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กรมสุขภาพจิต
DEPARTMENT OF MENTAL HEALTH

Mahidol University
Institute for Population and Social Research

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STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SYSTEMS AND SERVICES

for children and adolescents in East Asia and Pacific Region

THAILAND

COUNTRY REPORT
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Abbreviations

BoB	Bureau of the Budget
CAMRI	Child and Adolescent Mental Health Rajanagarindra Institute, Department of Mental Health
COVID-19	Coronavirus disease 2019
CRC	Convention on the Rights of the Child
EAPRO	Regional Office for East Asia and the Pacific (UNICEF)
GBD	Global Burden of Disease
GSHS	Global School-Based Student Health Survey
GSSWA	Global Social Service Workforce Alliance
HERO	Health and Educational Reintegrating Operation
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual
MHPSS	Mental health and psychosocial support
MICS	Multiple Indicator Cluster Survey
NESDC	National Economic and Social Development Council
NGO	Non-governmental organization
OBEC	Office of Basic Education Commission
RICD	Rajanagarindra Institute of Child Development
SAFE-B-MOD	School and Family Empowerment for Behavioural Modification in School-aged Children
TAG	Technical Advisory Group
ThaiHealth	Thai Health Promotion Foundation
UCS	Universal Coverage Scheme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YC	Youth Counsellor

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.[1,2] Additionally, millions more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder(s), 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 the total health expenditure,[5] despite accounting for 7 per cent of the total disease burden.[6] 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.[5]

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 community, schools, parents, service providers and children and adolescents themselves.

To support the urgent need to strengthen MHPSS systems and services for children and adolescents in the region, especially in the wake of COVID-19 with its 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) comprised of UNICEF, UNESCO, WHO and the Global Social Service Workforce Alliance, this initiative included the development of a regional conceptual framework that set 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 documents the application of the conceptual framework in Thailand and provides country specific recommendations for strengthening the provision of MHPSS for children and adolescents.

Children and adolescents aged 0–18 years in Thailand experience a high burden of poor mental health. One in 7 adolescents aged 10–19 and 1 in 14 children aged 5–9 are estimated to have a mental disorder (including developmental disorder).[1] Suicide is the third leading cause of death of adolescents aged 15–19.1 Risk factors for poor mental health are also prevalent. These include exposure to violence, peer victimization and bullying, and loneliness and social isolation, particularly in the context of COVID-19.

In response to these needs, Thailand has made important progress to address child and adolescent mental health. National policy and legislative frameworks are broadly supportive, recognizing, at least in part, the specific needs and considerations for this age group and the importance of a national multisectoral approach to mental healthcare, prevention and promotion. While a large focus of the current response has been on the clinical management of mental health conditions through the health sector, there are also important national approaches to improve and respond to mental health in schools, including through programmes to support early identification, screening and counselling, and to deliver curriculum-based mental health education. The social welfare and justice sectors also deliver multidisciplinary programmes to identify and support children and families at increased risk, including those who have been exposed to violence, abuse or neglect and children in conflict with the law.

Despite this progress, this analysis has identified some important gaps in the current MHPSS response. These include the accessibility and availability of child- and adolescent-friendly and multidisciplinary care for mental health conditions (particularly outside of specialized tertiary and institutional settings), comprehensive and coordinated whole-of-education approaches to mental health promotion, a national (and targeted) approach to support nurturing and responsive care provided by parents and carers, and coordinated programmes to support healthy peer relationships and address peer victimization. There are also important gaps in relation to programmes reaching marginalized, out-of-school and migrant children and adolescents.

Additionally, there are some critical cross-cutting challenges impacting on implementation of MHPSS. While mental health and well-being are 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 the 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 have contributed to limited coordination across sectors. 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 the health and social welfare sectors and time-consuming referral from other sectors such as education. Administratively complex and unclear referral protocols, particularly for referrals arising from 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.

In addition to specific recommendations to strengthen the multisectoral mental health system, there are a number of overarching recommendations to improve the implementation of MHPSS for children and adolescents in Thailand:

1. At national level, strengthen the National Mental Health Plan and Mental Health Act to more clearly articulate the specific considerations and protections for children and adolescents, and develop a multisectoral plan (and structure) for implementation of MHPSS, including cross-sectoral performance indicators.
2. Establish a national multisectoral council or subcommittee for child and adolescent mental health with responsibility for coordinating implementation.
3. At provincial, district and subdistrict levels, strengthen the role of subcommittees of the National Mental Health Commission and coordination with the Ministry of Interior and Local Administrative Organizations (including through capacity building of subnational leadership in mental health) to develop local multisectoral implementation plans, resource allocation and coordination.

4. Strengthen national, standardized protocols for child and adolescent health across government agencies, including validated screening tools and guidance on use, referral procedures, non-specialist management, and management of children and adolescents engaged in the child protection and justice sectors. Develop national standards for child and adolescent mental health services across sectors.
5. Increase government budget investment in child and adolescent mental health across the tiers of care, prevention and promotion. To support this, the Bureau of the Budget (BoB), with recommendation from the National Economic and Social Development Council (NESDC), should propose MHPSS as a new, agenda-based budget framework (led by the Ministry of Public Health) as part of the annual budget for consideration by the Cabinet. Also, establish MHPSS as a cross-sectoral budget programme with a focal point (host) (such as the Department of Mental Health/ National Mental Health Commission) designated for administering the budget, monitoring and supervising other agencies involved in the action plans.
6. Strengthen the multisectoral mental health workforce through further in-depth mapping to identify key roles across sectors (health, education, social welfare, justice) against the MHPSS priority actions and the required competencies and training needs to support these roles. Furthermore, improve the integration of child and adolescent development and mental health into pre- and in-service training of health professionals, social welfare workers, justice sector workers, teachers and other school-based staff that aligns with the roles and responsibilities with respect to MHPSS.
7. Improve the collection, use and accessibility of data at national and subnational levels – including data to identify mental health needs, support planning and implementation and track progress. Develop a minimum set of MHPSS-related indicators harmonized across sectors, including performance indicators related to multisectoral collaboration. Develop user-friendly platforms (such as a data dashboard) to improve access of service providers and communities to mental health data.
8. Increase opportunities for children and adolescents 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). Improve child- and adolescent-friendly mechanisms for providing feedback on MHPSS programmes and mental health services.
9. 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).

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.[3] 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.[1,2] Additionally, many millions more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder(s) but which has significant impacts on their health, development and well-being.

Thailand has around 14 million children and adolescents aged 0–18 years, making up approximately 20 per cent of the country's population.[2,4] Thai children and adolescents experience a substantial burden of poor mental health. Modelled estimates from the Global Burden of Disease Study (2019) indicate that mental disorders and self-harm account for 15 per cent of the total burden of disease among 10–19-year-olds, with suicide the third leading cause of death of 15–19-year-olds.[1] The COVID-19 pandemic has heightened the need for mental health and psychosocial support, with significant impacts on education, social connectedness, family stressors, inequality and disruption of essential services.[5–7]

BOX 1. DEFINITIONS OF MENTAL HEALTH

'Mental health and psychosocial wellbeing' 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 psychosocial distress through to mental disorders, that may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, common mental health conditions include: difficulties with behaviour, learning or socialisation; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, psychosis, bipolar disorder, eating disorders, substance use disorders, attention deficit/hyperactivity disorder, conduct disorder, intellectual disability, autism, and personality disorders.

Adapted from UNICEF's 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.[8,9] Poor mental health during the first two decades of life also has broad implications for communities and societies. The lost human capital from mental disorders during childhood and adolescence in East Asia and the Pacific is estimated to be US$74.68 billion (PPP) – the highest of any region.[2] While data for this age group is lacking in Thailand, mental disorders during adulthood were estimated to result in US$808.2 million in the Bangkok Metropolitan Region alone.[10]

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,[11] despite accounting for 7 per cent of the total disease burden.[12] 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.[11] Thailand has 196 psychiatrists with specialized training in child and adolescent mental health, and an estimated 20.1 registered social workers per 100,000 children.[13,14] 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, lack of coordination between sectors and substantial stigma remain significant barriers to ensuring that children, adolescents and their families have access to quality services and support.[2,15]

BOX 2. DEFINITION OF 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 wellbeing 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, complementary approaches to support children, adolescents and their families.

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

Thailand has made important efforts to address child and adolescent mental health through the provision of mental health services, school-based programmes to support early identification and prevention of poor mental health, and some integration of mental health services and supports into social welfare and justice settings reaching vulnerable children. However, despite the significant resources invested in mental health, access to services is still far from universal and unmet need is prevalent.[16] A greater understanding of how to effectively implement MHPSS for children and adolescents across multiple sectors is needed to address these gaps.

To ensure 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 community, schools, parents, service providers and children and adolescents themselves. This multisectoral approach is at the core of UNICEF's East Asia and Pacific Regional Conceptual Framework for MHPSS, and the Global Multisectoral Operational Framework for mental health and psychosocial support of children, adolescents and caregivers across settings.[17,18]

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 aimed at defining:

- 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, justice and education – and the role of other relevant ministries/agencies, non-governmental organizations (NGOs), young people and youth organizations, communities and the private sector;
- The legislative, policy, institutional and capacity building steps required to ensure a multisectoral mental health system.

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

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 and in parallel to inform the finalization of the regional conceptual framework.

BOX 3. OVERVIEW OF THIS REPORT

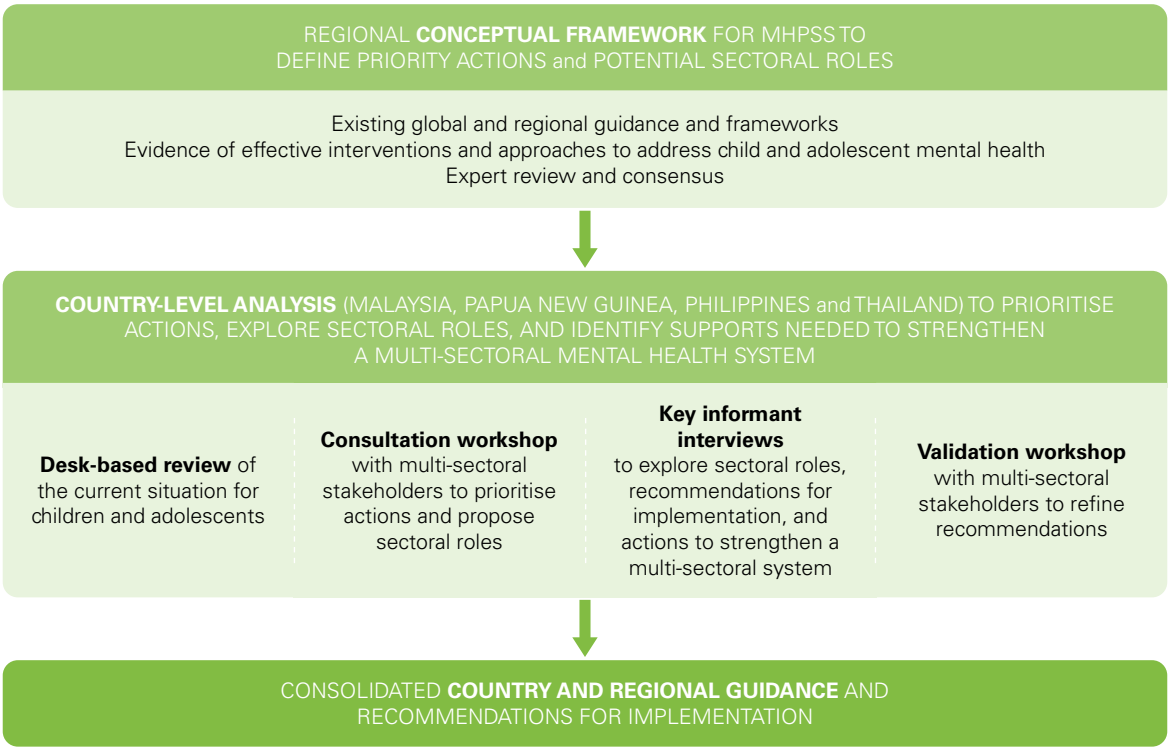
This report provides an overview of the overarching MHPSS regional conceptual framework, and synthesizes the findings of the desk-based review, consultation and validation workshops and key informant interviews to describe:

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

Overview of the approach

The overarching project was led by the Burnet Institute in partnership with the UNICEF East Asia and the Pacific Regional Office. At regional level, a TAG comprising UNICEF, UNESCO, WHO, the Global Social Service Workforce Alliance 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 project is provided in Figure 1.

FIGURE 1. OVERVIEW OF THE PROJECT APPROACH



Country-level analysis

The Thailand analysis was co-led by the Burnet Institute and the Institute for Population and Social Research (IPSR), Mahidol University, and supported by the UNICEF Thailand Country Office, the Department of Mental Health and the Country TAG, with oversight by the UNICEF East Asia and the Pacific Regional Office and the Regional TAG.

The specific objectives of the country-level analysis were to:

1. Synthesize existing data to describe the mental health needs of children and adolescents in Thailand;
2. Synthesize current policies, services and programmes (government and non-government) related to child and adolescent mental health to describe approaches, experiences and gaps;
3. Identify barriers and enablers to children and adolescents accessing MHPSS;
4. Define a tiered, multisectoral minimum services package for MHPSS; and
5. Explore how the MHPSS regional framework and package of priority actions can be effectively implemented, including identifying opportunities and challenges across key sectors (health, education, social welfare and justice) with particular attention to the system requirements (financial, human, governance) needed to support implementation.

This component included four main activities:

1. 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 the mapping of existing global and regional mental health indicators. Indicators were populated using available national level survey data (Global School Health Survey 2008, 2015 and 2021,[19–21] Thai National Mental Health Survey 2013, Multiple Indicator Cluster Survey 2019–2020),[22] and 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.[1]

Review and synthesis of available literature

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

- 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; and
- 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) Thailand. 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, Thailand, search terms included Thailand, Bangkok, and several other Thai city and province terms, such as Chiang Mai, Chonburi, and Hat Yai. 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 Thailand, included children and/or adolescents aged 0–18 years, and addressed one or more of the focus areas above.

Search results were uploaded to Covidence. A total of 1,968 studies were imported for screening, with 689 duplicates removed, 1,279 studies screened and 1,065 excluded. In total, 214 articles were included for full-text screening and extraction to the literature review as appropriate. Manual searching of reference lists from relevant articles was also conducted, to identify further peer-reviewed literature or grey literature.

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. English and Thai documents were included if they were:

- produced by the government, or described a government policy/plan/strategy/legislation;
- related to government intentions, actions or 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; conceptual framework tier(s) addressed; summary of key actions in relation to children and adolescents; and targets and indicators (where relevant). Additional identification and information about relevant policies and legislation was also explored during key informant interviews (see below).

2. Country-level stakeholder consultation workshops

Two half-day, online workshops were conducted on 30 June and 1 July 2021. These were attended by 38 government and non-government participants, including 11 from the education sector, 13 from the health sector, 3 from the justice sector, 7 from the social welfare sector, 2 from youth organizations and 2 from parent organizations. The objectives of the workshops were to present and reflect on the MHPSS regional conceptual framework, identify priority actions for MHPSS for children and adolescents in Thailand, and propose sectoral roles and responsibilities for implementation of the MHPSS package. To facilitate this, participants were invited to complete an online prioritization tool to provide feedback on each proposed MHPSS action and indicate a lead sector. Thirty-three participants completed the online tool, and findings were presented and discussed during the second workshop.

3. Key informant interviews with sector stakeholders

Key informant interviews were conducted to explore in depth:

Perceptions and understandings of priority child and adolescent mental health needs;

- Current programmes and approaches related to MHPSS;
- Barriers and enablers impacting on implementation;
- Recommended sectoral roles and responsibilities; and
- Challenges and considerations for strengthening a multisectoral mental health system.

Sector-specific question guides drew on the project regional conceptual framework and were refined following review by sectoral and mental health experts through the Regional and Country TAGs.

A total of 23 interviews were conducted by experienced and trained IPSR researchers with participants aged 18 years and over. These included 17 interviews with government stakeholders from the health (four), education (five), social welfare (two) and justice (four) sectors, and public financing (two). Four interviews were also conducted with representatives from youth organizations, and two with non-government social welfare organizations. All interviews were conducted via Zoom due to COVID-19 restrictions. Interviews were conducted in Thai, facilitated by experienced IPSR 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 in Thai. 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. Ethics approval was obtained from the Alfred Ethics Committee (Australia), with a Letter of Support provided by Child and Adolescent Mental Health, Department of Mental Health, Ministry of Public Health, Thailand. The protocols and tools used in the research also obtained ethical approval from the Institutional Review Board of the Institute for Population and Social Research, Mahidol University, Thailand, reference number COA. No. 2021/06–141.

4. Validation and dissemination workshops

Following data analysis, an online, half-day workshop was conducted with 17 members of the Country TAG (8 March 2022) to present and obtain feedback on the key findings of the country-level analysis and refine recommendations for implementation. A further dissemination workshop was held with sectoral stakeholders and youth representatives on 30 March 2022 to share findings and seek further feedback on recommendations. Fifty-eight participants joined the online workshop, including representatives from the education, justice, health and social welfare sectors, UNICEF, youth organizations, public financing, NESDC), NGOs and academic institutes.

Further details on the workshops, prioritization tool and interview guide are provided in Appendix A.

Limitations

The Thailand analysis has some key limitations. First, the synthesis of peer-reviewed literature was initially restricted to studies published in English. However, key publications in Thai relating to the criteria above were identified and reviewed by IPSR researchers for inclusion in the desk review. Not all policy/strategy/legislative documents were able to be accessed online – these gaps were filled through key informant interviews and in consultation with the Country TAG. Additionally, the desk review was limited to national and high-level policies – specific details regarding protocols, guidelines, training programmes and standard operating procedures in relation to MHPSS were not included. Similarly, key informant interviews were limited primarily to national level stakeholders, so some specific approaches, priorities and challenges at subnational level may not have been explored in depth. This project also focused intentionally on supply-side priorities and challenges with respect to implementing MHPSS in non-humanitarian settings. Representatives from youth-focused and parent organizations and networks were included in workshops and interviews to provide perspectives on demand-side barriers, enablers and service delivery preferences. However, further research is needed to explore these issues in more depth with children, adolescents and their parents/carers (including those with lived experience) – **this research is currently being conducted with findings planned to be published in 2022.** Finally, the determinants and therefore actions needed to support psychosocial well-being are broad, encompassing secure housing, the environment and climate change, poverty, nutrition, social justice and equality, disaster, conflict and political contexts. Following consultation and expert review, the framework and analysis for this project were focused more narrowly on policies, legislation and actions to support community engagement. Therefore, there are other broad actions relevant to child and adolescent well-being that are not included here in detail.

Regional conceptual framework for MHPSS for children and adolescents in East Asia and the Pacific

The first phase of the project developed a regional conceptual framework for MHPSS for children and adolescents. The framework was developed through: 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 four Country TAGs and Thailand stakeholders during consultation workshops. 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 pre-dates 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 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.

