizations (NGOs) should increase opportunities for children and adolescents (and parents/caregivers) to participate in MHPSS policy and programming, including establishing more formal roles for young people (such as representation on mental health committees and other bodies at national and subnational level), and improved child- and adolescent-friendly mechanisms for providing feedback and complaints on MHPSS programmes and mental health services.
9. Governments, with support from development partners and NGOs, should expand national and community-based programmes to address mental health-related stigma and discrimination and improve mental health literacy (particularly targeting children, adolescents and parents/carers).

Introduction

The mental health of children and adolescents (aged 0–18 years) is one of the most neglected health issues globally. Before COVID-19, the WHO estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.[1] In East Asia and the Pacific, almost 1 in 7 boys and 1 in 9 girls aged 10–19 years have a mental disorder, with suicide estimated to be the third[ii] leading cause of death of 15–19-year-olds in this region.[2,3] Additionally, millions more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder but which has significant impacts on their health, development and well-being.

BOX 1. DEFINITIONS

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

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

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

Poor mental health can have profound impacts on the health, learning, social well-being and participation of children and adolescents, limiting opportunities for them to reach their full potential. This age spectrum encompasses a time of critical brain growth and development, when social, emotional and cognitive skills are formed, laying the foundation for mental health and well-being into adulthood. In addition to mental disorders arising during this age, many risk factors for future poor mental health also typically have their onset in this developmental stage.[6,7]

Despite this burden, there is a substantial unmet need for MHPSS for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of total health expenditure,[4] despite accounting for 7 per cent of the total burden of disease.[5] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescent is <0.5 per 100,000 population, and there are fewer than two outpatient facilities for child and adolescent mental health per 100,000 population.[4] There are also many gaps and missed opportunities to prevent poor mental health and promote well-being, with approaches often fragmented and small-scale. In addition to inadequate human and financial resources, a lack of coordination between sectors and substantial stigma remain significant barriers to ensuring children, adolescents and their families have access to quality services and support.[2,8] COVID-19 both exacerbated mental health issues impacting children and young people across the region and highlighted the significant gaps in systems and services.[9,10]

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ii This estimate is from the Global Burden of Disease Study, 2019. The UNICEF report The State of the World's Children 2021 estimated that suicide is the fourth leading cause of death for 15-19-year-olds in this region.

BOX 2. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Mental health and psychosocial support (MHPSS) refers to any support, service or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders.

Originally defined by the Inter-agency Standing Committee Reference Group on mental health and psychosocial support in humanitarian settings, this composite term is now widely used and accepted by UNICEF, partners and practitioners in development contexts, humanitarian contexts and the humanitarian-peace nexus. It serves to unite as broad a group of actors as possible and underscores the need for diverse, complimentary approaches to support children, adolescents and their families.

The focus of this project is primarily on actions required in non-humanitarian settings.

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

- Shift the emphasis from medicalization of mental illness to the value of ensuring mental health and well-being to society and communities;
- Address the overemphasis on scaling up specialist clinical services for mental disorder and move to providing an optimal mix of services and supports to promote mental health across sectors;
- Expand the scope of mental health to include a focus on creating an enabling environment that enhances protective factors and reduces risk factors across the life cycle, recognizing the gendered nature of mental health and the importance of resilience, empowerment and social cohesion for psychosocial well-being; and
- Ensure that the perceptions, experiences and views of children and adolescents are central not only to understanding their mental health needs but also to shaping and strengthening mental health services and systems

This research initiative seeks to provide guidance for this transformation, with a focus on the provision of a holistic and tiered approach to MHPSS that includes actions to: promote well-being; prevent poor mental health by addressing risks and enhancing protective factors; and ensure quality and accessible care for those with mental health conditions. This requires the mobilization of all sectors – including health, education, social welfare and justice – as well as engagement with communities, schools, parents, service providers and children and adolescents themselves. This multisectoral approach is therefore at the core of UNICEF's East Asia and Pacific regional framework on MHPSS, and UNICEF's Global Multisectoral Operational Framework for mental health and psychosocial support of children, adolescents and caregivers across settings.[11,12]

Project aims, objectives and approach

Aims and objectives

To support the urgent need to strengthen MHPSS systems and services for children and adolescents in the East Asia and Pacific region, UNICEF embarked on a research initiative to identify how MHPSS can be most effectively implemented for those aged 0–18 years. This initiative included the development of a regional conceptual framework to define:

- A tiered and multisectoral package of services required for child and adolescent mental health and psychosocial well-being (package of priority actions);
- The systems, structures and resources needed to deliver these services;
- Multisectoral roles and responsibilities – health, social welfare, education and justice – and the role of other relevant ministries/agencies, NGOs, young people, youth organizations, communities and the private sector; and
- The legislative, policy, institutional and capacity building steps required to ensure a multisectoral mental health system.

The specific **objectives** were to:

1. **Develop a regional framework** for the delivery of multi-tiered MHPSS for children and adolescents specific to this region identifying:
   - Actions needed for responsive care, prevention and mental health promotion;
   - Sectoral roles (with a focus on the health, social welfare, education and justice sectors);
   - Roles of other key government agencies, NGOs, UNICEF and the private sector; and
   - Considerations for strengthening a multisectoral mental health system.
2. Undertake an **in-depth analysis in four countries** (Malaysia, Papua New Guinea, the Philippines and Thailand) to apply the regional framework and explore how MHPSS could be implemented in diverse contexts and inform the final regional MHPSS framework. The four participating countries were selected by UNICEF to reflect diverse sociocultural and economic contexts and current national responses to mental health.
3. Develop specific **recommendations and guidance** for governments and UNICEF to support implementation of MHPSS for children and adolescents in the region.

While the importance of MHPSS in emergency settings is acknowledged, this work focused specifically on implementation of MHPSS in non-emergency contexts.

Overview of the approach

The overarching project was led by the Burnet Institute in partnership with UNICEF East Asia and the Pacific Regional Office (EAPRO). At regional level, a Regional TAG comprising UNICEF, UNESCO, WHO and the GSSWA, and sectoral and child and adolescent health experts provided overall feedback and guidance on the conceptual framework, project approach and regional findings and recommendations.

An outline of the overall project is provided in Figure 1.

FIGURE 1. OVERVIEW OF THE PROJECT APPROACH

REGIONAL **CONCEPTUAL FRAMEWORK** FOR MHPSS TO DEFINE PRIORITY ACTIONS and POTENTIAL SECOTRAL ROLES

Exisiting global and regional guidance and frameworks
Evidence of effective interventions and approaches to address child and adolescent mental health
Expert review and consensus

COUNTRY-LEVEL ANALYSIS (MALAYSIA, PAPUA NEW GUINEA, PHILIPPINES and THAILAND) TO PRIORITISE ACTIONS, EXPLORE SECTORAL ROLES, AND IDENTIFY SUPPORTS NEEDED TO STRENGTHEN A MULTI-SECTORAL MENTAL HEALTH SYSTEM

Desk-based review of the current situation for children and adolescents	**Consultation workshop** with multi-secotral stakekolders to prioritise actions and propose sectoral roles	**Key informant interviews** to explore sectoral roles, recommendations for implementation, and actions to strenghten a multi-sectoral system	**Validation workshop** with multi-sectoral stakeholders to refine recommendations

CONSOLIDATED **COUNTRY AND REGIONAL GUIDANCE** AND RECOMMENDATIONS FOR IMPLEMENTATION

A detailed description of the project approach is provided in Appendix A. In brief, the project comprised three key components:

1. Development of a regional framework for MHPSS

The approach to development of the preliminary regional framework was consultative and iterative. The initial conceptual framework defined three major tiers of actions needed for MHPSS (responsive care, prevention and mental health promotion). Within these tiers, specific actions for children and adolescents were identified through:

- **Synthesis of available evidence** for MHPSS (a review of existing global frameworks and guidance for mental health and a scoping review of evidence from peer-reviewed and grey literature);
- **Expert consultation** to review and provide feedback on proposed actions (through the Regional TAG and external content experts); and
- **Country-level review** through online workshops (in Thailand, Philippines, Papua New Guinea and Malaysia) with key stakeholders and implementation partners across health, education, social welfare and youth advocacy representing government, non-governmental, private sector and United Nations (UN) agencies to provide feedback on, and prioritize, proposed MHPSS actions.

The preliminary framework also proposed broad sectoral roles in implementing MHPSS and considerations for strengthening a multisectoral mental health system.

2. Country-level analysis

Country-level analysis was co-led by the Burnet Institute (lead team and Papua New Guinea Country office), the Centre for Coordination of Clinical Research Network, National Institute of Health, Malaysia, the Research Institute for Mindanao Culture, Xavier University, Philippines, and the Institute for Population and Social Research, Mahidol University, Thailand. The UNICEF Country Office and the Country TAG in each country provided support, with oversight from UNICEF EAPRO and the Regional TAG. This component included four main activities:

- **Desk-based review** of available national level and comparable data to describe the mental health needs of children and adolescents aged 0–18 years; a review and synthesis of available, peer-reviewed and grey literature to examine the risks and determinants of mental health and/or psychosocial well-being, the barriers and enablers to accessing quality MHPSS, and evidence of interventions and approaches to address mental health and/or psychosocial well-being; and mapping of policies, strategies, plans and legislation related to mental health.
- **Consultation workshops** held online with government, non-governmental and UN agency stakeholders from the health, education, justice, and social welfare sectors to provide feedback on the regional framework, prioritize MHPSS actions and propose sectoral roles
- **Key informant interviews** (see Table 1) conducted online with government, non-government, UN agency and youth representatives from each key sector to explore in depth: the perceptions and understandings of priority child and adolescent mental health needs; current programmes and approaches related to MHPSS; the barriers and enablers impacting on implementation; recommended sectoral roles and responsibilities; and the challenges and considerations for strengthening a multisectoral mental health system.
- **Validation workshops** held face to face and/or online with the Country TAG to present and provide feedback on the key findings and co-develop recommendations.

Table 1. Number of key informant interviews, by sector

	Malaysia	Papua New Guinea	Philippines	Thailand
Health	5	10	8	13
Education	2	1	9	11
Social welfare	10	5	5	7
Justice	4	1	3	3
Youth and parent organizations	4	1	2	4

3. Consolidated guidance

The regional framework, proposed MHPSS actions, and recommendations for implementation were reviewed and refined through country-level validation and dissemination workshops with the Country TAG, key stakeholders and implementation partners across health, education, social welfare , justice and youth advocacy representing government, non-government, private sector and UN agencies. Additionally, an online regional workshop attended by country research partners, the Regional TAG and UNICEF focal points for the four countries was held in January 2022 to provide feedback on the preliminary findings and develop recommendations for UNICEF.

BOX 3. OUTLINE OF THIS REPORT

This report provides an overview of the regional framework for MHPSS and synthesizes findings and recommendations from the country-level analyses to describe:

1. Mental health and psychosocial well-being of children and adolescents: the current situation (mental health needs, and policy and programming responses);
2. Priority package of MHPSS actions;
3. Recommended sectoral roles; and
4. Recommendations for strengthening the multisectoral mental health system.

Detailed findings related to the country-level analyses and recommendations are provided separately in country reports for Papua New Guinea, the Philippines, Malaysia and Thailand.

Mental health and psychosocial well-being:

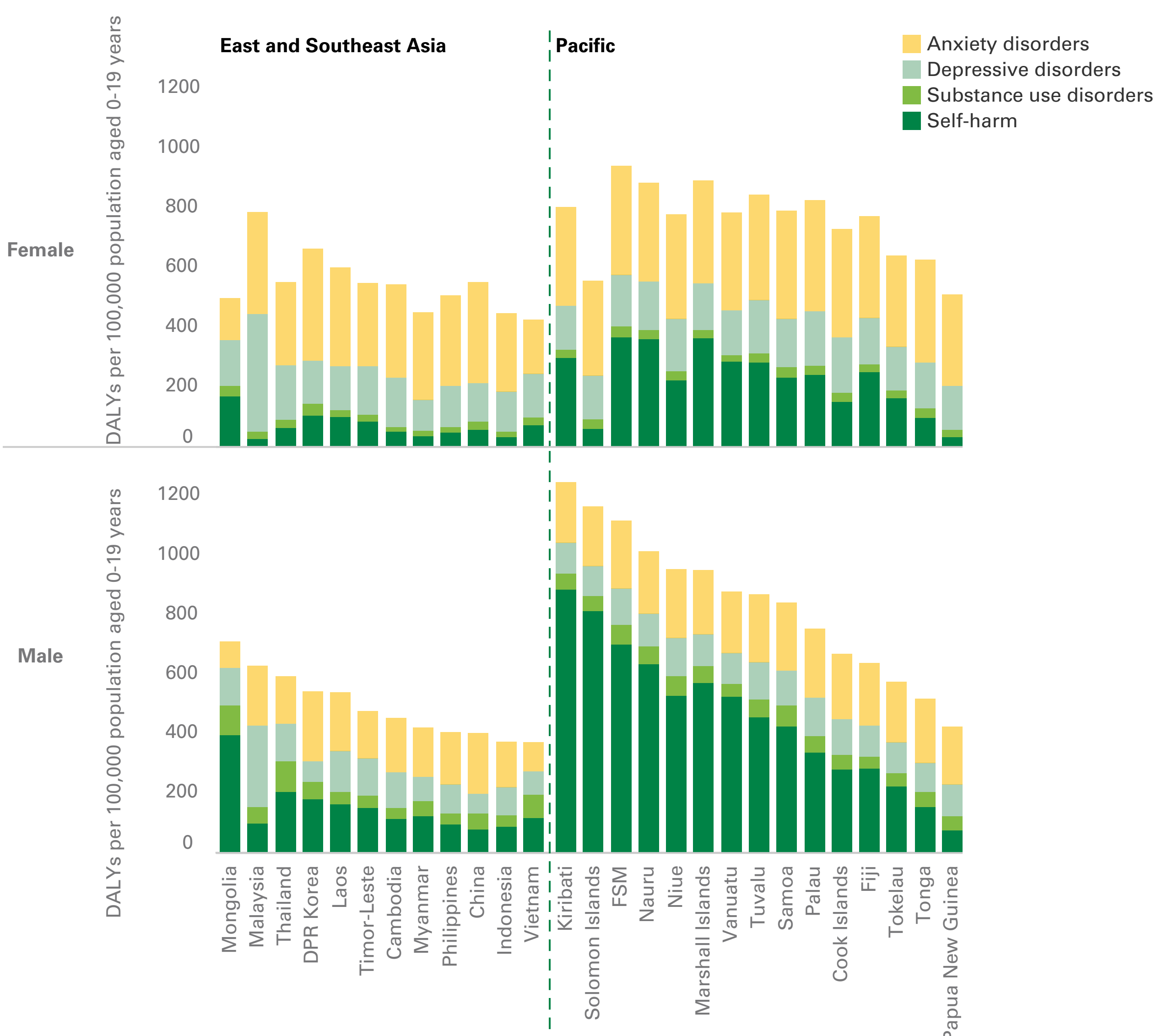
The current situation for children and adolescents in East Asia and the Pacific

Mental health outcomes for children and adolescents

Children and adolescents aged 0–18 years in East Asia and the Pacific experience a substantial burden of poor mental health. UNICEF's report *The State of the World's Children 2021* reported that in this region, **more than 1 in 10 girls (11.3 per cent) and almost 1 in 7 boys (13.6 per cent) aged 10–19 have a mental disorder**, with many millions more experiencing psychological distress. Modelled estimates from the Global Burden of Disease Study (2019) similarly report that around 15 per cent of 10–19-year-olds have a mental disorder, with **mental disorders (particularly depression and anxiety) and intentional self-harm accounting for 16 per cent of the total burden of disease among adolescents in this region.**[3] Among younger adolescents and children aged 5–14 years, mental disorders are the leading cause of poor health, with conduct disorder and anxiety disorder alone accounting for almost 5 per cent of the total burden of disease in this age group.[3]

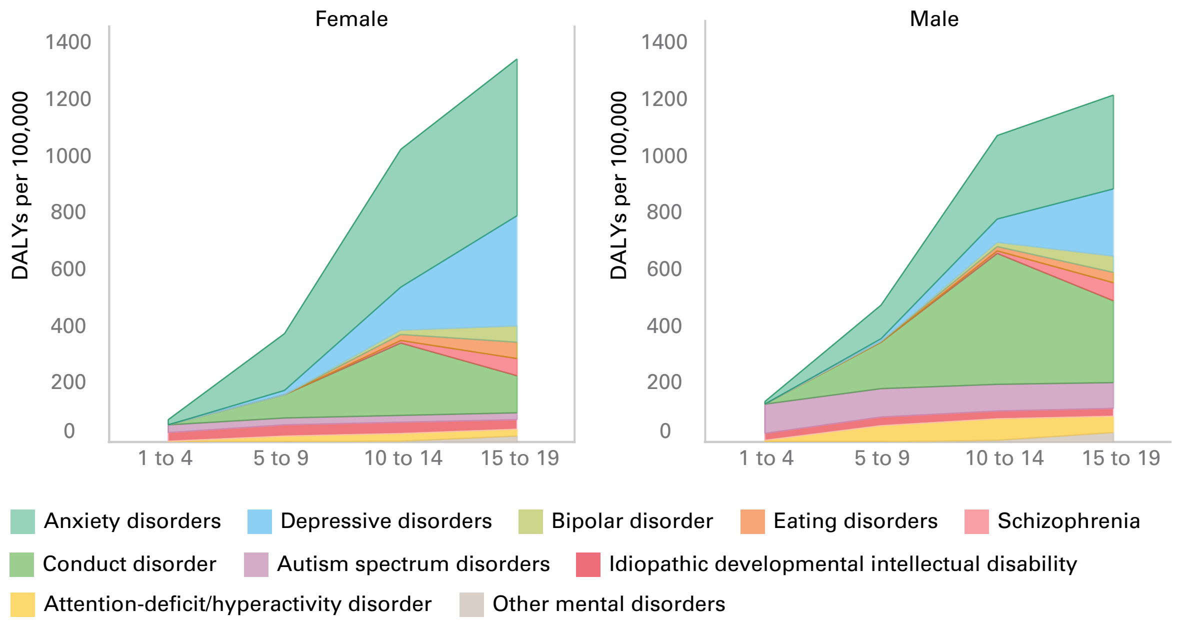
Figure 2a shows the burden of disease due to common mental disorders and intentional self-harm, reported as disability-adjusted life years (healthy years of life lost due to either disability (illness) or premature death) per 100,000 children and adolescents aged 0–19 years. In most countries, girls have a higher burden of poor health due to anxiety and depressive disorders, compared with boys. Boys, however, experience a significantly higher burden of poor health due to self-harm. The burden of disease due to mental disorder increases substantially during childhood and adolescence, with the greatest increases being during later childhood and early to mid-adolescence (see Figure 2b). The specific causes of poor mental health vary substantially by age: for young children, developmental disorders predominate; for young adolescents there is a sharp increase in conduct disorders and depression and anxiety; for older adolescents there is a predominance of depression and anxiety, with an emergence of psychosis and eating disorders.

FIGURE 2a. BURDEN OF DISEASE DUE TO SELECTED MENTAL DISORDERS AND INTENTIONAL SELF-HARM AMONG 0–19-YEAR-OLDS (IN DISABILITY-ADJUSTED LIFE YEARS PER 100,000 POPULATION AGED 0–19), EAST ASIA AND THE PACIFIC



Source: IHME GBD 2019.

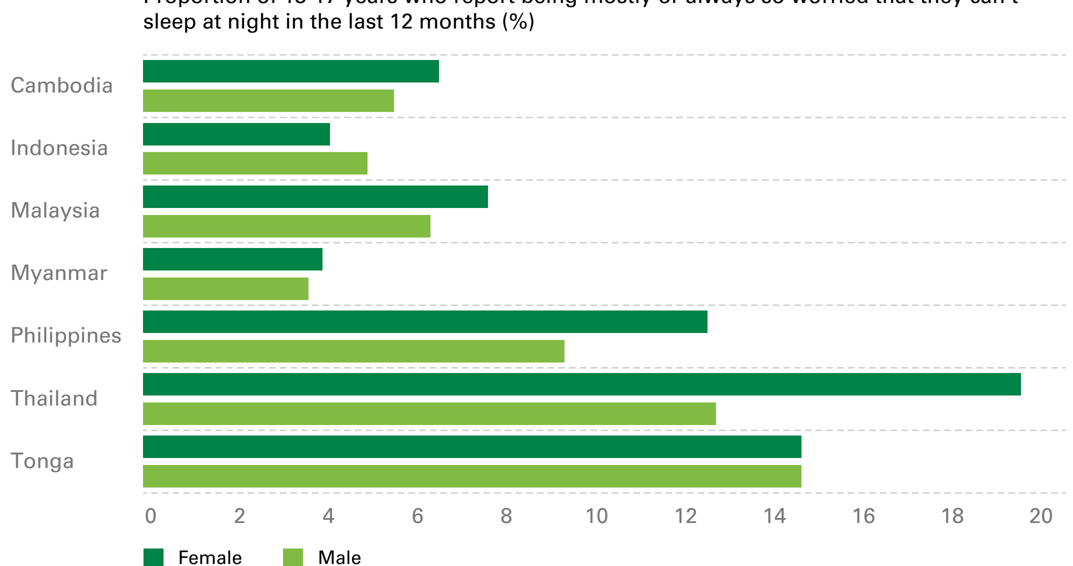
FIGURE 2b. BURDEN OF DISEASE DUE TO MENTAL DISORDERS DURING CHILDHOOD AND ADOLESCENCE, FOR EAST ASIA AND THE PACIFIC



Source: IHME GBD 2019.

Data from primary studies, such as the Global School-Based Student Health Survey (GSHS) also describe a high burden of mental health conditions among adolescents. In countries with available data, the proportion of 13–17-year-olds reporting feeling so worried that it disrupted their sleep (a marker of anxiety) ranged from 4–16 per cent, with rates generally higher among girls compared with boys (see Figure 3). In Thailand, where the most recent estimates are available, the prevalence of significant worry more than doubled among 13–15- year-olds between 2008 (6.5 per cent) and 2021 (16.3 per cent).[13–15] Nationally representative studies from Thailand and Malaysia have reported prevalence of depressive symptoms of around 18 per cent among adolescents, with conduct disorders and attention deficit/hyperactivity disorders also common among children.[16–18] **Primary data describing the prevalence of other mental disorders are generally very limited for children and adolescents in this region**.

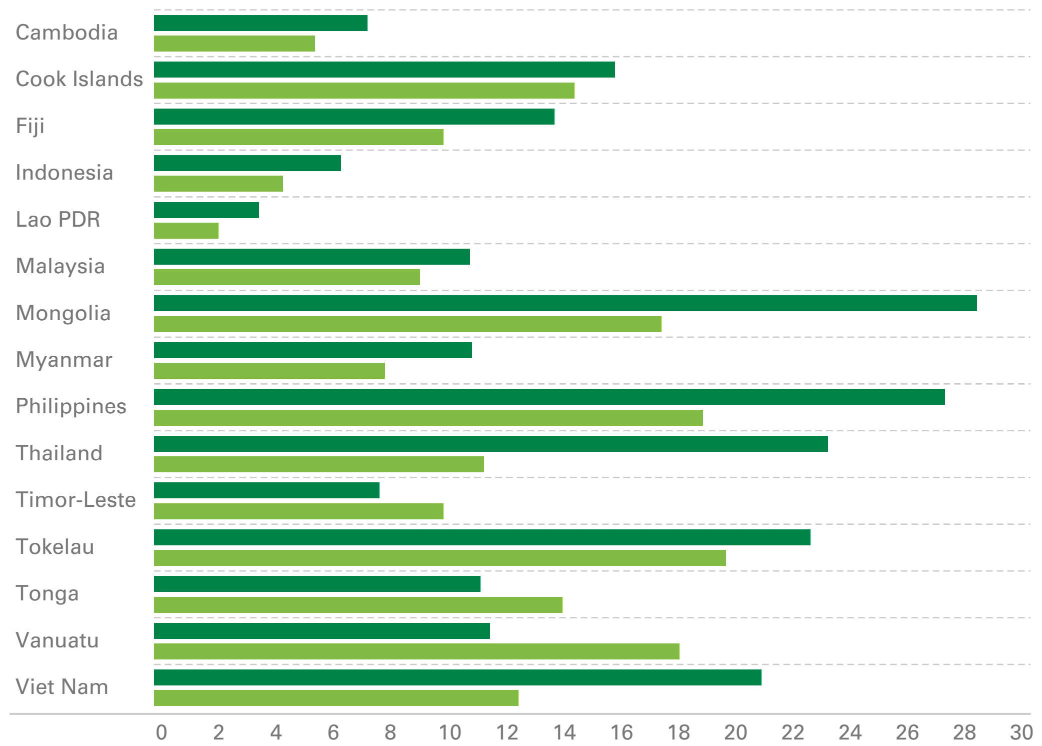
FIGURE 3. PREVALENCE OF SIGNIFICANT WORRY AMONG 13–17-YEAR-OLDS, SOUTHEAST ASIA AND THE PACIFIC (IN COUNTRIES WHERE DATA ARE AVAILABLE)

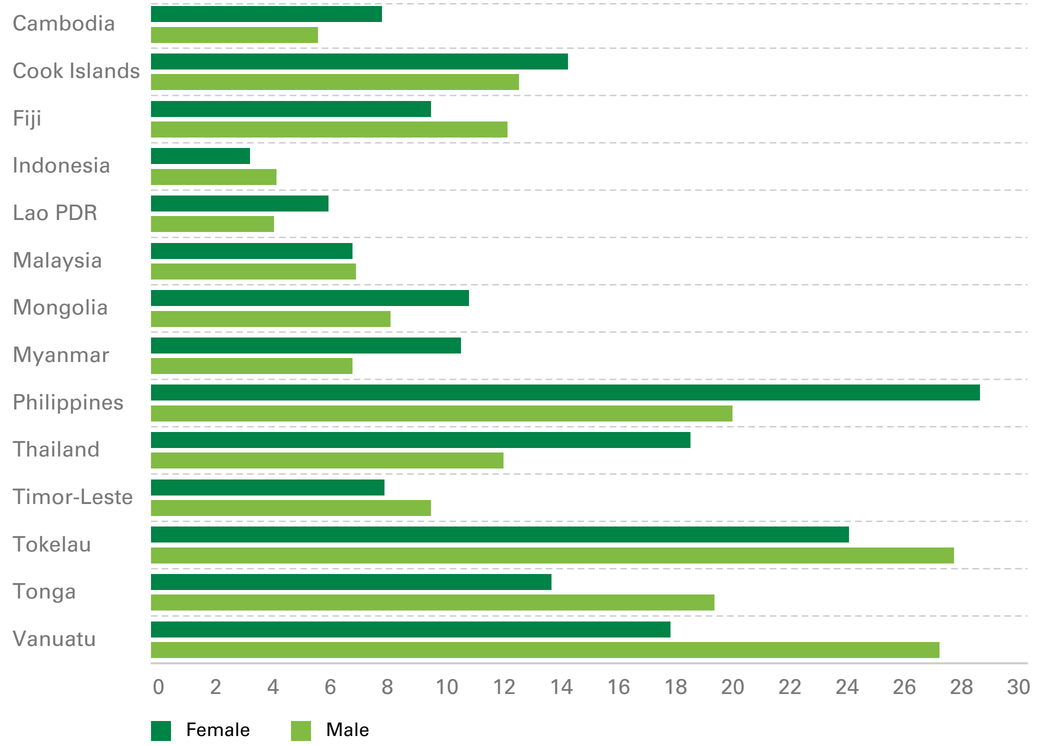


Source: GSHS 2013–2021.