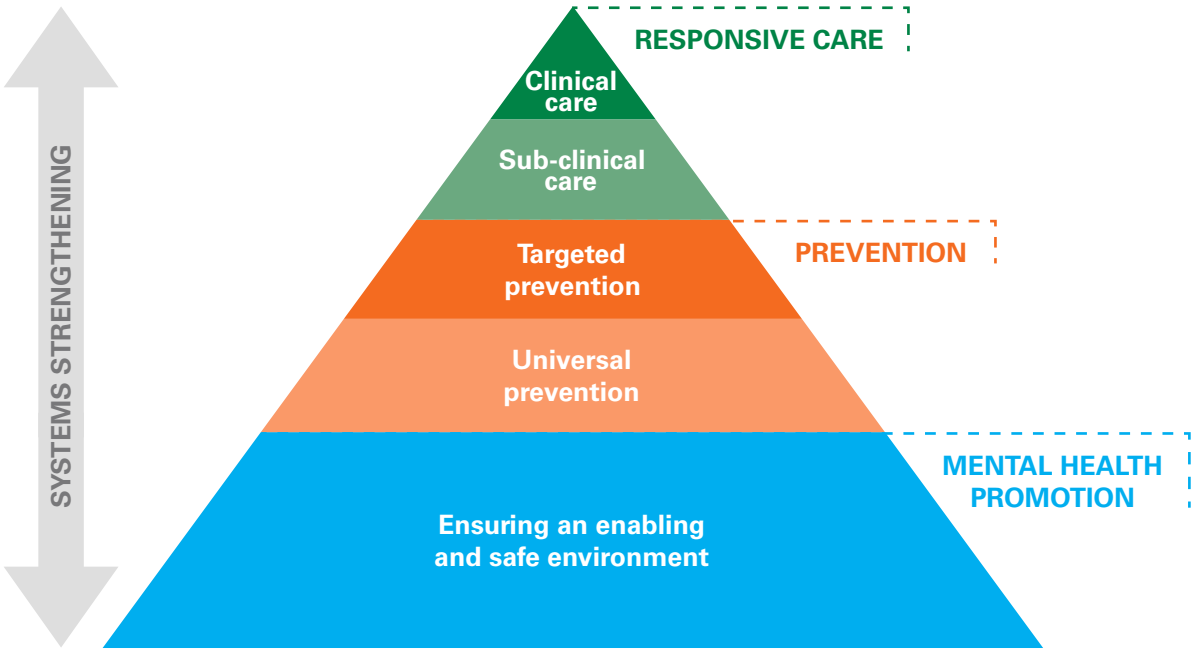
Guiding principles of the framework

Aligned with the Global Multisectoral Operational Framework, the regional framework takes a **socioecological approach** to addressing MHPSS, recognizing that mental health and the 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 the next generation. Responses to mental health needs and risks need to be adapted to *developmental stages* and needs, rather than based on a rigid application of biological age. Responses should also 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 behaviours and outcomes with respect to mental health. Children with disabilities also experience unique mental health needs and barriers accessing MHPSS. Responses, therefore, must take specific measures to ensure that MHPSS is **gender-responsive, accessible, inclusive and seeks the active participation** of children, adolescents and their families.

A regional framework for child and adolescent MHPSS

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 2).

FIGURE 2: 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 actions 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 the 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 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 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). They include four groups of interventions, 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, 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 young people and those with lived experience of poor mental health, 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.[23]

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 3). The specific roles and responsibilities of each sector 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 and 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 preventive interventions for children and adolescents with comorbid health conditions, those identified to have risk behaviours such as substance use and those in high-risk settings as well as supporting positive parenting and parents with mental health conditions). The health sector may furthermore play a key role in mental health promotion (increasing mental health literacy and addressing harmful norms and stigma) and have an overall leadership and advocacy role in MHPSS given that the sector is paramount in the provision of mental health services.

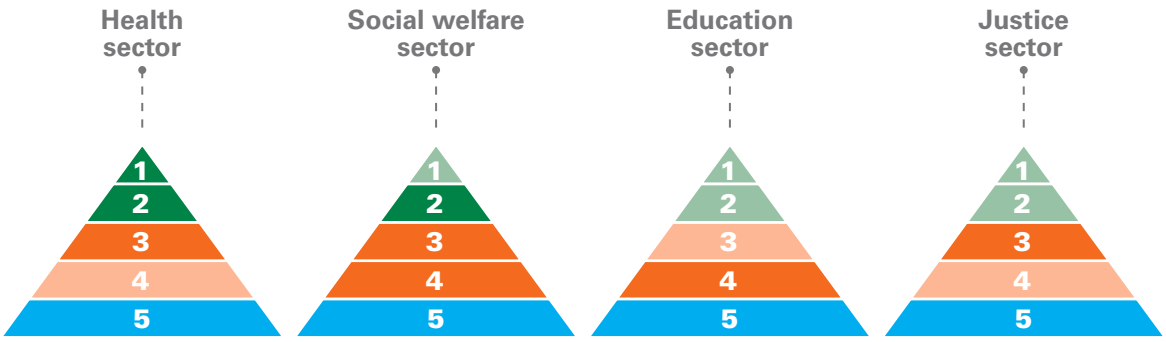
The **social welfare sector** has a significant role in the delivery of MHPSS. The social service workforce broadly encompasses government and non-government professionals, paraprofessionals and community volunteers who not only work within social welfare or community development but may also be employed 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 exposure to 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 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 and psychologists and volunteers (such as peer counsellors) have the potential to reach large numbers of children and adolescents. In addition to delivering 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 are an important contributor 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, the 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 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, 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 harmful use of substances and programmes to build individual assets and skills).

FIGURE 3. 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.

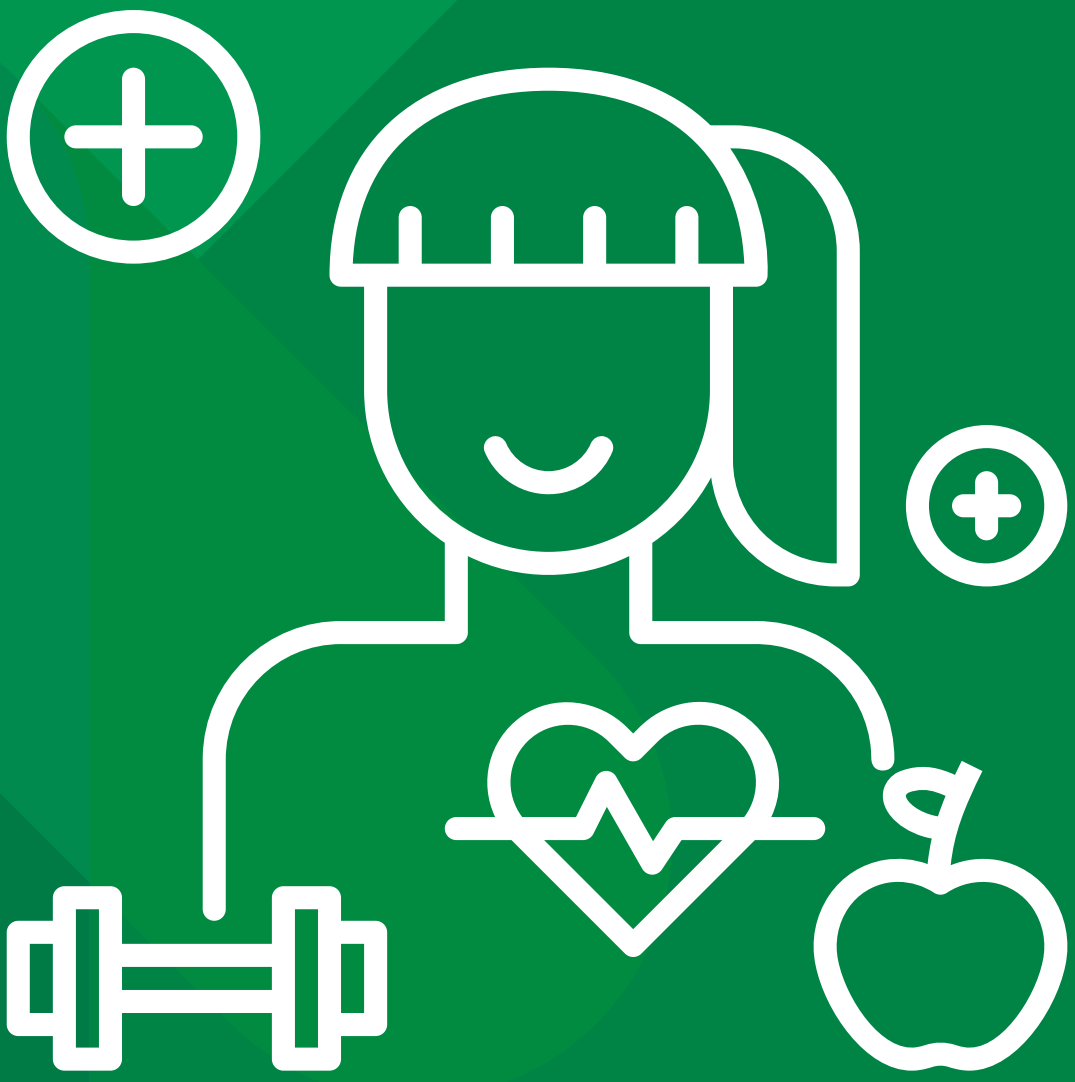
Finally, the regional framework also identifies eight pillars of **systems strengthening** required to enable effective and equitable implementation of these actions within and across key sectors (see Figure 4).

FIGURE 4. PILLARS OF SYSTEMS STRENGTHENING

Legislation and policy	*To promote an enabling environment, providing 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 service 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 multisectoral 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 equitable 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

Mental Health and Psychosocial Well-being:

The current situation for children and adolescents in Thailand



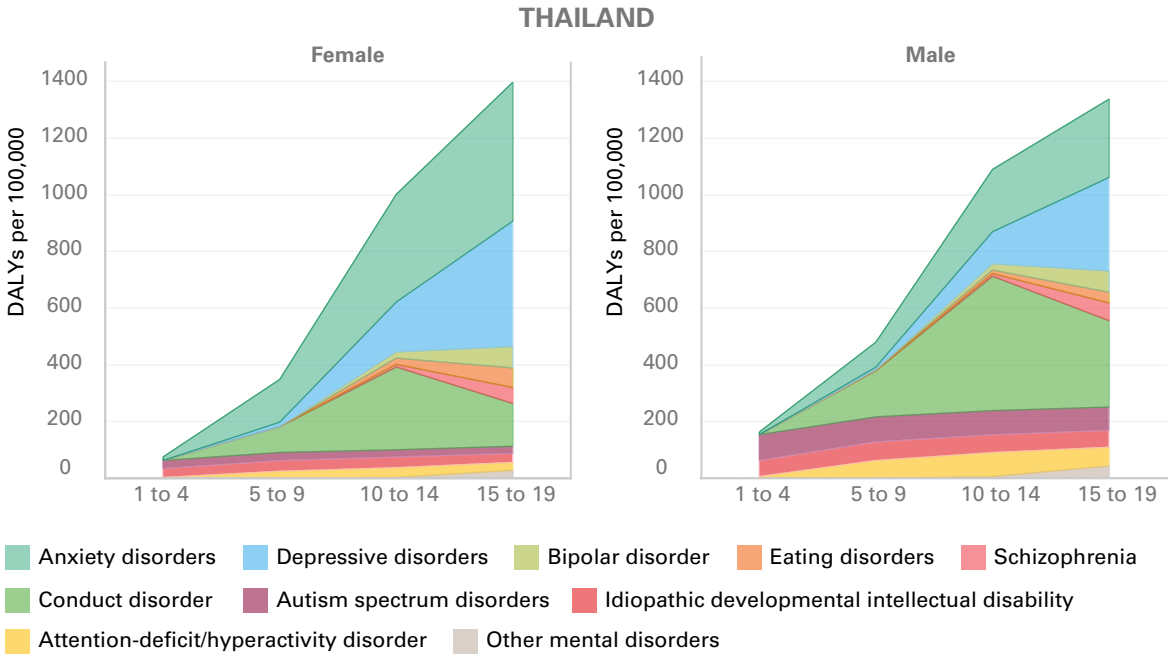
Mental health needs of children and adolescents

Mental health outcomes for children and adolescents

Children and adolescents aged 0–18 years in Thailand experience a substantial burden of poor mental health. Modelled estimates from the Global Burden of Disease Study (2019) indicate that mental disorders and self-harm account for 15 per cent of the total burden of disease among 10–19-year-olds.[1] Among younger adolescents and children aged 5–14 years, mental disorders are the second leading cause of poor health, with conduct disorder and anxiety disorder alone accounting for 7 per cent of the total burden of disease in this age group.[1] One in seven adolescents aged 10–19 and 1 in 14 children aged 5–9 are estimated to have a mental disorder (including developmental disorder).[1]

Figure 5 shows the burden of disease due to mental disorders across childhood and adolescence, reported as disability-adjusted life years (healthy years of life lost due to either disability (illness) or premature death). Several important observations can be made. First, the burden of disease due to mental disorder increases substantially during childhood and adolescence, with the greatest increases occurring during later childhood and early to mid-adolescence. Second, 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 and young adults there is a predominance of depression and anxiety, with an emergence of psychosis and eating disorders. Third, there are important differences in the burden and pattern of mental disorder by gender. Girls have an overall larger burden of mental disorder that is mostly driven by excess depression and anxiety, with boys having an excess burden of conduct disorder.

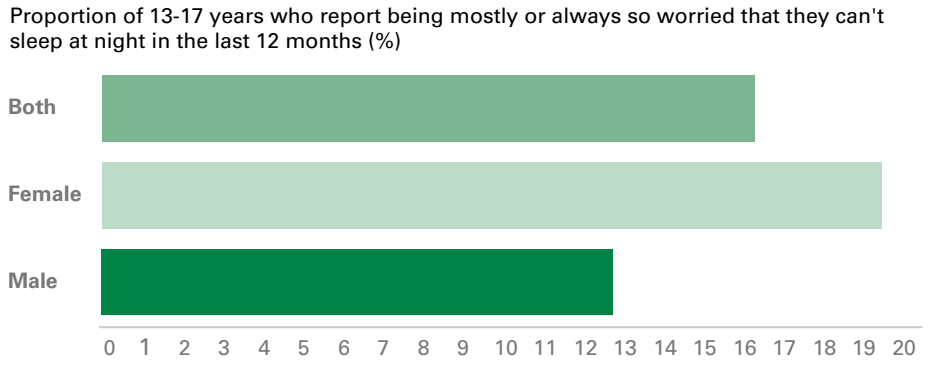
FIGURE 5. DISEASE BURDEN DUE TO MENTAL DISORDERS ACROSS CHILDHOOD AND ADOLESCENCE IN THAILAND (IN DISABILITY-ADJUSTED LIFE YEARS – YEARS OF LIFE LOST TO EITHER CAUSE-SPECIFIC DEATH OR DISABILITY).



Source: *IHME GBD 2019.*

Primary data describing the mental health needs of Thai children and adolescents also highlight a substantial burden of needs (see also Appendix C). A national survey of students aged 13–17 years from 18 provinces across the country in 2015–2016, using the Diagnostic Interview for Children and Adolescents – Revised, found an overall 15 per cent prevalence of DSM-IV mental disorders, of which generalized anxiety disorder, attention deficit hyperactivity disorder, and conduct disorder were the most prevalent. Substance use disorders were also found in 15.6 per cent, most commonly alcohol use disorders. In addition, around 0.4 per cent reported to have recently attempted suicide.[24] A recent national survey of depression and suicidal risks among school youths aged 11–19 from 13 provinces across the country, using the Patient Health Questionnaire for Adolescents, found that 17.5 per cent had moderate to severe depressive symptoms, and around 6.4 per cent had attempted suicide at least once in their lifetime.[25] In 2016, the Thai Health Promotion Foundation estimated that 13 per cent of secondary students reported a lifetime history of depression.[26,27] A 2017 study in northeast Thailand found the prevalence of depression symptoms amongst high-school students to be 18.6 per cent (almost 1 in 5).[28] In serial global school-based student health surveys (GSHS), the proportion of adolescents aged 13–15 years reporting feeling so worried that it disrupted their sleep (an indicator of anxiety) increased from 6.5 per cent in 2008 to 16.3 per cent in 2021, with a higher rate among girls (20.2 per cent) compared with boys (12.5 per cent) (see Figure 6).[19–21] In the aforementioned 2017 study in schools in northeast Thailand, severe anxiety prevalence was 16.4 per cent.[28] There is little primary data regarding other mental health conditions in children and adolescents in Thailand other than a 2010 study which estimated the prevalence of schizophrenia to be 0.52 per cent in males and 1.1 per cent in females aged 15–24 years.[29]

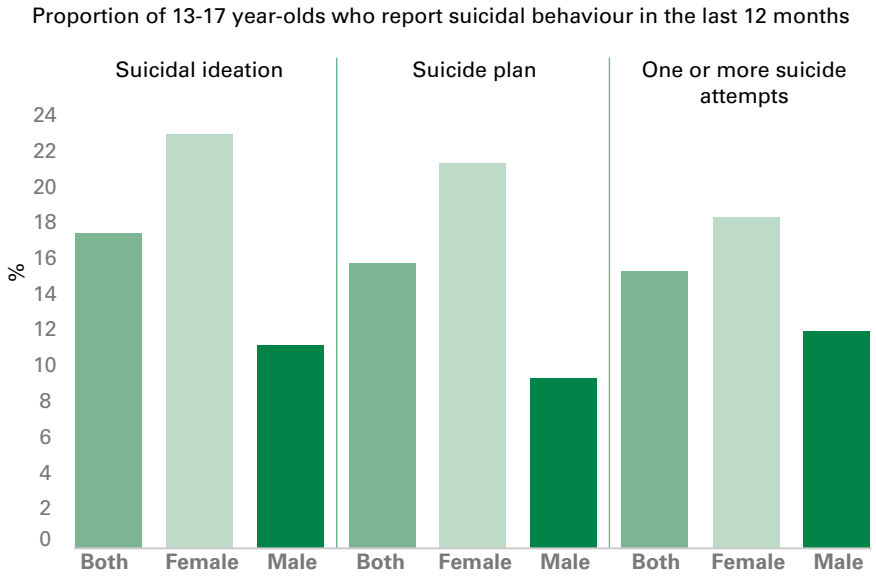
FIGURE 6. PREVALENCE OF SIGNIFICANT WORRY FOR 13–17-YEAR-OLDS



Source: *GSHS 2021.*

Suicide is closely related to poor mental health. National level data on suicidal ideation, plans and attempts amongst adolescents in Thailand vary significantly between sources. The most recent estimates for this age group come from school-based surveys. Serial GSHS found that the proportion of adolescents aged 13–15 with suicidal ideation in the previous 12 months increased from 8.5 per cent in 2008 to 18.1 per cent in 2021, with a substantially higher rate among girls (24.5 per cent) compared with boys (11.5 per cent). Around 1 in 4 girls and 1 in 10 boys has made a specific suicide plan.[19] In 2021, 13.2 per cent of boys and 20.4 per cent of girls had attempted suicide at least once in the previous 12 months (see Figure 7), rates that are higher than in most other countries in the Southeast Asian region.[19]

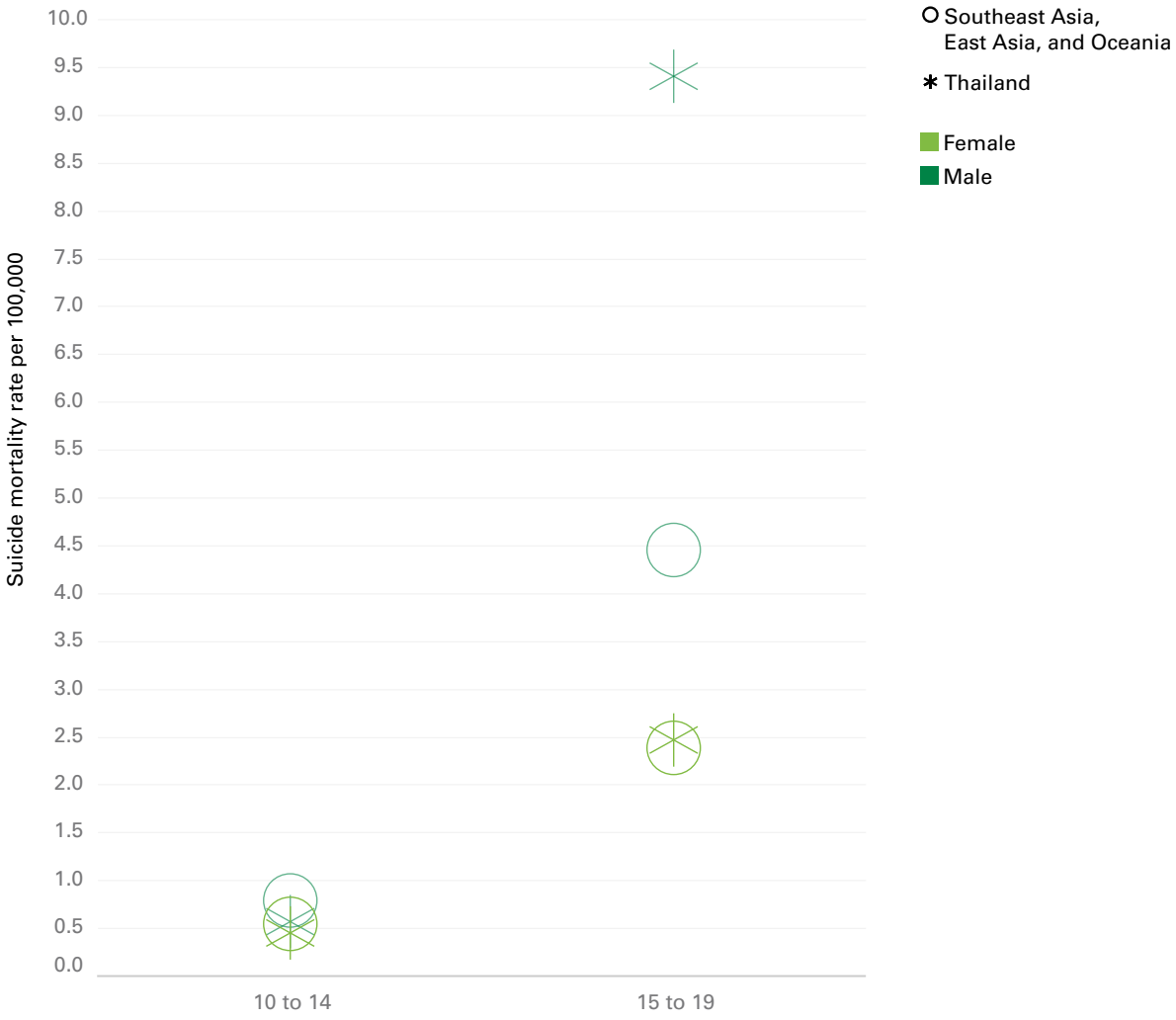
FIGURE 7. SUICIDAL BEHAVIOUR SELF-REPORTED BY ADOLESCENTS



Source: *GSHS 2021.*

While estimates of suicidal ideation and behaviour vary, suicide is one of the leading causes of death among Thai adolescents.[30] The Department of Mental Health reported that the overall national death rate (all ages) from suicide was 7.4 per 100,000 population in 2021. Of the 4,418 reported deaths due to suicide in 2019, 111 were among adolescents aged 10–19 years (a mortality rate of 0.17 per 100,000).[31] Adjusting for missing data (for example, deaths not reported) or misclassification of cause of death, the GBD 2019 estimated that the mortality rate due to self-harm in Thailand for adolescents aged 10–15 was 0.51 per 100,000 population, and 6.00 per 100,000 population for those aged 15–19 (see Figure 8). While the prevalence of non-fatal self-harm is higher among girls, boys in Thailand have a higher rate of suicide mortality compared to girls and also a higher rate compared to other boys in the region.[32]

FIGURE 8. SUICIDE MORTALITY AMONG 10–19-YEAR-OLDS



Source: *IHME GBD 2019.*

There are limited data on the coverage or uptake of mental health services by children and adolescents. A published descriptive study of Thai public health records in 2010 found that 0.77 per cent of all hospital admissions for adolescent boys and 0.88 per cent of all admissions for adolescent girls were due to mental health and behavioural problems.[33] This may have been an underestimate, given the substantial stigma regarding mental health. The most common reason for hospital admission was poisoning or injury, accounting for 11.53 per cent of male admissions and 4.64 per cent of female admissions,[33] a proportion of which may have been undiagnosed self-harm. The Child and Adolescent Mental Health Rajanagarinda Institute (CAMHRI) reported that 9,928 children and adolescents sought mental health services in 2019, and 9,206 in 2020.[34]

Available survey data and published studies of mental health needs in Thailand most commonly relate narrowly to mental disorder. To explore broader understandings of mental health needs during childhood and adolescence, stakeholders who participated in interviews and workshops were also asked to describe their own understanding of mental health during this age. The most commonly identified mental health needs, grouped by stakeholder sector, are presented in Table 1. Stakeholders generally identified needs that related to their own sectoral focus. While health stakeholders prioritized mental disorder, the education sector, for example, more broadly described mental health in terms of impact on learning and education. Young people, in particular, had a more holistic understanding of mental health, reflecting a focus on well-being rather than the presence (or absence) of mental disorder.

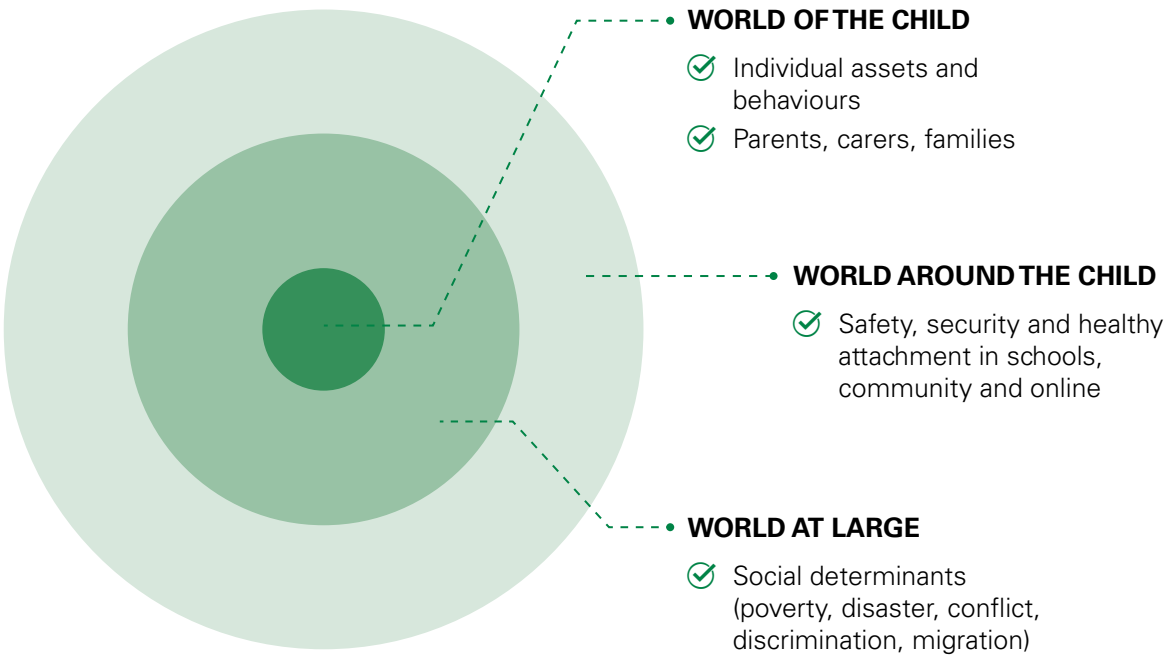
Table 1. Mental health needs of children and adolescents identified by sector during key informant interviews

Health	Suicide, depression, attention deficit and hyperactivity disorder, COVID-19's impact on mental health, substance use
Education	Problems that impact on learning, stress related to online learning, parents' and families' expectations, entrance exam, school drop-out as a result of COVID-19
Social welfare	Mental health related to child protection (neglect, violence and exploitation), substance use, criminal justice, marginalized groups, children in institutional care, school drop-out as a result of COVID-19
Justice	Mental health conditions and behaviours linked to crime (e.g. substance use), poor mental health of children and families in contact with the justice system
Young people	Stress related to political unrest (south), conflicts, peer relationships, poor self-esteem

Risks 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 school, communities and online), and the 'world at large' (social determinants including poverty, disaster, conflict, discrimination, migration) (see Figure 9).[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 who experience 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 9. SPHERES OF INFLUENCE ON MENTAL HEALTH AND WELL-BEING



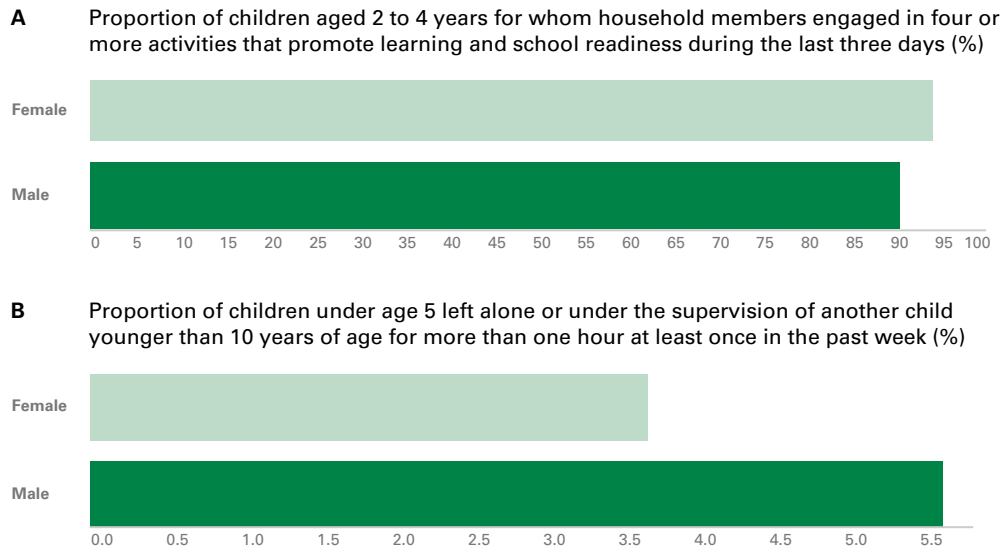
Source: Adapted from UNICEF's *The State of the World's Children 2021*[2] *report*

The world of the child

For young children, **healthy attachment with parents and other caregivers and nurturing, responsive care** are powerful determinants of mental health and well-being. In 2019, almost 1 in 4 children aged 0–18 years did not live with a biological parent, with grandparents being the most common caregiver of these children. Not living with a biological parent was most prevalent among children from the poorest households (39 per cent not living with a parent versus 10 per cent among the richest households).[22] National survey data describing the quality of caregiving are limited. As shown in Figure 10, most young children receive early stimulation and only a small proportion (around 5 per cent) are inadequately supervised.[22] 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 in Thailand are limited. In the 2021 GSHS, only 25.5 per cent of school-going adolescents aged 13–17 years reported that their parents or caregivers understood their problems and worries, and 34.7 per cent had supported or encouraged them in the previous 30 days.[19] There are no national level data describing the quality of caregiving in alternative care or other institutional care settings.

In addition to national level survey data and published studies of risks, stakeholders who participated in key informant interviews also highlighted the importance of family factors for mental health and the well-being of Thai children and adolescents. Stakeholders emphasized the critical influence of parents' mental health and mental health literacy, attachment and quality of carer relationships, and exposure to family violence on the well-being of children.

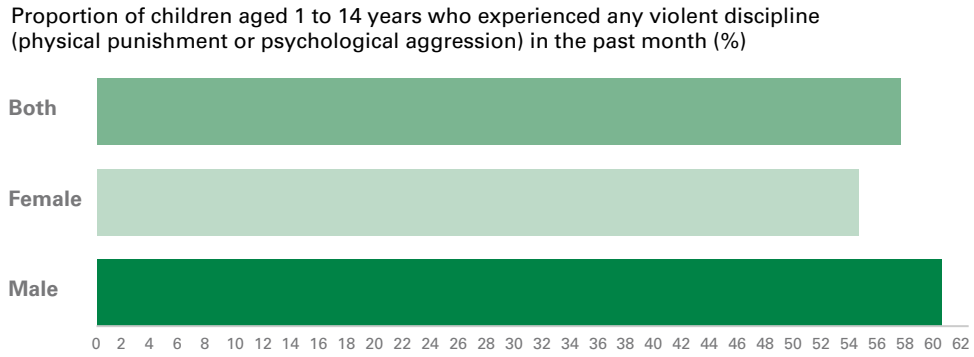
FIGURE 10. EARLY STIMULATION (PANEL A) AND INADEQUATE SUPERVISION (PANEL B)



Source: *National Statistical Office MICS 2019–2020.*

Violence and neglect experienced within households and families are key risk factors for mental health conditions.[35,36] Over half (57.6 per cent) of Thai children aged 1–14 have experienced any form of violent discipline (physical punishment or psychological aggression) at home within the past month (see Figure 11), including 44.0 per cent who experienced physical punishment and 40.4 per cent who experienced psychological aggression.[22] Children and adolescents who experience trafficking are also at increased risk of poor mental health. A 2015 survey of 387 children and adolescent survivors of human trafficking in Thailand, Viet Nam and Cambodia found that 56 per cent screened positive for depression, 33 per cent for an anxiety disorder, 26 per cent for post-traumatic stress disorder, and 20 per cent had tried to self-harm or commit suicide in the preceding month. Mental health symptoms were strongly associated with a history of abuse at home, physical violence and sexual violence.[37]

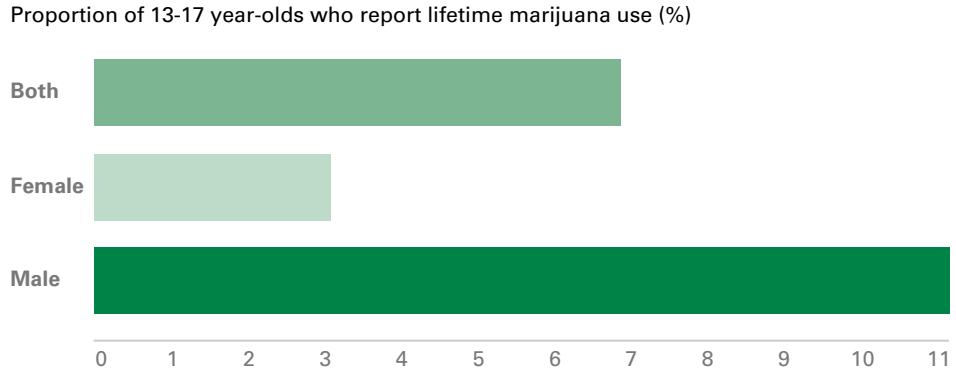
FIGURE 11. VIOLENT CHILDHOOD DISCIPLINE



Source: *National Statistical Office MICS 2019–2020.*

For older children and adolescents, **substance use and misuse** are important individual-level risk factors for poor mental health.[27] The proportion of Thai adolescents aged 13–15 who report currently drinking alcohol increased from 15.6 per cent in 2008 to 27.4 per cent in 2021, the second highest in the Southeast Asian region.[19] Alcohol use and misuse has also been associated with psychological distress, tobacco use, cannabis use, school truancy and physical fights and injuries among Thai adolescents.[38] The 2021 GSHS found that 6.9 per cent of adolescents aged 13–17 in Thailand had used marijuana (see Figure 12) and 3.9 per cent had used amphetamines.[19]

FIGURE 12. LIFETIME MARIJUANA USE



Source*: GSHS 2021.*

Sedentary behaviours and screen time are also an important influence on psychosocial well-being. The 2022 GSHS reported that almost two thirds (64.3 per cent) of students aged 13–17 years spent three or more hours per day sitting (watching television, playing computer games, doing homework, talking with friends when not in school), and 31.6 per cent were not physically active for at least 60 minutes per day.[19] Thailand has among the highest daily internet use in Southeast Asia, with data for adolescents and adults aged 16–64 years suggesting that individuals spent on average 9.06 hours per day on the internet in 2021 (behind the Philippines at 10.27 hours and Malaysia at 9.10 hours).[39] Age-disaggregated data for children and adolescents in Thailand are limited and this field is fast moving, but recent studies indicate that children and adolescents are among the most active users of the internet, estimated to spend on average over 40 hours per week online.[40, 41] In a 2014 national survey by the Rajanagarindra Institute, 10–15 per cent of children stated they were 'heavily addicted' to online games, Facebook and the LINE messaging application.[41] A 2015 study of 295 Grade 4–5 students in Bangkok found a gaming addiction prevalence of 7.5 per cent.[42] In both studies, addiction was measured using a game addiction screening test developed by the Rajanagarindra Institute.