Suicide is closely related to poor mental health. Data from the GSHS and other comparable national-level surveys conducted between 2013 and 2021 reveal that between 3 per cent and 23 per cent of 13–17-year-olds had seriously considered suicide in the 12 months preceding the survey, and between 4 per cent and 28 per cent had attempted suicide in the past 12 months. The highest rates of suicide attempts were reported by adolescents in the Philippines and some countries of the Pacific (see Figure 4). Suicidal ideation and attempts were higher among girls compared with boys in most countries where data are available.

FIGURE 4. PREVALENCE OF SUICIDAL IDEATION AND SUICIDE ATTEMPTS IN THE PAST 12 MONTHS, EAST ASIA AND THE PACIFIC (IN COUNTRIES WHERE DATA ARE AVAILABLE)

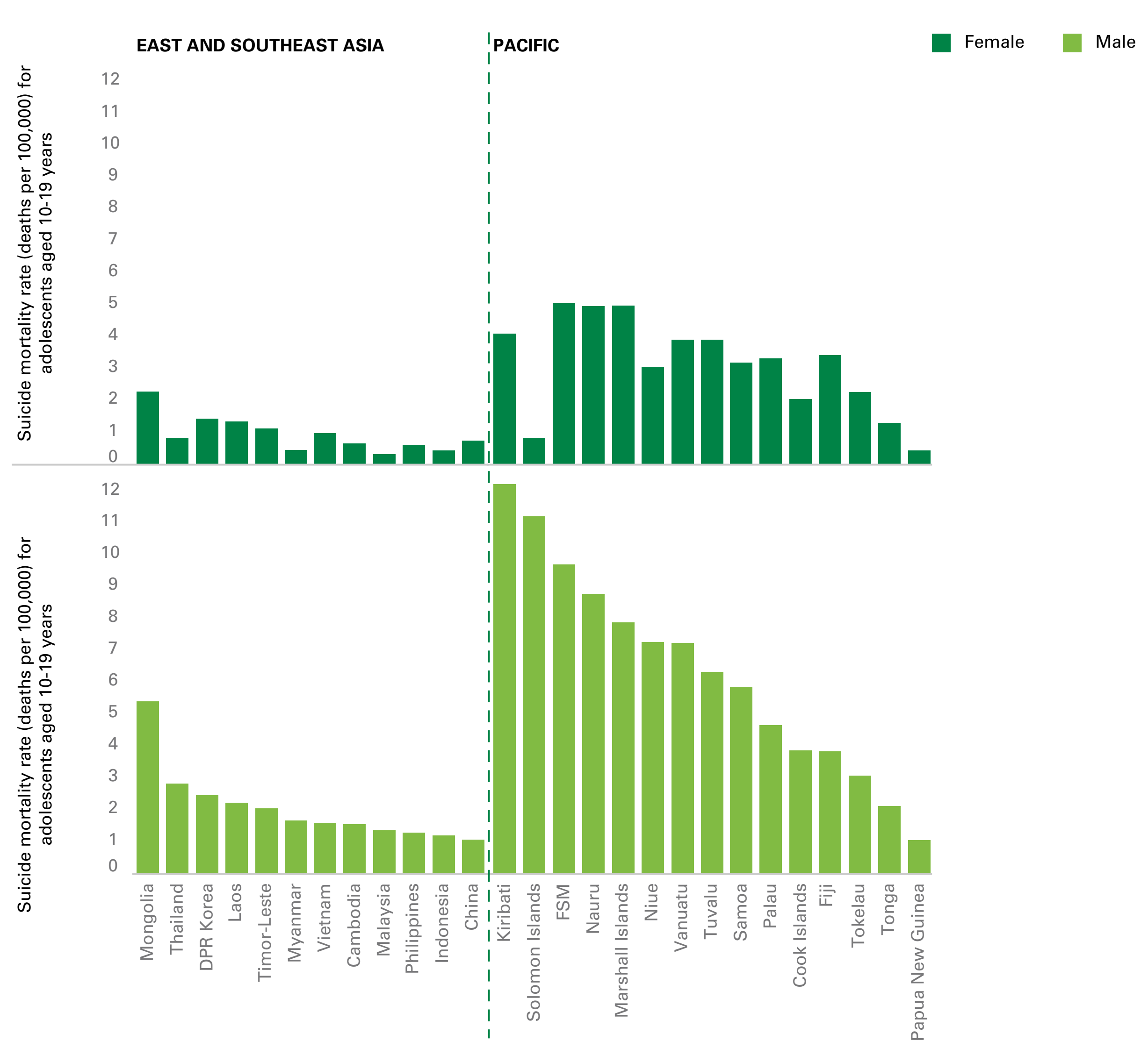




Source: GSHS 2013–2021.

The availability of national-level data for suicide mortality among adolescents is very limited. While some countries (such as Thailand) have a national suicide registry that reports age-disaggregated data, other countries do not currently have a national suicide surveillance system in place. Adjusting for missing data (e.g., deaths not reported) or misclassification of cause of death, the **GBD 2019 estimated that suicide is the second leading cause of death of girls aged 15–19 years, and the third leading cause of death of adolescent boys in East Asia and the Pacific** (the third leading cause for both sexes combined).[3] This is similar to UNICEF and WHO estimates that indicate suicide is the fourth leading cause of death for 15–19-year-olds in this region.[2] The estimated regional mortality rate due to suicide for East Asia and the Pacific in 2019 for children aged 10–14 was 0.68 per 100,000 population, and for adolescents aged 15–19, 3.47 per 100,000 population, accounting for over 5,500 deaths of 10–19- year-olds.[3] Despite a lower prevalence of suicidal ideation and suicide attempts, adolescent boys have around four times the mortality rate due to suicide compared with girls, and mortality rates were substantially higher among girls and boys in many Pacific countries compared with East Asia (see Figure 5).

FIGURE 5. SUICIDE MORTALITY (DEATHS PER 100,000 IN PERSONS <20 YEARS OF AGE), EAST ASIA AND THE PACIFIC (IN COUNTRIES WHERE DATA ARE AVAILABLE)

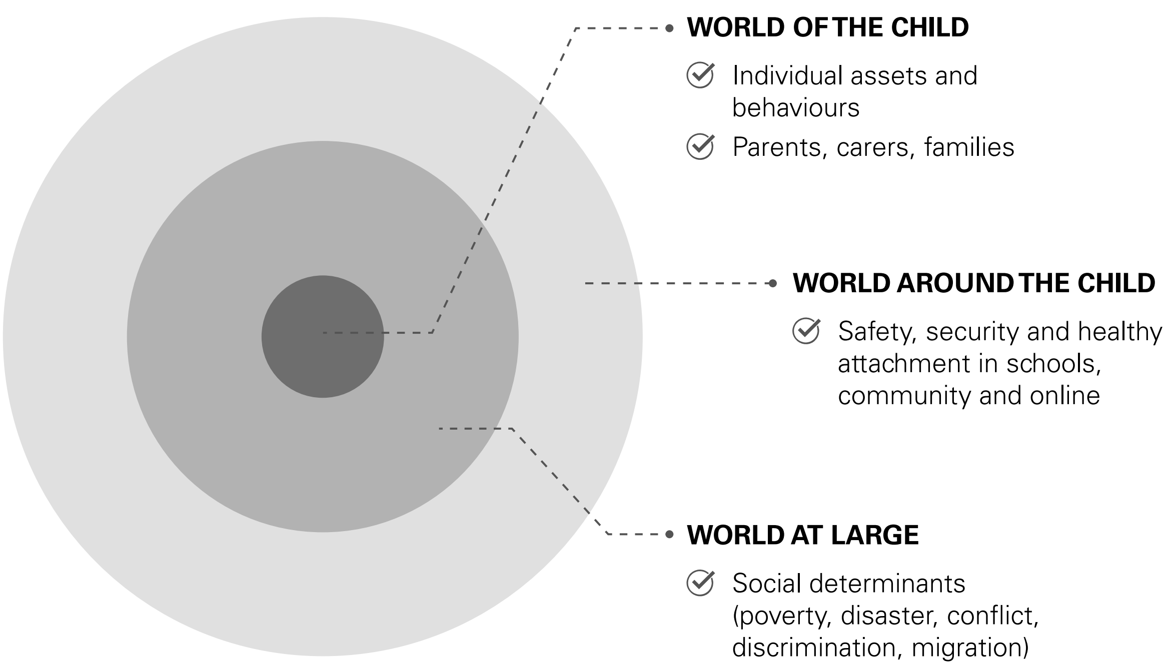


Source: GBD 2019.

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

UNICEF's *The State of the World's Children 2021* report defines three spheres of influence that shape the mental health and well-being of children and adolescents. These are the 'world of the child' (individual assets, parents, carers and families), the 'world around the child' (safety, security and healthy attachment in schools, communities and online), and the 'world at large' (social determinants, including poverty, disaster, conflict, discrimination and migration) (see Figure 6).[2] Childhood and adolescence are times of rapid change in social context and roles, and the timing and nature of exposures from the environment and immediate social context can powerfully shape mental health and well-being for children and adolescents across their lives. These risks and protective factors are cumulative across the life course and are often clustered – with children experiencing multiple adverse childhood experiences (abuse, neglect, violence or dysfunction within families, peers or the community) having the highest risk of poor mental health.[2]

FIGURE 6. SPHERES OF INFLUENCE ON MENTAL HEALTH AND WELL-BEING



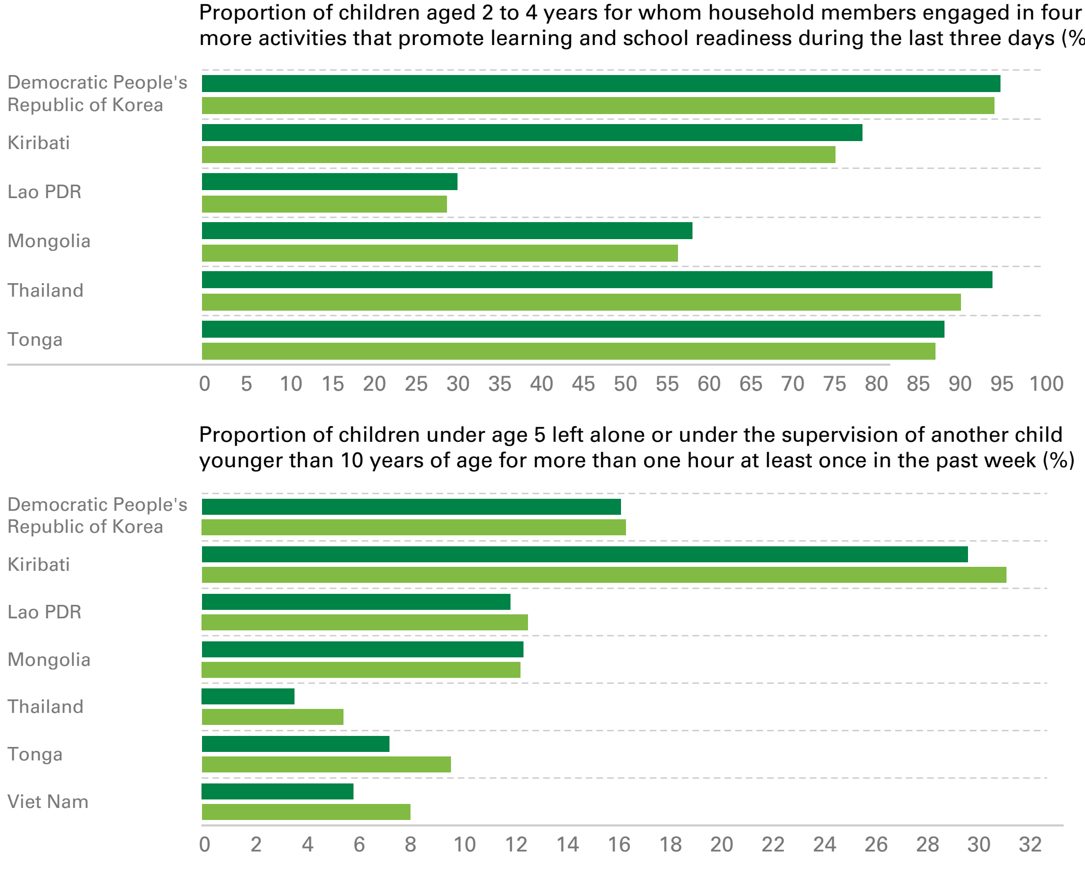
Source: Adapted from UNICEF's report *The State of the World's Children 2021*[2].

THE WORLD OF THE CHILD

For young children, ***healthy attachment to parents and other caregivers and nurturing, responsive care*** are powerful determinants of mental health and well-being. Attachment is the emotional relationship between a child and their parents or caregivers that gives a child a sense of safety and protection and fosters the development of social and emotional skills. While attachment is crucial and evolves over the course of childhood and adolescence, it is one of the defining influences on mental health and well-being during infancy and early childhood.[2] The mental health of parents and caregivers also impacts on their capacity to provide responsive care and healthy attachment, including for adolescent parents.[19]

National level data describing attachment and the quality of caregiving in the region are very limited. Data from UNICEF's Multiple Indicator Cluster Surveys (MICS) report that most children under the age of five years are adequately supervised at home. However, more than 1 in 10 young children are left alone, or under the care of another young child, for at least one hour during the past week in Lao PDR, Mongolia, DPR Korea and Kiribati. The majority of children under the age of five years receive early stimulation from household members to promote early learning and school readiness, with Lao PDR a notable exception where less than a third of 2–4-year-olds received early stimulation at home (see Figure 7).

FIGURE 7. EARLY STIMULATION AND INADEQUATE SUPERVISION, EAST ASIA AND THE PACIFIC (IN COUNTRIES WHERE DATA ARE AVAILABLE)

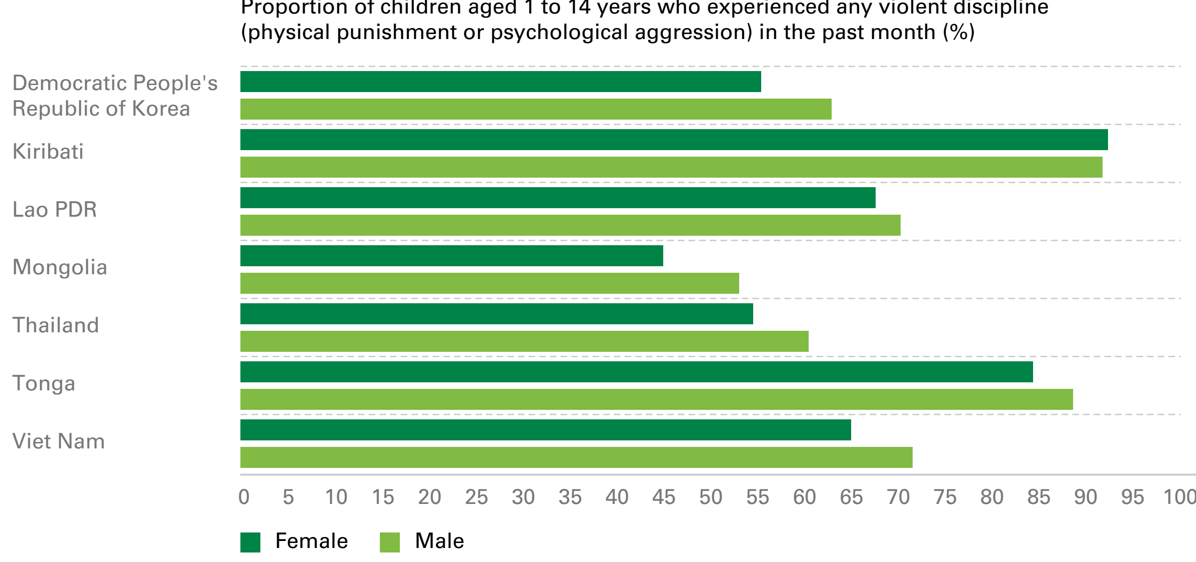


Source: MICS 2014–2019.

Relationships with parents and carers are also vital for the mental health and well-being of adolescents. However, national data and studies exploring the quality of parenting and attachment during adolescence are very limited. GSHS reveal that in most countries with data, fewer than a third of 13–17-year-olds report that their parents or guardians understood their problems or worries, and in Thailand, only 35 per cent of adolescents had felt supported or encouraged by their parents in the previous 30 days.[15]

Violence and neglect experienced within households and families are key risk factors for mental health conditions. Across the region, between 49 and 92 per cent of children aged 1–14 years have experienced any form of violent discipline (psychological aggression and/or physical punishment) at home in the past month, with similar rates among girls and boys (see Figure 8). Additionally, many children and adolescents experience sexual abuse in the home. Violence Against Children Surveys conducted in Cambodia[20] and Lao PDR [21] report that 6 per cent and 4 per cent of girls aged 13–17 years, and 5 per cent and 6 per cent of boys in each country, respectively, have experienced sexual abuse, with most abuse taking place in the home and perpetrated by family members, neighbours or friends. In the Philippines, almost 1 in 7 adolescents aged 13–18 report experiencing sexual violence in the home.[20] Witnessing family violence is also an important risk factor. Globally, around 1 in 4 children have witnessed intimate partner violence, increasing the risk of psychological distress.[22] In the Philippines, 41 per cent of adolescents aged 13–18 years report witnessing physical violence in the home.[20]

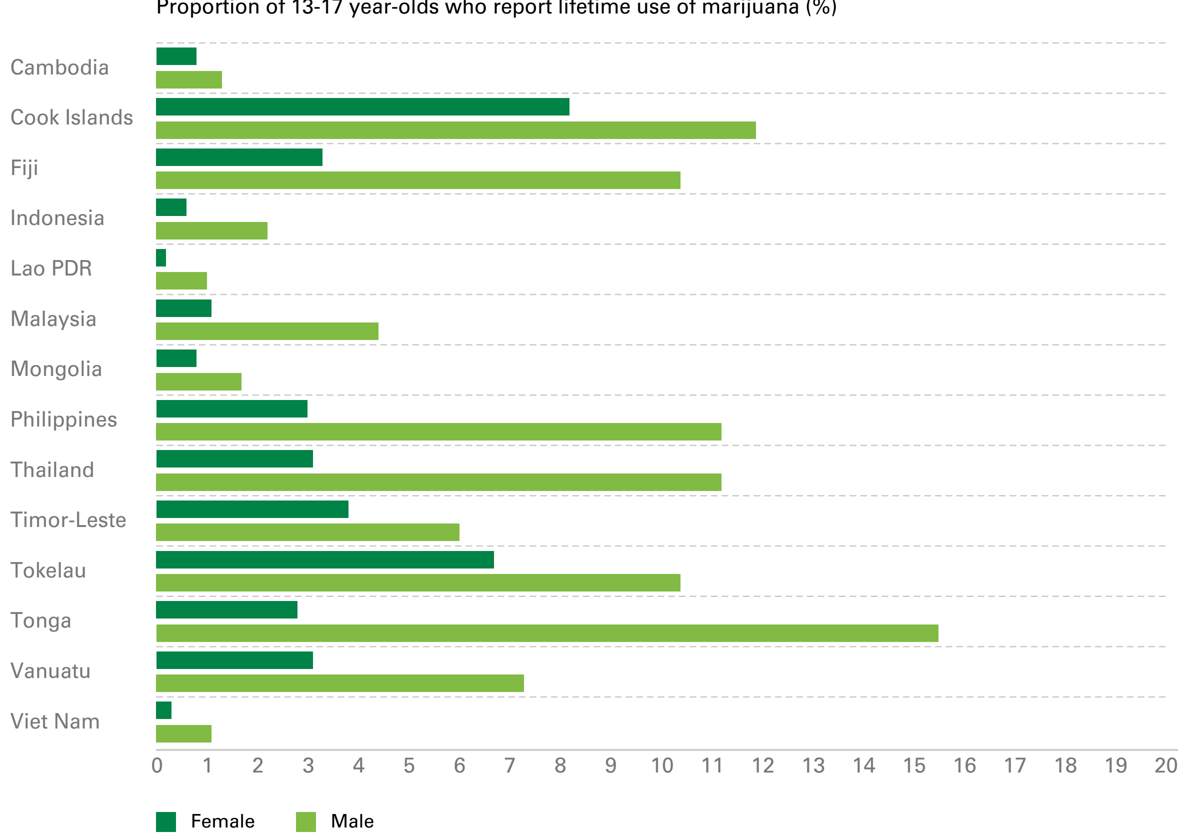
FIGURE 8. VIOLENT DISCIPLINE, EAST ASIA AND THE PACIFIC (IN COUNTRIES WHERE DATA ARE AVAILABLE)



Source: MICS 2014–2019.

For older children and adolescents, ***substance use and misuse*** are important individual-level risk factors for poor mental health.[23] Among school-going 13–17-year-olds, between 1 and 10 per cent report having ever used marijuana (see Figure 9) and between 1 and 7 per cent amphetamines, with the percentage higher among boys than girls. ***Sedentary behaviours and screen time*** are also an important influence on psychosocial well-being. In Malaysia, the Philippines and Thailand, only 20 per cent, 7 per cent and 68 per cent of adolescents, respectively, reported being physically active for 60 minutes or more every day, and between half and two thirds reported sitting for at least three hours per day.[15,24,25] While data are limited, smaller studies in Thailand and Malaysia have reported a high prevalence of internet, smartphone and gaming addiction, correlated with poor mental health.[26–28] In Kuala Lumpur, for example, 38 per cent of adolescents reported internet addiction.[17]

FIGURE 9. LIFETIME MARIJUANA USE, EAST ASIA AND THE PACIFIC (IN COUNTRIES WHERE DATA ARE AVAILABLE)



Source: GSHS 2013–2021.

Children and adolescents with chronic illness and disability may also experience a higher burden of poor mental health, although data describing the health needs of these children are currently very limited. Most available data relate to the mental health of children living with HIV. A 2021 study in adolescents and young people with perinatally acquired HIV in Thailand and Cambodia found that 25.6 per cent reported significant HIV-related stigma, and this was strongly associated with more depressive symptoms.[29]

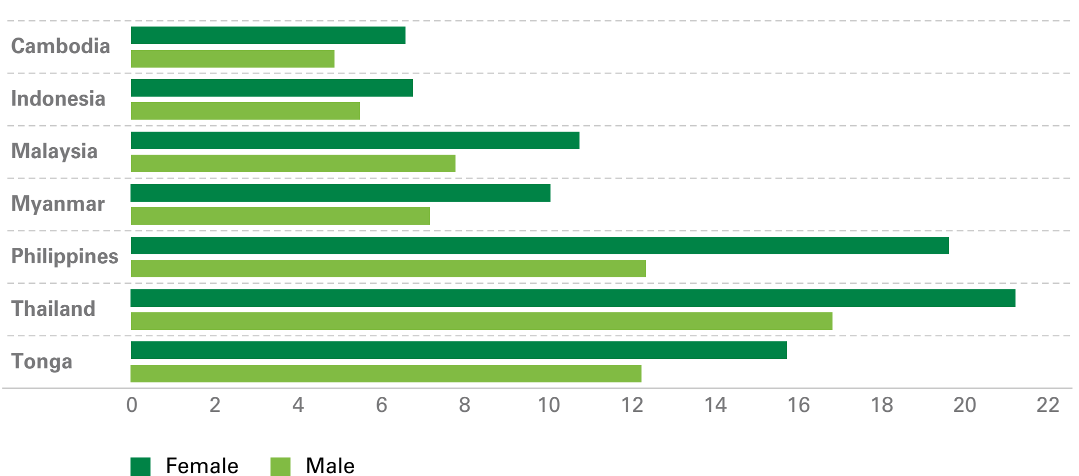
Child marriage and early pregnancy are also associated with poorer mental health outcomes, with some studies from the region reporting higher rates of perinatal depression and anxiety among adolescent mothers compared with adults.[30–32] In Southeast Asia, around 1 in 10 girls (and 1 in 20 boys) aged 15–19 years are currently married, with 1 in 7 girls (and 1 in 30 boys) married in the Pacific.[33] Adolescent pregnancy is also common – 1 in 13 girls in Southeast Asia and 1 in 8 in the Pacific have commenced childbearing by the age of 18 years.[33]

Children and adolescents living in alternative care, including residential care, are also at increased risk of poor mental health and exposure to risk factors, such as violence. Accurate data on the numbers of children living in alternative care are limited; however, UNICEF estimated that in 2016 there were around 772,000 children in East Asia and the Pacific in residential care.[34] There are very limited data describing the mental health needs or risks for these children. Small studies have reported higher rates of behavioural problems, depression and anxiety among children in care compared to those living with parents,[35] and those who have exposure to risk factors for poor mental health such as corporal punishment, caregiver and peer violence and aggression, and prolonged institutionalization and family separation.[36,37]

THE WORLD AROUND THE CHILD

In addition to healthy parent/carer relationships, ***peer relationships and connectedness*** also influence mental health and well-being, particularly during adolescence. GSHS for this region report that between 2 and 19 per cent of adolescents felt lonely most or all of the time during the 12 months preceding the survey (see Figure 10), and between 3 and 16 per cent had no close friends. In all countries with data, more girls reported being lonely compared with boys. In Thailand, where the most recent data are available, the rate of loneliness among adolescents doubled from 2015 (9.9 per cent) to 2021 (19.2 per cent).[15]

FIGURE 10. PREVALENCE OF LONELINESS AMONG 13–17-YEAR-OLDS, SOUTHEAST ASIA AND THE PACIFIC (IN COUNTRIES WHERE DATA ARE AVAILABLE)



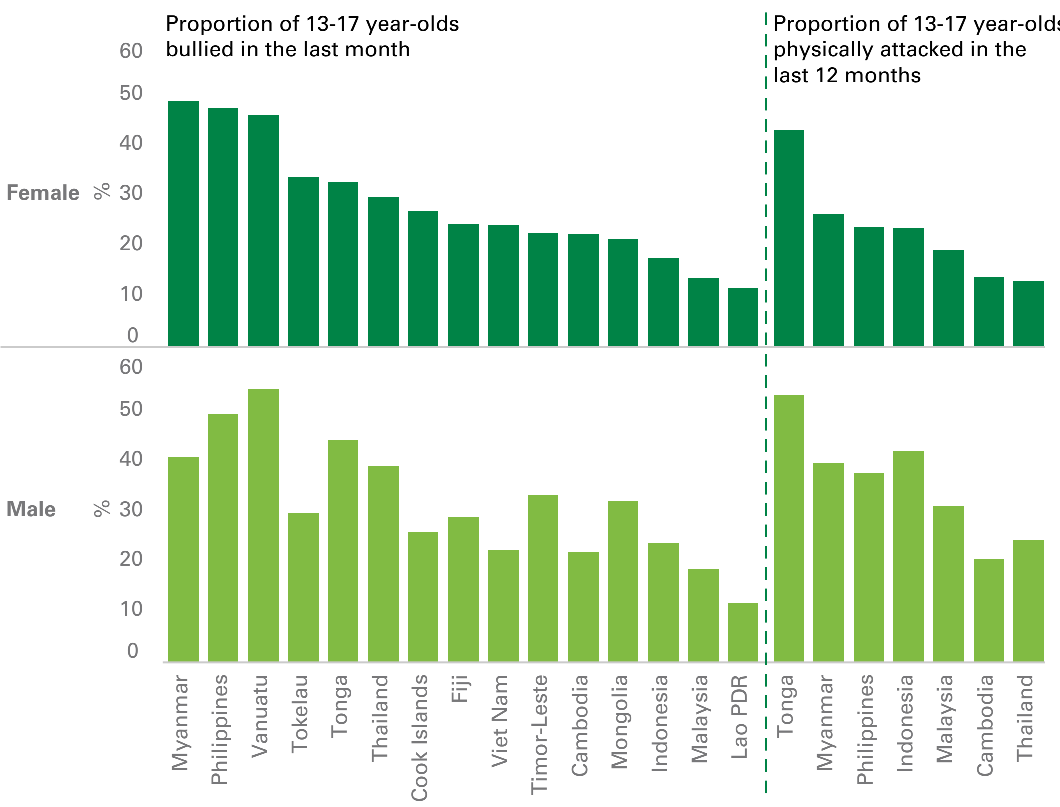
Source: GSHS 2013–2021.