Children and adolescents with chronic illness and disability may also experience a higher burden of poor mental health. While data for these children are limited, studies of children with perinatally acquired HIV report a high burden of poor mental health. Thailand has the highest HIV prevalence in Asia, with 8,000 children and adolescents living with HIV in 2020.[43] A 2021 study of 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.[44]

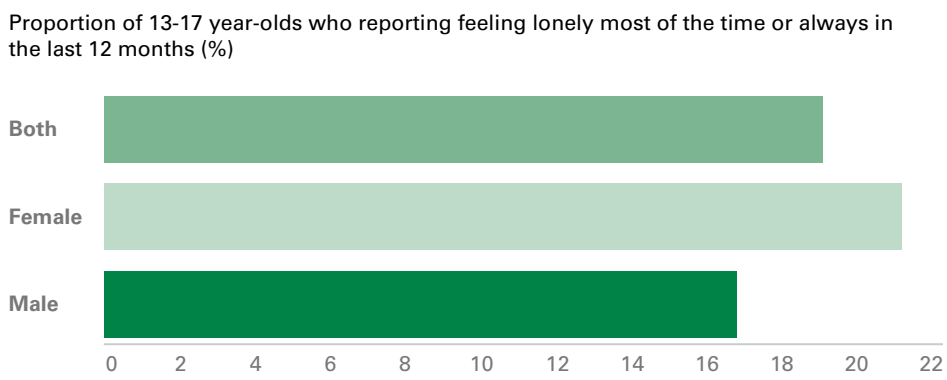
Child marriage and early pregnancy are associated with poorer mental health outcomes. In Thailand, 23 per cent of women aged 20–24 years were married before the age of 18, and 9 per cent commenced childbearing by the age of 18.[45] Of all the live births in Thailand in 2019, 11 per cent (63,831) were to girls aged 10–19 years.[46] While studies exploring the mental health of married Thai adolescents are limited, studies of perinatal depression among women report that young mothers (under 20 years of age) have almost double the risk of depression compared with older women.[47,48]

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. A 2015 UNICEF review of alternative care estimated that around 44,750 children were in residential care (including government facilities, provincial shelters and government boarding schools), and another 5,250 were in alternative family-based care (foster or kinship care).[49] Abandonment, poverty, orphanhood, abuse, behavioural problems and disability were among the key reasons for being placed in residential care. Family separation, lack of focus on deinstitutionalization and reintegration, insufficient resources and staffing capacity to provide child-centred care and protection, lack of accountability and exposure to corporal punishment are likely to increase risks for mental health.

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. The 2021 GSHS reported that 19.2 per cent of adolescents felt lonely most of the time or always (an increase from 9.9 per cent in 2015) (see Figure 13) and 6.4 per cent had no close friends.19

FIGURE 13. PREVALENCE OF LONELINESS AMONG 13–17-YEAR-OLDS



Source: *GSHS 2021.*

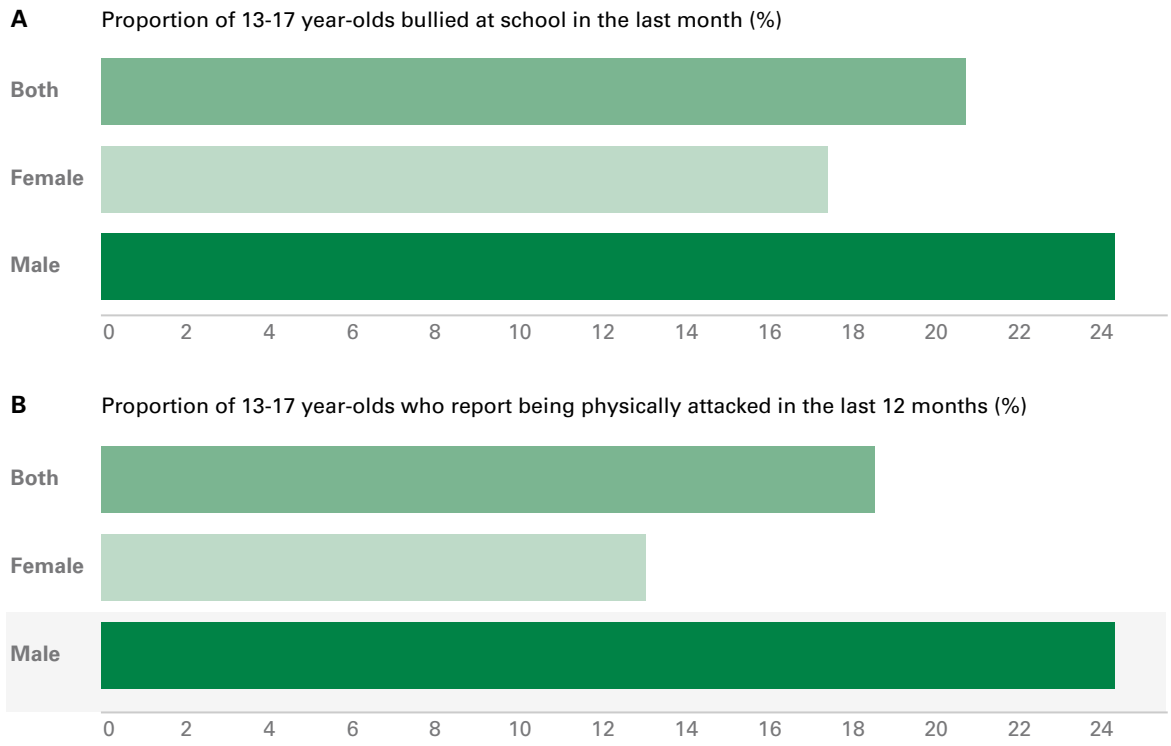
Exposure to bullying[i] **behaviour, harassment and violence** are risk factors for poor mental health and are highly prevalent among adolescents in Thailand. In the 2021 GSHS, 1 in 5 (20.8 per cent) of students aged 13–17 reported being bullied at school in the previous month and 1 in 10 experienced bullying outside of school.[19] In total, 35 per cent of 13–15-year-old, school-going adolescents experienced at least one day of bullying in the previous 12 months. Boys had a higher prevalence of all forms of bullying compared with girls (see Figure 14). In a National Public Health Foundation survey of 3,047 students in Grades 4–9, 40 per cent reported being bullied two to three times per month.[41] A 2017 nationally representative survey of 7,825 primary school students aged 6–12 years reported that 52 per cent of boys and 48 per cent of girls had ever been bullied, with students with a lifetime experience of bullying victimization 28.0 per cent less likely to report being happy.[50] A smaller 2017 study in Bangkok found that 34 per cent of primary school students had been the victim of bullying, 3.4 per cent had been the perpetrator and another 30.4 per cent had been both victim and perpetrator in recent months.[51] Being a bully was associated with externalizing symptoms, such as impulsivity and aggression, and being a bully-victim was associated with internalizing symptoms, such as withdrawal or depressed behaviour.[51]

Cyberbullying and online harassment are also prevalent. In the 2021 GSHS, 17 per cent of boys and 14 per cent of girls aged 13–17 years reported experiencing cyberbullying in the previous 12 months.[19] Other studies conducted in 2010[52] and 2015[53] 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. 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.[53]

Witnessing, perpetrating or being the victim of **physical violence** is also common. In the 2021 GSHS, a quarter of students aged 13–17 years reported involvement in a physical fight within the past year, and 18.6 per cent had been physically attacked.[19] Rates were much higher among boys, with 1 in 3 reporting being in a physical fight, compared with 1 in 6 girls. Data from One Stop Crisis Centres (Ministry of Health centres established in all public hospitals to respond to victims of physical and sexual assault) also indicate that many children and adolescents are exposed to non-peer violence and abuse. In 2019, 645 boys aged 0–19 years sought services at One Stop Crisis Centres, and 5,533 girls, accounting for 66 per cent of all male and 24 per cent of all female presentations to the centres.[54]

i. 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 14. BULLYING (A) AND VIOLENCE (B) AMONG 13–17-YEAR-OLDS



Source: *GSHS 2021.*

Sexual harassment, sexual violence and intimate partner violence are also important risk factors, most notably for adolescent girls. National level survey data report that 1 in 6 married or cohabiting women in Thailand have experienced psychological, physical, or sexual violence in their lifetime, with those experiencing violence more likely to report mental health disorder, substance use or suicidal behaviour.[55,56] However, national level data reporting intimate partner violence experienced by adolescent girls are lacking. Around 3 per cent of adolescent girls aged 15–19 years have ever experienced sexual violence from a non-intimate partner.[45] Many presentations to One Stop Crisis Centres are also due to sexual assault: In 2021, 12 per cent of presentations among boys aged 0–18 years were for sexual assault (28 in total), while sexual assault accounted for 80 per cent (2,349 presentations) among girls aged 0–18 years. A nationally representative household survey of 967 internet-using children aged 12–17 conducted in 2021 found that 9 per cent had experienced serious **online sexual exploitation and abuse** in the past year, 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.[57]

Safe and enabling learning environments profoundly influence mental health and well-being. Participation in early education, primary and secondary school are important protective factors. Data from the Ministry of Education reported that in 2019 a quarter of children aged 3–5 years were not enrolled in early childhood education. While the majority of those aged 6–11 years were enrolled in primary school (>99 per cent), 13 per cent of 12–14-year-olds and 37 per cent of 15–17-year-olds were out of school.[58] Other estimates report that around 800,000 children and youth were out of school in 2019, of which around 200,000 were migrant children.[59] Out-of-school children and adolescents were identified by stakeholders during workshops and interviews as being at particular risk of poor mental health due to poor access to MHPSS (as many programmes are school-based), and clustering of other risk factors (such as substance use, family conflict and violence). Children with developmental disorders or disability were also identified as experiencing excess risks for poor mental health in school settings, where resources to support them and their teachers are limited. Schools can also be a source of stress. Stakeholders (including young people) described academic

pressures, competition and family expectations around academic performance as contributing to high levels of psychological distress among students, particularly in secondary school. These pressures were noted to be exacerbated during the COVID-19 pandemic due to the increased pressures of remote learning coupled with social isolation and loss of peer support. Schools can also be a setting of violence and harassment, with high rates of bullying experienced among school students and corporal punishment, even though prohibited by law, and verbal abuse by teachers, commonly reported.[41]

The world at large

National level data and published studies exploring the association of social determinants with child and adolescent mental health in Thailand are limited. However, stakeholders identified several factors that are likely to influence mental health and well-being. These include poverty and economic instability (exacerbated by the COVID-19 pandemic), legislative and other barriers that limit access to MHPSS, and political unrest and exposure to conflict. There are an estimated 4–5 million **migrants** in Thailand, the majority of whom originate from Myanmar.[60] In 2021 there were 96,175 documented refugees and 554,103 stateless persons.[61] Multiple studies have detailed the 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.[62,63] Undocumented migrants lack legal status and protections, including access to health and other services critical for mental health and well-being.[64,65] **Child labour** is a major issue for this community, particularly in the shrimp and sea-food processing sector. There are an estimated 6,000–8,000 children aged under 15 and 20,000–30,000 adolescents aged 15–17 employed in the sector, and a majority are migrants without legal status.[41] A survey of adult migrant workers in Mae Sot revealed significant exploitation and abuse, leading to depression and anxiety symptoms.[65] Specific mental health issues have not been measured for children and adolescents in this group in Thailand; however, a regional study conducted by World Vision in 2020 reported that three quarters of children engaged in economic activities had experienced feelings of fear, anger and hopelessness.[66]

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 in Thailand.[67] 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.[68] A 2013 study conducted by Mahidol University, Plan International and UNESCO 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.[41]

A more recent threat to mental health is **COVID-19**.[5,69] Public health approaches that limit social interactions and disrupt education and employment (and the resultant isolation and increased use of social media and potential increase in exposure to family violence and conflict) have acute impacts on mental health, whilst the economic uncertainties and projected socioeconomic inequalities will have more long-term implications.[6] These disasters can also result in resources being diverted away from mental health services, and combined with greater need, can result in services being more difficult to access. In a UNICEF survey in 2020, 70 per cent of children and young people reported they had significant stress, worry and anxiety symptoms due to the pandemic.[70] Stakeholders also described the detrimental impacts of COVID-19 on mental health. First, it has negatively affected the family's economic situation, particularly wage-earning parents with middle-to-low and low income, creating family tension and stress. Second, online learning has led to many children studying alone at home, contributing to social isolation, boredom and school-related stress. Third, public health measures to control COVID-19 have reduced or suspended many mental healthcare services and mental health-related initiatives, including child protection services and supports to prevent and respond to risk factors that contribute to poor mental health.

Current responses to the mental health needs of children and adolescents

Key national policies, strategies and legislation

An overview of key national level policies and legislation relevant to mental health and MHPSS is provided in Table 2 and key documents are summarized by sector below.

Table 2. Summary of key MHPSS-related legislation and policy in Thailand

National mental health plan/policy/ strategy	**National Mental Health Plan 2018–2037** focuses on four key strategies: 1) promotion and prevention of mental health problems throughout people's life course; 2) development of mental health and psychiatry service system; 3) enforcement of the legal, social, and welfare measures; and, 4) academic and operating mechanism development to support mental health services. Supported by the **Mental Health Act (2008, 2nd amendment 2019)** that defines rights and protections of those with mental health conditions.	National Mental Health Plan 2018–2037 Mental Health Act B.E. 2551 (2008, 2nd amendment 2019)
Age of majority	20 years	Civil and Commercial Code
Age of consent to medical care	Not specified in the National Health Act B.E. 2550. Civil and Commercial Code age of majority = 20 years. In the Mental Health Act, the age of consent is 18 years old, although the 2019 amendment removes mandatory requirement for parental consent.	Civil and Commercial Code Mental Health Act B.E. 2551 (2008, 2nd amendment 2019)
Prohibition on physical restraint for those with acute mental illness	Treatment by the means of physical restraint, confinement or seclusion of a patient shall only be given provided that it is necessary for the protection of the patient, other persons, or properties of other persons and it is given under close monitoring. No additional provisions for minors.	Mental Health Act B.E. 2551 (2008)
Right to mental healthcare for those deprived of liberty	A child has the right to receive public health services of the highest quality standards available, without unfair discriminatory treatment.	Juvenile and Family Court and Procedure Act 2010 and Administration of Juvenile Offenders and Rehabilitation Act 2018

Criminalization of suicide	Suicide is not criminalized, however, if the suicide of a child under 16 years is aided or instigated by another, that person shall be punished with imprisonment or a fine.	Penal Code B.E. 2499
Mental health and education	The State shall provide basic education (12 years) to all persons, including persons with a mental disability.	National Education Act B.E. 2542, amendment 2562 (1999)
Rights of children and adolescents	Thailand became a party by accession to the Convention on the Rights of the Child on 27 March 1992. The Child Protection Act in Thailand provides protection to all children from abuse, violence, exploitation and neglect.	Child Protection Act B.E. 2546 (2003) National Child and Youth Development Act
Age of sexual consent	15 years. Exemption for girls who are married.	Penal Code B.E. 2499
Age of consent for marriage	17 years. Marriage for persons between the ages of 17–19 requires parental consent. Marriage for persons under 17-years-old requires consent of the family court.	Civil and Commercial Code
Prohibition of violence	Section 1567 of the Civil and Commercial Code states that a person exercising parental power (natural guardian) has the right to punish a child in a reasonable manner for disciplinary purposes, although physical violence is not specifically addressed. The Child Protection Act protects children from acts of torture, exploitation and discrimination.	Civil and Commercial Code Child Protection Act B.E. 2546
Laws on corporal punishment	Corporal punishment was prohibited in schools in 2000 but appears to be permitted in alternative care settings and day care. The Child Protection Act does not prohibit all corporal punishment. However, acts of corporal punishment may amount to physical abuse and be considered an offence.	Regulation on the Punishment of Students 2000 Child Protection Act B.E. 2546 Civil and Commercial Code
Prohibition of recruitment to armed forces	Every Thai male is required to enlist in the military reserve force at the age of 18 years. At the age of 21 years, they are screened for physical disabilities and recruited on a demand basis. There is no legislation explicitly prohibiting and criminalizing recruitment and/or use of children by state armed forces or nonstate armed groups. There is no legal provision for conscientious objection.	The Constitution of the Kingdom of Thailand B.E. 2560 Military Service Act B.E. 2497 (1954)

Minimum age of criminal responsibility	12 years (to come into effect May 2022). For juvenile offenders aged 14–17 years, the Court shall take into account their sense of responsibility. For a person aged 17–20 years, the Court may reduce the scale of the punishment.	Penal Code B.E. 2499
Age of child labour	Minimum age for employment is 15 years. Children younger than 18 years are protected from hazardous work.	Labour Protection Act B.E. 2541 (2017)
Same-sex consensual sex	There is no law prohibiting consensual same-sex sexual activity.	Penal Code B.E. 2499

Key sectoral policy and legislative frameworks

Health sector

The Mental Health Act 2008 (2nd Amendment 2019) is the key legislation for mental health in Thailand. The Act has five major components: 1) mental health promotion; 2) addressing determinants of mental health; 3) management and treatment of mental health problems; 4) psychosocial rehabilitation; and 5) protecting the rights of mentally ill patients, caregivers and society. The Act also describes five dimensions of mental health services: 1) mental health promotion; 2) prevention and control of threats against mental health; 3) mental health therapy; 4) mental health rehabilitation; and 5) protection of patient and caregiver rights. The 2019 amendment emphasizes the right of individuals with mental illness to access care, regardless of age, and addresses ambiguous requirements for parental or guardian consent. There are no other special protections for children and adolescents. The Act has played a major role in defining rights and protections with respect to mental health and was credited by stakeholders as helping to drive cross-sectoral collaboration.

The Department of Mental Health (Ministry of Public Health) is responsible for implementation and administration of the Act, including the translation of the Act into implementation protocols, referral mechanisms and coordination committees, and for monitoring service quality and performance. The Act is supported by the National Mental Health Plan 2018–2037, which focuses on four key strategies: 1) promotion and prevention of mental health problems throughout people's life course; 2) development of a mental health and psychiatry service system; 3) enforcement of the legal, social and welfare measures; and, 4) academic and operating mechanism development to support mental health services. The Department's strategic plan also encompasses improvement of service delivery, mental health literacy, management systems and mental health promotion and prevention (including for children and adolescents). Mental health is integrated into primary healthcare, including service delivery through community-based services.

Thailand has achieved near-universal health coverage through various health and social insurance initiatives. Mental healthcare provided through some clinical settings (such as hospitals) is included in the Universal Coverage Scheme (UCS) package, and several related medicines are included in the National List of Essential Medicines. Thailand has a national policy and service standards defining youth-friendly health services, which include mental health services targeting 10–24-year-olds. The Child and Adolescent Mental Health Rajanagarindra Institute (CAMHRI) has also developed policies to support child, adolescent and family-friendly mental health services delivered through the outpatient units of 17 hospitals under the Department of Mental Health, focusing on improving facility environments and provider competencies to reduce stigma and embarrassment.

Education sector

The National Education Act B.E. 2542 1999 outlines the educational rights and duties of Thai people. The Act stipulates that education shall aim at the full development of the Thai people in all aspects: physical and mental health; intellect; knowledge; morality; integrity; and desirable way of life so as to be able to live in harmony with other people. The Thai National School Health Policy was adopted from a WHO concept in 1998 and has a strong focus on mental health and emotional well-being. The policy identifies five components of a healthy school environment, including: 1) happy students, 2) happy organization, 3) happy environment, 4) happy family, and 5) happy community. In 2018 the Educational Service Area Psychologist Policy was introduced and piloted in 26 Educational Service Areas. The policy stipulates that there should be a school psychologist stationed at each area, supported also by the 'One School One Psychologist' programme which provides training for a selected teacher at each school to take on a psychology/counselling role. Under the Office of the Basic Education Commission (OBEC), the national Life Skills Education Framework also incorporates some key aspects of mental health and social and emotional learning, including coping with stress and emotions, self-awareness and empathy, critical thinking and problem-solving, and communication and interpersonal skills. The Ministry of Education is currently developing a curriculum to support competencies for social and emotional learning and mental health and well-being, including:

- Self-management (including managing emotions, resilience),
- Critical thinking (including problem-solving),
- Communication,
- Teamwork and collaboration (including interpersonal skills and conflict management), and
- Civic literacy (including respectful peer and community engagement).

Social welfare sector

There are a suite of policies and legislation addressing the social determinants of mental health for children and adolescents in Thailand. The Child Protection Act B.E. 2546 (2003) is the key legislation protecting the rights of children and adolescents. The Act provides protection from violence, abuse, neglect and exploitation to all children, including within families, out-of-home care, street children, orphans and children in difficult circumstances, such as impoverished, abandoned or disabled children. Section 22 of the Act states that the best interests of the child shall be given primary importance in the treatment of children, and discrimination of an unfair nature shall be prohibited. The Act also protects children from acts of torture, exploitation and discrimination. For children who experience violence, abuse or neglect the Act also requires provision of MHPSS in the acute and rehabilitation phase, including provision of temporary and longer-term protection through welfare institutions (emergency shelters, rehabilitation centres and other institutional care). While the Act provides important protections for children and adolescents, it does not prohibit all forms of corporal punishment, although it may consider that physical violence or abuse constitutes an offence. The National Strategy on Child Protection 2017–2021 also defines a multidisciplinary and community-based approach to respond to the needs of children and adolescents, with responsibility for implementation resting with the Ministry of Social Development and Human Security (Departments of Children and Youth, Women's Affairs and Family Development, and Social Development and Welfare) and the Ministry of Justice (Department of Juvenile Protection and Observation). The Domestic Violence Victim Protection Act, B.E. 2550 (2007) also provides protection from physical and mental harm within families, and requires a psychiatrist, psychologist or social worker to be present during interrogation of victims to provide advice.

The 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 the MHPSS services of the highest standard of quality. The Ministry of Social Development and Human Security through the Department of Children and Youth has overall responsibility for the development of children and youth, and for addressing factors that impact on their development, in collaboration with other government agencies. The Act also sets up the National Child and Youth Development Promotion

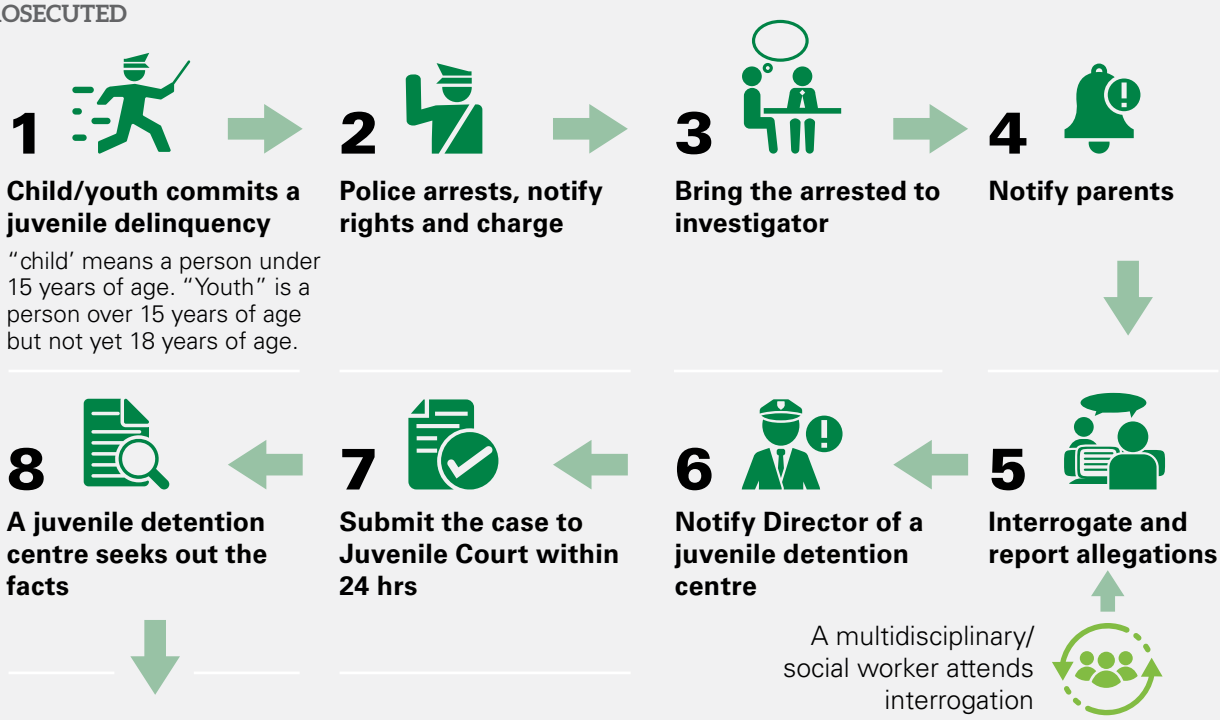
Commission (NCDPC), which comprises representatives from governmental agencies, experts and local administrations, including from the Child and Youth Council, to serve as the central mechanism for setting the rules and practices to ensure that children and youth have equitable access to services. The National Child and Youth Development Plan B.E. 2555–2559 (2017–2021) provides a framework for the development of programmes and activities for children and youth consistent with the Twelfth National Economic and Social Development Plan. The main goal of the Plan is to ensure that children and youth lead secure lives; have good physical and mental health; have ethics, morality and a sense of civic duty; be able to express themselves creatively; and be fundamentally happy.

Justice sector

The Juvenile and Family Court and Procedure Act B.E. 2553 (2010) specifies requirements for all judicial officers engaged in the juvenile and family court process to receive training in psychology, social welfare, counselling and child protection as well as having relevant experience in this area. It also stipulates the requirements of the court to coordinate with other organizations through a multidisciplinary committee to oversee the welfare of children in conflict with the law, and provide medical care during investigation, trial or custody, including engagement with a psychiatrist to assess mental health. This includes juvenile offenders as well as child victims and child witnesses. It also requires that children deprived of liberty receive education and training to support social welfare and mental health. The Criminal Procedure Code section 133 also includes some protections for children who are victims of, or witness, crime and are required to be interrogated. This includes conducting an inquiry in the presence of a psychologist or social worker with specific consideration of the impact of interrogation on mental health.

Since 2015, the Department of Juvenile Observation and Protection has also started implementing a system of rehabilitation for children and youth under the name 'Individual Routing Counselor' for young people convicted by the court. The system assigns a social worker as a mentor or coach, to form an individual 'life plan'. The Department of Juvenile Observation and Protection coordinates with external stakeholders and provides follow-up support after release within a year. The primary goal is to provide children and youth with clear goals in life by supporting their education and employment, and to reduce recidivism. The initiative remains in operation, although there has yet to be an evaluation of the programme to determine its effectiveness.

FIGURE 15. STEPS IN THE JUSTICE SECTOR WHEN A CHILD OR ADOLESCENT IS ARRESTED OR PROSECUTED



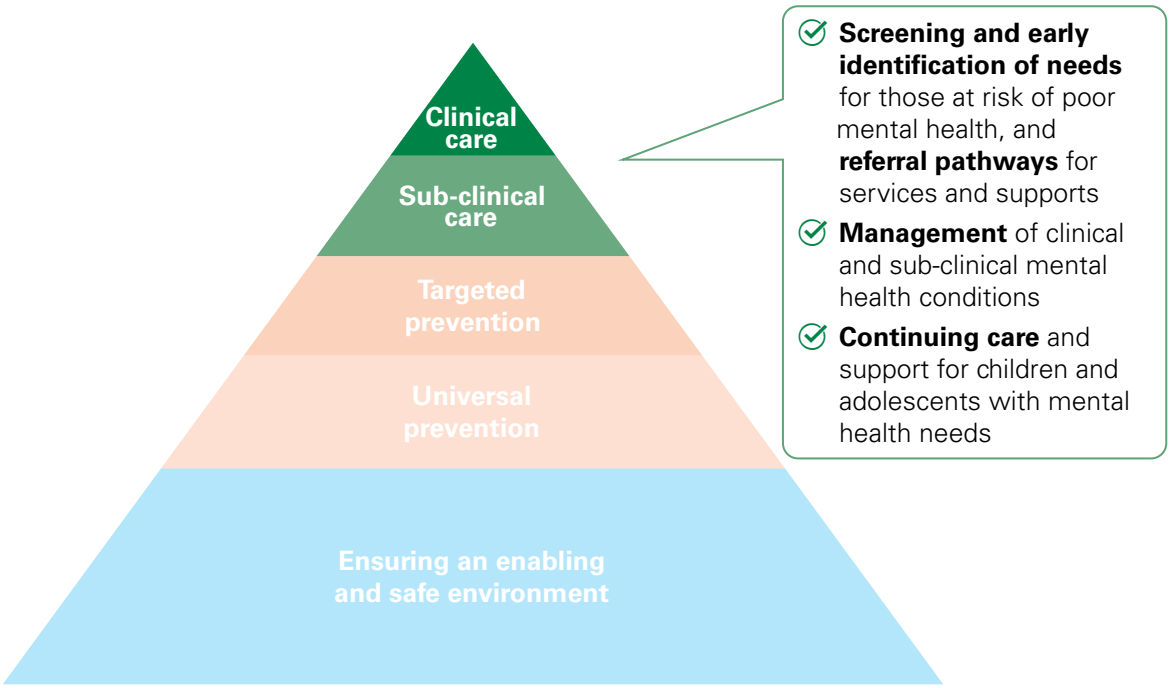
12 STEPS

in the justice sector when a child or youth is arrested or prosecuted

Source: adapted from Office of Justice Affairs & Department of Juvenile Observation and Protection

Current programmes and approaches to address child and adolescent mental health and psychosocial well-being

Responsive care for children and adolescents with mental health conditions



Provision of responsive care services is coordinated and regulated nationally by the Department of Mental Health within the Ministry of Public Health.[16] Within the Department of Mental Health, specific responsibility for children and adolescents lies with CAMHRI. The roles and responsibilities of CAMHRI are aligned with those of the Department of Mental Health, which include developing standards of specialist child and adolescent mental health services and formulating national policies. In addition, CAMHRI has a role in supporting the generation of new knowledge and technology in relation to mental health, and providing education and training and technical support to public and private sectors. CAMHRI also has a direct service-delivery role, providing quality diagnostic assessments, treatment and rehabilitation services to those with severe illness and complex needs, and strengthening the mental health service system to reduce inequity.

The focus of actions related to responsive care is largely on the delivery of clinical care through mental health services, which are integrated into general health services in each of the 13 catchment health service areas in the country. Since 2006, the Thai Government has directed significant resources to addressing mental health. This has included reforming the mental health system to improve screening for depression and suicidality through community volunteers, community hospitals and health facilities, improved treatment guidelines and efforts to increase mental health literacy.[71] However, child and adolescent mental health has received little attention and health services often lack sensitivity to their needs.[30]

Screening and early identification of mental health needs

Screening is well-established through health, school, social welfare and justice settings. Within the **health** sector, Thailand has a national system for screening for depression and suicidality using standardized tools administered by health workers (facility and community-based), including a two-question screening tool for depression (2Q), a nine-question tool (9Q) for depression severity, and an eight-question tool (8Q) for suicidal risks.[72] The lack of screening tools validated specifically for adolescents had been a key gap in this national system, but this has been addressed by CAMHRI with support from UNICEF in recent years through the development of a Thai version of the Patient Health Questionnaire for Adolescents; a short, self-reported questionnaire to screen for depression.[30] An accompanying practitioner handbook has been developed to help frontline workers, such as community health workers and teachers, to screen and refer adolescents with depression.[30] The health sector is currently piloting an innovative surveillance information management system ('Child Shield') in Health Region 8 that uses predictive analytics to screen and track children and families at risk of violence, exploitation, abuse and neglect. The mechanism screens data from the hospital information system for a range of factors identified from data from One Stop Crisis Centres that may suggest that a child is at risk of violence. The system identifies children and families that may require mental health services and assists with linkages to supports (such as the Parenting for Lifelong Health parenting course).

Thailand also has a national mental health hotline (1323), established by CAMHRI, to enable self-identification and referral, and a website, 'Mental Health Check In', that provides initial assessment and screening – including for those under the age of 18 years (https://checkin.dmh.go.th/register.php?formType=1). In 2019, around 10,000 children and adolescents aged 11–19 years sought services through the hotline, with stress/worry (51 per cent), relationship problems (21 per cent) and depression (10 per cent) the most common reasons for accessing the hotline.[73]

Outside of the health sector, OBEC, under the **Ministry of Education**, issued a policy in 2004 requiring all schools to jointly develop a mental healthcare system with the Department of Mental Health. The system consists of five components: 1) getting to know each student well; 2) mental health screening; 3) promotion and development, 4) management and prevention; and 5) referral to mental health services. Since the start of the COVID-19 pandemic, the new Health and Educational Reintegrating Operation (HERO) initiative was launched to support more effective mental health screening and support. The joint initiative between UNICEF, OBEC, the Department of Mental Health and the Faculty of Engineering KMITL uses a database and application to help teachers monitor and manage students who have behavioural, emotional or social problems. The application enables teachers to assess and monitor student well-being using the 9S form. The 9S or '9 symptoms' screens for common behavioural problems, including hyperactivity, absent-mindedness, difficulties with waiting one's turn, being easily irritated, bored or discouraged, not wanting to go to school, being bullied by friends, bullying friends, and having no friends. Stakeholders reported that screening in school settings has a number of challenges. For example, students reported a lack of trust in teachers to keep screening confidential and also the judgmental attitudes of teachers towards mental health. As such, the screening programme was seen to be stigmatizing, particularly in the absence of adequate services and supports. Teachers have also found the screening process to be complex (with many tools to choose from and inadequate training in their administration), time-consuming and difficult in the absence of clear referral pathways for students identified as having mental health needs.

Social workers (both government employed and NGO-based) engaged in **child welfare, child protection and justice settings** also provide screening and referral for mental health conditions and behavioural problems. Government-based social workers include those from the Department of Children and Youth, the Department of Women's Affairs and Family Development, Provincial Social Development and Human Security Offices, and the Juvenile and Family Court. Social workers are also based in NGOs that focus on child welfare and protection, including in justice settings. Social workers, commmunity development officers and NGOs play a key role in early identification and screening in community settings, particularly in identifying families or communities with high-risk exposures (for example, those impacted by COVID-19 restrictions or the death of a caregiver, or those in humanitarian or conflict settings). The Department of Children and Youth currently undertakes community-level screening of children at risk, coordinating with health-related agencies to support referral.

Referral pathways

Referral systems for responsive care exist within sectors as well as between sectors; however, many of these rely on informal mechanisms rather than standard referral protocols and processes. Within the **health** sector, cases identified by non-specialized personnel or at primary levels of care are generally referred to specialists within tertiary facilities. The limited number of health professionals with training or competencies to manage child and adolescent mental disorder or behavioural problems at primary care means that many children are referred to highly specialized services, resulting in long treatment delays. The Department of Mental Health has developed some guidelines and protocols on when to make referrals to child mental health specialists as part of mental healthcare quality assurance processes (for example, protocols recommending specialist referrals for children who have been treated pharmacologically or non-pharmacologically for at least three months but whose symptoms persist or have not improved). The Department has also developed guidance on how to manage patients with acute psychiatric conditions, and on when to make a referral to tertiary care. However, similar standard referral protocols and mechansims are not as well developed for other sectors, and even where guidance exists, bottlenecks and administrative barriers contribute to a reliance on less formal mechanisms.

In **school** settings, stakeholders reported that, in general, students identified by youth counsellors, school counsellors or teachers are initially referred to the homeroom teacher, who is responsible for alerting parents/carers and encouraging them to seek healthcare. A major challenge is overcoming parents' lack of awareness and stigma regarding mental health. School guidance counsellors are also required, as part of their role to liaise with the psychiatric department of the local or nearby hospital or health promotion centres within community-based hospitals, to facilitate referral. However, the limited availability of guidance counsellors in schools means that this responsibility may fall on teachers who may have received less training and support to carry out this role. While the school referral system presently relies on informal mechanisms, more formal processes are being developed through the 'School and Family Empowerment for Behavioural Modification in School-aged Children' (SAFE-B-MOD) (see below) and HERO projects, providing guidelines on screening, initial management and referral.

Children and adolescents who experience harassment, violence, abuse or neglect are referred to the **Ministry of Social Development and Human Security's** Shelter for Children and Families. The Ministry provides this facility on a 24-hour basis in every province. In these instances, children will commonly be referred from the **justice** sector, either by police officers or the inquiry officer. In the case of children under 18, referrals are facilitated by a government social worker who is part of the multidisciplinary inquiry team. For those under 18, the police or inquiry officer will contact a government social worker for referral. The Juvenile and Family Court also has a memorandum of understanding with the One Stop Crisis Centres in hospitals, with mental health one of the key issues included. The Juvenile and Family Court also provides psychologists to conduct screening and coordinate referrals for services.

NGOs also play an important role in the referral system, as they have close relationships with the community and officers from government sectors. This includes early identification of children or families at risk and facilitating referrals or linkages to services. NGOs were also noted by stakeholders to have more flexible work hours and operations, enabling them to more quickly respond to acute needs in the community outside of official working hours. In these instances, working outside of the usual official government protocols and approvals processes was seen as an advantage, as it facilitated more timely referrals and access to services.

Referral systems for child and adolescent health were highlighted as a key bottleneck for responsive care. Across all sectors, stakeholders described administratively complex and time-consuming referral processes, inadequate tools and protocols (with reliance on informal referral networks) and a lack of available services and specialists to take referrals. Within the health sector, the lack of trained providers in primary and secondary level facilities leads to over-referral to tertiary level centres where providers are concentrated. This results in long delays between referral and care, and often requires families to travel large distances to access services. Similar challenges are common in other sectors, including over-reliance on residential care and institutional facilities, impacting on referrals within sectors as well as referrals to health services. In the absence of effective referrals and access to care, screening alone is reported to stigmatize children and families.

Management of mental health conditions and continuing care

Clinical management of mental health conditions is largely provided through the **health** sector. Thailand has 19 specialist psychiatric hospitals, 104 psychiatric units in general hospitals, one forensic inpatient unit and two psychiatric residential care facilities.[13] Of these facilities, only five inpatient psychiatric facilities cater for children and adolescents. According to the 2017 Thailand Mental Health Atlas, 537,000 cases of severe mental disorders had been treated in hospital in 2016, including adults and children.[13] A descriptive study of 2010 Thai public health records found that there were approximately 3,000 adolescent hospital admissions for mental health presentations.[33] Mental health admissions for adolescents were 8.49 days on average. However, there were also 27,000 adolescent hospital admissions for injury and poisonings, of which a portion may have been undiagnosed self-harm incidents.[33] There are 830 mental health outpatient facilities in Thailand, and 62 outpatient mental health facilities specifically for children and adolescents.[13] A study of 2010 records found that there were 165,000 outpatient and general clinic visits by adolescents for mental health and behavioural concerns.[33] Specialist medical services for children with developmental delays and developmental disabilities, such as autism spectrum disorder, attention deficit hyperactivity disorder, cerebral palsy and learning disorders are provided by the Rajanagarindra Institute of Child Development (RICD), Yuwaprasart Waithayopatham, Southern Institute of Child and Adolescent Mental Health, and Rajanukul Institute.[74] CAMHRI also offers online information about mental health, an online mental health assessment service and training services.