Exposure to bullying[iii] behaviour, harassment and violence are risk factors for poor mental health and are highly prevalent among adolescents in this region. Between 1 in 10 and 1 in 2 school-going adolescents aged 13–17 years report having experienced bullying behaviour (including teasing, verbal abuse, threats, harassment and physical violence from a peer(s)) in the past month (see Figure 11). Boys had a higher prevalence of experiencing all forms of bullying behaviour compared with girls (see Figure 11). ***Online bullying behaviour*** (also known as 'cyberbullying') and online harassment are also common in some countries. In Thailand, for example, 17 per cent of boys and 14 per cent of girls aged 13–17 years reported experiencing online bullying in the previous 12 months.[15] Other studies conducted in 2010[38] and 2015[39] among students and out-of-school adolescents found that around half had been victims of online violence or harassment in the past year, and 43 per cent had perpetrated online bullying behaviour. Perpetrating or experiencing online violence was strongly associated with perpetrating or being a victim of offline violence or harassment. In addition, three quarters of adolescents had witnessed online violence or harassment in the past year.[39] In the Philippines, online bullying behaviour was reported by 43.8 per cent of 13–18-year-olds in the National Baseline Study, including verbal abuse and sexual harassment (including receiving unsolicited and unwanted sexual images).[40]

Witnessing, perpetrating or being the victim of ***physical violence*** is also common. Across countries with available GSHS data, between 17 and 49 per cent of 13–17-year-olds reported being physically attacked in the prior 12 months (see Figure 11), with the prevalence of physical violence higher among boys than girls.

iii The term 'bullying' is used here as it is consistent with the survey measures referenced. However, it is noted that there is an emerging approach to redefine bullying as 'unhealthy relationships or situations', with a focus on the behaviour itself, its determinants and impacts, rather than on the child.

FIGURE 11. BULLYING BEHAVIOUR AND VIOLENCE AMONG 13–17-YEAR-OLDS, EAST ASIA AND THE PACIFIC (IN COUNTRIES WERE DATA ARE AVAILABLE)



Source: GSHS 2013–2021.

Sexual harassment, sexual violence and intimate partner violence are also important risk factors, most notably for adolescent girls. Among adolescent girls and young women aged 15–25 years who have ever had a partner, 17 per cent in Southeast Asia and 55 per cent in the Pacific report having ever experienced physical or sexual violence committed by their partner. Between 3 and 5 per cent of girls report having been the victim of non-partner sexual violence.[33] With rapidly increasing internet penetration in the region, ***online sexual exploitation and abuse*** is increasingly prevalent. Recent studies of internet-using adolescents aged 12–17 in Thailand and the Philippines reported that 9 per cent and 20 per cent in each country, respectively, had experienced serious online sexual exploitation in the past 12 months, including being blackmailed to engage in sexual activities, having sexual images shared without permission, or being coerced to engage in sexual activities through promises of money or other gifts.[41,42] Online sexual exploitation has been associated with high rates of post-traumatic stress, low self-esteem and behavioural problems (including sexualized behaviour).[43] The wide reach and permanence of images generated through online sexual exploitation and abuse also contribute to ongoing trauma and significant psychological distress.[44]

Safe and enabling learning environments profoundly influence mental health and well-being. Participation in early education, primary and secondary school are important protective factors. The majority of primary school-aged children in East Asia and the Pacific participate in primary education; however, around 1 in 10 children are not participating in early childhood education. Similarly, 1 in 10 adolescents are not participating in lower secondary education, with 24 per cent of boys and 16 per cent of girls not engaged in upper secondary education.[2]

Schools can also be a source of psychological stress and risks factors for poor mental health, including violence and bullying behaviour. In the Philippines, a national study on violence against children reported that 5.3 per cent of 13–18-year-olds reported ever experiencing sexual violence or harassment at school,40 and in Thailand 1 in 5 students had been bullied at school (compared with 1 in 10 outside of school).[15] Corporal punishment and verbal abuse by teachers is also commonly reported.[27] Academic pressure, including family expectations about academic performance and

perceived competition with peers, contribute to high rates of self-reported psychological stress among students, and have been associated with depression, anxiety and substance use.[45,46] Limited data suggest that these pressures have increased during the COVID-19 pandemic, with the pressure of online learning compounded by social isolation and disruption in the usual supports.[47]

THE WORLD AT LARGE

Multiple studies have described risk factors for poor psychosocial development affecting ***refugee, displaced and stateless children***, such as child abuse, neglect and chronic exposure to adult mental health problems, substance abuse and violence.[48,49] Undocumented migrants often lack legal status and protections, including access to health and other services critical for mental health and well-being.[50,51] ***Exposure to conflict*** also increases the risk of poor mental health. For example, a 2018 study of 478 West Papuan refugee adults in Papua New Guinea found that exposure to conflict and childhood trauma increased the risk of any mental disorder, and complex post-traumatic stress disorder in particular.[52] Children and adolescents exposed to a ***natural disaster*** are also at increased risk of poor mental health, including post-traumatic stress disorder, anxiety and depression.[53] Over 900,000 children have been directly impacted by the most recent typhoon to strike the Philippines, with UNICEF estimating that 531,000 have urgent need for child protection services and MHPSS.[54]

Child labour is also likely to be an important determinant. Between 4 and 28 per cent of children aged 5–17 years are involved in child labour in East Asia and the Pacific. Data describing the mental health needs among child and adolescent workers are extremely limited; however, a 2012 study in the Philippines reported that two thirds of domestic workers were aged under 15 years, and feelings of being stressed and overwhelmed were common.[55] ***Child trafficking*** for sexual exploitation, forced labour, forced marriage or illegal adoption is also associated with significant psychological harm, trauma and mental disorder.[56] Between 23 and 36 per cent of children experience severe ***poverty*** in at least one dimension of deprivation in Mongolia, Timor-Leste, Lao PDR, Cambodia, Myanmar and Papua New Guinea, and only 14 per cent of children in the region are covered by social protection.[2] While data for this region are limited, global studies have demonstrated that children from the poorest households are at increased risk of poor mental health as well as exposure to other risk factors impacting on psychological well-being (such as family stress and violence, trauma, carer attachment, limited access to education, and stigma and discrimination).[2]

Stigma and discrimination are also important contributors to mental health. Misconceptions and stigma associated with mental health are common and an important contributor to poor access to MHPSS.[57] For adolescents in particular, stigma and discrimination experienced by those whose sexuality and/or gender identity do not conform to rigid norms also contributes to a high burden of poor mental health. In a 2019 study in Chiang Mai, northern Thailand, sexual minority youth (homosexual, bisexual and questioning) were found to have significantly higher emotional and behavioural problems than heterosexual youth. This was considered likely related to social stigma, exclusion and discrimination.[58] A 2013 Mahidol University study found that 55.7 per cent of lesbian, gay, bisexual, or transgender students reported having been bullied, with 30.9 per cent reporting physical abuse, 29.3 per cent verbal abuse, 36.2 per cent social abuse and 24.4 per cent sexual harassment.[27]

A more recent threat to mental health is ***COVID-19***.[9,10] Public health approaches that limit social interactions and disrupt education and employment (and the resultant isolation and increased use of social media and the potential increase in exposure to family violence and conflict) and online sexual exploitation have acute impacts on mental health, whilst the economic uncertainties and projected socioeconomic inequalities will have more long-term implications.[59] These crises can also result in resources being diverted away from mental health services, and combined with greater needs, can result in services being more difficult to access. In a UNICEF survey in Thailand in 2020, 70 per cent of children and young people reported they had significant stress, worry and anxiety symptoms due to the pandemic.[60] In a 2020 survey of nearly 2,000 Filipinos, adolescents and youth aged 12–21 were the age group reporting the highest levels of stress (19.8 per cent reporting moderate or above), anxiety (37.4 per cent) and depression (26.3 per cent).[61] A regional study conducted by World Vision reported that 1 in 18 children reported feeling so hopeless that they did not want to continue living in the two weeks prior to the survey, and one third said that feelings of hopelessness had increased since COVID-19.[62] Other qualitative studies have also reported high levels of stress and anxiety related to the COVID-19 pandemic, including fear of illness, feelings of hopelessness and isolation, worry related to financial stress, and stress related to online learning.[47]

A regional framework for MHPSS for children and adolescents in East Asia and the Pacific

The first phase of this project developed a regional conceptual framework for MHPSS for children and adolescents. The framework was developed through: a review and synthesis of existing global and regional frameworks for mental health and evidence for effective interventions; review and expert consensus provided by the Regional TAG and external content experts; and review and feedback from the Country TAG and stakeholders in Malaysia, Papua New Guinea, the Philippines and Thailand during consultation workshops. Further details are provided in Appendix B.

An important foundation for this framework is the *UNICEF Global Multisectoral Operational Framework for mental health and psychosocial support of children, adolescents and caregivers across settings.*[12] The Global Framework defines a range of interventions to promote psychosocial well-being and prevent and manage mental health conditions, providing guidance to support planning and implementation. While the inception of this research initiative predates the finalization of the Global Framework, the regional framework has sought to include and harmonize key actions for MHPSS in East Asia and the Pacific with the global guidance. The purpose of the regional framework is specifically to define the MHPSS actions that are a high priority for East Asia and the Pacific and provide detailed guidance to support implementation, with a focus on describing sectoral roles and recommendations to strengthen a multisectoral mental health system.

Guiding principles of the framework

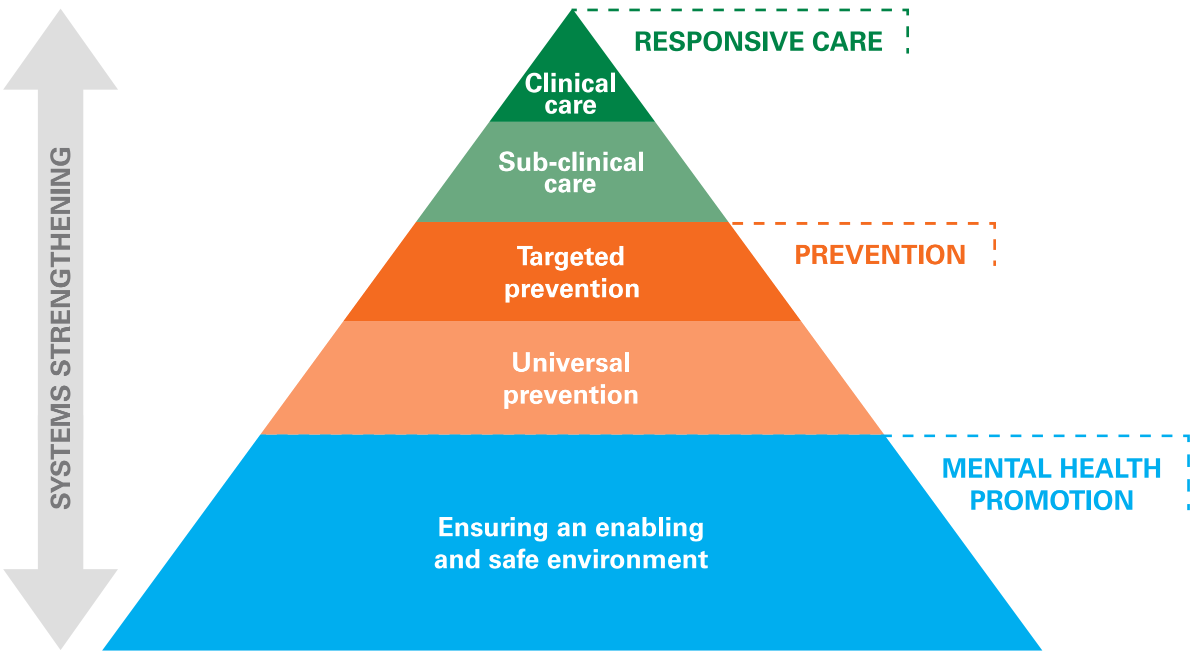
Aligned with the Global Multisectoral Operational Framework, the regional framework adopts a **socioecological approach** to addressing MHPSS, recognizing that the mental health and well-being of children and adolescents is profoundly influenced not only by individual attributes and experiences, but also by relationships with family, peers, communities and the broader environment within which children grow, learn and socialize. The framework also considers mental health and well-being across the **life course**, recognizing childhood and adolescence as critical periods of cognitive, social and emotional development with implications for mental health and well-being that extend into adulthood and to the next generation. Responses to mental health needs and risks should be based on developmental stages and needs, rather than on a rigid application of biological age, and should consider the cumulative impacts of risks (or protective factors) across the life course. Finally, the framework also acknowledges that there are significant gendered differences in risks, experiences, care-seeking behaviour and outcomes with respect to mental health. Children with disabilities also experience unique mental health needs and barriers to accessing MHPSS. Responses, therefore, must take specific measures to ensure that MHPSS actions are **gender-responsive, accessible, inclusive and seek the active participation** of children, adolescents and their families.

A regional framework for child and adolescent MHPSS

Priority MHPSS actions for children and adolescents

The regional framework defines three key tiers of actions required to ensure the mental health and well-being of children and adolescents, with systems strengthening as a cross-cutting theme (see Figure 12).

FIGURE 12. KEY TIERS OF MHPSS ACTIONS FOR CHILDREN AND ADOLESCENTS



Within each of the three tiers are **domains of action**:

Responsive care for children and adolescents with mental health conditions

This includes care that is **age- and developmentally appropriate, gender and disability-inclusive, and non-discriminatory**. Key domains include:

- ***Screening, assessment and early identification of mental health needs*** to identify children and adolescents who are at risk or have mental health conditions, with a focus on those who would most benefit from care. It also includes the ***referral pathways*** (between and within sectors) for those requiring specialized care or social support and protection, noting that screening in the absence of referral and accessible care can be stigmatizing.
- ***Management/treatment*** that is responsive to the needs of children and adolescents, including care that is developmentally appropriate, accessible, comprehensive and culturally appropriate, including for:

- ***Clinical mental disorders,*** which refers to a clinically diagnosable disorder generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (5th edition) or the International Classification of Diseases.
- ***Subclinical mental disorders and mental health conditions,*** when children and adolescents show signs or symptoms of a mental or psychological disorder that is below the clinical threshold for mental disorder.

- ***Continuing care***. Mental health typically fluctuates for individuals over their life cycle. For those with identified needs, these may increase or decrease over time and may be exacerbated by stressful life events. Continuing care (that ensures accessible care and support as required) is essential to ensuring the best outcomes for children and adolescents, as well as ensuring optimal outcomes across the life course.

Prevention of mental health conditions in the immediate social context

These actions aim to address risk factors for poor mental health and enhance protective factors. These can be universal (that is, applicable to all children and adolescents, for example limiting access to alcohol and other drugs), or targeted (focused on children and adolescents with high-risk behaviours or in high-risk settings, for example interventions to address harmful substance use). It includes four domains of action, coarsely mapped against the socioecological framework:

- ***Building individual assets of children and adolescents***, aimed at fostering individual-level assets (physical health, intellectual development, psychological and emotional development, and social development). This includes a focus on social and emotional learning, building resilience and improving mental health literacy in children and adolescents.
- ***Strengthening positive peer support (including online),*** given that peer relationships are a critical protective factor for good mental health. This also includes addressing harmful peer relationships (online and offline), including bullying and victimization (including cyberbullying).
- ***Psychosocial competence building for parents/carers,*** including positive parenting practices and improving their skills in responsive and nurturing caregiving. This includes a focus on preventing harmful parenting, as well as addressing parental mental health.
- ***Safe and enabling learning environment*** that ensures a pro-social environment in a setting where children and young people are connected, supported and not subject to harmful exposures (all forms of physical or mental violence, injury and abuse, discrimination and exclusion, neglect or negligent treatment, maltreatment or exploitation, including online sexual exploitation and abuse).

Ensuring a safe and enabling environment to promote mental health

- These actions seek to address the structural determinants of mental health and well-being in relation to where children and adolescents live, grow and learn through policy and legislation, and community engagement. The determinants of psychosocial well-being are very broad, encompassing factors such as secure housing, the environment and climate change, poverty, nutrition, social justice and equality, disaster, conflict, economic and fiscal contexts, and political contexts. Following consultation with the Regional TAG and expert advisors, this tier of the framework was narrowed to specifically focus on actions in relation to:
- ***Community engagement and participation*** – the active involvement of people from communities, including adolescents and those with lived experience of poor mental health and risk factors, in the process of planning, delivering, monitoring and evaluating policies and programmes, and in mental health advocacy. The involvement of community members is essential to determine their own priorities in dealing with mental health conditions with respect to cultural context. Community engagement is also central to addressing harmful norms, attitudes and beliefs that contribute to poor mental health (for example, discriminatory attitudes towards non-conforming

gender identity or expression), to poor care-seeking behaviour (for example, harmful norms around masculinity that discourage seeking help), and to stigma and discrimination against children and adolescents with mental health problems.

- ***Policy and legislation*** that both enables and protects the rights of children and adolescents with mental health conditions, protects children and adolescents from harm and risks associated with poor mental health, and provides a clear framework for the system and sectoral roles in responding to and supporting mental health, including sufficient allocation of public resources for MHPSS. Legislation should reflect the values and principles of human rights and the Convention on the Rights of the Child (CRC), with the best interests of children and adolescents as a primary consideration. This includes, but is not limited to, the right to equality and non-discrimination, dignity and respect, privacy and individual autonomy, and information and participation.[63]

The MHPSS actions for each domain are set forth in Table 2 below.

Table 2. Package of priority MHPSS actions for children and adolescents

Accessible and responsive services for mental health conditions	
Screening and early identification of needs	
Early identification of mental health conditions and risks	Train and sensitize providers engaged in child and adolescent development, education and welfare to identify, support and refer children and adolescents with mental health needs (for example, nutrition actors, teachers, school-based counsellors, social welfare workers and justice-sector workers).
	Train and sensitize primary healthcare providers to identify, support and refer children and adolescents with mental health needs.
Screening children and adolescents at higher risk for poor mental health	Strengthen screening of children and adolescents (and parents/caregivers) with high-risk behaviours (e.g., substance use) in clinical settings, and consider this for school, child protection and justice settings.
	Strengthen screening of children and adolescents (and parents/caregivers) with high-risk exposures (e.g., family violence, sexual violence, family separation, chronic illness, HIV) in clinical settings, and consider this for school, child protection and justice settings.
	Strengthen screening of pregnant and postpartum adolescent girls through antenatal and postnatal services.
Strong referral pathways	Establish referral criteria and mechanisms both within the health system and from other sectors/settings (schools, social welfare/child protection, justice).
	Strengthen self-referral through helplines/hotlines/online.
	Integrate mental health into primary healthcare and physical health services.
Management of clinical and subclinical mental health conditions	
Accessible and inclusive mental health services	Establish child, adolescent and family-friendly services that are inclusive.
	Deliver community-based and mobile services, including for underserved children and adolescents (and their families).
Responsive care for subclinical conditions	Establish child and adolescent specialist support, case management and therapy provided by multidisciplinary team.
	Establish specialized services and support to families of children with complex behaviours and needs in social welfare/child protection/justice settings.

Responsive care for mental disorders	Establish specialist clinical child and adolescent mental health treatment and care (including hospital-based care).
	Provide child and adolescent mental health residential rehabilitation services.
Continuing care	
Continuing care for those with mental health conditions	Provide person-centred care that includes social support, peer support, mental health professionals to support recovery and rehabilitation.
	Ensure ongoing participation in education for those with mental health conditions.
	Provide education and support for parents of children and adolescents with mental health conditions.
Prevention of mental health conditions in the immediate social context	
Build individual assets of children and adolescents	
Social and emotional learning, resilience, and problem-solving skills	Implement universal interventions and approaches in early education, schools and out-of-school settings that focus on: social and emotional learning; positive behaviours; social connectedness; effective problem-solving; help-seeking behaviours; digital literacy; mental health literacy; and common risk factors for poor mental health.
Targeted interventions for children and adolescents at risk	Deliver selective, intensive programmes in clinical, school, community, residential care and justice settings for children and adolescents with high-risk behaviours (such as substance use) or exposures (including as part of emergency response in humanitarian or disaster settings). Interventions can be packaged with counselling and referral to services for screening and further care.
	Provide guidance and support to schools on effective interventions following crisis (including suicide in the community).
Build the psychosocial competence of parents and carers	
Safe, stable parenting and attachment	Implement programmes to raise awareness about nurturing and responsive care, positive parenting, non-violent discipline, and social and emotional learning/mental health of children and adolescents.
	Implement parenting programmes focused on building skills in nurturing and responsive care, positive parenting practices and non-violent discipline across early childhood, childhood and adolescence, including targeted support for parents and caregivers of children with disabilities or at higher risk of poor mental health.
	Implement programmes to raise awareness and build capacity in positive and non-violent caregiving for providers of alternative care (including residential care).
	Identify and address the mental health needs of parents/guardians/caregivers.
Strengthen positive peer support, including online	
Positive peer relationships	Establish and support peer-to-peer groups and youth clubs in school and community settings.
	Develop or strengthen online social networks that promote mental health literacy and positive peer support among children and adolescents.

Address peer-victimization	Implement programmes to promote online and digital civility and digital literacy among children, adolescents, parents and education staff. Integrate education on digital civility and literacy into the school curriculum.
	Implement school policies and curricula that promote healthy and respectful peer relationships and address peer-to-peer violence and harassment as part of wider skills development.
Ensure safe and enabling learning environments	
Optimal school environment for mental health and well-being	Implement a whole-of-education approach to mental health promotion (early education, primary, and secondary levels). In addition to curriculum-based and other approaches to support social and emotional learning and positive peer relationships outlined above, this should also include strategies and policies to ensure a safe, respectful and inclusive environment with a focus on well-being; positive approaches to behaviour management; violence prevention; promotion of positive teacher-student relationships; and participation and partnerships with students, parents, community and service providers.
	Promote teacher-parent communication on the safety and well-being of children and adolescents.
Teacher and education staff capacity to support student mental health	Provide training and resources to teachers, school counsellors and other education-based workers to build mental health literacy and skills to support mental health and social and emotional learning of children and adolescents.
	Implement programmes to support the mental health and well-being of teachers and education-based workers.
Mental health promotion: Ensuring an enabling and safe environment	
Community engagement and participation	
Community-based mental health promotion	Implement campaigns to: raise awareness about mental health; address mental health-related stigma, discrimination and abuse; and promote help-seeking behaviours.
	Train community-based workers, volunteers, young people, religious and community leaders and educators to raise awareness about mental health, promote mental health literacy and address harmful social and gender norms.
	Build the capacity of adolescents and provide opportunities for them to participate in the planning, design and evaluation of MHPSS policy and programmes and mental health advocacy (including adolescents with lived experience of mental health).
Supportive mental health-related policies and legislation at national and subnational level	
Policies, strategies and plans for child and adolescent mental health	Assess and address the barriers for children and adolescents in accessing mental healthcare, particularly for marginalized groups
	Adopt a national mental health strategy/policy that details the multi-tiered and multisectoral vision and plan for mental health, and develop and adopt a multisectoral (costed) implementation plan with specific goals, actions and performance indicators for child and adolescent mental health.

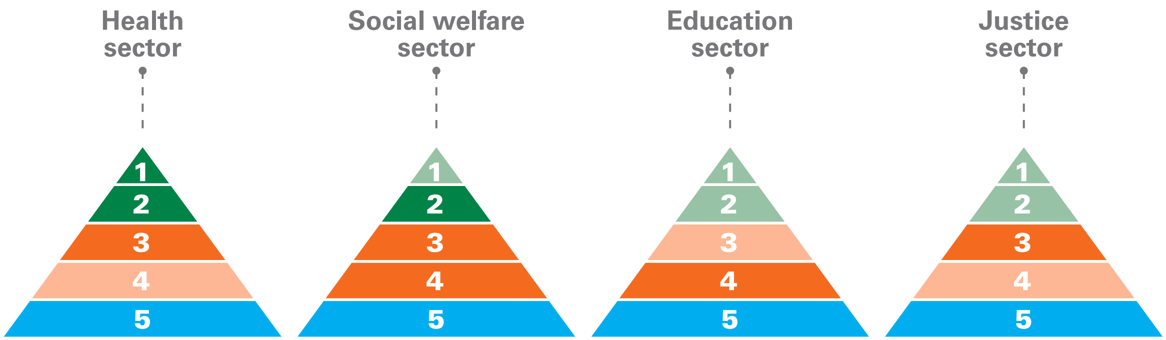
	Ensure sufficient allocation of public resources to implement the national policy through detailed costing, defined budget lines, and allocation and expenditure tracking across all key sectors.
	Adopt a multisectoral, national suicide-prevention plan and integrate prevention of suicide and self-harm across child and adolescent health, development and welfare programmes.
	Integrate mental health into child and adolescent health, primary healthcare, nutrition, and maternal and child health policies and plans.
	Integrate mental health into education sector policies and plans, including a whole-of-education approach to mental health promotion.
	Integrate mental health into early childhood development, child protection/ending violence, social welfare and social protection policies and plans.
	Integrate the mental health of children and adolescents into juvenile justice and justice health policy and plans.
Legislation and actions required for effective mental health services	Adopt national standards that define high-quality mental healthcare for children and adolescents (minimum standards of care) that include relevant sectors and government, non-government and private providers.
	Adopt legislation and develop implementation guidance that ensures children's and adolescents' right to access mental health services in accordance with their evolving capacities and in a manner that protects confidentiality. This includes removing mandatory requirements for parental consent for adolescents and identifying core statutory services.
	Adopt legislation that mandates access to mental healthcare for children and adolescents who are deprived of liberty, in conflict with the law, or in out-of-home placements.
	Address legislation that denies access to mental healthcare for migrant, displaced or other marginalized children and adolescents.
	Remove legislation that criminalizes suicide or attempted suicide.
Legislation to protect children and adolescents within the mental health system	Prohibit physical restraint of children and adolescents with acute mental conditions in home, school, healthcare or any other settings providing services or care.
	Adopt protections (legislation, regulation, monitoring and complaints mechanisms) to ensure that deprivation of liberty, including detention for mental health purposes, is a last resort, for the shortest appropriate period, and subject to periodic review.
Policies, programmes and legislation to protect children and adolescents from harm and discrimination	Prohibit all forms of violence (physical, sexual, emotional) against children and adolescents in all settings, including home, school, online, and in places of alternative care and detention.
	Prevent family separation by addressing the drivers or causes of alternative care (such as abuse, neglect, poverty) as well as policies that support deinstitutionalization and reintegration of children in residential care.
	Prohibit early marriage of children under the age of 18 years.