Recognizing the burden on specialist and tertiary level services, mental health reforms in Thailand have led to the significant upskilling of community health workers (Village Health Volunteers), nurses and general practitioners in primary care in assessing and treating mental health issues.[16] However, there is limited documented evidence of how well child and adolescent mental health issues have been addressed through these initiatives. At community level, **social welfare** workers, including social workers and psychologists (local officers of the Ministry of Social Development and Human Security) commonly collaborate with NGOs, Local Administrative Organizations and health units to provide social welfare and child protection services and supports to children and families in need, and referral for clinical mental healthcare. However, a lack of recognition of the importance of mental health among social workers, high case-loads and a lack of coordination between the health and social welfare sectors was described by stakeholders as a significant implementation challenge. The Department of Children and Youth currently operates over 2,000 childcare institutions and 107 rehabilitation centres for children and adolescents who are experiencing psychological distress or other mental health needs. Psychologists provide assessment, care and referral, but the lack of psychologists in rehabilitation centres, and shortages of other professionals (such as registered nurses) have impacted on timely and multidisciplinary care. Over-reliance on institutionalized care and limited attention to home-based and community-based programmes has also been noted as a barrier to expanding access to services for children and families.[14]

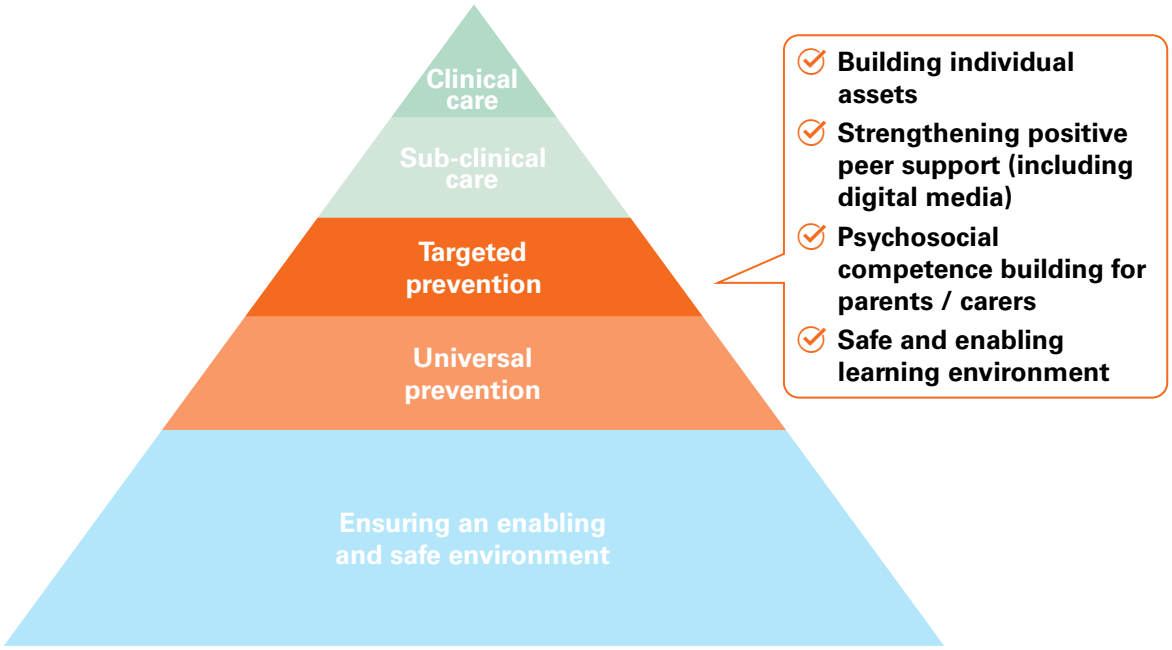
In **school** settings, the Department of Mental Health has developed the SAFE-B-MOD programme to support teachers and, in better resourced settings, school-based psychologists to manage uncomplicated mental health conditions and behavioural problems without requiring referral to health facilities. This programme, delivered at all school levels, includes two-day group training to equip teachers with behavioural modification skills to manage children with emotional and behavioural problems. The national programme of youth counsellors in junior secondary schools has also been established to facilitate early identification, peer support and counselling (see 'Prevention' below). A major challenge identified by stakeholders is that many school-based counsellors and teachers lack the skills needed to handle students with mental health conditions, in particular behavioural modification and counselling skills.

The School Mental Health Programme is a psychiatric community service based in a limited number of local schools in Bangkok. The programme was initiated by the Department of Psychiatry, Faculty of Medicine at Siriraj Hospital. The programme aims to proactively identify potential mental health conditions in the community instead of waiting for patients to be admitted to hospital. The programme targets students, parents and teachers using a multidisciplinary approach involving psychiatrists, psychologists, teachers and social workers. Programme activities include screening, individual assessment, classroom observation, case interviews, family assessment, home visits, family education and counselling, teacher counselling, individualized education programmes, multidisciplinary intervention and follow up.

Within the **justice** sector, Counselling Centres within the Provincial Juvenile and Family Court have been introduced in provinces nationwide since 2011. In this new court process, a judge may decide to give children in conflict with the law an opportunity to undergo psychological therapy and rehabilitation at the centre, instead of sending them into confinement in places run by the Department of Juvenile Observation and Protection, which are often seen as stigmatizing. The counselling service is provided by a multidisciplinary team including psychologists, social workers and associate judges. However, because of difficulties in recruiting properly trained psychologists to act as counsellors, associate judges are instead offered training in counselling skills and take up this role.[75] Stakeholders from the justice sector also reported that the Department of Juvenile Observation and Protection currently works with multidisciplinary teams (including psychologists) from other government agencies to provide mental health services to children and adolescents in conflict with the law, and victims of crime.

There are also some examples of **digital or online delivery of responsive care**. Path2Health and UNICEF have collaborated to deliver 'LoveCare Station', an online chatroom service providing counselling sessions with professional psychologists for adolescents aged 10–19.[7,76] Counselling covers topics such as mental health and well-being, bullying and referrals to partner organizations. Between 2017 and 2020, over 55,000 adolescents received online counselling through this service.[7,76] Recently, a similar service was added to the Teen Club Line platform, a government-led health information and counselling service for adolescents led by the Bureau of Reproductive Health. Ooca, a private start-up company, has also developed an online platform and app that connects users with networks of psychologists and psychiatrists able to provide online counselling and other services through video-conferencing. The platform was launched in 2017 and has reached 63,000 users, although there are no data concerning uptake by children and adolescents.[77] Online delivery of interventions has also shown some promise for developmental disorders. A pilot study of a web-based learning programme (social stories and interactive games) for children with autism spectrum disorder reported an improvement in behaviour and empathy following the three-month programme.[78] To address suicide, the NGO Samaritans Thailand (an international organization based in the United Kingdom) provides a crisis hotline and counselling service staffed by trained volunteers – although this is not specifically targeted to children and adolescents. The Department of Justice has also provided counselling services online or via telehealth to children in conflict with the law in the context of COVID-19.

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. In recent years, many interventions have been piloted to improve mental health literacy and prevent mental health disorders in children and adolescents in Thailand. The health, education, justice and social welfare sectors along with NGOs and youth organizations all play key roles in supporting current mental health prevention programmes targeting the general population, school children and teachers, parents and at-risk children and adolescents.

Building individual assets

As part of the Ministry of Education's project to provide all teachers in Thailand with a guideline to integrate the learning of life skills into the curriculum, OBEC, UNICEF Thailand and the Right to Play Thailand Foundation developed the 21st Century Skills Education Teacher Manual. The manual includes social and emotional learning and aspects of mental health. Although the manual is comprehensive and easily accessible, young people participating in interviews and workshops noted key gaps in mental health literacy in the national curriculum, particularly with respect to building psychosocial skills.

On a smaller scale, there have been recent examples of using web-based and online platforms to support the delivery of mental health education in schools. In southern Thailand, a pilot, web-based project was conducted to support the mental well-being of adolescents.[79] A total of 180 students from three secondary schools were recruited, with 12 teachers acting as programme tutors. The quasi-experimental study allocated students to: small groups using the web programme; a group using the programme independently; and a control group not using the programme. The programme, known as 'DepisNet-Thai', consisted of a series of one-hour modules taken weekly over seven weeks. The programme aimed to provide education, self-reflection skills and self-management skills on topics such as psychological stress, physical well-being, family relationships and friendships. While the evaluation did not show a statistically significant improvement in symptoms of depression, stress or satisfaction, adolescents found the programme to be an acceptable way to deliver mental health education, particularly if it was conducted individually.[79]

There are also several examples of small-scale programmes and pilot projects delivered in schools to address specific risk factors, such as harmful use of the internet and gaming. These have included classroom-based sessions to build self-regulation skills as well as interactive, online programmes to build self-esteem and social skills and to address addictive behaviours. These have shown promise in small studies.[40,80]

The private sector also provides mental health prevention and tools to support social and emotional learning. For example, the Rakluke Learning Group, with financial support from the Thai Health Promotion Foundation, developed the Executive Function tools and training. This is disseminated to private schools and parents for free to help improve skills such as memory, flexible thinking and self-control and it is currently being piloted in 1,000 schools. Other recent programmes delivered through schools to support social and emotional learning and life skills in relation to mental health are described below.

Strengthening positive peer support

In addition to components of curriculum-based life skills education focusing on healthy relationships and social skills, junior high schools have also introduced the Youth Counsellor (YC) project to build peer support (in addition to supporting early identification of mental health needs). The Ministry of Education initiated this programme in 2010, although current data about programme coverage is lacking. All schools can opt into the programme, and YC members are selected by teachers on the basis of good interpersonal skills, volunteering experience and public-mindedness. They receive training from school guidance counsellors in order to help counsel their friends and peers. The YC project has been well received by teachers, particularly those who are overwhelmed by the number of students in their care. This programme acknowledges that students are often more comfortable consulting their friends, particularly on sensitive matters.

Outside of the school setting, non-government youth organizations have also played a key role in supporting positive peer relationships and networks, particularly through social media. These include the online provision of information, resources and counselling to children and adolescents. Examples of NGO, peer-led prevention include initiatives such as Understand: Living room of the heart, Be PSY U, Lovecarestation and Mindventure.

There are also some initiatives to address cyberbullying and peer-victimization online. For example, the Internet Foundation for Thai Development is a not-for-profit organization that engages with other NGOs and government agencies to promote online safety and digital literacy. The Foundation has implemented several projects that aim to improve digital literacy among children and young people, and support protections for children online. These include mechanisms to support surveillance of online harms, resources and training and learning materials to support digital literacy and resources for parents and teachers.[81]

Psychosocial competence building for parents and carers

There is limited information available about larger-scale, national parenting programmes to build skills in responsive and nurturing care. The Department of Children and Youth has established counselling centres at subdistrict level to support the parenting skills of parents and carers – supported by a network of agencies that facilitate monitoring and tracking of children at risk. The Department of Justice currently works directly with the families and parents of children and adolescents in conflict with the law to support parenting skills to reduce recidivism. In collaboration with the Thai Health Promotion Foundation, the Department has also supported online parenting programmes.

There are some examples of small projects and pilot studies. An online platform (Net PAMA) providing free parenting management training programmes was recently developed and made available for the general public, following a smaller trial that showed promise.[82] Other examples include the Thai Suicide Prevention Programme for Secondary School Students, which was developed, piloted and evaluated in a school in Chiang Mai province.[83] Adolescent leaders helped to implement a programme focused on suicide awareness that targeted parents, in addition to students and teachers.[83] Overall, in before and after analyses, the intervention was associated with a significant improvement in suicide knowledge and attitudes amongst adolescent peer leaders, parents and teachers.

The Parenting of Lifelong Health for Young Children programme,[84] developed by Oxford University, WHO and UNICEF, was recently adapted and piloted in Thailand. This programme focused 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) delivered through home visits, group sessions, phone calls and messages, and a parent handbook. The pilot was conducted in Udon Thani province among 60 caregivers of children aged 2–9 years (parents and grandparents), and demonstrated a 58 per cent reduction in child maltreatment, a 69 per cent increase in overall positive parenting, a 48 per cent reduction in carers' mental health conditions (depression, anxiety, stress) and a 79 per cent reduction in child behaviour problems.[85] The programme, developed with the Ministry of Public Health and delivered by nurses, public health officers, social workers and Village Health Volunteers, was also found to have the potential for scale-up through existing community-level structures. Important considerations for implementation included linking the programme with early childhood development, schools and child protection services as an entry point for engaging caregivers in the initiative, as well as providing support to children and families at risk and considering approaches to better engage fathers and other male caregivers.

A 2017 publication described a parenting and family skills intervention for Burmese migrant and displaced children living in 20 communities in Tak Province.[86] The 'Strengthening Families Programme' is an evidence-based intervention involving 14 weekly sessions on social skills for children and parenting skills for caregivers, with activities including structured and unstructured play.[86] Children who received the intervention were found, one month later, to show significantly reduced externalizing behaviours such as aggressive or rule-breaking behaviour compared to the control group, and a significant increase in prosocial, protective factors. There was no significant treatment effect on internalizing symptoms such as withdrawn or depressed behaviour.[86]

A recent publication by Tungpunkom and colleagues[87] identified a significant gap in programmes to address the mental health of parents – an important risk factor for poor mental health among children. A recent international meta-analysis found that children with a parent with serious mental illness had a 41 per cent to 77 per cent increased risk of developing mental health issues themselves. [88] Tungpunkom and colleagues assessed the capacity of Thailand's mental health workforce to provide family focused or child-focused practices to support the children of patients with mental illness.[89] A quarter of 76.8 per cent of mental health workers reported no training in family focused practices and 79.7 per cent reported no training in child-focused practices. Most professions, including psychiatrists and psychiatric nurses, reported poor workplace support for family focused practices, a lack of knowledge and skills regarding family focused practices, lack of engagement with the family of patients and lack of referral of family members to other services. All mental healthcare professional groups reported a need for more training in working with families.[89]

Safe and enabling learning environments

Since 2013, the Thai Health Promotion Foundation has provided funding for development projects in schools aiming to enhance healthy behaviours in children and youth groups. Nine major projects have been funded and over 1,000 schools across Thailand have participated. 'A Healthy School' aims to achieve 'happy students' through a reduction in risk factors, adjustment, structure and system management for the school, environment, family and community and the promotion of student health and well-being in social, physical, mental and intellectual fields. The projects are either systems-based (such as the Healthy Schools Network; Healthy Literacy for Children, Youths, and Family Educational Network; Development and Management of Scouting Activities to Enhance Life Skills; and Development of Royal Police Cadet Academy to Healthy Promotion Organization), or issue-based (such as the Development of Integrated Learning Systems: Life Skills and Sex Education; Health Promotion for Thairath Wittaya School; Non-smoking Schools Network; and Youth Justice and Empowering Children and Community). The school HERO programme described in 'responsive care' above also includes actions to improve mental health literacy and skills. While many of these initiatives are promising, there are limited documented studies or evaluations to determine their impact.

School-based guidance counsellors (who have an educational degree in psychology) also provide psychological and life skills counselling to students, as well as advice on study and career pathways. Guidance counsellors are also often involved in organizing special lectures or events in collaboration with the health and justice sectors to raise awareness and provide information about mental health. Although school guidance counsellors play a key role in mental health prevention at schools, it was noted by stakeholders that not enough are employed in the system to reach all students.

In 2022, the Ministry of Education launched a pilot programme in eight provinces to address safety in schools, in collaboration with the Ministries of Interior, Health, Natural Resources and Environment, Defence, Transport, Digital Economy and Society, the Prime Minister's Office, and the Royal Thai Police. The 'Ministry of Education Safety Centre' is a digital-based system that defines safety standards in educational institutions (including safety in relation to mental well-being), provides information and advice and allows students, teachers, education staff and communities to report concerns or breaches of safety through a website, call centre, phone app or social media.90 The programme includes four user-friendly channels, including the MOE Safety Centre application, the website (www.MOESafetyCenter.com), email (LINE@MOESafetyCenter.com) and a call centre (02–126–6565).

Targeted interventions for children and adolescents at higher risk

There are various programmes targeting children and adolescents who are at increased risk for poor mental health due to risk behaviours or high-risk exposures. A major focus are specialized programmes to **prevent and respond to child abuse, violence, exploitation and neglect**. These include intensive, multidisciplinary programmes to provide care and support to victims of violence to prevent poor mental health (and ensure timely identification and management for those children with mental health needs). Primary responsibility lies with the Ministry of Social Development and Human Security's Department of Children and Youth, including for investigation of child abuse, providing support for at-risk families, maintaining a national database of child and youth protection matters, coordinating adoption and fostering, and providing temporary shelters for children and

families in 77 provinces.[91,92] The Department also operates 30 residential institutes that "promote child development, virtue incubation, and rehabilitation".[92] The Ministry of Social Development and Human Security runs a large network of shelters, residential facilities and training facilities for physically, developmentally and intellectually disabled children and adolescents, children and women affected by trafficking and youth recovering from substance use problems.[93] Other departments within the same Ministry that are engaged in child protection include the Youth Housing Council, the Department of Social Development and Welfare and the Department of Women's Affairs and Family Development.[92] Thai youth organizations also collaborate with rural community leaders to design policies for child protection and organize capacity building workshops for young people. Youth development committees work with subdistrict authorities to identify and respond to mental health needs. For example, one youth representative described working with local youth organizations to implement a programme using art-based activities to identify needs, which then informed the design of activities to prevent depression as a result of political unrest.