Policies, programmes and legislation to protect children and adolescents from harm and discrimination	Prevent and eliminate child labour (defined as work that deprives children of their childhood, their potential, their dignity, and is harmful to physical health or mental development).
	Prohibit the association of children and adolescents with and their recruitment by armed forces/groups.
	Legislate a minimum age of purchase of substances (alcohol and other drugs). Introduce alternatives to criminalization of possession and use of substances by adolescents under the age of 18 years.
	Adopt legislation that restricts access to lethal means (firearms, poisons, drugs).
	Legislate a minimum age of criminal responsibility (UNCRC recommends at least 14 years).
	Adopt legislation to protect children and adolescents from discrimination on the basis of gender identity or sexual orientation, and decriminalize consensual sexual acts.
	Adopt legislation to prohibit discrimination on the basis of gender, race, ethnicity, religion, disability, HIV-status, nationality, political affiliation or geographic location.
	Implement social protection programmes (social insurance, social protection schemes and other means) with a focus on families and carers of children and adolescents.

Sectoral roles and defining the multisectoral mental health workforce

In addition to identifying what 'actions' are required within each of these tiers, the framework also describes broad roles for key sectors in implementing MHPSS for children and adolescents (see Figure 13).

FIGURE 13. SUMMARY OF BROAD SECTORAL ROLES FOR MHPSS DARKER SHADE INDICATES WHERE A SECTOR SHOULD HAVE A LEADERSHIP ROLE OR PRIMARY RESPONSIBILITY FOR IMPLEMENTATION, BY TIER OF ACTION.



1 Clinical **2** Subclinical **3** Targeted prevention **4** Universal prevention **5** Ensuring environment

Darker shade indicates where a sector should have a leadership role or primary responsibility for implementation, by tier of action.

The **multisectoral mental health and psychosocial support workforce** required to deliver these actions is challenging to define as it is diverse and dynamic, incorporating specialist providers whose primary roles relate to mental health through to providers and volunteers who may not identify as part of a 'mental health workforce' but who are required to deliver aspects of MHPSS (even if this is not considered part of their primary role). The three tiers of MHPSS action (responsive care, prevention, mental health promotion) can be coarsely mapped against the corresponding multisectoral MHPSS workforce as shown in Figure 14.

FIGURE 14. KEY TIERS OF THE WORKFORCE REQUIRED TO ENSURE MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The specific roles and responsibilities of each sector and related workforce were explored in depth during country-level analysis; however, the regional framework proposes broad overarching roles:

The ***health sector*** plays a central role in ensuring accessible and responsive mental health services for children and adolescents with mental health conditions. This includes the delivery of early identification, screening, referral and management by non-specialist providers (general practitioners, nurses, midwives, community health workers and volunteers, auxiliary health providers) through to specialized care for severe or complex cases by child and adolescent psychiatrists, mental health nurses, neurodevelopment and behavioural paediatricians, clinical psychologists, occupational therapists and speech therapists. The health sector may also play an important role in targeted prevention for those at risk of poor mental health (for example, provision of preventative interventions for children and adolescents with comorbid health conditions, those identified to have risk behaviours such as substance use, those in high-risk settings, supporting positive parenting and parents with mental health conditions), and in mental health promotion (increasing mental health literacy and addressing harmful norms and stigma). The health sector may also have an overall leadership and advocacy role in MHPSS, given that the health service plays a key role in mental health service provision.

The ***social welfare sector*** has a significant role in the delivery of MHPSS. The social service workforce broadly encompasses government and non-government professionals, paraprofessionals and community volunteers who not only work within social welfare or community development, but may also be employed by other sectors (including health, education and justice). Because of the particular focus on child protection and working with families at risk, this sector has a crucial role in the delivery of targeted, preventive interventions to address key risk factors, in particular for children and adolescents and their families with high-risk exposures for poor mental health (for example, those exposed to violence, neglect or exploitation). This also includes delivering and supporting programmes to improve responsive and nurturing caregiving, which may be universal or targeted to those at increased risk (such as parents with mental health conditions). This sector also has a key role in early identification and screening in some settings, supporting a strong referral system, and the provision of responsive care for mental health conditions as part of a multidisciplinary team. There is also a broader opportunity to ensure an enabling environment for good mental health through social welfare and social protection that addresses the social determinants of health. The social welfare sector may also play a key role in community-based and national advocacy that can help to address stigma and harmful norms.

The ***education sector*** is critical for implementation of universal, preventive interventions, as well as ensuring that school and learning environments promote mental health and well-being. The education sector arguably comprises the biggest MHPSS workforce as teachers, school-based counsellors, psychologists and volunteers (such as peer counsellors) have the potential to reach large numbers of children and adolescents. In addition to delivery of curriculum-based approaches to support social and emotional learning, there is also an opportunity for schools to shape attitudes and norms around mental health and positive relationships that contributes significantly to building an enabling environment for good mental health. Teachers, school counsellors and school-based psychologists can also play a role in early identification and assessment of mental health needs, referral, behavioural management and targeted prevention. Schools also have an important role in supporting children and adolescents with mental health needs, including through ongoing opportunities for education, as well as providing alternative learning pathways. Schools may also provide an opportunity for screening, with careful consideration; screening alone, in the absence of accessible services and support, can be stigmatizing. Additionally, lack of age, cultural and language-validated tools, limited training in their application and a lack of confidentiality may contribute to misdiagnosis, pathologizing normal behaviours, and stigma.

The ***justice sector*** also has a significant role in supporting children and adolescents who are at increased risk of poor mental health, including those who are in conflict with the law and those who are victims (or witnesses) of violence. This includes responding to existing mental health needs and risk factors (such as exposure to violence or substance misuse) for children in conflict with the law, as well as preventing (or responding to) further harm and risks exacerbated by detention. In collaboration with the social welfare and health sectors, the police, public prosecutors, court psychologists, probation officers, detention centre workers, social service workers and judges could support the delivery of early identification and screening in some settings, as well as referral and linkages with mental health services, and targeted prevention and response in justice settings (including addressing the harmful use of substances and programmes to build individual assets and skills).

Primary responsibility for implementation, mapped against the tiered actions of the framework, are summarized in Table 3.

Table 3. Sectoral roles in implementing MHPSS actions Actions in *bold* indicate where a sector is recommended to have a leading role or primary responsibility for implementation

Accessible and responsive services for mental health conditions			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Screening for those at risk (including parents/ caregivers with mental health conditions)	Early identification of those with mental health conditions or risks, potential to also include more formal screening in schools	Screening for children and adolescents (and parents/caregivers) with high-risk exposures	Screening for high-risk behaviours and exposures
Referral systems and mechanisms Self-referral hotlines	Referral linkages and mechanisms	Referral linkages and mechanisms. Self-referral hotlines	Referral linkages and mechanisms
Multidisciplinary case management and support Targeted education and support for parents of children with mental health conditions and complex behaviours	Ongoing education participation for those with mental health conditions Integration of behavioural modification and psychological first aid	Multidisciplinary case management Targeted education and support for parents of children with mental health conditions and complex behaviours	Specialized services and supports – including provision of mental health services in detention settings
Community-based and outreach services		**Community-based and outreach services,** particularly for children and families at risk	Community-based programmes for children and families engaged in the justice system
Establishing specialized and clinical services		**Establishing specialized services and case management for families**	
Establishing residential services		Supporting residential mental health services	

Prevention of mental health conditions in the immediate social context			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Support to mental health approaches in education, including teacher well-being	**School and education-based programmes and approaches:** - Whole-of-education mental health promotion, including a focus on creating safe, respectful and inclusive learning environments, supporting social and emotional learning, and supporting positive peer and peer-teacher relationships -Teacher-parent communication -Teacher and staff well-being	Support to mental health approaches in education	
	Establishing youth and peer support groups	Establishing youth and peer support groups	
Digital literacy, **online networks for mental health**	**Digital literacy and civility education**	Digital literacy, **online networks** for mental health	
Intensive interventions to address risk factors Support to schools following crisis (e.g., suicide in community)	Intensive interventions to address risk factors **School-based interventions following crisis in the community (e.g., suicide)**	**Intensive interventions to address risk factors**	Supporting intensive interventions to address risk factors, including substance use
Identify and address mental health needs of parents/carers	Raise awareness about positive parenting	**Parenting programmes** to build skills in nurturing and responsive care, non-violent discipline and mental health literacy	Supporting parenting programmes for families engaged in the justice system

Mental health promotion: Ensuring an enabling and safe environment			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
National, multisectoral mental health plans and strategies, including suicide prevention	**Integrating mental health into education policies**	**Integrating mental health into early childhood development, child protection/ending violence, social welfare and social protection policies and plans**	**Integrating mental health of children and adolescents into juvenile justice and justice health policy and plans**
Integration of mental health into maternal and child health, adolescent health, nutrition, and HIV policies and strategies			
Policy and standards for high-quality mental healthcare		Identifying barriers in access to mental health services for marginalized groups	**Protections for children and adolescents in the mental health system**
		Social protection programmes for families	
Training and community-based programmes to address stigma and discrimination	Address stigma and discrimination as part of mental health education	**Training and community-based programmes to address stigma and discrimination**	
Capacity building for adolescents to support participation, including those with lived experience of mental health needs, in the planning and design of MHPSS	**Capacity building for adolescents to support participation,** including those with lived experience of mental health needs, in the planning and design of MHPSS	**Capacity building for adolescents to support participation,** including those with lived experience of mental health needs, in the planning and design of MHPSS	
All sectors were identified as having an important role in advocating for, and implementing, legislation to protect children and adolescents from harm and discrimination and ensuring their rights to confidential, non-discriminatory mental healthcare.			

In addition to sectors having key responsibility for implementing different MHPSS actions within each tier, there are **several critical areas of convergence** where effective implementation of specific actions requires strong collaboration across sectors. These include actions to:

- Improve early identification, screening and referral to multidisciplinary care;
- Ensure continuing care and support for children, adolescents and their families experiencing mental health conditions or who are at increased risk;
- Implement targeted, intensive interventions for children and adolescents who are at increased risk of poor mental health (particularly in relation to high-risk exposures such as violence and conflict with the law);
- Implement whole-of-education approaches to prevent poor mental health and promote well-being; and
- Support positive parenting and provide services and supports to parents and carers of children with mental health needs, or for their own mental health needs.

NGOs also have a potentially important role in the implementation of MHPSS. Many organizations are engaged in areas that relate in some way to mental health and well-being (such as physical health, sexual and reproductive health, child welfare and child development), providing a platform to integrate more specific MHPSS actions. In particular, strong partnerships with communities and understanding of community needs would facilitate delivery of actions around mental health literacy, addressing stigma, community-based service delivery (identification, referral and first aid), and programmes to support parents and families. Additionally, the NGO sector, including youth organizations, has a potentially important role in supporting mental health advocacy. Youth organizations can also support actions to promote mental health literacy and youth participation in the design and implementation of preventive and care interventions in community, online and school settings.

The ***private sector*** also has a potential role in filling service-delivery gaps, including through government out-sourcing, particularly where public services are limited. The private sector also has a potential role in providing financial support or other resources (technology, including digital technology, expertise, training opportunities) to support MHPSS initiatives through corporate social responsibility programmes.

Considerations for strengthening a multisectoral mental health system

Finally, the regional framework also identifies eight pillars of **systems strengthening** required to enable effective and equitable implementation of these actions within and across key sectors (see Figure 15), and outlines some key considerations for strengthening a multisectoral mental health system (see Table 4).

FIGURE 15. PILLARS OF SYSTEMS STRENGTHENING

Pillar	Description
Legislation and policy	*To promote and enabling environment, provide the legal and regulatory frameworks required to support implementation of MHPSS, and policies and plans to strengthen systems and services delivery
Leadership and governance	*To enable coordination within and across sectors, between levels of government, and with non-government and informal providers, with clearly defined roles, responsibilities, and accountability
Service delivery	*Modules of delivery to ensure services are equitable, inclusive, accessible to all, and age / developmentally appropriate. Includes identifying what actions can be integrated into existing platforms and what new models / platforms are required
Standards and oversight	*To support quality assurance and accountability
Workforce	*The multi-sectoral mental health workforce (across health, education, social welfare and justice), with defined roles, competencies, training and supervision
Budget and financial resources	*Adequate allocation and expenditure of resources, and financing mechanisms to ensure quitable access and quality of services
Participation	*Engagement and participation of children adolescents, families and communities in planning, design, delivery and evaluation of MHPSS
Data, information and research	*Mechanisms for collection, analysis and dissemination of reliable and timely information to support planning, implementation and monitoring and evaluation

Table 4. Considerations for strengthening a multisectoral mental health system

Pillar	Considerations
Legislation and policy	Laws, policies and strategies related to mental health need to: • Clearly define sectoral roles, responsibilities and accountability; • Establish regulation, accreditation and licensing with respect to the multisectoral mental health workforce. This may include the development of new policy and legal frameworks recognizing the profession of some mental health workers, including those in sectors other than health (for example, social workers and school-based counsellors); • Consider whether to develop stand-alone or new mental health policies/plans within sectors or integrate mental health into existing policies and plans; • Consider how MHPSS strengthening is integrated into ongoing system strengthening efforts for health, education, social welfare/ child protection and justice.
Leadership/ governance	• Identify the lead ministry/agency for MHPSS, with management and administrative capacity; • Clearly define the leadership role and responsibilities; • Establish or expand government department/unit to take up responsibility for mental health of children and adolescents in each relevant ministry (this could include integrating this responsibility into an existing department, such as child and adolescent health); • Establish or expand coordination structures for MHPSS, including institutional agreements, inclusive of key sectors, government and non-government agencies, and across the tiers of enabling environment, prevention and response; • Establish mechanisms for joint planning and programme design with respect to service delivery, information sharing, and monitoring; • Establish mechanisms for coordination of MHPSS within and between national and subnational levels; • Identify and clearly define sectoral roles, responsibilities and accountability at national and subnational levels; • Establish feedback mechanisms between national and subnational levels to enable monitoring, oversight and review.
Service delivery	• Define a minimum-services package (MSP), or priority package of actions, for MHPSS for children and adolescents, spanning the continuum of enabling environment, prevention and response. Identify what aspects of the MSP can be integrated into existing services/response, and what new services are required; • Define service-delivery models that reach children and adolescents and meet their needs (including what services can be integrated into existing platforms and what new models need to be developed);

Pillar	Considerations
Service delivery	• Identify which services and supports will be delivered by public/government agencies, and which by non-government (private sector and not-for-profit), and define the role of government in relation to non-government-delivered services (coordination, accreditation, monitoring and quality assurance, contracting, etc); • Define clear sectoral roles and responsibilities with respect to delivery of the priority package of actions; • Develop operating procedures and protocols with respect to screening and identification of children and adolescents at risk, referral pathways, multidisciplinary case management, and continuity of care; • Integrate mental health services and supports (including screening, referral, management, targeted prevention) with general physical health services to improve accessibility, early identification and referral, and holistic care; • Ensure MHPSS is inclusive, gender-, age- and disability-responsive, and is accessible to marginalized children and adolescents by: engaging diverse stakeholders in the design of policy/strategy/services; integrating gender and disability and other equity analysis into programme design; identifying and addressing key barriers to access; and developing gender-, age- and disability-sensitive monitoring and evaluation.
Standards and oversight	Development (by government or other national authority) of standards of care with respect to: • MSP components (for example, guidelines around screening for mental health risks or problems); • Child, adolescent and family-friendly standards of care/guidelines; • Confidentiality and privacy; • Parental consent; • Mandatory reporting for children and adolescents at risk of harm; • Referral pathways; • Use of physical restraints and deprivation of liberty/administrative detention; • Complaint processes/feedback; • Accreditation or certification of facilities (health, education, social welfare, justice, etc) and providers (including non-government and private sector providers); • Clear delegation of oversight responsibility and accountability across and within relevant sectors; • Where national ombudspersons, commissioners and institutions are in operation for children/children's rights/human rights, ensure that their mandate covers children's access to MHPSS and treatment and protection within mental health services and facilities.

Pillar	Considerations
Multisectoral mental health and psychosocial well-being workforce	• Based on policy/strategy for mental health, define the multisectoral. multi-tiered mental health workforce, including the roles, tasks and competencies required across sectors; • Identify those roles, tasks and competencies that can be integrated into existing workforce cadres, and what new roles/tasks/ competencies need to be developed; • Adopt legislation, policy and regulations with respect to the recognition and professionalization of the mental health workforce in the health sector and other sectors (for example, social service workforce); • Strengthen training for the multisectoral mental health workforce (pre-, in-service and continuing training) with consideration of core competencies, identification of training providers/institutions and recognition/accreditation of training; • Develop mechanisms for supportive supervision of the mental health workforce across sectors; • Establish and mandate in law professional associations in relation to the multisectoral mental health workforce (including consideration of a code of ethics); • Consider the skills mix and distribution of the mental health workforce (including geographical distribution, distribution from national to subnational levels, and within levels or facilities of the mental health system (community, school, levels of the health system, justice, social welfare settings, etc); • Strengthen or develop new job aids to support the provision of MHPSS.
Budget and financial resources	• Cost MHPSS based on the policy/strategy and actions included in the priority package, and workforce needs; • Progressively allocate funding to implement MHPSS and the priority package of actions; • Include mental health in universal health coverage (including outpatient services); • Create fiscal space and budget allocation in sectors beyond health (education, social welfare, justice, etc); • Adopt policy and other guidance with respect to user fees and other out-of-pocket expenses; • Introduce social and financial protections to prevent catastrophic economic shocks associated with mental health and accessing MHPSS, and consider other targeted financing mechanisms to increase equitable access.

Pillar	Considerations
Participation	• Establish mechanisms at national and subnational level to enable the participation of adolescents and caregivers in the development of policy, planning and programmes in relation to MHPSS; • Establish mechanisms to engage adolescents, carers and communities in monitoring and evaluation of MHPSS from feedback, monitoring and evaluation at facility/service level (for example, school MHPSS programme) to subnational and national level policy and programming; • Support and engage youth networks, civil society organizations and advocates, including young people with lived experience of poor mental health.
Data, information and research	• Establish an active surveillance system for mental health and suicide monitoring (disaggregated by facility, age, sex, etc); • Embed mental health information needs and indicators (outcomes, risks) into national health information systems and population-based surveys; • Develop and include mental health indicators into routine data collection/information systems of other sectors; • Develop mechanisms and information sharing and reporting systems with respect to mental health for non-government providers and agencies (NGO programmes, private sector, etc); • Establish clear and timely mechanisms for analysis, interpretation and feedback of data and information collected from stakeholders; • Develop a prioritized national research agenda in mental health that is multisectoral; • Improve research capacity, including capacity to assess needs and evaluate programmes to assess impacts on mental health outcomes as well as impacts on important risk/protective factors and determinants; • Strengthen cooperation between universities and other research institutes to address key research questions and knowledge gaps (for example, consider specific mental health research funding schemes).

Overview of the current response to the mental health needs of children and adolescents:

A focus on Malaysia, Papua New Guinea, the Philippines and Thailand

This section highlights the main findings of the country studies, which applied the regional framework to the national context.

Mental health policies, strategies and legislation

An overview of key mental health policies and legislation is provided in Table 5.

Important progress has been made with respect to mental health policy and legislation in the region. All four focal countries have a **mental health act** that defines the rights and protections of individuals with mental health conditions, including those within the mental health system. This includes rights and protections in relation to the least restrictive assessment and treatment possible, involuntary treatment, physical restraint and deprivation of liberty for mental health reasons, appeal and complaints. The Philippines and Thailand include specific rights of minors to consent to mental healthcare; however, there are no other specific protections or considerations for children and adolescents.

National mental health policies and plans exist in all four countries, and broadly outline key actions needed to address child and adolescent mental health. While the focus is on services and supports delivered by the health sector (particularly with respect to treatment of mental disorders), all four national plans also include some important actions in relation to mental health promotion and prevention. Importantly, all emphasize the need to shift service delivery from institutional, specialized clinical treatment to strengthening community-based services and giving more attention to rehabilitation, recovery, and social integration and supports. National plans from the Philippines and Malaysia explicitly address some aspects of child and adolescent mental health, such as integration of mental health into basic education settings and the need for child and adolescent health services, but in general policies lack a comprehensive plan for child and adolescent mental health that includes attention to the particular needs and MHPSS required for this age group. A significant gap is the lack of policy guidance in relation to programmes to build skills in positive parenting/caregiving to support child and adolescent mental health.

All national mental health policies articulate the need for multisectoral collaboration and coordination, including recognizing the contribution of the education, social welfare/child protection and justice sectors in supporting mental health and well-being. However, policies and plans from the four focal countries are generally lacking in a clear vision for child and adolescent mental health that encompasses key sectors, and do not provide detailed guidance about the roles and responsibilities of each sector or the structures needed to support coordination. Neither do they include performance indicators to monitor effective coordination. An exception is the Philippines. The Philippines Mental Health Strategic Plan, developed in collaboration with key sectors, provides some guidance on the roles and actions required by the education, social welfare and justice sectors, and some performance indicators for non-health sectors.

Mental health and well-being has been integrated to some extent into the policies and plans of other key sectors. No country currently provides an overarching mental health strategy for the **education sector** that clearly outlines an approach to whole-of-education mental health promotion, although the role of education in supporting emotional development and resilience is articulated in most national education policies. Thailand, the Philippines and Papua New Guinea have developed policies that address specific aspects of mental health and well-being, particularly in relation to providing early identification and counselling in schools and the provision of a curriculum that addresses social and emotional learning. Similarly, all countries have **child protection** legislation and policies that aim to protect children from violence, abuse and neglect, recognizing their detrimental impacts on mental health. Thailand and the Philippines also mandate the provision of MHPSS in child protection settings, including in emergency settings. Thailand, Malaysia and the Philippines also include specific protections and requirements to provide MHPSS for children engaged in the **justice sector**, including children in conflict with the law and child victims or witnesses.

Table 5. Overview of mental health policies, plans and legislation

	Malaysia	Papua New Guinea	Philippines	Thailand
Mental Health Act	***Mental Health Act 2001*** Includes general rights and protections for individuals. While the Act defines the role of a guardian in providing consent for 'minors', it does not define special protections for children or adolescents under the age of 18 years.	***Mental Health Act 2015*** Includes general rights and protections for individuals, but no specific protections or considerations for children and adolescents.	***Mental Health Act RA No. 11036 2018*** Includes general rights and protections for individuals. Requires incorporation of mental health topics in the educational system. Includes rights of minors to presumption of capacity to provide consent and the rights of children to express their preferences and views on all matters affecting their mental health.	***Mental Health Act 2008 (2nd amendment 2019)*** Includes general rights and protections for individuals, and mental health promotion in addition to treatment. Removes mandatory requirements for parental consent, but no other specific protections for children and adolescents.
National Mental Health policy/ plan/ strategy	***National Strategic Plan for Mental Health 2020–2025*** Includes actions to address mental health in children and adolescents, include screening for early detection and intervention, training of students and teachers in psychological first aid, and continuous education programme on mental health for teachers.	***National Mental Health Policy 2011*** Priorities include establishing psychiatric units in all provincial hospitals, addressing workforce gaps, expanding community programmes, and improving community awareness. Limited inclusion of child and adolescent mental health.	***National Mental Health Strategic Plan 2019–2023*** Includes specific actions around ensuring age-appropriate mental health education for children and adolescents, and a national suicide-prevention programme with a focus on youth, but no further details about delivery of mental health services or other MHPSS for this age group.	***National Mental Health Plan 2018–2037*** Key strategies: 1) promotion and prevention of mental health problems throughout people's life course (including childhood); 2) development of mental health and psychiatry service system; 3) enforcement of legal, social and welfare measures; and, 4) academic and operating mechanism development to support mental health services.

	Malaysia	Papua New Guinea	Philippines	Thailand
Inclusion of mental health in child protection/ welfare	***The Child Act 2001*** Provides protection for children from violence, abuse and neglect, but not corporal punishment ***National Policy for Children and National Child Protection Policy*** Guarantees protection from all forms of harm (including psychological and emotional). Objectives include increasing awareness and commitment to child protection, creating safe and child-friendly environments, encouraging organizations to develop child protection policies, protecting children from all forms of violence, enhancing support services to address neglect, abuse, violence and exploitation, and enhancing research and development.	***Lukautim Pikinini (Child Welfare) Act 2015*** Objective is to protect and promote the rights and well-being of all children and to protect children from all forms of violence, abuse, neglect, exploitation and discrimination, with a clear focus on services for prevention and family strengthening.	***Special Protection of Children Against Child Abuse, Exploitation and Discrimination Act*** Provides protection to children from all forms of abuse, neglect, cruelty, exploitation, discrimination and child labour. ***Children's Emergency Relief and Protection Act, RA No. 10821 2015*** Mandates the provision of emergency relief and protection for children before, during and after disasters and other emergency situations, including MHPSS.	***Child Protection Act B.E. 2546 (2003)*** Provides protection to all children from violence, abuse, neglect, exploitation or torture, including within families, out-of-home care, street children, orphans and children in difficult circumstances, such as impoverished, abandoned or disabled children. Requires provision of MHPSS for children who experience violence, abuse or neglect. ***Child and Youth Development Promotion Act B.E. 2550 (2007), and its amendment in 2017*** Defines the rights of children and youth to receive public health services, including MHPSS

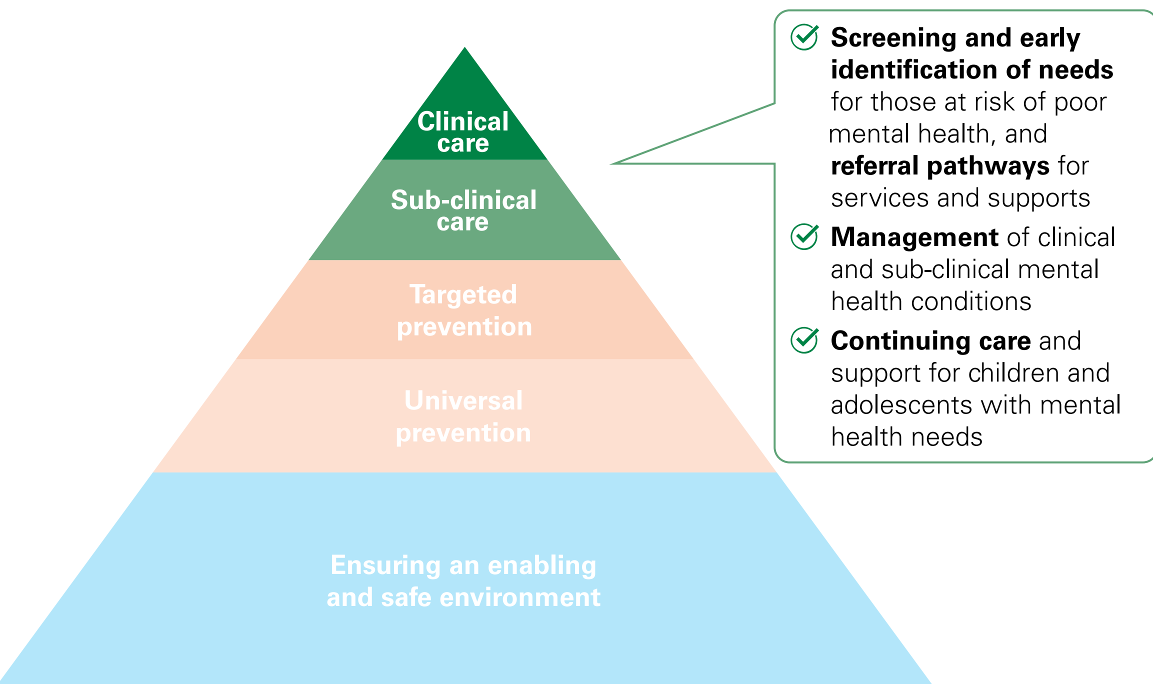
	Malaysia	Papua New Guinea	Philippines	Thailand
Inclusion of mental health in education policy/ plans	***National Education Blueprint 2013–2025*** Emphasizes a commitment to holistic development of children and adolescents, including emotional development and the importance of the school environment and curriculum to address resilience, emotional skills and positive peer relationships. However, there are no specific actions or programmes in relation to MHPSS.	***National School Health Policy 2015*** Mental health is included as a key issue in the National School Health Policy. The policy commitment to this is in 'Policy statement five: Counselling service'. Includes provisions such as counselling services to be provided to all school children, referrals for any behavioural disorders or significant emotional stress, and education of school children about mental health issues.	***The national Mental Health Strategic Plan***, developed with the Department of Education, includes actions for the basic education sector, including mental health promotion and mental health education. No overarching education policy for mental health; however, several ***Department orders and memos*** include specific directives for MHPSS (provision of MHPSS in schools, adaptation of learning continuity plan to address mental health during COVID-19). The ***Anti-Bullying Act 2013*** directs all schools to enact policies addressing bullying.	***National Education Act B.E. 2542 1999*** Stipulates that education shall be for the full development of Thai people, including in mental health. ***Thai National School Health Policy 1998*** Includes a focus on mental health and emotional well-being. ***Educational Service Area Psychologist Policy 2018*** Includes a trained psychologist stationed in each area to support the One School One Psychologist programme (training for a teacher in each school to provide counselling).

	Malaysia	Papua New Guinea	Philippines	Thailand
Inclusion of mental health in juvenile justice policy/ plans	***Child Act 2001*** Requires medical assessment, examination and access to treatment (including psychiatric care) and protections for children who are suspected of being a victim of ill treatment, neglect or abuse. ***Guideline on Medical Assessment of Child Custody Cases 2018*** Requires the assessment of emotional and psychological needs and defines the referral process for children in conflict with the law.	***Lukautim Pikinini (Child Welfare) Act 2015*** Includes some protections for children in conflict with the law (including in custody) and child victims. There is a commitment to recruit 300 child protection officers and volunteers. No specific details regarding MHPSS for children in conflict with the law or child victims or witnesses. ***Juvenile Justice Act 2014*** Includes a focus on diversion for juvenile offenders, and on supporting the role of the family unit to support rehabilitation and reintegration. There are some protections with respect to minimizing psychological harm during arrest or justice processes, and an option to provide counselling as part of diversion, but no specific requirements to provide mental health assessment or services.	***Republic Act 8369: Family Courts Act of 1997*** Requires establishment of a family court in every province with exclusive jurisdiction over child and family cases. Within this, a social services and counselling division, in coordination with social welfare, is required to provide case management, assessment, counselling and referral for mental healthcare. ***Republic Act 9344: Juvenile Justice and Welfare Act of 2006*** Includes protections for children in conflict with the law or those at risk (including a focus on prevention and rehabilitation, protection from violence or degrading treatment). Requires immediate access to mental health assessment and protection from treatment that may have a detrimental impact on psychological well-being.	***Juvenile and Family Court and Procedure Act B.E. 2553 2010*** Requires all judicial officers engaged in the juvenile and family court process to receive training in psychology, social welfare, counselling and child protection. Also requires provision of mental health assessment and care through a multidisciplinary team for all children in conflict with the law or child victims/ witnesses. Also requires children deprived of liberty to receive education and training to support mental health. ***The Criminal Procedure Code section 133*** Provides protections for children during interrogation – including the presence of a psychologist or social worker.

Overview of current programmes and approaches to address child and adolescent mental health and psychosocial well-being

To address the mental health and psychosocial well-being of children and adolescents there is a need for a holistic and tiered approach to MHPSS that includes actions to: promote well-being; prevent poor mental health by addressing risks and enhancing protective factors; and ensure quality, accessible and responsive care for those with mental health conditions. To date, much of the focus on child and adolescent mental health programmes in this region has been on the delivery of responsive care, particularly the delivery of clinical treatment for mental and developmental disorders through specialized health services. However, there have also been some important efforts to integrate MHPSS into education, child protection and justice settings, including programmes to address key risk factors.

Accessible and responsive care for children and adolescents with mental health conditions



In all four focal countries, the primary responsibility for the delivery of responsive mental health services lies with the health sector. In Thailand, the Child and Adolescent Mental Health Rajanagarindra Institute within the national Department of Mental Health provides overall guidance and leadership, as well as service delivery, with respect to child and adolescent mental health. There are no similar agencies in the Philippines, Malaysia or Papua New Guinea, with child and adolescent mental health coordinated by the ministry of health.

Screening and early identification of children and adolescents with mental health conditions: Thailand has a relatively well-established national approach to early identification and screening through health, education, social welfare and justice settings, including the use of screening tools specifically validated for children and adolescents. In addition to screening in health, child protection and justice settings, Thailand has also introduced a national programme to deliver mental health screening in schools, providing teachers and school counsellors with tools and training to support screening of all students for behavioural problems, psychological distress, depression and peer victimization. The Ministries of Health and Education in Malaysia have also implemented a school-based screening programme for 16-year-old students using an internationally validated screening tool for depression, anxiety and stress. Important challenges impacting on school-based screening

include inadequate teacher training and support, significant time required to complete screening on top of heavy teaching workloads, and a lack of student trust in the confidentiality of screening. Additionally, screening can be stigmatizing, particularly in the absence of accessible mental health services or effective referral mechanisms. The Philippines and Malaysia include a general tool for psychosocial risk assessment delivered through adolescent-friendly health services, and include mental health assessment in child protection and justice settings. However, there are currently no validated tools or standardized protocols for early identification or formal screening in Papua New Guinea, and limited availability of age-specific, validated tools in non-health settings. In these settings, stakeholders described systems relying on self-identification (by children, adolescents or their carers) and families attempting to navigate often unclear referral pathways to access care. All four countries have mental health or crisis hotlines to support self-identification and referral (in addition to providing some counselling and support) provided by government organizations or NGOs, including hotlines specifically for children and adolescents. Thailand's Department of Mental Health also provides an online 'mental health check-in' to support assessment, referral and access to services with an assessment application specifically for children and adolescents under the age of 18 years.

Referral mechanisms: In all four countries, weak referral systems within and between sectors were identified as a major bottleneck to providing responsive care for children and adolescents. Across all sectors, stakeholders described a lack of clear protocols (or limited awareness of existing protocols among providers) to guide referral, particularly between agencies or sectors. In many settings, referral relies on informal networks or relationships between local facilities or individual providers, or the burden is on families to navigate services and referral systems to access care. Limited availability of mental health services and providers to take referrals and/or lack of awareness of where to refer, also contribute to weak referral mechanims. Within the health sector, the lack of trained providers in primary and community-based services in all countries leads to over-referral to tertiary-level hospitals where specialist providers are concentrated. This results in long delays between referral and care, and often requires families to travel large distances to access services.

Multidisciplinary management, care and support: While there has been important progress in expanding the delivery of community-based mental health services, there is currently still an over-reliance on hospital-based and specialist services to deliver mental healthcare for children and adolescents. Health facilities and specialists that provide child and adolescent mental health services are very limited (see Table 6), leading to significant treatment delays and poor access to care. Limited integration of mental health into primary and community-level services, lack of mental health training for primary-level health providers, and very limited availability of psychologists, social workers and occupational and speech therapists also contribute to poor access to multidisciplinary and person-centred care for children and adolescents.

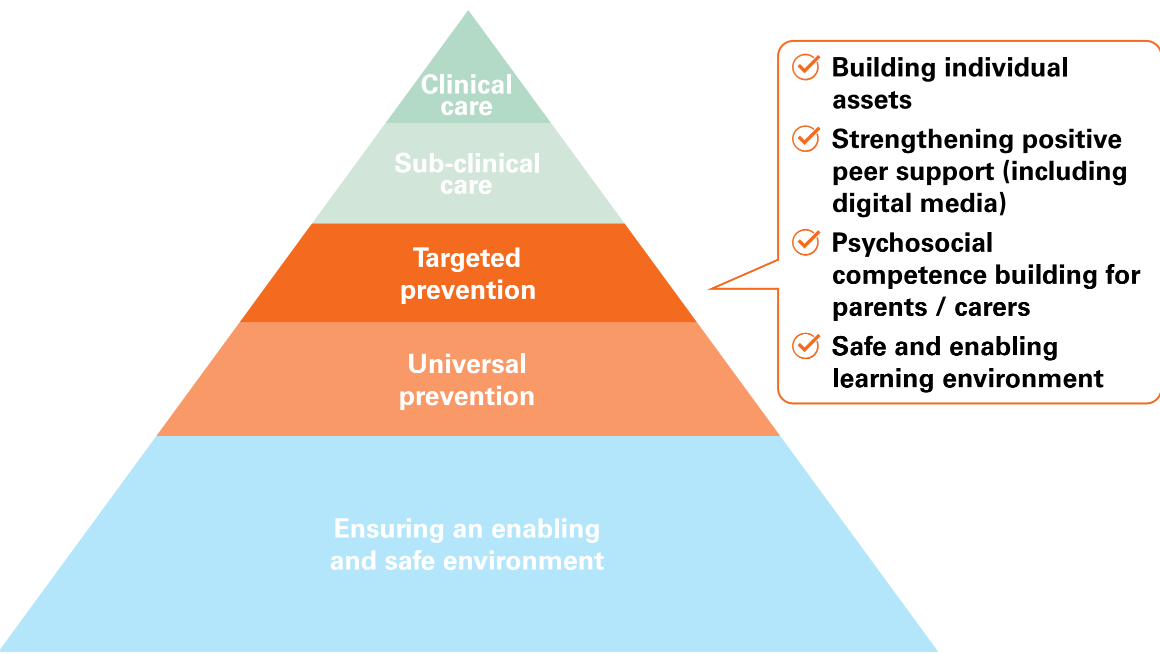
Table 6. Number of mental health facilities (inpatient and outpatient)

<table>
<tr><th></th><th>Malaysia</th><th>Papua New Guinea</th><th>Philippines</th><th>Thailand</th></tr>
<tr><td>Hospital-based outpatient mental health facilities</td><td>47</td><td rowspan="2">20 (data not disaggregated by facility type)</td><td>85</td><td>830</td></tr>
<tr><td>Community/non-hospital/other outpatient facilities</td><td>980</td><td>120</td><td>4</td></tr>
<tr><td>Outpatient facilities and services specifically for children and adolescents</td><td>28</td><td>No data</td><td>11</td><td>65</td></tr>
<tr><td>Total inpatient mental health facilities</td><td>51</td><td>21</td><td>144</td><td>126</td></tr>
<tr><td>Total inpatient facilities specifically for children and adolescents</td><td>38</td><td>No data</td><td>11</td><td>5</td></tr>
</table>

Source: WHO Mental Health Atlas 2014–2017.[64–67]

Similar challenges were also noted by social welfare and justice settings, with an over-reliance on institutional or facility-based delivery of MHPSS and shortages of psychologists and other trained personnel to deliver mental health services. In Thailand and the Philippines there have been some programmes to provide initial care and support to children and adolescents with uncomplicated behavioural problems or mental health conditions in schools. This includes teacher training and provision of youth counsellors and guidance counsellors in schools to deliver initial counselling and behavioural modification; however, insufficient teacher training and support and a lack of school counsellors are noted challenges. In the context of COVID-19, the Philippines has introduced a number of initiatives, including online programmes, to provide psychological first aid and psychosocial support for students and caregivers (including children with disabilities) at primary and secondary schools. These have included teacher guides to integrate mental health into remote learning, mental health educational materials, television and online modules and other resources to support mental health. Similarly, there are a number of examples of online applications and hotlines in Thailand, Malaysia and Papua New Guinea that provide counselling, online consultation and referral for children and adolescents, many introduced in response to the COVID-19 pandemic.

Prevention of mental health conditions in the immediate social context



Actions to prevent poor mental health by addressing risk factors and enhancing protective factors are critical to ensuring mental health and well-being. For children and adolescents, this requires a focus on factors related to where they live, grow, learn and socialize, with parents/carers, peers and learning environments a high priority. Additionally, efforts to prevent poor mental health also need to include actions to build social and emotional competencies and the individual assets of children and adolescents. In recent years, many interventions aiming to prevent mental health disorders in children and adolescents have been implemented as small projects or pilot studies. There are, however, limited large-scale or national approaches that comprehensively address important risk factors.

Building the individual assets of children and adolescents: Most of the recent approaches to support social and emotional learning and build individual assets have been delivered through schools. Thailand and the Philippines have national, curriculum-based life skills education programmes that include content on social and emotional learning and mental health. In the Philippines the national curriculum, delivered through health classes, addresses mental health, positive peer relationships,

bullying, coping skills and awareness of common mental disorders. As noted above, the Philippines Department of Education has also introduced additional programmes and tools to support mental health during the COVID-19 pandemic, including online programmes to support coping skills and stress management. Thailand is currently strengthening the national curriculum to improve the focus on competency-based education (a key gap noted by youth stakeholders) to build skills in self-management, critical thinking, communication, interpersonal skills and respectful peer and community engagement. Malaysia also has examples of school-based programmes to build social and emotional skills from pre-school to secondary school through the use of multimedia and peer-led approaches. There are also examples of smaller-scale programmes and pilot studies in Malaysia and Papua New Guinea to support coping skills and self-management and to improve mental health literacy delivered online through schools or by youth leaders.

Strengthening positive peer support: Despite the importance of promoting healthy peer relationships, addressing bullying and violence, and establishing positive peer support networks, there are limited examples of large-scale programmes to strengthen peer support. Both the Thailand and Philippines national, curriculum-based life skills education programmes include some aspects of healthy peer relationships and social skills. Thailand also has a national Youth Counsellor programme to help improve peer support in schools, although data describing coverage and effectiveness of the programme are lacking. There were no examples of other school-based approaches to address peer victimization, and only limited examples of out-of-school programmes to improve peer support. In Thailand, there are some peer-led and NGO-led online initiatives that provide information, resources and support to adolescents (including to address cyberbullying and online safety), but none have been evaluated.

Psychosocial competence building for parents/carers: An important gap in the current response to mental health is the limited implementation of national programmes to support positive, nurturing and responsive parenting and care. There are many examples of subnational or pilot programmes to support positive parenting. The Parenting of Lifelong Health for Young Children programme,[68] developed by Oxford University, WHO and UNICEF, was recently adapted and piloted in Thailand, and is currently being piloted in the Philippines. The programme focuses on supporting behaviour change among caregivers (focusing on a range of techniques such as child-led play, social and emotional communication, responsiveness, positive instruction, praise, problem-solving and mindfulness) and in Thailand reported a 69 per cent increase in overall positive parenting and a 58 per cent reduction in child maltreatment.[69] In all four countries there are examples of programmes (many delivered online) to support parents in the context of the COVID-19 pandemic. In the Philippines, the Online Parental Support Intervention on Effective Parenting or 'Gabay Bahay' programme was launched by the Department of Education to support students, parents and caregivers. UNICEF has also supported programmes in Malaysia and Papua New Guinea providing parenting advice and support through social media.

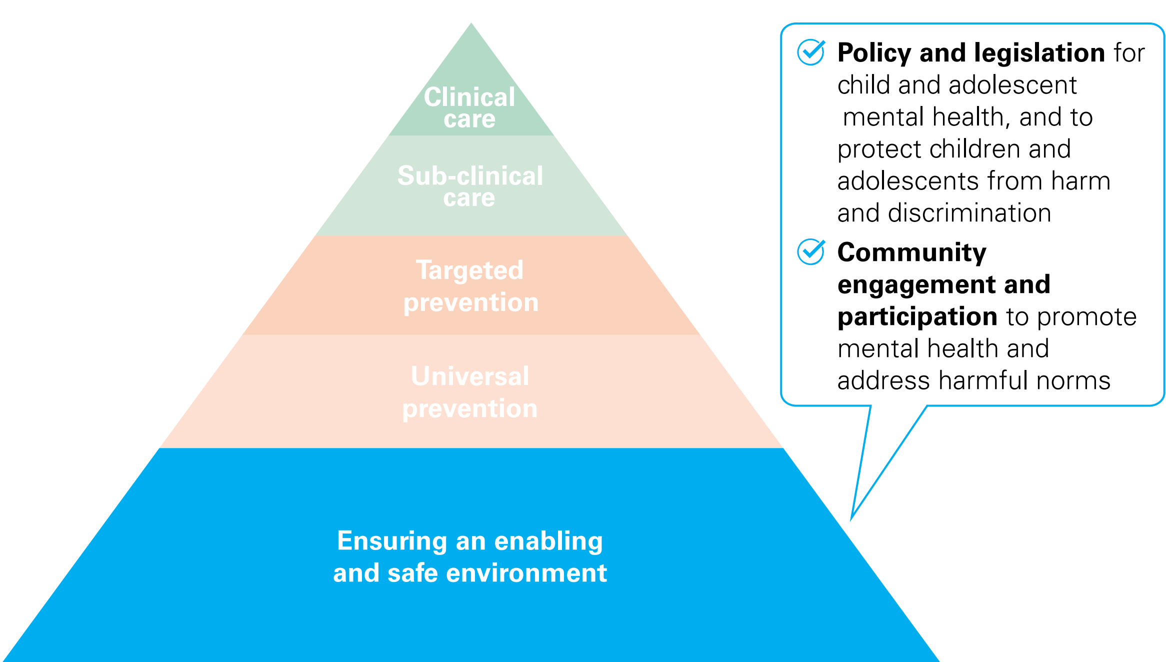
Other programmes have specifically targeted parents and families of children at increased risk of poor mental health. For example, in Thailand, the Department of Children and Youth has established counselling centres at subdistrict level to support the parenting skills of children at risk, and the Department of Justice also has programmes (including online) to support the parents of children and adolescents in conflict with the law to reduce recidivism. There are also some examples of pilot studies in Malaysia and Thailand to support the parents of migrant, refugee or displaced children. However, there is currently no nationwide approach to support positive parenting and caregiving in the four focal countries, and a lack of clarity around which sector(s) have primary responsibility for the development and delivery of parenting programmes. An additional gap is the limited attention to the mental health needs of parents and carers. In Thailand, for example, a recent assessment of family focused mental healthcare found that over three quarters of mental health workers had no training in family or child-focused care, contributing to limited engagement with family members of children with mental health needs, and lack of screening or referral of parents and carers for mental healthcare.[70]

Safe and enabling learning environments: In all four countries, aspects of mental health have been integrated into learning environments, with a focus on primary and secondary schools. This includes integration of mental health and social and emotional learning into curriculum-based teaching (Thailand and the Philippines), mental health education and support materials in emergency settings and in response to COVID-19 (the Philippines), school-based programmes to support early identification and screening (Thailand and Malaysia), provision of school-based counsellors (Thailand, Malaysia

and Papua New Guinea), and the inclusion of mental health in school health programmes (Papua New Guinea, Malaysia and Thailand). The Ministry of Education in Thailand has also started piloting a digital-based system to address safety in schools (including in relation to mental well-being) that allows students, teachers, education staff and communities to report concerns or breaches of safety through a website, call centre, phone app or social media.[71] However, there are currently no national, whole-of-education approaches to promote mental health that recognize and address the impacts of the school culture, environment and teaching approaches on mental health – with a focus on student safety, well-being and respect. Similarly, there is a significant gap in addressing learning environments outside of formal school settings.

Targeted interventions for children and adolescents at higher risk: Programmes targeting children and adolescents who are at increased risk due to risk behaviours or exposures have primarily focused on children engaged in child protection, those impacted by humanitarian or disaster settings, and children in conflict with the law. All countries have programmes to identify and support children and adolescents who have ***experienced violence, abuse, exploitation or neglect***. Programmes are generally led by the social welfare sector, often in collaboration with UNICEF and NGOs. The main focus of current programmes is on institutional or centre-based care (temporary shelters, residential care and crisis centres), including delivery of intensive and multidisciplinary services to provide psychosocial support and prevent poor mental health (with additional services and referral for children with mental health conditions). Similarly, the social welfare sector with UN agencies and NGOs also provides support to children impacted by ***humanitarian or disaster settings***, including integration of MHPSS for children and parents into the emergency response, establishment of child-friendly spaces, support for ongoing education, and child protection services (including prevention and response to violence). The justice sector, often in coordination with social welfare, also provides intensive interventions for ***children in conflict with the law***. Thailand and the Philippines have programmes focused on diversion and prevention of recidivism for juvenile offenders, including programmes to address ***substance use***, support life skills development (including emotional skills) and provision of counselling. These are often provided in institutional settings (such as juvenile detention centres) but there is an increasing focus on community-based programmes.

Ensuring a safe and enabling environment to promote mental health



In addition to the policies and legislation related to mental health described above, all countries have also introduced legislation to protect children and adolescents from harm and discrimination and provide social protection to children to a limited extent (see Table 7).

Table 7. Legislation to protect children and adolescents from harm

	Malaysia	Papua New Guinea	Philippines	Thailand
Protection within the mental health system				
Prohibition on physical restraint	Partial (prohibited under the age of 12)	Partial	Partial	Partial
Protection to ensure deprivation of liberty for mental health reasons is a last resort, for the shortest appropriate period, and subject to review	Yes (but no specific considerations for children)	Yes (but no specific considerations for children)	Yes (but no specific considerations for children)	Yes (but no specific considerations for children)
Decriminalization of suicide	No (prison term of up to one year for attempted suicide)	No (prison term of up to one year for attempted suicide)	Yes	Yes
Protection from harm				
Prohibit all forms of violence, abuse and neglect in all settings	Partial (corporal punishment in home and school lawful, and can be used by court in sentencing)	Partial (corporal punishment permitted in home and school)	Partial (corporal punishment lawful in the home)	Partial (corporal punishment in home, alternative care may be permissible)
Prohibit early marriage	Partial (Muslim girls minimum age 16 or younger with court permission)	No (18 for boys, 16 for girls)	Yes (new legislation currently being implemented)	Partial (age of marriage 17 years)
Decriminalization of same-sex consensual sex	Criminalized between men	Criminalized between men	Yes	No law prohibiting same-sex sexual activity

	Malaysia	Papua New Guinea	Philippines	Thailand
Prohibit child labour	Minimum age 15 years	Minimum age 16 years	Minimum age for employment 15 years, children under 18 protected from hazardous work	Minimum age for employment 15 years, children under 18 protected from hazardous work
Prohibit association and recruitment of children with armed forces	Minimum age 17 years	Minimum age with parental consent 16 years	Yes	No legislation explicitly prohibiting and criminalizing recruitment and/or use of children by state armed forces or non-state armed groups
Minimum age of criminal responsibility	10 years	7 years	15 years (proposal to lower to 12)	12 years
Protection to ensure custody, detention, confinement or imprisonment of children <18 years is a last resort	Partial (imprisonment and whipping can be ordered if over 14 years of age)	Yes	Yes	Yes
Proportion of children covered by social protection[2]	3%	No data	31%	21%

There have also been important initiatives to address mental health-related stigma and improve community awareness and mental health literacy. In all countries, significant stigma, misconceptions about mental health and limited awareness of the mental health needs of children and adolescents are major demand-side barriers to care and support. National mental health policies in the region include actions to promote mental health and well-being, with an emphasis on national campaigns and community-based awareness programmes. Current approaches have included national mental health days and multimedia anti-stigma campaigns. There are also some examples of community-based programmes to promote mental health literacy, supported by NGOs or implemented by social workers, including programmes to target communities at increased risk or to respond to specific cultural understandings of mental health.

Applying the regional framework in East Asia and the Pacific

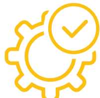
The priority package of MHPSS actions for children and adolescents

In each of the four countries, all actions proposed in the regional framework were considered a high priority by stakeholders. While progress has been made to introduce many of these actions, stakeholders across sectors noted significant challenges impacting on implementation, particularly at scale, and a need to strengthen coordination and delivery.

Accessible and responsive care for children and adolescents with mental health conditions

The highest priority was given to actions related to responsive care. In all countries, establishing (or strengthening) a national approach to **early identification and screening** was identified as a critical action to be implemented within the short term. This includes strengthening early identification and screening outside of traditional health settings, such as through schools, in child protection settings and through the justice sector. In Thailand, where screening programmes are more established, clearer screening protocols and improved training and support to non-health sector providers (such as teachers, social workers and counsellors) is needed to strengthen screening in non-health settings and address concerns about stigma and lack of confidentiality. Stakeholders in Thailand also identified a need for screening protocols to more clearly identify children and adolescents who need urgent referral for specialist care, versus those who could be supported by non-specialist providers. In Malaysia, the Philippines and Papua New Guinea, the priority is to establish protocols for early identification and potentially screening in health and non-health settings, validate screening tools for children and adolescents (including from diverse ethnic and cultural backgrounds), and identify and train providers to support early identification and/or screening in primary healthcare, schools, child protection and justice settings. Strengthening 24-hour, national crisis hotlines that are child- and adolescent-focused is also a high priority to support self-identification, with provision of initial support and capacity for referral to more specialist services and supports as needed.

It is critical that screening does not happen in isolation but is implemented in the context of strong referral systems and access to quality care and support. All countries identified improving or establishing referral mechanisms for children and adolescents as a key priority in the short term. This includes the development of clearer protocols that define criteria for referral, identify where children and adolescents should be referred across the tiers of MHPSS, and provide clear guidance on communication and coordination between agencies and sectors. Over-reliance on highly specialized and institutional-based mental health services and limited availability of child, adolescent and family-centred services were identified as key barriers to care in all countries. As such, high priority in the short to medium term was placed on establishing and/or **strengthening primary and community-based mental health services**, including through health, social welfare, child protection and juvenile justice programmes. Improving mental health training for non-specialist providers and increasing the availability of trained social workers, psychologists and speech therapists at community level is needed to support person-centred and multidisciplinary care and support. Telehealth and online delivery of mental healthcare (self-identification, screening, counselling and referral) was also identified as a priority, particularly in the context of COVID-19.



Prevention of mental health conditions in the immediate social context

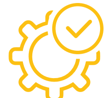
The next highest priority was given to actions related to prevention. Among these, **school-based actions** (from early education through to secondary education and higher) were considered central to preventing poor mental health and enhancing protective factors. In all countries, high priority actions included: developing or strengthening a national competency-based curriculum for mental health with a focus on mental health literacy, building skills and supporting social and emotional learning; digital literacy; approaches to improve peer relationships and address peer victimization (including cyberbullying); improving mental health training and support for teachers, including skills in positive behaviour management; and investing in approaches to create mental health-promoting schools. Additionally, youth representatives in particular emphasized the importance of addressing the school environment and culture to address academic pressures, poor teacher-student relationships, and stigmatization and lack of awareness of mental health.

Similarly, high importance was placed on strengthening the quality and coverage of **parenting programmes** to support positive parenting and improve mental health literacy and care-seeking. This also included programs to better support parents or carers of children and adolescents with disability and/or mental health needs, including through greater financial and social protection, and programmes to identify and respond to parents' mental health needs. Increasing access to parenting programmes through antenatal and postnatal care, improving the focus on parenting knowledge and skills at different developmental stages, and developing tailored programmes for parents from different backgrounds or risk exposures were identified as important for strengthening current approaches. In Papua New Guinea, high priority was placed on actions to prevent and respond to family violence, including expanding the coverage of family crisis centres and ensuring that these centres also provide child-friendly spaces and trained staff who can provide MHPSS.