A major government intervention has been the One-Stop Crisis Centres. These were launched in 1999 to provide multidisciplinary services to victims of violence under one roof. There are now One-Stop Crisis Centres in 96 provincial hospitals and 734 district hospitals. In 2019, 14,220 people reported abuse or sought assistance at these Crisis Centres, of which 44 per cent were children and adolescents.[54] Services provided by these Centres include medico-legal examination, evidence collection, investigation of child abuse cases, treatment and prevention of sexually transmitted infections, and psychosocial support.[94] NGOs and United Nations agencies have also worked with the Government to address child protection issues. In 2019, UNICEF partnered with the Thai Government to launch the 'One Thousand Nightmares Can End With Your One Voice' campaign to raise awareness about the government's 1300 helpline for people to report suspected child abuse and increase community participation in protecting children from violence.[95] In mid-2021, the Department of Children and Youth, the Equitable Education Fund, UNICEF and CAMHRI announced the new 'Care Centre for Children with COVID-19 scheme'. The scheme has set up four foster homes, each with a 160-bed capacity, to provide temporary accommodation for children who have lost parents to COVID-19, or whose parents (one or both) are infected with the virus.[96]

Physical and psychological violence against children is also a risk factor in the juvenile justice sector. The Department of Juvenile Observation and Protection managed over 36,500 cases in 2014, the majority boys aged 15–17.[41] The revised Criminal Procedure Law included provisions for child-friendly investigation procedures to protect juvenile offenders. However, implementation of the law has been uneven due to human and financial resource constraints.[41] The Department of Juvenile Observation and Protection has attempted to reduce the number of juveniles incarcerated in these conditions by helping to fund child and adolescent psychologists in schools to provide counselling and cognitive behavioural therapy to students at risk. They have also invested in diversionary sentencing programmes to keep children out of problematic institutions.[41]

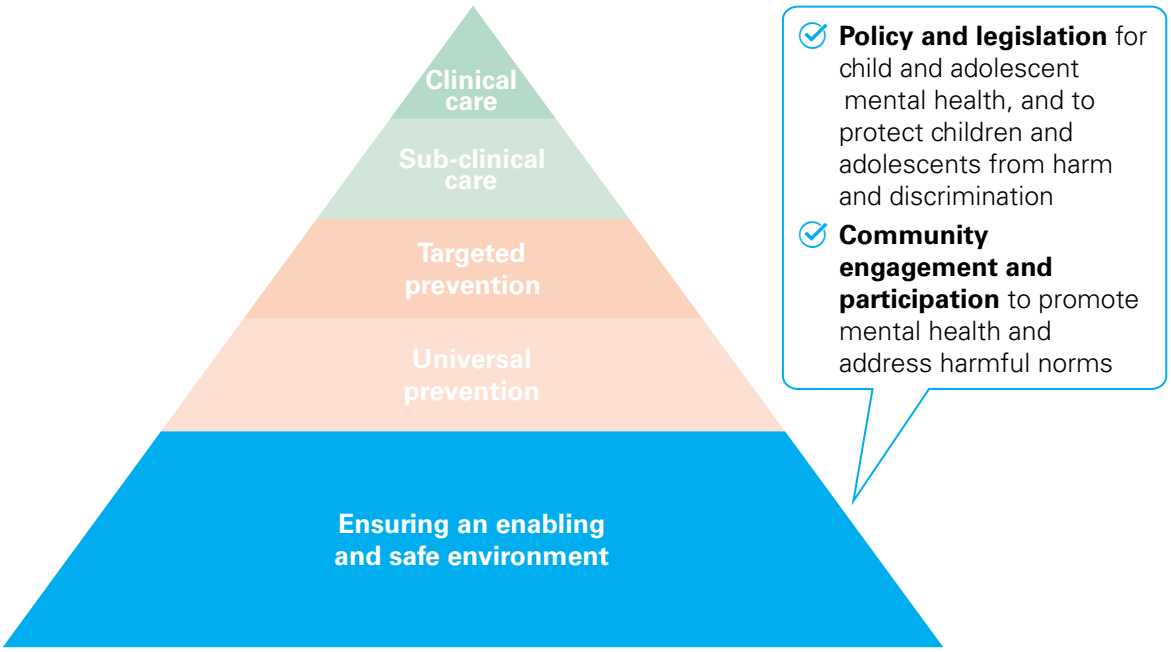
In addition to addressing violence against children, there are also examples of targeted programmes to address other key risk factors. 'To Be Number One' is a programme aiming to reduce the **harmful use of substances** and build self-esteem using activities such as sport and the performing arts. In 2020, a total of 217 schools and 56 juvenile detention centres were involved in the project,[97] which is strongly supported by schools and Education Service Area Offices. The criminal court system has also piloted 'a psychosocial clinic' in a number of provinces since 2009 – an initiative that it aims to scale up nationwide. This initiative generally focuses on cases related to drug use and family violence, with the objective of addressing various social problems and providing rehabilitation to convicted individuals. During or after the court process, a judge may order a defendant to access services provided by the clinic. Counsellors at the clinic are volunteers and judicial officers who have been trained in a set of psychosocial and counselling skills. They are supervised by a team of forensic mental health professionals at the Department of Mental Health. The results of the pilot phase found that clinic services could substantially reduce reoffending rates.[98]

There are also examples of programmes aimed at **building skills or supporting children and young people who are marginalized or disadvantaged**. The Foundation for the Better Life of Children is a non-profit organization involved in mental health prevention for vulnerable children, such as street children, children in construction worker camps, orphans and children of imprisoned parents.[99]

The Foundation has been successful in gaining the trust of the communities in which it works. The key success factors are long-term, continuous support, familiarity with the staff, evidence of outcomes, accessibility, and commitment to the community. Private firms are also involved in providing jobs or occupational training for young people engaged in the justice and social welfare sectors. In cases where judges order juvenile offenders to undertake social work or community service, local private firms help to provide work opportunities. For children and adolescents in detention centres, private firms send staff to run occupational training. When they are allowed to work, a special request can be made to private firms to provide job opportunities and help raise their self-esteem. These programmes are not practiced widely, but there is low-level evidence in some locations of positive outcomes.

The internationally adopted CHAMP+ (Collaborative HIV Prevention and Adolescent Mental Health Program) was piloted with a group of Thai adolescents with HIV in 2015 and 2016 to address mental health issues and risk behaviours.[100] The intervention involved a social worker or counsellor delivering group interventions on HIV-related stigma, disclosure of HIV status, grief, puberty, social support, communication and HIV treatment adherence. Youth in the intervention group showed significantly improved scores compared to control groups on several measures of mental health, youth-caregiver communication, caregiver-reported internalized and externalized HIV stigma, and caregiver-reported HIV-related social support.[100]

Ensuring a safe and enabling environment to promote mental health



In addition to key policies and legislation for MHPSS and to protect children from harm (described above), the Thai Government, since 2006, has participated in significant mental health initiatives, including mental health promotion in the wider community. In campaigns such as the 'National Mental Health Campaign: Destigma', the Department of Mental Health has utilized radio advertisements, songs, documentaries, short movies, social media, activities in schools and workplaces and pamphlet distribution to raise awareness of mental illness and reduce stigma.[16,71] Social welfare workers, including social workers, engage in community health education and awareness programmes that include efforts to address children's needs and risks.[14]

The Department of Mental Health, NGOs and UNICEF have been significant contributors to changing social norms around mental health and increasing mental health literacy. During the COVID-19 crisis, the UNICEF Thailand COVID-19 website provided advice on mental health issues for parents, caregivers and young people through a range of formats including infographics, podcasts and videos. The website was viewed more than 45 million times in 2020.[70] In 2020, the Thai Government, UNICEF and private businesses (including the music streaming service Joox) collaborated on the 'Sound of Happiness' campaign to raise public awareness about services and platforms for mental health for young people, and to reduce mental health-related social stigma.[70] The campaign involved story telling by people who had struggled with mental health challenges in their youth and who had sought help. There have also been efforts to increase young people's participation in mental health programmes. The Thai Health Promotion Foundation recently created a group of youth leaders in mental health to support peer-led responses to mental health promotion. UNICEF has also played an important role in supporting youth advocacy for improved access to mental health services.

A priority package of MHPSS actions for children and adolescents

The package of priority MHPSS actions was defined during the development of the regional conceptual framework in the initial phase of this project. As described previously, these actions were identified through a review of existing frameworks, guidance, evidence and expert consensus. As part of the application of the regional framework to national contexts, this package was then reviewed, refined and prioritized in Thailand during consultation workshops and through an online prioritization tool and key informant interviews. The final package of actions prioritized for Thailand is set forth in Table 3.

Table 3: Package of priority MHPSS actions for children and adolescents

Accessible and responsive services for mental health conditions	
Screening and early identification of needs	
DOMAIN	**ACTION**
Early identification of mental health conditions and risks	Strengthen training and support for social workers, justice-sector workers, teachers and other education staff, school-based counsellors to identify, support and refer children and adolescents with mental health needs
	Train and sensitise frontline and community-based health workers to identify, support and refer children and adolescents with mental health needs
	Scale up the pilot "Child Shield" surveillance system to identify children and families at risk
Screening children and adolescents at higher risk for poor mental health	Strengthen screening of children and adolescents with high-risk behaviours (e.g. substance use) in clinical, school, child protection and justice settings
	Strengthen screening of children and adolescents with high-risk exposures (e.g. family violence) clinical, school, child protection and justice settings
	Strengthen screening of pregnant and postpartum adolescent girls through antenatal and postnatal services
Strong referral pathways	Establish and/or strengthen 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 health care and physical health services
Management of clinical and sub-clinical mental health conditions	
DOMAIN	**ACTION**
Accessible and inclusive mental health services	Establish child, adolescent and family-friendly services that are inclusive
	Deliver community-based, online and mobile services for underserved children and adolescents
Responsive care for sub-clinical conditions	Establish child and adolescent specialist support, case management and therapy provided by multi-disciplinary teams
	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	
DOMAIN	**ACTION**
Continuing care for those with mental health conditions	Provide person-centred care that includes social support, peer support and, 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	
DOMAIN	**ACTION**
Social and emotional learning, resilience, and problem-solving skills	Implement universal interventions and approaches in schools and out-of-school settings that focus on: social and emotional learning; positive behaviours; social connectedness; effective problem solving; help-seeking behaviour; 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). 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 psychosocial competence of parents and carers	
DOMAIN	**ACTION**
Safe, stable parenting and attachment	Implement programmes to raise awareness about nurturing care, positive parenting and non-violent discipline
	Implement parenting programmes focused on building skills in nurturing and responsive care, positive parenting practices, and non-violent discipline, such as the Parenting for Lifelong Health programme
	Identify and address the mental health needs of parents / guardians / carers, including through improved early identification and screening
Strengthen positive peer support, including online	
DOMAIN	**ACTION**
Positive peer relationships	Establish and support peer-to-peer groups and youth clubs in school and community settings, and youth counsellor programmes
	Develop or strengthen online social networks that programmes mental health literacy and positive peer support among children and adolescents

Address peer-victimisation	Implement programmes to programmes online and digital civility and digital literacy among children, adolescents, parents and teachers. 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, bullying and harassment
Ensure safe and enabling learning environments	
DOMAIN	**ACTION**
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 as outlined above this should also include strategies and policies to ensure a safe, respectful and inclusive environment with a focus on well-being; positive approach to behaviour management; violence prevention; 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 mental health and well-being of teachers and education-based workers
Mental health promotion: Ensuring an enabling and safe environment	
Community engagement and participation	
DOMAIN	**ACTION**
Community-based mental health promotion	Implement campaigns to address mental health-related stigma and discrimination
	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 capacity of adolescents and provide opportunities for them to participate in 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	
DOMAIN	**ACTION**
Policies, strategies and plans for child and adolescent mental health	Assess and address the barriers for children and adolescents in accessing mental health care, particularly for marginalised groups
	Strengthen the National Mental Health Plan to provide a more multi-tiered and multisectoral vision and plan for mental health, and develop and adopt a multisectoral implementation plan
	Ensure sufficient allocation of public resources to implement the national policy, through detailed costing, defined budget lines, 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, nutrition, and maternal and child health policies and plans
	More explicitly integrate mental health into the education sector policies and plans, including a whole-of-education policy for mental health promotion
Supportive mental health-related policies and legislation	
DOMAIN	**ACTION**
Policies, strategies and plans for child and adolescent mental health	Strengthen the integration of mental health into early childhood development, child protection / ending violence, social welfare and social protection policies and plans with clear roles and actions in relation to MHPSS
	Strengthen the integration of mental health of children and adolescents into juvenile justice and justice health policy and plans with clear roles and actions in relation to MHPSS
Legislation and actions required for effective mental health services	Adopt national standards defining high-quality mental health care for children and adolescents (minimum standards of care) that includes 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 ensuring effective implementation of legislation and policies that support the right of adolescents to access care without mandatory parental consent
	Adopt and implement legislation that mandates access to mental health care 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 health care for migrant, displaced or other marginalized children and adolescents
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, health care or any other setting 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 – including clarifying legislation with respect to corporal punishment within homes and other settings
	Prevent family separation by addressing 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 forced (non-consensual) marriage of adolescents under the age of 18 years
	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 and recruitment of children and adolescents with armed forces/groups
Supportive mental health-related policies and legislation	
DOMAIN	**ACTION**
Policies, programmes and legislation to protect children and adolescents from harm and discrimination	Legislate a minimum age of purchase of substances (alcohol and other drugs). Strengthen 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)
	Increase the minimum age of criminal responsibility (UNCRC recommends at least 14 years)
	Adopt legislation to explicitly protect children and adolescents from discrimination on the basis of gender identity or sexual orientation
	Adopt legislation to prohibit discrimination on the basis of gender, race, ethnicity, religion, disability, 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

All actions proposed in the regional conceptual framework were considered high priority for inclusion in an MHPSS package for Thailand. While there has been progress on introducing many of these actions, stakeholders across sectors noted significant challenges impacting on implementation, particularly at scale, and a need to strengthen coordination and delivery.

Responsive care for children and adolescents with mental health conditions

The highest priority was given to actions related to responsive care. Improving **early identification and screening** beyond traditional healthcare settings (such as in schools) is essential. However, it is critical that screening occurs in the context of a **strong referral system** and accessible services and supports. As such, stakeholders considered addressing the administrative bottlenecks impacting on timely referral and increasing the availability of child and adolescent mental health services among the most pressing priorities for MHPSS. This includes addressing complex and time-consuming referral processes, inadequate tools and protocols (with reliance on informal referral networks) and the lack of available services and specialists to take referrals. Improving coordination between sectors at the local level was seen to be critical to strengthening referral pathways.

Within school settings, stakeholders recommended improving screening protocols (and training) to make screening more straightforward and less time-consuming, and to more clearly identify children who need urgent specialist care versus those who could be managed by non-specialist providers (such as teachers, guidance counsellors, social workers and community development officers). Further assessment of the validity and acceptability of screening tools for children and adolescents from diverse ethnic backgrounds is also needed to support improved screening programmes.

Given the current constraints to providing traditional facility-based services, importance was also placed on establishing and/or strengthening the delivery of responsive care in school, community, online and home-based settings, including through building the capacity of non-specialist providers and multidisciplinary teams to provide basic care and support. Strengthening existing services to make them more **accessible and acceptable to children and adolescents** was also a priority. Youth representatives suggested that counselling spaces and facilities could be made more welcoming, approaches to counselling should be less formal and intimidating, and that approaches should be flexible and responsive to the age and developmental stage of young people (for example, drawing as part of therapy may not be perceived as valuable for older adolescents).

Prevention of mental health conditions in the immediate social context

The next highest priority was given to key 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. High priority actions included: strengthening the national standard curriculum for mental health with a focus on mental health literacy, skills and supporting social and emotional learning; improving mental health training and support for teachers; and investing in approaches to create mental health-promoting schools. Addressing stress and anxiety related to academic pressure and family expectations of academic performance were also seen as a high priority. This included approaches that address learning environments and teaching methods, as well as approaches to increase parents' awareness of mental health and their support of positive parenting.

High importance was also 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 programmes to better support parents or carers of children and adolescents with disability and/or mental health needs, including through greater financial support, and reaching grandparents who play an important role in caregiving. Another priority, particularly in the context of COVID-19, was integrating family violence into parenting programmes, as well as improving early identification, screening and referral for parents with mental health conditions. Increasing access to parenting programmes during pregnancy, improving linkages with school-based parent networks, 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. This could include working more closely with social workers to identify and tailor programmes for families who are at risk but not currently formally engaged in child protection. A key challenge for parenting programmes was a lack of clarity around which sector currently has primary responsibility, with stakeholders recommending that a national body be established to develop and coordinate a national approach.

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 campaigns and programmes to **address stigma and discrimination** and harmful norms, noting that stigma remains a significant barrier to seeking services and supports. Youth representatives emphasized the need to improve understanding of mental health among young people, parents and communities to address misconceptions and stigma and create an enabling environment for children and adolescents to seek help. Reaching young people through social media or other online programmes was identified as an important strategy to build mental health literacy but also to allow young people themselves to share experiences and perspectives on mental health.

The importance of **engaging young people** and community leaders with training and education around mental health and supporting greater participation of young people 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 accountabilities. An area of increasing priority, particularly noted by youth representatives and the justice sector, relates to online and digital spaces. While young people and other stakeholders stressed the need to make better use of online delivery of MHPSS (care, prevention and promotion), the justice sector also highlighted the need for greater online protections for children and adolescents in terms of preventing violence, exploitation and abuse (including cyberbullying and online crime).

Actions given the highest priority for implementation in the next two years:

Responsive care

- Strengthening early **identification and screening** in health and non-health settings
- Improving **referral mechanisms** within the health sector and between sectors
- Ensuring access to and quality of **child, adolescent and family-friendly mental health services**
- Establishing **specialized and multi-disciplinary mental health services** and support

Prevention

- Implementing **school-based programmes** to support healthy peer relationships and address violence and bullying, including a national curriculum to support social and emotional learning and mental health literacy
- Implementing **parenting programmes** focusing on nurturing, responsive care and non-violent discipline
- Improving **online networks** for mental health support, literacy and referral and education to address digital civility

Mental health promotion

- **Integrating mental health into other sectoral policies** and plans (education, social welfare and child protection, justice)
- **Increase protections** against violence, harm and discrimination
- Implement programmes to address **stigma, discrimination and harmful norms**

Recommended sectoral roles and responsibilities

Table 4 provides an overview of the key recommended roles of the health, education, social welfare and justice sectors in implementing the priority package of MHPSS actions.

The health sector was identified as having an overarching leadership role with respect to setting national policy, planning and oversight of MHPSS (see Figure 16). Stakeholders across sectors also described a critical role for the education and social welfare sectors in terms of prevention and promotion of mental health, noting that an increased focus on and investment in preventive actions through these sectors would reduce the overall demand for responsive care and also help to prevent children and adolescents coming into contact with the justice sector.