Ensuring a safe and enabling environment to promote mental health

Among actions related to ensuring a safe and enabling environment, high priority was given to national campaigns and community-based programmes to **address stigma and discrimination and harmful norms**, noting that stigma remains a significant barrier to seeking services and supports. While addressing stigma and low mental health literacy of parents and communities was a priority in all countries, it was particularly so in Papua New Guinea. In this context, developing and delivering national and community programmes to increase awareness, improve mental health literacy, and address substantial misconceptions and stigma were identified as crucial to enabling the implementation of other MHPSS actions.

The importance of engaging young people and community leaders with training and education around mental health and supporting **greater participation of children and adolescents** in the planning and design of MHPSS were rated as high priorities among youth representatives. Other stakeholders across key sectors also noted the need to more explicitly integrate mental health into key sectoral policies, with clear descriptions of roles, responsibilities and accountability. While most countries have legislation to protect children and adolescents from harm, stakeholders in all four countries noted the need to strengthen enforcement.



Recommended sectoral roles and responsibilities

In all four countries, the health sector was identified as having an overarching leadership role with respect to setting national policy, planning and oversight of MHPSS, and primary responsibility for delivery of responsive mental health services. However, stakeholders across sectors also described a critical role for the education and social welfare sectors, not only in developing and implementing actions to prevent and promote mental health but also to strengthen multidisciplinary and accessible responsive care. The justice sector was also identified as having a current role in supporting children and families who are at particularly high risk of poor mental health to have better access to MHPSS, as well as a potentially much larger role in supporting targeted interventions to address risk factors.

Health sector

The health sector, specifically the ministry or department of health (or equivalent), was recommended in all countries to have an overall leadership role with respect to technical guidance and policy for MHPSS, including responsibility for coordination and oversight of MHPSS across all three tiers. This includes primary responsibility for strengthening national policy, developing strategic and implementation plans, and setting and monitoring performance indicators. The health sector was also identified as having responsibility for developing specific technical guidance and protocols (for example, screening and referral), quality assurance for clinical care, and accreditation of mental health facilities. Capacity building of the mental health workforce was also identified as a responsibility of the health sector. While this primarily includes the training and education of the health workforce, in all countries the health sector was also nominated as having a role in supporting other sectors to provide overall technical guidance for mental health training for non-health providers, including social workers, teachers and counsellors, to ensure consistency.

The health sector was also identified as having primary responsibility for the implementation of actions related to responsive care. While this reflects the sector's current role and mandate with respect to the delivery of clinical services, stakeholders also emphasized that the health sector should have a much greater role in prevention and promotion, including strengthening collaboration with schools, communities and families to support preventive actions and address community-based norms and stigma. Specifically, the health sector was identified as being an important technical partner to support schools and whole-of-education approaches to promote mental health, increase mental health literacy, support the delivery of targeted interventions to address risk factors, and work with schools to support screening and referral. Similarly, while parenting programmes were identified as being the primary responsibility of the social welfare sector, the health sector is an important technical partner in identifying and supporting families at risk and integrating parenting programmes into maternal and child health services.

Education sector

The education sector, through the ministry of education (or equivalent), was recommended to have the leading role in coordination and implementation of whole-of-education approaches for mental health promotion. This includes consideration not only of the individual programmes to address specific risk factors (such as peer victimization) but also actions needed to recognize and address the impacts of the school culture, environment, academic pressures and teaching approaches on mental health – with a focus on student safety, well-being and respect. Schools, in particular, were identified in all countries as a key platform for delivery of preventive actions, including through the development or strengthening of the national curriculum to support social and emotional learning, promote positive and respectful peer relationships, address key risks (bullying, substance use) and improve mental health literacy. However, the importance of schools was noted to extend beyond being a mechanism for delivering MHPSS interventions to also recognizing the importance of addressing school environments and academic cultures as determinants of mental health and well-being.

The education sector was also recommended to have a greater role in early identification of children and adolescents with mental health needs, including developmental and learning difficulties, and supporting access to care by establishing strong referral systems with health and social welfare services. In Thailand, this role currently extends to formal screening of students for mental health

conditions and delivery of initial management or behavioural modification by trained teachers and/or guidance counsellors – although improved training and support for teachers and guidance counsellors (including to address attitudes and confidentiality) and strengthening referral pathways and linkages with mental health services were identified as crucial to supporting a greater role for schools in responsive care. Stakeholders in Malaysia and the Philippines also recommended a greater role for schools in providing a more standardized approach to early identification and potentially screening using validated tools, supported by strong referral linkages to the health and social welfare sectors, teacher training and the provision of psychologists or guidance counsellors in schools with specific training in mental health. The education sector was also identified as having the main responsibility for ensuring that children and adolescents with mental health conditions have access to ongoing education, including establishing specialized programmes to support the inclusion of children with developmental disorder(s) in formal education.

With its links to families and communities, the education sector was also recommended to assume a greater role in supporting mental health awareness and anti-stigma programmes at community level (in addition to addressing stigma through curriculum-based education), and supporting efforts to raise awareness of positive parenting. Schools were also identified as important for supporting peer-led initiatives to improve support networks, such as the Youth Counsellor programme in Thailand, or by establishing peer groups focused on promoting well-being and peer support. Children and adolescents outside of the formal education/school system were identified as particularly underserved by the focus on school-based programmes – and many stakeholders noted a need for programmes to extend to other learning environments and institutions, as well as linkages with the social welfare sector to reach marginalized children and their families.

Social welfare sector

Stakeholders in all countries recommended that the social welfare sector (departments of children and youth, social welfare, community development, or equivalent) have a leading role in planning, coordinating, developing and monitoring actions related to child and youth welfare. This sector was identified as being a critical link between families and communities and the health, education and justice sectors because of the focus on, and engagement with, children and adolescents who are at increased risk of poor mental health. This not only included a key link for service delivery, but also for strengthening the identification and monitoring of children most at risk.

Specifically, this sector was recommended to have a key role, with the health sector, in implementing early identification and screening of children and adolescents with high-risk behaviours or exposures (including in community, education, alternative care and justice settings), supporting a strong and efficient referral system and being part of a multidisciplinary team to provide acute and continuing care. Through child protection programmes, the social welfare sector in all countries was identified as having lead responsibility for developing and delivering intensive services and supports to children (and their families) at risk, including in emergency settings. This sector was also noted to have a leading role in establishing social protection programmes and in the delivery of programmes to reduce violence, abuse and neglect of children.

In all countries, there is currently a lack of clarity around which sector has primary responsibility for coordinating and developing parenting programmes – with all sectors (and UN agencies and NGO partners) engaged in delivering some aspects of parenting programmes, although often not in collaboration. Because of the social welfare sector's linkages and focus on child and family welfare, including engagement with families at risk, this sector was recommended in all countries to have this leadership role – particularly with respect to developing and coordinating a national approach to positive parenting. Social welfare was also noted to have responsibility for developing and delivering tailored programmes for families at increased risk of poor mental health or those from diverse sociocultural backgrounds.

Similar to the education sector, social welfare was also recommended to have a role in developing and implementing community-based actions to improve mental health literacy, working with the health sector to train frontline community responders, and in efforts to address stigma and discrimination.

Justice sector

The justice sector, through contact with children and adolescents who are at increased risk of poor mental health, has a key role to play in supporting early identification, screening and referral for mental health services. While this relies on engagement with other sectors and agencies, stakeholders in all countries also noted that the police, judicial and court officers and other justice sector workers also provide frontline mental health services and therefore require mental health training and support to take on these roles.

In addition to screening and referral in the acute setting for children who are victims or witnesses of violence and those in conflict with the law, the justice sector was also recommended to have a greater role in supporting continuing care. This includes follow-up and support to families who have been in conflict with the law or have had contact with the justice system. A strengthened role in implementing interventions to build individual assets and address key risk factors was also noted, specifically through more meaningful skills training for young offenders. The justice sector was also identified as having a central role in improving and enforcing legislation to protect children and adolescents from harm. Additionally, this sector was identified as having primary responsibility for strengthening protections for children and adolescents in contact with the justice system and ensuring that protocols and procedures (such as interrogation and sentencing) for children and adolescents do not cause psychological harm.

Other government sectors

Other sectors identified as relevant to the implementation of MHPSS include the ministries of labour to reach out-of-school youth with MHPSS actions, and ministries and departments with responsibility for digital technology to support online platforms for MHPSS and actions related to digital civility, safety and literacy. Ministries and agencies responsible for leadership of local government units and implementation at a subnational level were also identified as being critical partners in supporting MHPSS implementation. These agencies, in addition to local level authorities, were noted in all countries to have responsibility for planning, resource allocation and service delivery. Furthermore, lack of engagement with these agencies was seen to contribute to limited implementation despite the existence of national policy and plans.

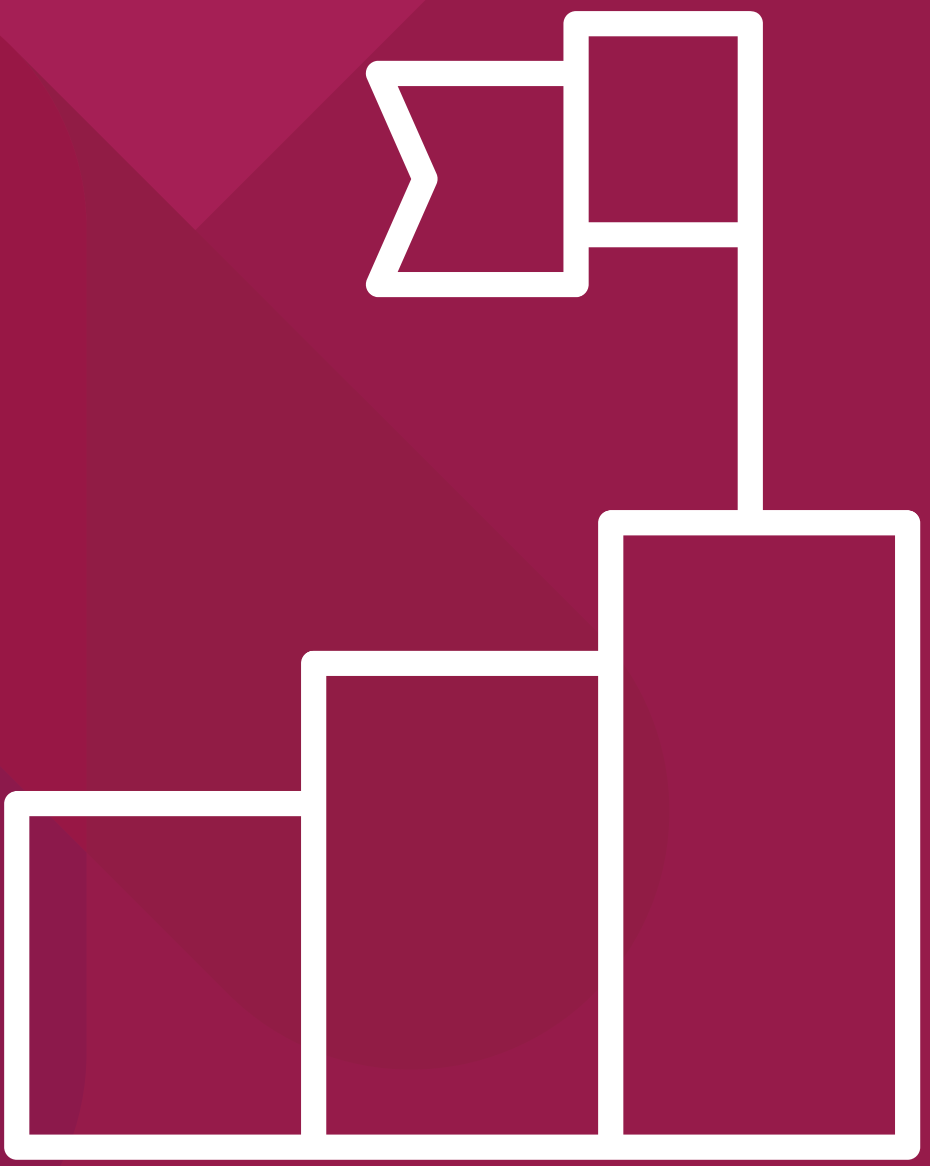
Non-governmental organizations

Not-for-profit NGOs were seen to play an important role in implementation of MHPSS, particularly in humanitarian settings where many agencies are mobilized and coordinated to provide psychological first aid and other MHPSS interventions in the acute setting. In other contexts, key roles for NGOs noted by stakeholders included: advocacy (both at government level and community level); mental health literacy (including through use of multimedia and digital technology); provision of capacity building and training in mental health for service providers as well as community members; and provision of some services to fill gaps in public MHPSS. It was also recognized in all countries that while current engagement in mental health by NGOs is limited, many are involved in activities that are linked to child and adolescent health and well-being, and therefore provide an important platform for integrating MHPSS. In particular, strong partnerships with communities and understanding of community needs would facilitate delivery of actions around mental health literacy, addressing stigma, community-based service delivery (identification, referral and first aid), and programmes to support parents and families. NGO youth organizations were also recommended to have a significant role in supporting advocacy and mental health awareness, addressing stigma and facilitating positive peer networks (including online supports).

Private sector

The private sector (including health and education) was identified as playing a smaller but important role in filling service-delivery gaps through government out-sourcing, particularly where public services are limited. In Malaysia, stakeholders noted that specialized psychiatrists are primarily based in the private healthcare sector and that through improved public-private partnerships, this group of specialized mental health experts could be engaged to deliver clinical services as well as support workforce training (including clinical placements) and provide advice and support to programmes to establish or improve child and adolescent-centred care. Private schools were also viewed as an important platform for the delivery of national MHPSS actions, although challenges with engaging the private sector in these programmes were noted. In general, stakeholders in all countries recommended that further mapping was required to better understand the current roles and capacities of the private sector in mental health, and for greater coordination and regulation of the sector. More broadly, the private sector was also identified as having a potential role in providing financial support or other resources (technology, including digital technology, expertise and training opportunities) to support MHPSS initiatives through corporate social responsibility programmes.

Challenges and recommendations for strengthening the multisectoral mental health system



In addition to identifying what 'actions' are required within each MHPSS tier, this project also aimed to explore the challenges and supports needed to enable effective and equitable implementation across key sectors, using the right pillars of **systems strengthening** defined in the regional framework. The challenges and recommendations for strengthening the multisectoral mental health system across the four countries are summarized below.

Legislation, policy and strategy

In all countries, **mental health legislation** could be strengthened to improve specific protections and considerations for children and adolescents, including the:

- Explicit right to the least restrictive assessment and treatment possible, including specific consideration of the use of physical restraint, involuntary seclusion, and deprivation of liberty for those under the age of 18 years;
- Right of children and adolescents to make decisions about mental healthcare and recovery to the fullest extent possible, with consideration of the best interests of the child or adolescent and clear legislation that removes mandatory requirements for parental or guardian consent for adolescents;
- Appointment of a personal representative, other than a family member, if necessary;
- Right to have contact with family or other support persons during assessment, treatment and recovery; and
- Right to recreational activities, education and other supports that respond to individual needs (including children in institutional care).

National mental health policies and plans broadly outline the key actions that are needed to address child and adolescent mental health. However, overall policies lack a comprehensive plan for child and adolescent mental health that includes attention to the particular needs and MHPSS required for this age group. Key gaps in all countries include a lack of policy guidance with respect to:

- Standards of child and adolescent-centred mental healthcare and multidisciplinary care;
- Programmes to build skills in positive parenting/caregiving to support mental health and well-being;
- Multisectoral suicide prevention plans;
- Addressing the needs of children and families who are at higher risk of poor mental health; and
- Strategies to reach children and adolescents who are not engaged in formal primary or secondary education (early childhood education, out-of-school) and other marginalized groups (including migrants).

All national mental health policies articulate the need for multisectoral collaboration and coordination, including recognizing the contribution of the education, social welfare/child protection and justice sectors in supporting mental health and well-being. However, policies and plans from the four focal countries are generally lacking in a clear vision for child and adolescent mental health that encompasses key sectors. Moreover, they do not provide detailed guidance about the roles and responsibilities of each sector or the structures needed to support coordination or include performance indicators to monitor effective coordination. An exception is the Philippines. The Mental Health Strategic Plan, developed in collaboration with key sectors, provides some guidance on the roles and actions required by the education, social welfare and justice sectors, and some performance indicators for non-health sectors.

Strengthening an overarching, multisectoral strategy for child and adolescent mental health is critically important in the context of COVID-19 to ensure a coordinated approach to addressing mental health and well-being, and to ensure that mental health is addressed in all COVID-19 recovery plans.

Mental health and well-being has been integrated to some extent into the policies and plans of other key sectors. Within the **education sector,** all countries have developed policies that broadly acknowledge the importance of emotional learning and mental health, and address specific aspects of MHPSS (for example, school-based screening and counselling). However, no country currently provides an overarching mental health strategy for the education sector that clearly outlines an approach to whole-of-education mental health promotion.

Similarly, all countries have **child protection** legislation and policies that aim to protect children from violence, abuse and neglect, recognizing their detrimental impacts on mental health. Thailand and the Philippines also mandate the provision of MHPSS in child protection settings, including in emergency settings. Thailand, Malaysia and the Philippines also include specific protections and requirements to provide MHPSS for children engaged in the **justice sector**, including children in conflict with the law and child victims or witnesses. However, in all countries there is a need to more explicitly include mental health and MHPSS in social welfare, child protection and justice sector policies (including ensuring provision of MHPSS as part of the immediate response) – with goals and objectives that are aligned with the national mental health policy and clear articulation of the specific responsibilities, actions and accountability.

In all countries, stakeholders also noted that in addition to addressing these gaps, there was a need for implementation strategies, plans and frameworks that more clearly defined the roles and responsibilities of agencies, including subnational government authorities. Limited dissemination of key policies, plans and legislation at a local level was identified as a significant barrier to implementation, with many policymakers at this level not aware of key policies, their specific roles, or guidance around implementation. This was seen as particularly critical in the context of decentralization as local authorities have responsibility for implementation and resource allocation but may not prioritize mental health due to limited awareness.

Finally, legislative reforms are needed in all countries **to improve protections from harm and discrimination**. This includes: prohibiting all forms of violence (including corporal punishment) in homes, schools and alternative care and residential facilities; increasing protections against early and forced marriage; increasing the minimum age of criminal responsibility, labour, and recruitment to armed forces; decriminalizing attempted suicide (Malaysia and Papua New Guinea) and addressing criminalization and discrimination against adolescents with diverse sexual orientation and/or gender identity/expression.

KEY RECOMMENDATIONS – LEGISLATION AND POLICY:

- Ensure 'mental health in all policies' with more explicit recognition and actions to address mental health in non-health sector policies and as part of the COVID-19 response.
- Expand existing national mental health policies, or develop specific child and adolescent mental health policies, to provide clearer and more comprehensive guidance on actions to promote, prevent and respond to the mental health needs of this age group.
- Strengthen mental health legislation to include specific protections and considerations for children and adolescents.
- Develop multisectoral implementation plans and guidance with clear roles, responsibilities and accountability at all levels (including key performance indicators related to multisectoral coordination).
- Review legislative and regulatory barriers to access (e.g., undocumented migrants, mandatory requirement for parental consent) and to greater coordination between sectors.
- Develop policies and strategies to reach out-of-school children and adolescents and other marginalized groups.
- Improve dissemination of MHPSS-related policies and plans across sectors and to administrative and implementation agencies.
- Develop multisectoral mental health plans at subnational level to support coordination and implementation.
- Strengthen legal protections against all forms of harm and discrimination.

Leadership, coordination and governance

While there are examples in all four countries of programmes that have engaged multiple sectors, limited multisectoral collaboration and lack of coordinated leadership across sectors was identified as one of the major challenges to the implementation of MHPSS.

National level

Limited high-level, multisectoral coordination of policy and planning remains a challenge in all countries. Stakeholders across sectors noted that each sector has a different policy focus, planning cycle and budget priorities and that these are not currently aligned around a common vision or goal for child and adolescent mental health. Limited awareness or prioritization among non-health sectors (where mental health is not the primary focus) contributes to other issues taking precedence over MHPSS (such as academic performance in the education sector). In all countries, the health sector was recommended to have overall leadership and accountability for MHPSS, including responsibility for mental health policy, technical guidance, oversight of training, and monitoring and evaluation. However, the social welfare and education sectors were also recommended to have key roles in national coordination and leadership given their current mandates and the substantial roles of these sectors in implementing many MHPSS actions.

Stakeholders across sectors emphasized the need for collaborative, high-level support for mental health with a clear, multisectoral vision, while acknowledging that many of the determinants and necessary actions for mental health lay outside of the traditional scope of the health sector. To facilitate better collaboration and coordination, all countries included recommendations to establish or strengthen a national multisectoral council or committee for child and adolescent mental health, with authority and resources to drive action. Thailand, the Philippines and Malaysia currently have (or have plans to develop) national, inter-ministerial committees for mental health. For example, the recent strategic plans developed in the Philippines and Malaysia include establishment of national

coordinating bodies, with representation from health, education, labour, social welfare and local government units to support greater coordination and integration of mental health into all policies. In Thailand, stakeholders recommended restructuring the National Mental Health Committee to include all relevant sectors and that it be chaired by a Deputy Prime Minister.

Subnational and implementation levels

In addition to greater coordination at a national policy level, there is also a critical need to improve coordination and governance at subnational implementation levels. In the context of decentralization, provincial, district and local government authorities are responsible for planning, prioritization, resource allocation and implementation. Lack of awareness of MHPSS-related policy and legislation at provincial and local levels and a disconnect between national and subnational agencies contribute to limited implementation and coordination between sectoral units, and inconsistent delivery of national programmes in different administrative areas. Lack of consistent policy goals and objectives in relation to mental health across sectors was also highlighted, leading to fragmented implementation and gaps in delivery.

To overcome these challenges, stakeholders in all countries recommended establishing or strengthening coordination at subnational level in several ways. First, they recommended improving communication and dissemination of relevant national mental health policies and strategies to local units to improve awareness of mental health and MHPSS, and support prioritization. Second, it was recommended that existing subnational coordinating bodies (such as the National Mental Health Commission subcommittee in Thailand) be strengthened to include key sectors to support cross-sectoral coordination. Where such mental health bodies do not currently exist, these could be established (as set out in the Philippines National Mental Health Strategic Plan), or other agencies that have cross-sectoral responsibility for local government units (such as the ministry of the interior) could be strengthened to improve awareness of mental health to support implementation and planning. Third, it was recommended that specific, cross-sectoral mental health implementation plans be developed at subnational level (aligned with national goals) with the flexibility to respond to local needs.

KEY RECOMMENDATIONS – LEADERSHIP AND GOVERNANCE:

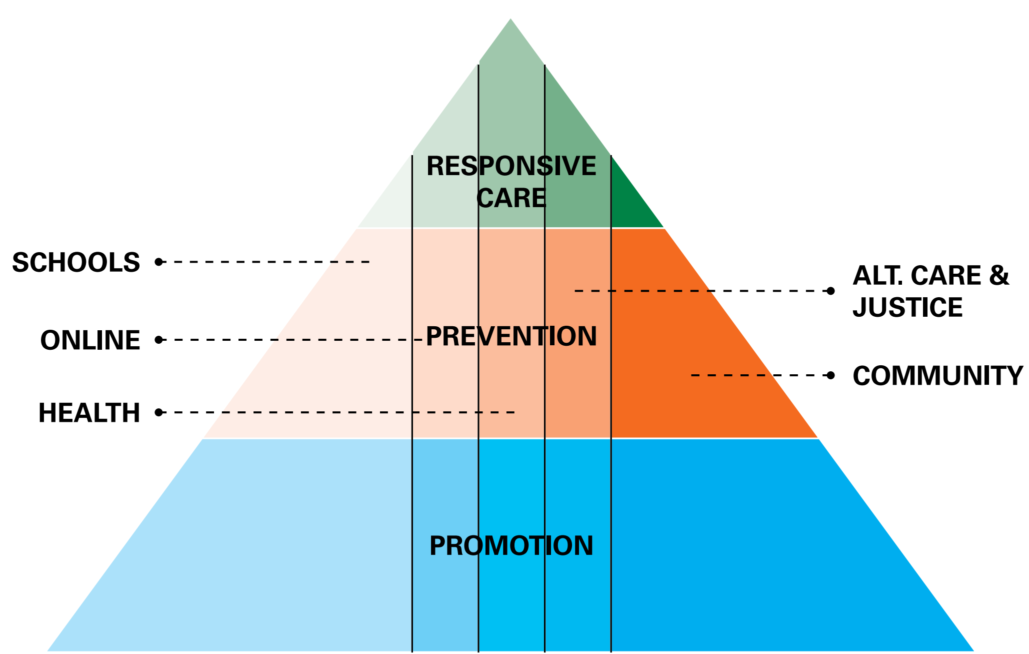
- Establish or strengthen a high-level, multisectoral national coordinating body with representation from all key sectors and with the authority and resources to drive action.
- Build the capacity of subnational and local authorities in MHPSS to support local planning, coordination and resource allocation.
- Establish or strengthen local, multisectoral committees to support coordination and implementation of the priority MHPSS package.
- Develop subnational implementation plans for MHPSS that clearly articulate sectoral roles and responsibilities and are aligned with national goals and strategies for mental health.

Service delivery

Multiple platforms exist to support the delivery of MHPSS actions (see Figure 16). Within responsive care, **health facilities** (primary, secondary and tertiary level) remain an important setting to deliver screening through to specialized care. All countries have plans to strengthen primary-level and community-based mental health services, shifting from an over-reliance on highly specialized and often stigmatizing institutional-based care. In all countries, greater investment is needed in developing child/adolescent-centred and friendly care models and strengthening entry points for children, adolescents and their families through maternal and child health services, nutrition programmes, adolescent health and other physical health services. Stakeholders also recommended expanding models of service delivery outside of traditional clinical settings, in particular transitioning to community-based

and mobile services to improve access to screening, referral and care, and home-based services to provide more person-centred care (particularly for subclinical or continuing care) and to reduce the burden on health facilities. Integrating MHPSS actions (early identification, screening, referral and promotion) into existing community-based structures and service provider roles may be one such model for strengthening community-based delivery.

FIGURE 16. PLATFORMS FOR MHPSS DELIVERY THAT CUT ACROSS THE THREE TIERS OF MHPSS ACTIONS



In addition to the delivery of responsive care actions, **community-based delivery** was also identified as a critical platform for implementing actions to address mental health literacy, shift community norms and stigma, and deliver preventive actions (including parenting programmes, family violence programmes and targeted interventions for children, adolescents and families at risk). For the social welfare sector, reprioritizing resources to family and home-based services for children at risk rather than institutional-based services was also recommended, particularly by stakeholders in Thailand, so that preventive and responsive care actions could be more effectively implemented. To address gaps in service delivery and workforce, community-based organizations and NGOs were identified as important partners, with opportunities to work with existing NGOs to integrate MHPSS actions into their programming.

Additionally, peer delivery of MHPSS actions is currently unrecognized and underutilized, with its potential to support community and school-based delivery of MHPSS. Young people in all four countries emphasized that adolescents and children often turn to peers first for help, and that peers may be a trusted provider of information and support in the context of stigma. Existing or new youth and peer groups were recommended as delivery platforms for improving mental health literacy, early identification, psychological first aid and referral, although attention to building the capacity of young people, supervision to support quality assurance and ensuring confidentiality were noted.

Schools and other learning environments are a critical platform for reaching large numbers of children and adolescents with MHPSS. All sectors identified school-based delivery as essential to the effective implementation of MHPSS, with a focus on improving early identification and potentially screening, contributing to multidisciplinary and continuing care, and actions to build individual assets, promote positive peer relationships and create safe learning environments. Programmes in Thailand, Malaysia and the Philippines, and to some extent in Papua New Guinea, have demonstrated that schools and education-based staff can be effectively engaged in supporting MHPSS. However, much greater attention

is needed with respect to coordination and leadership of school-based programmes, the training and supportive supervision needs of teachers and school counsellors, referral linkages with other sectors and service providers and consideration of the additional demands on teachers' time and workloads to deliver actions such as screening. Schools are not only a platform for delivering interventions. Learning environments in and of themselves have a profound influence on mental health and well-being from early childhood through to adolescence – and in all countries stakeholders recognized the importance of addressing the school/learning culture, academic pressures, and respect and inclusiveness through the development of whole-of-education approaches to mental health promotion.

The potential of **online and digital platforms** has received increasing recognition, particularly in the context of COVID-19. In all four countries there are several examples of hotlines, helplines and online applications providing information, mental health literacy and referral linkages. However, these platforms are currently underutilized, and there is a potential to make better use of online technology to support counselling, telehealth for mental healthcare, interactive parenting programmes, and integrating mental health into academic online education for students. Young people in Thailand particularly highlighted the opportunity to integrate MHPSS into platforms commonly used by children and adolescents (such as Facebook, Twitter, Clubhouse and Tik Tok), for example, to improve mental health literacy, promote positive peer networks, provide online counselling and self-referral, and to supplement more traditional classroom-based education on mental health. Sectoral stakeholders also highlighted this potential but noted the need for greater investment in technology and skilled expertise and oversight to support online delivery and ensure the quality of services, with consideration of equity in terms of access.

Justice settings are also important for delivery of screening, referral, targeted interventions to address risk factors and continuing care for children who are victims or witnesses of crime, as well as juvenile offenders. Several existing models of collaborative care were noted in the Philippines and Thailand, with the justice, health, social welfare and education sectors at provincial level collaborating to deliver programmes (including MHPSS) to promote long-term welfare and reduce recidivism.

All sectors noted significant barriers impacting on **equitable access** to MHPSS. Rural and remote communities and ethnic minorities were recognized as having limited access to facilities, services and skilled providers, with both government and NGO services concentrated in more urban settings. Children and adolescents not engaged in formal education were also noted as a key underserved group as most national policies and programmes are focused on school-based delivery. Children and adolescents living with disability were also identified as having high unmet needs for MHPSS and very poor access to inclusive care. Stakeholders recommended further research in order to understand the barriers and service-delivery preferences, as well as improved coordination with community-based organizations to better serve marginalized groups.

KEY RECOMMENDATIONS – SERVICE DELIVERY:

- Develop models and standards of child and adolescent-centred health services for mental health.
- Transition to integrated community-based services that span the three tiers of MHPSS.
- Integrate MHPSS into other health services at community level, including maternal and child health, nutrition, adolescent health and general medical/physical health.
- Build on existing school-based models to strengthen responsive care as well as key preventive actions.
- Develop and evaluate online and digital service delivery models that link mental health promotion, positive peer relationships, parenting programmes and responsive care (self-referral and counselling).
- Identify barriers and service-delivery preferences for marginalized and underserved communities, particularly strategies needed to reach out-of-school children and adolescents, and those living with disability.

Standards and oversight

Several recommendations were made to strengthen the quality of MHPSS and improve oversight. At a national level, the department of health (or equivalent) was identified in all countries as having primary responsibility for quality assurance through setting technical standards and guidance, establishing indicators and monitoring performance. While this role is more clearly defined with respect to responsive care and clinical health services, oversight in relation to actions against the other tiers (prevention and promotion) are less clearly articulated. To support oversight, all countries recommended developing a harmonized set of indicators for MHPSS that could be used to monitor performance and quality.

A high priority in all countries is developing (or in the case of Thailand, strengthening) a national protocol for early identification and screening to identify those with mental health conditions, and those at increased risk. This would include developing locally validated and age-appropriate screening tools and detailed protocols for administering these within different settings (health, education, child welfare and justice). Standardized protocols and procedures for referral of children and adolescents with mental health needs are also critical not only for efficient referral within the health system, but to support referral between sectors (for example from schools or child protection settings to health services).

To support responsive care, national standards for child and adolescent-friendly health service delivery should be expanded to provide more specific service standards in relation to mental health. Similarly, standards of care provided in other settings are also needed – for example, protocols and service standards for the provision of psychological first aid or the initial management of behavioural problems in schools and the provision of MHPSS in social welfare and justice settings. For the justice sector specifically, stakeholders recommended that protocols be developed to provide greater guidance on the management (health and legal) of children in conflict with the law who have a mental health condition. They also recommended protocols to minimize the harmful impacts on the mental health of juvenile offenders and child victims/witnesses. Standard operating procedures and protocols that cover multiple agencies are also needed for children and adolescents engaged in the justice or social welfare sectors. These should include detailed guidance on the roles and responsibilities of each sector and relevant agencies in screening, referral, management, preparation for release or discharge, and follow-up.

In the Philippines, a point was raised about the need for policies and guidelines to support a suicide prevention programme, including guidelines for suicide prevention hotlines, emergency response and care for suicide (for health professionals, non-health providers and first-responders) and suicide surveillance.

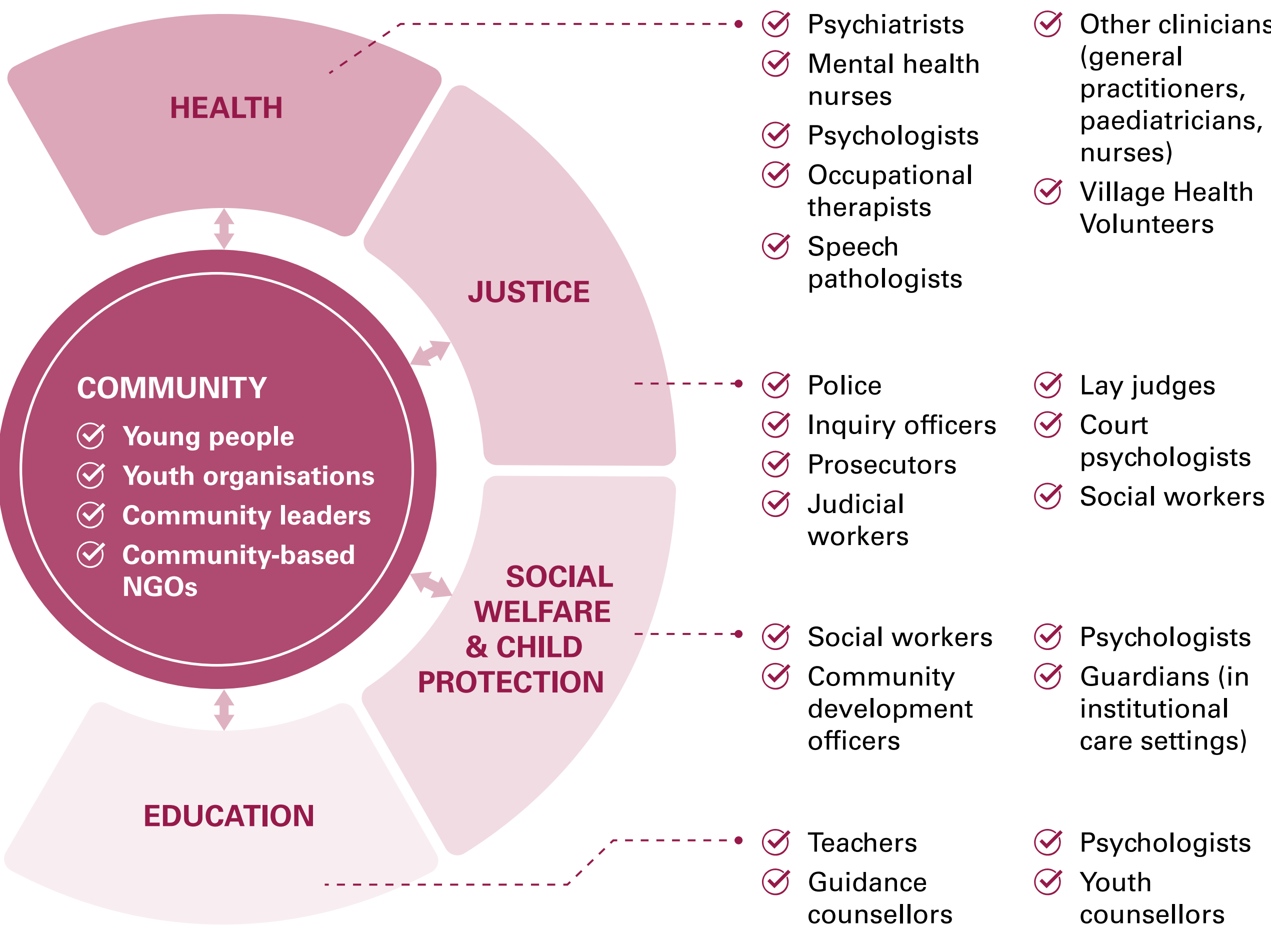
KEY RECOMMENDATIONS – STANDARDS AND OVERSIGHT:

- Define clear, multisectoral indicators to monitor MHPSS performance.
- Strengthen guidance, protocols and procedures with respect to delivery of child and adolescent-friendly mental health services, including clarity around parental consent.
- Develop clear guidance and protocols for early identification, screening and referral (within and between sectors), with clearly defined roles and accountabilites of key actors.
- Standard operating procedures across agencies to support coordinated care of children and adolescents engaged in child protection or justice settings.
- Strengthen justice-related protocols to minimize harm to children and adolescents who come into contact with the justice sector.

Multisectoral mental health and psychosocial support workforce

In this region, the mental health workforce includes government, non-government and private sector actors across the health, education, social welfare, justice and community sectors. Key service providers common across the four focal countries are summarized in Figure 17.

FIGURE 17. MULTISECTORAL MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT WORKFORCE



In all countries, workforce shortages are a major challenge impacting on the implementation of MHPSS policy and programmes. Limited numbers of professionals trained to deliver components of MHPSS (including health professionals, teachers, school counsellors, psychologists and social workers) contribute to constraints in service delivery, very high caseloads and over-reliance on tertiary services, resulting in referral bottlenecks and delayed access to care (see Box 4). To address inequity in access to MHPSS, there is also a need to consider the skills mix and distribution of the workforce, noting the need for collaborative and multidisciplinary teams. In addition to increasing the number of skilled providers in rural areas, there is also a need for workforce diversity in terms of gender and ethnic and cultural backgrounds so that communities have access to an appropriate and trusted provider. To support greater planning and coordination of the workforce, stakeholders in the Philippines recommended establishing a **mental health workforce taskforce** comprising all relevant sectors, that could have an overarching role in defining the required workforce (roles, competencies, qualifications, settings of practice), making recommendations for training and supportive supervision, and supporting workforce planning and development. Establishing sector-specific committees to oversee the development, management and support of the mental health workforce was also recommended (for example, stakeholders in Malaysia recommended establishing an MHPS committee within the Ministry of Education to support workforce development).

BOX 4. COMMON WORKFORCE CHALLENGES

Cross-cutting workforce challenges:

- Insufficient numbers of mental health professionals, paraprofessionals and non-specialist providers across all sectors;
- Inappropriate distribution of mental health specialists, concentrated in urban areas;
- Lack of competency-based training, particularly for non-specialist providers, limited access to in-service training and a lack of supportive supervision;
- Lack of recognition and accreditation of training for non-specialist clinicians;
- Lack of job aids and other tools to support roles;
- Lack of supportive supervision;
- Providers in all sectors working in silos, with little connection to multisectoral teams or networks to support a tiered response to mental health.

The current MHPSS workforce and recommended MHPSS roles

Many priority MHPSS actions are already integrated into existing workforce roles although providers' capacity to carry out these roles is hampered by the challenges noted above. Table 9outlines key recommended roles by sector.

Within the **health sector**, specialist clinicians in all countries (psychiatrists and mental health nurses) have primary responsibility for delivery of responsive care. However, the limited number of specialists, particularly those with additional training and expertise in child and adolescent mental health, is currently a significant bottleneck, with many of these specialist providers concentrated in urban areas and in tertiary hospital settings (see Table 8).

Table 8 Number of mental health-related workers (per 100,000 population) in Malaysia, Papua New Guinea, Philippines and Thailand

	Malaysia	Papua New Guinea	Philippines	Thailand
Psychiatrists	1,05	0.1	0.52	0.99
Child psychiatrists	0.07	Not reported	0.06	0.26
Other specialist doctors	0.97	Not reported	Not reported	1.24
Mental health nurses	6.84	Not reported	Not reported	6.74
Psychologists	Not reported	Not reported	0.88	0.75
Government registered social workers (per 100,000 children)	Not reported	Not reported	13.9	20.1
Occupational therapists	Not reported	Not reported	0.30	0.98
Speech pathologists	Not reported	Not reported	0.26	0.19
Other paid mental health workers	Not reported	Not reported	Not reported	1,893.45

Source: WHO Mental Health Atlas 2014–2017[64–67] and Global Social Service Workforce Alliance 2019.[72]

To address this bottleneck, stakeholders recommended strengthening collaborative care models by integrating mental healthcare into the roles of non-specialist providers (such as paediatricians, family doctors, general practitioners, nurses and midwives), supported by specialist psychiatrists and tertiary facilities where needed. Integrating mental health into the roles of community-level providers (including lay providers and youth volunteers/workers) was also recommended, particularly actions that could be effectively delivered at community level (such as screening, referral, first aid, follow up and support). In addition to responsive care, it was recommended that health providers also take on a greater role in prevention and promotion of mental health, specifically in education and mental health literacy, and supporting parenting programmes and school health.

The **education sector** arguably comprises the biggest mental health and psychosocial workforce, although in Malaysia, the Philippines and Papua New Guinea in particular the roles supporting MHPSS are not well defined. In all four countries, the current roles of teachers include some aspects of mental health-related education (for example, through life skills education). Mental health policies in Malaysia, the Philippines and, to a larger extent, in Thailand, also include roles for teachers and other school-based staff (such as counsellors) in providing early identification, screening, referral and basic psychosocial support. Many stakeholders noted the very heavy workload expected of teachers, with a significant time and administrative burden associated with conducting school-based screening and mental health education and awareness activities, in addition to other academic responsibilities. Many MHPSS roles were seen by teachers as an add-on to their academic role rather than understood as being part of their core responsibilities. Insufficient numbers of school counsellors in all countries and limited collaboration and supervision provided by other mental health professionals were also raised as key challenges, particularly in the context of increasing mental health needs as a result of COVID-19. A key recommendation in all countries was increasing the numbers of school counsellors with specific training in mental health to ensure that all schools had access to at least one skilled counsellor. In Thailand, school counsellors (or psychologists) were also recommended to have a broader role in establishing whole-of-school mental health programmes and coordinating actions for mental health with school staff, students, parents, communities and other MHPSS providers, in line with national mental health policies.

The **social service workforce**, including social workers, child protection officers, community development workers and psychologists in some settings, encompasses a broad professional workforce in this region that works across multiple sectors and is employed not only by social welfare (encompassing child protection) but also by the health (healthcare), education and justice sectors. Many are also employed through NGOs. While the exact numbers of social service workers in the region are difficult to determine, available estimates suggest there are very limited numbers of trained, registered social workers (see Table 8. Social service workers typically work as part of multidisciplinary teams, with current roles including case management, the provision of counselling and services in relation to child protection (including identification, referral, support for children experiencing family violence, neglect, child labour, those in conflict with the law, victims of sexual exploitation and trafficking, and children with disabilities). Social service workers also have a significant role in disaster relief and recovery. Workforce constraints and high caseloads are key challenges impacting on service delivery, particularly during times of crisis. The limited availability of social workers and psychologists in institutional settings was also noted in most countries – with difficulties attracting staff to work in social welfare institutions due to low remuneration and poor job security, a lack of supportive supervision, and restrictions on the licencing of clinical psychologists, particularly those working at community level in some countries. It is also important to note that while Thailand and the Philippines have recognized the profession of social work by law, Papua New Guinea and Malaysia are yet to adopt a law on social work.

Within the **justice sector**, stakeholders highlighted that frontline officers (police and judicial officers) are frequently called upon to provide social welfare or deal with acute mental health and behavioural concerns, but that they lack the expertise to effectively provide these services. Low awareness of child and adolescent development and mental health was also noted, with very limited numbers of judicial officers having had access to specific training in mental health to support children who come into conflict or contact with the justice sector. Providing early identification, screening and referral were identified as MHPSS roles that could be integrated into this workforce, in addition to increasing the number of court psychologists with specific training in child and adolescent mental health.

At **community level**, youth and peer groups, youth organizations, youth leaders and community-based organizations were recognized as an underutilized workforce with the potential to support early identification, mental health first aid and preventive programmes (in the community as well as through linkages with schools), and deliver community-based programmes to promote mental health literacy and address stigma and discrimination.

Table 9. Overview of recommended MHPSS roles, by sector

Sector	Provider	Responsive care	Prevention	Promotion
Health (including nutrition and early childhood development)	Specialist mental health clinicians	Screening, diagnosis and management as part of a multidisciplinary team	Targeted interventions to address risks (e.g., harmful substance use) Support to school-based approaches	
	Other non-specialist providers	Screening, diagnosis and management as part of a team and supported by specialists as needed	Supporting positive parenting across the life cycle and targeted interventions to identify and support children and families at risk Support to school-based approaches	Support mental health literacy
	Community health workers	Community-based early identification and screening, referral, supporting community-based care	Support universal prevention actions (e.g., promotion of positive parenting)	Mental health literacy, addressing stigma and discrimination
Education	Teachers	Early identification, screening and referral Behaviour modification for uncomplicated cases Support continuity of care and ongoing education	Supporting social and emotional learning, skills and resilience, promoting positive peer relationships (curriculum-based and participation in whole-of-school approaches)	Support mental health literacy and anti-stigma through greater engagement with families and school communities
	Guidance/ school counsellors	Screening and referral, provision of counselling and initial management of mental health conditions	Support school-based interventions to increase mental health literacy and social and emotional skills	Support mental health literacy and anti-stigma programmes

Sector	Provider	Responsive care	Prevention	Promotion
Education	School psychologists	Training and support to teachers and guidance counsellors for screening, referral and management	Support school-based interventions to increase mental health literacy and social and emotional skills	Support mental health literacy and anti-stigma programmes
	Youth counsellors/ peer counsellors	Early identification, referral and psychosocial support	Participation in school-based interventions to address risks and support positive peer relationships	Mental health literacy and anti-stigma programmes
Social welfare (social protection) and child protection	Social workers/ community development officers	Early identification, screening and referral of children and adolescents at increased risk Case management as part of a multidisciplinary team (facility, residential and community-based)	Parenting programmes (universal) and support to families in need (targeted) Other targeted interventions to address risks	Mental health literacy and programmes to address stigma and discrimination Social protection programmes for children and families
Justice	Police, public prosecutors, court psychologists, lay judges, social workers and other frontline justice workers	Early identification and referral for screening, diagnosis and management	Targeted interventions and follow-up of children, adolescents and families at risk (including harmful substance use, rehabilitation and meaningful skills training for young offenders)	
Community	Youth leaders, community leaders, community-based organizations	Early identification and mental health first aid	Promote positive peer relationships, positive parenting, and support to community-based interventions	Mental health literacy and programmes to address stigma and discrimination

Workforce planning, competencies, training and support

Common competencies required of the multisectoral MHPSS workforce are summarized in Figure 18. In all four countries, high priority was placed on improving the understanding of child and adolescent mental health and related behaviours, as well as specific skills in relation to screening, managing difficult behaviours and dealing with crisis (including psychological first aid) for the broad mental health workforce, particularly non-specialist providers.

FIGURE 18. COMMON CROSS-SECTORAL MHPSS COMPETENCIES

Common MHPSS competencies

Understanding of child and adolescent development and behaviour

Understanding of common mental health conditions and risks during childhood and adolescence

Understanding of relevant laws, policies and plans (and their role)

Skills: early identification, screening, behaviour management, psychological first aid

Communication skills (with children, adolescents and families and with implementing partners, local authorities, officers)

Specialist training programmes for **health sector** clinicians are relatively well established in Thailand, Malaysia and the Philippines. Accreditation and certification of the medical mental health workforce is provided through professional bodies, such as the Royal College of Psychiatrists and Royal College of Pediatricians. However, there are no such regulatory bodies with respect to non-clinical providers of MHPSS. It was recommended that the department of health, or equivalent, should have overall coordinating responsibility for the development and implementation of training not only of clinical health personnel but also of the multisectoral workforce in collaboration with the relevant ministries, to support more standardized mental health education.

While there is a need to increase postgraduate and specialized training for child and adolescent mental health clinicians, greater priority in all countries was given to including (and strengthening) mental health training and education for the broader mental health workforce. This includes integration of mental health into pre-service training and education for all health providers, teachers and educators, social workers, police and justice officials with an emphasis on improving the understanding of child and adolescent mental health and the skills to recognize and manage mental health conditions.

For the **education sector**, limited teacher training in mental health and well-being was described in all countries as contributing to low awareness of mental health, a lack of recognition of mental health conditions and behavioural problems, and limited recognition of the core role that schools and teachers have in supporting mental health and well-being. In Thailand, where teacher training in mental health is the most advanced, teachers have received training in mental health screening and simple behavioural management as part of the national HERO (Health and Educational Reintegrating Operation) and SAFE-B-MOD (School and Family Empowerment for Behavioural Modification in School-aged Children) programmes. The provincial level education offices are also responsible for providing training to guidance counsellors and school psychologists. While stakeholders described these programmes as having a positive impact, it was noted that two days of training was insufficient, particularly for building skills in managing difficult behaviours, and that teachers required ongoing

training and support. In all the focus countries it was recommended that all teachers and other school-based staff receive training in mental health (including understanding the role of schools in promoting well-being), skills to support children with developmental disorder, learning difficulties and other needs, and improving skills in early identification of mental health conditions (including training in the use of screening tools).

Within the **social welfare sector,** all four countries provide bachelor degree programmes in social work although the inclusion of mental health education and training is limited. Many workers in the sector have degrees, diplomas or certificate-level qualifications in other disciplines, some of them not relevant to social work given that social work licences can be obtained by individuals who have worked in a related field for a minimum period of time. This mix of training and qualification pathways creates challenges for ensuring that all social service workers have a basic education in mental health to support integration of MHPSS into primary roles.

For the **justice sector**, particular priority was given to training that improved understanding of the multidirectional links between mental health, behaviour, and conflict with the law. Improved understanding of child and adolescent development, communication skills, and improved knowledge and skills in trauma-informed care were also highlighted as important priorities for training within the justice sector.

Recommendations were also made to improve support and supervision of the mental health and psychosocial support workforce. These included establishing cross-sectoral, multidisciplinary teams at implementation level, particularly to improve support and supervision of non-specialist providers (such as linking teachers and social workers to psychologists and mental health professionals) and increasing the salary and remuneration of social workers, psychologists and others engaged in mental health and child protection to attract skilled and dedicated workers and improve retention and motivation. Establishing workforce networks, such as school counsellor networks, was also recommended to encourage the sharing of knowledge, experience and support. Additionally, it was recommended that developing clearer implementation protocols and job aids for different sectors and cadres with respect to MHPSS roles would improve performance. Attention to the mental health needs of providers is also needed, reflecting the often stressful and sometimes distressing roles required. Overall, greater coordination across sectors to map the mental health workforce, roles and competencies is needed to support workforce planning – including training, supportive supervision, distribution and collaboration through multidisciplinary teams at a local level.

KEY RECOMMENDATIONS - MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT WORKFORCE:

- Establish a multisectoral taskforce or working group for the development, planning and support of the mental health workforce. This could also include subcommittees within sectors to support workforce development.
- Undertake further detailed mapping of the multisectoral mental health workforce and existing mental health competencies to identify gaps (numbers, skills, distribution).
- Integrate and strengthen pre-service mental health training for health, education, social welfare and justice sector providers.
- Strengthen job aids, tools and protocols to support key MHPSS roles (screening, referral, behaviour management, mental health first aid).
- More explicitly integrate MHPSS actions into the defined roles and performance indicators of key cadres (teachers, counsellors, social workers, justice officers).
- Improve remuneration and job security/career pathways for social workers, psychologists and other mental health professionals.
- Establish mechanisms for supportive supervision of the mental health workforce through multidisciplinary teams, support networks and services and supports to address the mental health of providers.

Budget and financing

All countries reported having insufficient budgets to adequately implement MHPSS, while current government expenditure on mental health is very low (see Table 10). Most of the current government funding is directed to mental health hospitals, with very limited data on funding for other MHPSS programmes or allocation of funding for MHPSS within other sectoral budgets. All sectors reported that current funding was insufficient to implement MHPSS, particularly given increased demand in the context of the COVID-19 pandemic. In the Philippines, for example, education stakeholders described schools being asked to prioritize mental health activities, but with operational budgets having already been set, the funding for these new activities had to be drawn from school maintenance and other operating expenses, with no education budget for mental health programmes.

Table 10. Government expenditure on mental health as a percentage of total government health expenditure in Malaysia, Papua New Guinea, the Philippines and Thailand

	Malaysia	Papua New Guinea	Philippines	Thailand
Government expenditure on mental health as % of total health expenditure	1.3%	No data	0.2%	0.3%

Source: WHO Mental Health Atlas 2014–2017.[64–67]

Mental health services are included in the national Universal Health Coverage Scheme in Thailand. Only hospital-based care for acute psychosis or drug dependence is covered in the Philippines, and mental health is not currently included in the Universal Health Coverage Scheme in Malaysia. Current national plans for mental health in the Philippines and Malaysia include plans to cover mental health services (including outpatient counselling and services) through national health insurance programmes. Papua New Guinea's Free Primary Healthcare and Subsidized Specialized Service Policy does not specifically identify mental health services. However, several related medicines are included in the national list of essential medicines.

In addition to an overall lack of funding to support MHPSS, other key challenges impacting on the budget and resourcing for mental health in all focus countries include:

- Lack of agenda-driven budgeting and lack of a structure to support cross-sectoral budget planning. In all four countries, mental health is not currently included as a national goal within social and economic development plans (or the equivalent) and/or included as a primary programme within the ministry of health, and so has no national budget line. Budgets and budget allocations are aligned with individual government units, not with a common goal or objective for mental health. Therefore, aspects of MHPSS may be included within individual unit budgets, but these are not coherent or coordinated, resulting in gaps in budget allocation. Individual units also have competing priorities and planning cycles, and it is not clear which unit/department is responsible for funding specific aspects of MHPSS. At the department or bureau of budget (or equivalent) there are also no structures that allow a cross-sectoral review of budgets to assess alignment with national policy or to support efficient allocation of resources across a multisectoral programme.
- MHPSS programmes are generally not costed. While health services (primarily clinical care) may be costed, other actions in relation to prevention and promotion, particularly for non-health sectors, are often not costed. Many stakeholders also noted that there is often no specific budget line for implementation – for example, stakeholders in Thailand reported that the national programme in relation to educational area psychologists does not have a specific budget assigned for this role or related activities.
- Moreover, there is no specific budget allocation for mental health at subnational and local government level, with resource allocation highly dependent on local authorities and their awareness and prioritization of mental health.

To address these challenges, stakeholders recommended that mental health be elevated as a national goal in social and economic and development plans and/or a primary programme within the department of health, to ensure that a budget line is assigned. A minimum-services package for MHPSS (based on the framework priority actions) should also be defined and costed, clearly identifying costs related to key sectors. To support cross-sectoral budget planning and resource allocation that is agenda-driven, stakeholders recommended establishing cross-sectoral committees to plan and prepare budgets to ensure that unit budgets included consistent budget requests for MHPSS. It was also recommended that cross-sectoral committees be established within the department or bureau of budget to review and assess budgets and ensure alignment with national mental health plans and to support efficient allocation of resources. Furthermore, it was recommended that greater support be provided to local government units (through mental health subcommittees or the ministry of interior) to assist with prioritization and planning and ensure adequate resource allocation for implementation of MHPSS programmes. Finally, stakeholders in Thailand and Malaysia recommended establishing a national public fund for mental health to increase available resources. In Thailand, for example, it was suggested that the Thai Health Promotion Foundation could provide additional resources to support mental health research and implementation activities, including funding for new innovations that could be rigorously evaluated and then scaled up.

KEY RECOMMENDATIONS – BUDGET AND FINANCIAL RESOURCES:

- Include mental health services (including outpatient services) within universal health coverage and national insurance schemes.
- Include a national mental health goal in social and economic plans and/or as a primary programme within the ministry of health.
- Define a detailed minimum-services package for child and adolescent mental health (based on the tiered framework of actions) addressing responsive care, prevention and promotion that can be costed, with budget responsibility across key sectors clearly defined.
- Establish a national cross-sectoral planning body and cross-sectoral budgeting committees for MHPSS to support efficient and coordinated budget requests and processes.
- Increase support for subnational and local government units to improve resource allocation for implementation of MHPSS, as well as efficient use of public resources.
- Consider establishing a public fund to provide additional funding for prevention, promotion, research and innovation with respect to mental health.

Participation

Mental health-related stigma, discrimination and lack of mental health literacy are major barriers to seeking support and services. Across countries it was reported that terms like ‘mental health’ or ‘psychiatry’ have negative connotations, and mental health stigma remains a significant challenge in society. These barriers were described as contributing to a lack of care-seeking by parents (including withholding consent for referral), with a preference for keeping mental health conditions and symptoms secret and addressed within the family. Misunderstandings and misconceptions about mental health and behaviour are also common, with teachers and parents reportedly dismissing signs of poor mental health as attention-seeking or simply bad behaviour. Limited mental health literacy among children, adolescents and their parents/carers also contributes to delays in seeking care and a lack of awareness of available supports and services.

Engaging communities and strengthening the participation of children, adolescents and families is central to ensuring that policies, programmes and services respond to needs and address barriers. Stakeholders had a number of recommendations to support participation. At a policy and planning level, supporting opportunities for youth organizations and representatives and parent representatives, including those

with lived experience of mental health conditions, to participate in establishing high-level priorities and designing policies and programmes is critical – as is building the capacity of youth advocates and leaders in mental health. While UNICEF was identified as a key partner in supporting youth participation, formally including a role (and representation) for young people in national government mental health committees or other similar bodies (commissions or coalitions) was recommended. Importantly, it was recognized that additional responses were needed to specifically engage marginalized young people and communities (including out-of-school adolescents, migrants, refugees and young people living with disability) as the needs and preferences of these groups were often neglected and their opportunities to participate in policy and programme development very limited.

At an implementation level, young people themselves were identified as important implementation partners. Providing opportunities for training and capacity building for youth leaders, peer educators, counsellors and advocates could help to strengthen peer-led early identification, referral and support (including peer counselling) in community and school settings. Additionally, youth and peer groups are currently an underutilized resource for supporting community engagement in mental health and delivering mental health literacy and anti-stigma and discrimination programmes. To support this engagement, stakeholders recommended establishing more formal roles for youth volunteers through schools, youth centres and other community structures, with clear responsibilities, training and support. It was also recommended that local level mental health subcommittees should include youth representatives or that a local child and adolescent task force be established to help inform child- and adolescent-friendly implementation. Many stakeholders also noted that there was a need for more formal mechanisms for linking government agencies directly with communities to identify needs and to support the implementation of community-based actions. Parent-teacher associations and other similar school structures were also seen as underutilized platforms for reaching parents and engaging them more directly in MHPSS programmes.

Strengthening mechanisms for community feedback and monitoring is also important. Stakeholders recommended that communities be more closely engaged to develop key indicators to monitor progress and evaluate the responsiveness of MHPSS to local needs. An accessible and responsive system to support feedback and complaints in relation to mental health services is also needed. The Department of Mental Health in Thailand provides a national online system for feedback, complaints and suggestions to improve services through the Complaint Management System. This platform could be broadened to include MHPSS services beyond health settings, and consideration could also be given to providing a more child- and adolescent-friendly system for feedback. Similar national systems have not yet been established in the Philippines, Malaysia or Papua New Guinea.

KEY RECOMMENDATIONS – PARTICIPATION:

- Build the capacity of and increase opportunities for young people and youth organizations to participate in MHPSS policy and planning, including those with lived experience and marginalized young people. Consider formal roles for youth and parent representatives on national mental health committees or similar bodies.
- Strengthen engagement between government agencies, communities and youth groups to ensure that MHPSS approaches meet local needs and support implementation, including more formally defined roles for young people in planning and delivery of MHPSS.
- Include youth and parent representatives in subnational mental health committees and/or establish child and adolescent task forces to support planning.
- Establish or strengthen mechanisms for feedback and complaints, including for feedback in non-health settings and in child- and adolescent-friendly formats.

Data, health information and research

Several data and information needs were identified. At a national level, timely and reliable statistics (disaggregated by location, age and sex) related to the prevalence of common mental health conditions and risks is needed to inform policies and support prioritization and implementation plans, and budgeting. These include estimates of common mental disorders (depression, anxiety, developmental disorders, psychosis), suicide rates, psychological distress and behavioural problems, key risk factors (substance use, bullying, violence, adolescent pregnancy) and population and service delivery data (such as the number of families requiring social welfare). Some data are collected through routine health information and surveillance systems (such as suicide rates in Thailand). Other indicators are included in school and household surveys (such as GSHS and MICS), although it is noted that these are more suited to monitoring longer-term trends and progress as they are not conducted annually. There is currently no national suicide surveillance system in Malaysia, the Philippines or Papua New Guinea.

In all focus countries, stakeholders highlighted the need to include mental health indicators in the routine data collection of sectors outside of health. They also emphasized a need to improve the sharing of data and data linkage within and between sectors to support planning and implementation, with consideration of privacy laws to protect children, adolescents and their families. For example, enabling timely sharing of data collected through the education, social welfare and justice sectors with multidisciplinary teams, for instance through data linkage, would improve the identification, planning and follow-up of children and families at risk. Currently there are no mechanisms to collate, manage or share data efficiently between sectors. Establishing a multisectoral mental health information system that includes relevant government, private sector and NGO providers was a high priority in all four countries, as was building a user-friendly platform to enable access to timely and relevant data.

Improved access to data describing the multisectoral system was also a noted priority, including up-to-date information about the multisectoral workforce, MHPSS service availability and distribution, coverage and use of services such as hotlines, and data about non-government actors in MHPSS. To support this, the four countries recommended that a minimum set of harmonized indicators be developed that all sectors and relevant units would report or contribute to. It was also recommended that NGOs and the private sector also collect and report routine mental health data into a central system to enable greater transparency and oversight.

In addition to data to inform policy and programming and monitor progress, better use and availability of data is also important to support frontline mental health workers and communities to improve efficiency and flexibility at the local level and contribute to workforce motivation. For example, in Thailand, stakeholders recommended developing a dashboard linked to the HERO programme so that teachers, school administrators, parents and students could receive timely information on the performance of the programme. Strengthening information systems at a local level (including resourcing dedicated staff to manage health information rather than relying on service providers) was also identified as important for supporting more efficient referral processes to support implementation.

Research priorities include further studies to understand the needs, barriers and service-delivery preferences of children and adolescents, studies to determine the effectiveness of specific MHPSS interventions (such as referral hotlines) and implementation research to understand effective models of service delivery. To support impactful research, it was also recommended that a national multisectoral research agenda for mental health be established. Stakeholders furthermore recommended better dissemination of research findings, such as establishing a central national repository of mental health research.

KEY RECOMMENDATIONS – DATA, INFORMATION AND RESEARCH:

- Establish a national suicide and self-harm surveillance system.
- Include mental health indicators in routine health information systems and provide age and sex-disaggregated data.
- Integrate child and adolescent mental health indicators into the routine information systems of education, social welfare and justice.
- Improve mechanisms for timely analysis, reporting and sharing of data within and across sectors to support implementation of MHPSS and continuity of care for those at risk.
- Invest in further research to understand demand-side needs, barriers and service-delivery preferences, and build the evidence for specific actions and of effective implementation models.

Key recommendations and conclusions

Children and adolescents in East Asia and the Pacific experience a substantial burden of poor mental health and face considerable unmet needs for mental health and psychosocial support. Recognizing this, countries in this region have made important progress to address child and adolescent mental health. National policy and legislative frameworks are broadly supportive, responding at least in part to the specific needs and considerations for this age group, and recognizing the need for a national, multisectoral approach to mental healthcare, prevention and promotion. While a large focus of the current response in Thailand, the Philippines, Malaysia and Papua New Guinea has been on the clinical management of mental health conditions through the health sector, there are also many examples of national and subnational programmes delivered through education, social welfare and justice settings to improve early identification and assessment, multidisciplinary management (particularly of children at risk) and programmes in schools, child protection and justice settings to address risk factors.

This analysis has identified some important gaps in the current MHPSS response. These include:

- Limited availability and accessibility of community-based, child- and adolescent-friendly, family-centred and multidisciplinary care for mental health conditions (particularly outside of specialized tertiary and institutional settings);
- Lack of comprehensive and coordinated whole-of-education approaches to mental health promotion;
- Limited coverage of national (and targeted) programmes to support nurturing and responsive care provided by parents and carers;
- Lack of coordinated programmes to support healthy peer relationships and address peer victimization in schools, communities and online spaces; and
- Gaps in relation to programmes reaching marginalized, out-of-school and migrant children and adolescents.

There are also some critical cross-cutting challenges impacting on implementation of MHPSS. While mental health and well-being is integrated to some degree in the sectoral plans of education, social welfare and justice, these generally focus narrowly on specific actions (such as mental health screening or provision of counselling) rather than encompassing a more holistic vision for mental health and well-being and clear articulation of the sector's role and response. At a subnational level, the lack of clear plans, guidance and structures to support implementation and multisectoral collaboration has contributed to limited coordination. Across all sectors, insufficient numbers and inappropriate distribution of skilled personnel were noted as a major barrier to implementation, contributing to heavy workloads, long delays in access to care and inconsistent delivery of interventions (such as screening). Limited availability of services responsive to the needs of children and adolescents, particularly at community level, and over-reliance on tertiary and institutional-based care also contribute to high unmet needs and delays in access to services through health and social welfare sectors, and time-consuming referral from other sectors such as education. Unclear referral protocols, particularly for referrals arising outside of the health sector, also contribute to delays in access to services and supports, as do the lack of standardized protocols across agencies for supporting children at high risk. Insufficient budgets for MHPSS-related programmes and budgeting processes that do not currently support agenda-based and cross-sectoral budget planning are also key challenges.

Overarching recommendations

In addition to specific recommendations to strengthen the multisectoral mental health system, overarching recommendations to improve the implementation of MHPSS for children and adolescents in East Asia and the Pacific include:

1. At national level, mental health legislation and national mental health policies should be strengthened to more clearly articulate the specific MHPSS actions and protections for children and adolescents and detail a multisectoral plan (and coordination structure) for implementation of MHPSS, including cross-sectoral performance indicators. This should be based on a collective vision for the provision of MHPSS services for children and adolescents. Sufficient allocation of public resources for MHPSS to all relevant sectors (not only health), as well as ensuring effective expenditure, is critical to enable legislation and policies to be implemented.

2. Governments should establish or strengthen a national multisectoral committee (or similar body) for child and adolescent mental health with responsibility for coordinating planning and implementation. At subnational level (provincial or district level), governments should establish or strengthen the role of mental health subcommittees and provide capacity building of subnational leadership and local government to improve awareness of mental health and support the development of local multisectoral implementation plans, resource allocation and coordination.

3. Ministries of health, in consultation with other sectors and technical partners, should strengthen national, standardized protocols for child and adolescent health across agencies, including:
    a. Validated screening tools and guidance on use;
    b. Referral procedures;
    c. Non-specialist management;
    d. Case management of children and adolescents engaged in the child protection and justice sectors; and
    e. National quality service standards for child and adolescent mental health services across sectors.
4. Governments should include mental health services (including outpatient services) within universal health coverage and national insurance schemes and increase public resource allocation for mental health across the tiers of care, prevention and promotion. To support this, ministries of health should consider including mental health as a primary programme, and a minimum-services package (based on the regional framework) should be defined and costed, with budget allocation and responsibility clearly defined across key sectors. Governments should also consider establishing a national cross-sectoral body or cross-sectoral committee on MHPSS within the department or bureau of budget to support coordinated and comprehensive budget requests that align with national MHPSS goals.
5. Ministries of health and social welfare should prioritize the integration of MHPSS into primary and community-level services for children, adolescents and their families, including through primary healthcare and community-based approaches to child protection and support for families.
6. Governments, with support from professional associations, training institutions and development partners, should strengthen the multisectoral mental health and psychosocial support workforce through:
    a. Further in-depth mapping to identify key roles across sectors against the MHPSS priority actions and the required competencies and inter-sectoral training needs to support these roles;
    b. Development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for key providers across sectors;
    c. Integration of child and adolescent development and mental health into the pre-service training of health professionals, the social service workforce, justice sector workers, teachers and other school-based staff that aligns with roles and responsibilities with respect to MHPSS;
    d. Strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers), social service workers, justice sector workers, teachers and education staff that is competency-based and aligned with expected MHPSS roles;
    e. Training provided to relevant ministry-level staff from the health, education, social welfare and justice sectors to support planning and development of the workforce as well as broader MHPSS programmes;
    f. Expansion of the number of posts at national and subnational levels; and
    g. Improved supervision and support for MHPSS providers across sectors, including establishing provider support networks and multidisciplinary teams, improved remuneration, job security and career pathways, and attention to the mental health needs of providers themselves.
7. Governments, in consultation with academic and development partners, should improve the collection, use and accessibility of data at national and subnational levels – including data and

mechanisms to identify mental health needs, support planning and implementation and track progress. This should include strengthening data linkage and sharing across agencies, in conjunction with privacy laws to protect children and adolescents. In addition to greater investment in mental health research, national information systems (health, education, child protection, justice) should be strengthened to include a minimum set of child and adolescent MHPSS-related indicators harmonized across sectors, and national suicide surveillance systems should be established.

8. Governments, development partners and NGOs should increase opportunities for children and adolescents (and parents/caregivers) to participate in MHPSS policy and programming, including establishing more formal roles for young people (such as representation on mental health committees and other bodies at national and subnational level), and improved child- and adolescent-friendly mechanisms for providing feedback and complaints regarding MHPSS programmes and mental health services.
9. Governments, with support from development partners and NGOs, should expand national and community-based programmes to address mental health-related stigma and discrimination and improve mental health literacy (particularly targeting children, adolescents and parents/carers).

A way forward for UNICEF in East Asia and the Pacific

UNICEF, because of its country presence, engagement across all sectors that are relevant to MHPSS and leading role with children and adolescents, has a key role to play in the transformation of MHPSS in the region. This includes strengthening the MHPSS system and the provision of MHPSS services. However, UNICEF does not have the capacity, resources or expertise to support the entire MHPSS agenda at country level. Other agencies, such as WHO, also have a comparative advantage to lead aspects of MHPSS strengthening.

Through this research, the role of UNICEF in the short and longer term was considered from the perspective of partners and stakeholders as well as UNICEF EAPRO and Country Offices.

Broadly, stakeholders in all four countries identified a key role for UNICEF in drawing attention to child and adolescent mental health and advocating for evidence-based policy action through both national and regional platforms. UNICEF was identified as having an important role and comparative advantage in:

- Leading advocacy efforts for MHPSS for children and adolescents, including advocacy for adequate and equitable budget allocation and implementation;
- Playing a crucial convening role at country level, including facilitating linkages between sectors and supporting cross-sectoral dialogue, strategic planning and public finance management for MHPSS;
- Generating evidence through its capacity to:
  - collate and synthesize data to describe mental health needs and risks;
  - undertake analysis and research to strengthen financing for MHPSS;
  - integrate mental health measures into UNICEF-led initiatives (such as Multiple Indicator Cluster Surveys);
  - support new mental health research through established networks with national, regional and global technical partners;
  - provide funding for new initiatives, pilot projects and innovations to test new ways of implementing MHPSS for children and adolescents; and
  - measure the impact of MHPSS programmes by supporting monitoring and evaluation.
- Integrating MHPSS into existing UNICEF programmes and platforms (including primary healthcare, education, parenting programmes and child protection);
- Supporting and delivering programmes to address mental health-related stigma and improve mental health literacy through national level advocacy and community-based programming; and
- Integration of MHPSS in emergency settings.

To fulfil its role, UNICEF needs to take a whole-office approach to mental health, overseen and coordinated by senior management. While the whole office has a role to play in mental health, as specified above, the recommended roles and actions for UNICEF sections at country level to support **sectoral engagement in MHPSS**, as set out by the regional framework, are set forth in Table 11.

Table 11. Recommended roles for UNICEF in supporting MHPSS for children and adolescents

UNICEF Health (Nutrition and Early Childhood Development)	UNICEF Education	UNICEF Child Protection (Social Policy and Gender)	UNICEF Adolescent Development and Participation
Integrate MHPSS into existing health programmes by supporting capacity building of workforce to provide: • Early identification and screening of children and caregivers through maternal and child health, nutrition, early childhood development, and adolescent health programmes; • Primary-level services and supports for mental health conditions.	Support development or strengthening of education curriculum with a focus on social and emotional competencies, positive peer relationships, digital literacy and mental health literacy.	Inclusion of mental health and MHPSS in child protection, violence prevention, social protection, early marriage, and other programmes reaching at-risk children and adolescents (e.g., out-of-school) (integration of activities to improve mental health awareness, early identification, multidisciplinary care, intensive interventions to address risk factors, inclusion of MHPSS in case management).	Support adolescent participation in advocacy, activism and engagement in policy and programming related to mental health – particularly those with lived experience.
Support the delivery of parenting programmes through maternal and child health and early childhood development programmes.	Advocate for, and support, inclusion of mental health and MHPSS as part of the recovery plan for COVID-19: • Raise awareness about impacts of school closure on mental health; • Integrate MHPSS in remote learning programmes; • Include MHPSS (screening, referral and support) as part of school reopening plans; • Develop and support training packages for teachers on mental health.	Support workforce capacity: • Integration of mental health into efforts to strengthen the social service workforce and the justice workforce; • Development of training and tools to support early identification, screening and referral by social workers, child protection officers and community development officers, as well as law enforcement and justice actors.	Support research to understand adolescents' mental health needs, experiences, barriers and service-delivery preferences, and implementation of research to identify and build the evidence for effective models of service delivery for MHPSS.

UNICEF Health (Nutrition and Early Childhood Development)	UNICEF Education	UNICEF Child Protection (Social Policy and Gender)	UNICEF Adolescent Development and Participation
Ensuring MHPSS is integrated into the COVID-19 response.	Advocate for, and support, whole-of-education approach to mental health promotion.	Ensure that mental health services and support are included in case management, including referral protocols and pathways for children assisted by child protection services and justice services.	Support co-design of innovative models of service delivery, for example, online/ digital services.
Explore opportunities to support other sectors in mental health awareness, early identification and referral (schools, early childhood programmes, child protection, online and digital platforms).		Support parenting programmes by: • Building the evidence-base for parenting programmes through support for research; • Advocating for a national approach/ programmes to support positive parenting; • Delivering programmes, particularly to families at risk; • Integrating mental health literacy into parenting resources and programmes being developed in response to COVID-19 (all sections engaged in parenting programmes).	Support, through resourcing and capacity building, youth-led positive peer support networks for mental health (including online) to address norms, stigma and online victimization and provide safe spaces for peer support.

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Appendix A:
Project overview

Development of the regional framework for MHPSS

Synthesis of the available evidence

An important foundation to this initiative is the framing of mental health and well-being in UNICEF's The State of the World's Children 2021 report.[2] One of the core recommendation's of the report is to consider the 'spheres of influence' that shape mental health and well-being from an early age. The key spheres described are 'the world of the child' (mothers, fathers and caregivers), 'the world around the child' (schools and communities), and 'the world at large' (the social determinants). In a related commentary co-authored by UNICEF, opportunities to intervene were broadly mapped against these spheres of influence:[73] Mental health promotion largely targets the social determinants of health which impact on the world of the child, with preventative and treatment services more targeted towards the world of and around the child. The following additional documents and resources were reviewed in drafting the conceptual framework: UNICEF reports focusing on MHPSS; [74–77] WHO guidelines related to mental health;[63,78–81] the Lancet Commissions on Global Mental Health and Sustainable Development, and on Adolescent Health and Well-being;[82,83] UN guidance on social and emotional learning;[84,85] and available country-level operational guidance on implementation of MHPSS from both high-income settings[86–88] and available guidance from focal countries for this project (Thailand and the Philippines).[27,89–92] The draft framework considered the context of the region, and in particular the experience and capacity of key sectors to implement MHPSS.

Review by the Regional Technical Advisory Group

The Regional Technical Advisory Group (TAG) was assembled specifically for this project by UNICEF with membership including experts in child and adolescent mental health and well-being, UNICEF regional focal points related to child and adolescent mental health, as well as UNICEF representatives from each of the four countries where focal research was being undertaken. The conceptual framework was first presented during a virtual meeting, with the framework then circulated for written feedback in April 2021. All members of the TAG provided feedback and subsequently endorsed the framework.

Additional review by content experts

Further to input from the TAG, written input was sought from content experts in: social and emotional learning; interventions to address the social determinants of mental health; and the roles and responsibilities of the social welfare sector in mental health. Input was also sought from programming and implementing partners in each focal country, as well as the technical lead for MHPSS at UNICEF headquarters with consideration of the forthcoming Minimum-Services Package for MHPSS (in development) in refining the conceptual framework and actions.

Finally, extensive feedback was sought from country-level stakeholders during an online, two-day workshop in each focal country and a regional workshop with UNICEF focal points.

Each online workshop (in Thailand, the Philippines, Papua New Guinea and Malaysia – see below) was held with key stakeholders and implementing partners across health, education, social welfare and youth advocacy representing government, non-government, private sector and United Nations agencies. Additionally, an online regional workshop attended by country research partners, the Regional TAG and UNICEF focal points for the four countries was held in January 2022 to provide feedback on the preliminary findings and explore recommendations for UNICEF.

Country-level analysis

Country-level analysis was co-led by the Burnet Institute (lead team and and Papua New Guinea Country office), the Centre for Coordination of Clinical Research Network, the National Institute of Health, Malaysia, the Research Institute for Mindanao Culture, Xavier University, Philippines, and the Institute for Population and Social Research, Mahidol University, Thailand, supported by the UNICEF Country Office and the Country TAG in each country. This component included four main activities:

Desk-based review

Synthesis and secondary analysis of existing survey data

Priority indicators describing mental health outcomes and risks for children and adolescents aged 0–18 years were identified following mapping of existing global and regional mental health indicators. Indicators were populated using available national level survey data disaggregated by age and sex, where possible. Where data were not available, modelled estimates were sought from the Global Burden of Disease Study 2019.

Review and synthesis of available literature

To address the gaps and limitations of survey data, published literature was sought to describe the:

- Mental health needs of children and adolescents;
- Risks and determinants of mental health and/or psychosocial well-being;
- Barriers and enablers to accessing quality MHPSS;
- Evidence of interventions and approaches to address mental health and/or psychosocial well-being.

Articles published in English from January 2010 were sought from Medline, Embase, Emcare, and PsychINFO. The search strategy involved three main concepts: 1) Mental health, 2) Children and Adolescents, and 3) Country. For concept 1, Mental Health, search terms included mental health, psychology, psychosocial care, mental disease, suicidal behaviour, psychotherapy, anxiety management, and several specific mental diagnoses and psychotherapy modalities. For concept 2, Children and Adolescents, search terms included child, adolescent, and youth. For concept 3, search terms included Malaysia, Papua New Guinea, Philippines, and Thailand. This review included all relevant studies including narrative reviews, systematic reviews, randomized controlled trials, quasi-experimental trials, observational studies and case series. Studies were included if they were conducted in in one of the four focal countries and included children and/or adolescents aged 0–18 years and addressed one or more of the focus areas above.

Mapping and review of existing policies, strategies, plans and legislation

Government policies, plans, strategies and legislation were sought from relevant government websites and United Nations agencies. Relevant government ministries or departments from each sector (health, education, social welfare and justice) were first identified, and websites searched

using similar search terms to those above to identify potentially relevant documents relating to mental health. Documents were included if they were:

- Produced by the government, or described a government policy/plan/strategy/legislation;
- Related to government intentions, actions, decision-making;
- National in scope;
- The most recent available;
- Addressed one or more tiers of the conceptual framework for MHPSS (care, prevention, promotion).

These were then mapped and reviewed to identify: the sector; the extent to which they included specific actions for children and/or adolescents aged 0–18 years; the conceptual framework tier(s) addressed; summary of key actions in relation to children and adolescents; and targets and indicators (where relevant).

Country-level stakeholder consultation workshops

Two half-day, online workshops were conducted in each country between June and October 2021. These were attended by representatives from government (primarily from the health, education, social welfare and justice sectors), NGOs, the private sector, UN agencies and youth organizations. The aim of the workshops was to present and reflect on the MHPSS conceptual framework, identify priority actions for MHPSS for children and adolescents, and propose sectoral roles and responsibilities for implementation of the MHPSS package. To facilitate this, participants were invited to complete an online prioritization tool, provide feedback on each proposed MHPSS action and indicate a lead sector. Findings were presented and discussed during the second workshop.

Key informant interviews with sector stakeholders

Key informant interviews were conducted to explore in depth: the perceptions and understandings of priority child and adolescent mental health needs; current programmes and approaches related to MHPSS; the barriers and enablers impacting on implementation; recommended sectoral roles and responsibilities; and the challenges and considerations for strengthening a multisectoral mental health system. Sector-specific question guides drew on the project conceptual framework and were refined following review by sectoral and mental health experts through the Regional and Country TAGs.

A total of 108 interviews were conducted with stakeholders aged 18 years and over from the health, education, social welfare and justice sectors, including government, non-government, UN agency and youth representatives. All interviews were conducted via Zoom or over the phone due to COVID-19 restrictions. Interviews were facilitated by experienced researchers who had completed a three-day, intensive training workshop covering the study objectives, study procedures and ethical considerations. Interviews were audio-recorded and transcribed verbatim. Transcripts were analysed thematically using a Framework Method, and a detailed synthesis of the findings was provided in English.

All participants provided voluntary informed consent. Overarching ethics approval was obtained from the Alfred Ethics Committee (Australia). Additional letters of support and ethics approval were obtained from: Child and Adolescent Mental Health, Department of Mental Health, Ministry of Public Health, Thailand; Institutional Review Board of the Institute for Population and Social Research, Mahidol University, Thailand; Ministry of Health Medical Research and Ethics Committee, Malaysia; Ministry of Education Malaysia through their Educational Research Application System (eRAS 2.0); Secretary for Health, Department of Health, Papua New Guinea; and Council for the Welfare of Children, Philippines.

Validation workshop

Following data analysis, a participatory workshop was conducted with participants from the Country TAG and other key sectoral stakeholders in each country to present and reflect on the key findings and refine the recommendations.

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