FIGURE 16. BROAD ROLES OF KEY SECTORS IN MHPSS

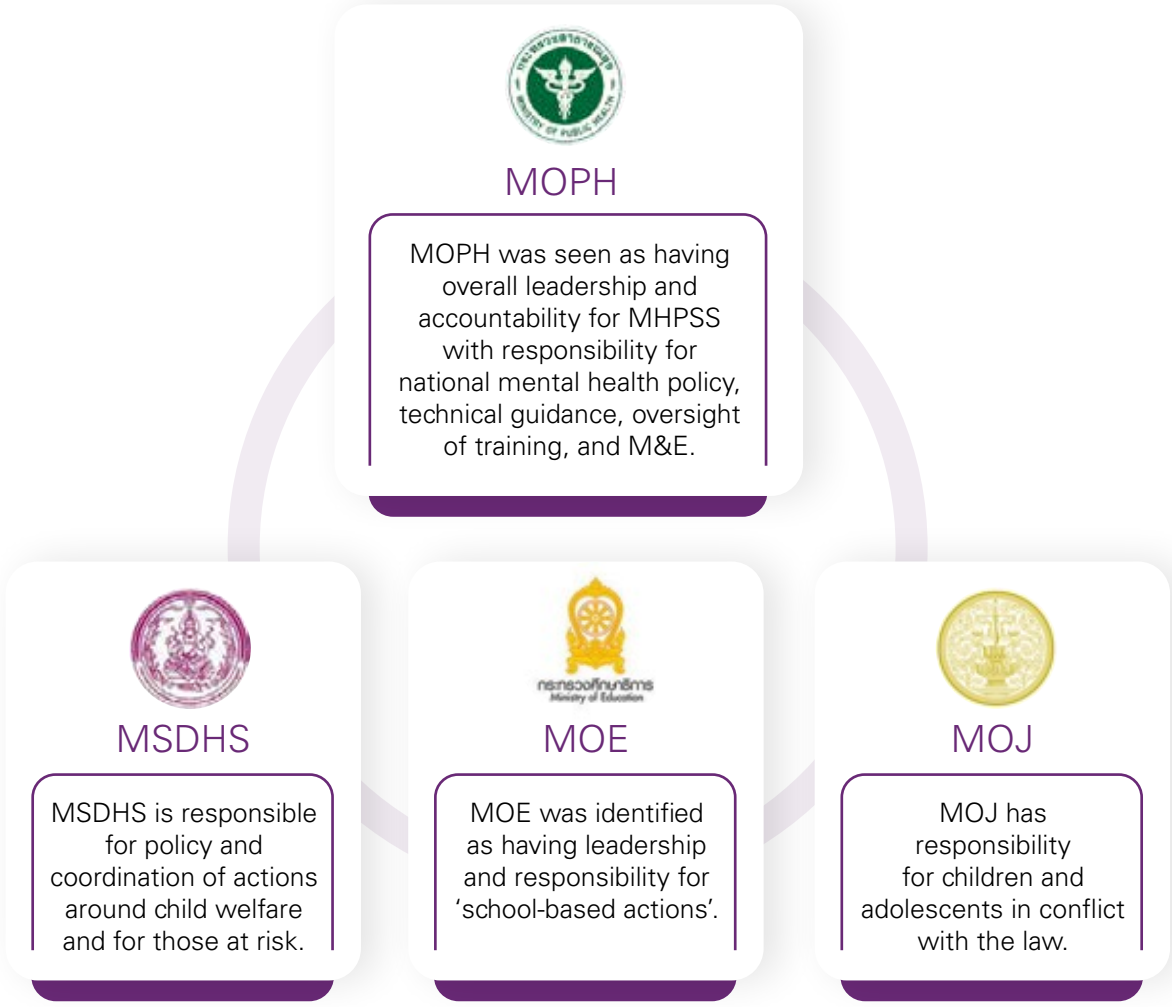


Table 4. Sectoral roles in implementing MHPSS actions Actions in bold indicate where a sector is recommended to have a leading role or primary responsibility for implementation

Accessible and responsive services for mental health conditions			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Screening for those at risk	Early identification of those with mental health conditions or risks	Screening for children and adolescents with high-risk exposures	Screening for high-risk behaviours and exposures
Referral systems and mechanisms (referral criteria and protocols both within the health system and from other sectors/ settings (schools, social welfare / child protection, justice)) Self-referral hotlines	Referral linkages and mechanisms (particularly protocols for referral of children identified through schools for health or social welfare services)	Referral linkages and mechanisms (particularly protocols and mechanisms for referral of children at risk for specialized case-management and health services) Self-referral hotlines	Referral linkages and mechanisms particularly protocols and mechanisms for referral of children at risk for specialized case-management and health services)
Multidisciplinary case management and support	Ongoing education participation for those with mental health conditions	Multi-disciplinary case management Targeted education and support for parents of children with mental health conditions and complex behaviours	Specialized services and supports
Community-based, online and outreach services		Community-based, online and outreach services	
Establishing specialised and clinical services			
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, violence prevention, and supporting positive peer and peer-teacher relationships -Teacher-parent communication -Teacher well-being	Support to mental health approaches in education	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 the community)	Intensive interventions to address risk factors **School-based interventions following crisis in the community (e.g. suicide)**	**Intensive interventions to address risk factors**	Intensive interventions to address risk factors
Identify and address mental health needs of parents / carers	Raise awareness about positive parenting Supporting **parenting programmes** to build skills in nurturing and responsive care, and non-violent discipline	**Parenting programmes** to build skills in nurturing and responsive care, and non-violent discipline	

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**	**Integrate 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 health care		Identifying barriers to accessing mental health services for marginalised groups	
Legislation mandating access to mental health care, including removing mandatory parental consent requirements			**Legislation mandating access to mental health care for children and adolescents deprived of liberty and in out-of-home placements**
Protections for children and adolescents in the mental health system		Support to legislation and policies to protect children and adolescents from violence and harm Development and delivery of social protection programmes for families	**Legislation and policies to prohibit violence, harm, discrimination** - Enforcement of existing legislation to protect children from violence, harm and discrimination - Decriminalising youth substance use - Adopting legislation that prohibits discrimination on the basis of mental health
Training and community-based programmes to address stigma and discrimination		**Training and community-based programmes to address stigma and discrimination**	

Mental health promotion: ensuring an enabling and safe environment			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Capacity building of adolescents to support participation including those with lived experience of mental health needs, in the planning and design of MHPSS	**Capacity building of adolescents to support participation** including those with lived experience of mental health needs, in the planning and design of MHPSS	Capacity building adolescents to support participation including those with lived experience of mental health needs, in the planning and design of MHPSS	

Health sector

The health sector, specifically the Department of Mental Health (Ministry of Public Health), was recommended to assume 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. CAMHRI, under the Department of Mental Health, was identified as having this leadership role with respect to national policy, service provider training, supporting school health programmes, and monitoring and evaluation of MHPSS, although it was noted that implementation would rely on relevant agencies (government, non-government and private sector) to deliver MHPSS-related services.

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 school 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.

Education sector

The education sector, through the Ministry of Education, was recommended to assume the leading role in coordination and implementation of preventive actions needed to optimize safe and enabling learning environments, build individual assets and support healthy peer relationships. Broadly, the education sector was identified as having responsibility for developing and implementing a whole-of education approach to mental health promotion, with 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 and teaching approaches on mental health – with a focus on student safety, well-being and respect. The education sector was also recommended to lead more focused efforts to strengthen a 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.

Significantly, the education sector was also recommended to play a greater role in early identification and screening of children and adolescents with mental health conditions through improved training and support for teachers and school-based psychologists or counsellors and greater linkages with health services. It was noted that teachers are often the first to identify children and adolescents with mental health conditions (or those who are at risk) and the first link between families and

other mental health services. Schools and other education settings were also identified as having a key role in providing initial care and support for mental health conditions, including counselling and behaviour modification interventions. 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 of schools in responsive care.

Social welfare sector

Through the Department of Children and Youth (Ministry of Social Development and Human Security), the social welfare sector was recommended to assume a leading role in planning, coordinating, developing and monitoring actions related to child and youth welfare, and social supports and protection to address social determinants of mental health and well-being. 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 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 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. Additionally, the social welfare sector was identified as having primary responsibility for developing and implementing parenting programmes (through the Department of Women's Affairs and Family Development) – including the development of tailored programmes for families at increased risk of poor mental health or those from diverse sociocultural backgrounds. This sector was also recommended to play 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 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 in supporting early identification, screening and referral for mental health services. While this currently relies on engagement with other sectors and agencies, stakeholders also noted that police, judicial and court officers and other justice sector workers were also increasingly providing frontline mental health services, and so required additional training and support to take on these roles.

In addition to screening and referral in the acute settings 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, and improved referral to social welfare services. 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. In addition to existing legislation prohibiting all forms of violence against children, the sector noted an increasing role in terms of addressing online risks for children and adolescents.

Other government sectors

Other sectors identified as relevant to the implementation of MHPSS include the Ministry of Labour to reach out-of-school youth with MHPSS actions, and the Ministry of Digital Economy and Society to support online platforms for MHPSS and actions related to digital civility, safety and literacy. The Ministry of Interior was also identified as having a key role in supporting implementation of MHPSS through overall leadership of government units at a provincial level. Currently, the Ministry has a role in supporting child development, welfare and education at a local level given its mandate and the lack of authority from other government agencies working at subdistrict level.[14]

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 at increased risk of poor mental health (particularly in relation to high-risk exposures such as violence, conflict with the law and harmful substance use);
- implement whole-of-education-based approaches to prevent poor mental health and promote well-being;
- 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; and
- social protection and supports to address broader determinants of mental health and well-being.

Non-governmental organizations

Not-for-profit NGOs were seen to play a potentially important role in the implementation of MHPSS. While current NGO involvement in mental health is limited, many organizations are nevertheless 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. The greater flexibility of the NGO sector to respond to community needs and adopt new models of delivery without the bureaucratic constraints of the government sector was a noted advantage. Additionally, the NGO sector was seen to have an important role in supporting mental health advocacy. Within this sector, youth organizations were also identified as key to supporting actions to promote mental health literacy and participating in the implementation of preventive and care interventions in community and school settings.

Private sector

The private sector (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 were limited. 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 was noted. In general, stakeholders recommended that further mapping was required to better understand the current roles and capacities of the private sector in mental health, and with greater coordination and regulation of the sector. The private sector was also identified as having a potential role in providing financial support or other resources (such as technology, including digital technology, expertise and training opportunities) to support MHPSS initiatives through corporate social responsibility programmes.

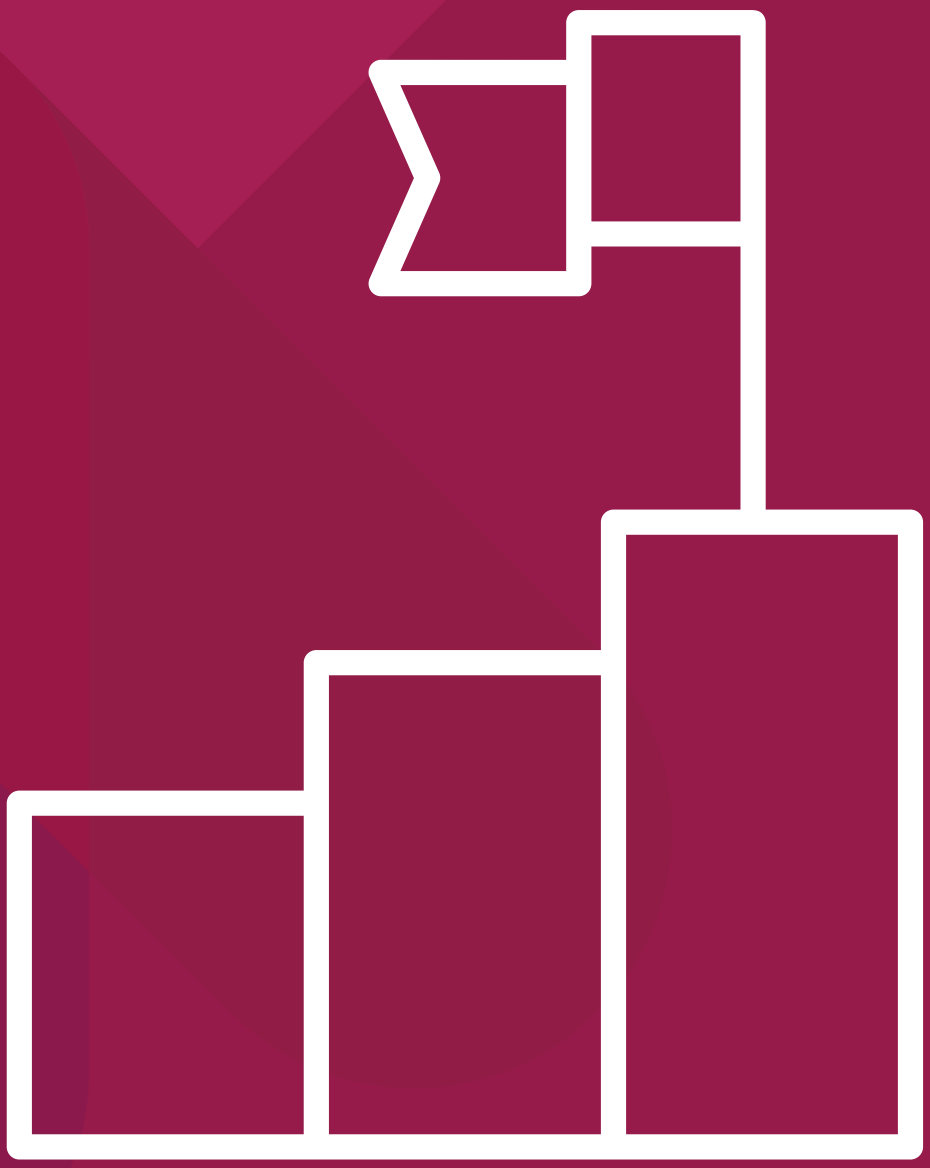
UNICEF

UNICEF was noted to have a key role in supporting mental health research and developing new programmes and models of delivery, facilitated by strong linkages with national, regional and global academics, technical experts and professionals. In its capacity to collate and synthesize data and research, UNICEF was also identified as having an important role in drawing attention to key mental health needs and advocating for evidence-based policy action. Stakeholders also highlighted the potential for UNICEF to provide funding to support new initiatives, pilot projects and other innovations to test new ways of implementing MHPSS for children and adolescents.

Through consultations with UNICEF representatives in the region, UNICEF was also identified as having an important role and comparative advantage in:

- leading advocacy efforts;
- assuming a crucial convening role, including the capacity to facilitate linkages between sectors (such as health, social welfare, child protection and education) and support cross-sectoral dialogue, planning and resource allocation;
- 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
- integrating MHPSS in emergency settings.

Current challenges and recommendations for strengthening the multisectoral Mental Health system



Legislation, policy and strategy

Thailand has a strong legislative and policy framework for supporting MHPSS and ensuring the mental health and well-being of children and adolescents. Most notably, the **Mental Health Act (2008, 2nd amendment 2019) and the National Mental Health Plan (2018–2037)** lay the foundations for multisectoral action to promote well-being, prevent poor mental health, provide responsive services and protect the rights of children and adolescents. However, the current Plan does not sufficiently include a multisectoral approach to mental health. While it does identify specific ministries, units or supporting organizations responsible for implementation, it currently does not articulate a clear multisectoral vision for mental health or describe the mechanisms needed to enable cross-sectoral collaboration and accountability. This includes a lack of performance indicators or other mechanisms to monitor collaboration or coordination. Stakeholders also recommended that the Mental Health Act be expanded to include MHPSS beyond clinical mental health services.

While the Act includes some general protections of rights of those within the mental health system in relation to physical restraint, deprivation of liberty, involuntary treatment and appeal, there are no specific protections for children and adolescents. Such protections could include:

- Specific protections for children and adolescents with respect to the least restrictive assessment and treatment possible, including use of physical restraint, involuntary seclusion and deprivation of liberty;
- The 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;
- Appointment of a personal representative, other than a family member, if necessary;
- The right to have contact with family or other support persons;
- The right to recreational activities, education and other supports that respond to individual needs.

A recent guidance provided by the Department of Mental Health included provision of counselling and assessment of children without requiring parental consent. However, parental consent is still required for treatment of mental health conditions, unless it is in the best interests of the child.

An additional gap in legislation still exists for undocumented migrants and asylum seekers, including children and adolescents. Due to their lack of legal status, these children may not be eligible for some healthcare services.

Mental health has been integrated to some extent into the **sectoral policies and plans of education and social welfare**. Within the education sector, the National School Health Policy, and the One School One Psychologist Policy are considered to have been positive in supporting mental health, although considerable implementation challenges related to workforce shortages were noted. Youth stakeholders in particular identified gaps in current education policy in relation to greater inclusion of mental health literacy and social and emotional learning within the national standard curriculum. Stakeholders also noted the need to review the use of psychological testing to screen college applicants, as this was seen to be discriminatory and to add to stigma (particularly in the absence of available services). Other policy priorities identified included standard programmes to build mental health literacy and skills among teachers, programmes to build stronger engagement with families and communities to support student well-being, and strengthening the YC programme through improved training, supportive supervision and financial resources. A major gap in current policies are strategies to reach out-of-school children and adolescents with MHPSS. The education sector in particular noted the need for greater guidance and targeted programmes for marginalized children and adolescents (in and out of school) whose needs were more complex.

Thailand has a suite of laws, policies and plans related to child welfare and protection that address some of the key determinants of mental health (violence, trafficking, education, participation) and include actions in relation to MHPSS, such as supporting positive parenting and addressing risk factors such as substance use. However, it was noted that social and financial protection policies should be

prioritized for children and adolescents most in need. The justice sector in particular highlighted the need to update child protection legislation (such as the Child Protection Act 2003) to better address risks associated with online harms, including online exploitation and abuse.

Across sectors, stakeholders 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, particularly local units. Limited dissemination of key policies, plans and legislation at the local level was identified as a significant barrier to implementation, with many units not aware of key policies, their specific roles, or guidance around implementation. To address this, it was recommended that provincial-level mental health plans be developed, with a multisectoral implementation plan to support local coordination. It was noted that the National Mental Health Commission includes a provincial subcommittee that should be responsible for local level implementation.

KEY RECOMMENDATIONS – LEGISLATION AND POLICY:

- Include 'mental health in all policies' with more explicit recognition and actions to address mental health in non-health sector policies.
- Expand the Mental Health Act to include MHPSS more broadly, so that provision is not limited to clinical mental health services.
- Strengthen the Mental Health Act to include specific protections and provisions for children and adolescents within the mental health system.
- Develop a national multisectoral implementation plan and guidance with clear roles, responsibilities and accountabilities at all levels (including key performance indicators related to multisectoral coordination).
- Develop multisectoral mental health plans at provincial level to support coordination and implementation.
- Review legislative and regulatory barriers to access (e.g., undocumented migrants), and to greater coordination between sectors.
- Develop policies and strategies to reach out-of-school children and adolescents and other marginalized groups.
- Strengthen the Mental Health Act to include specific protections for children and adolescents within the mental health system.
- Strengthen child protection and criminal legislation to better respond to risks related to online harms and integrate MHPSS into the forthcoming National Child Protection Strategy.
- Improve dissemination of MHPSS-related policies and plans across sectors and to administrative and implementation agencies.

Leadership and governance

National level

While there has been some important cross-sectoral collaboration around key aspects of MHPSS (such as school-based screening), limited high-level, multisectoral coordination of policy and planning remains a challenge. Stakeholders across sectors noted that each sector has a different policy focus, planning cycle and budget priorities and 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). Lack of policy alignment was also noted within sectors. For example, health sector stakeholders described limited coordination in approaches between health facilities under the Department of Mental Health and those under the Office of the Permanent Secretary of Public Health. Hospitals under the Office of the Permanent Secretary of Public Health have prioritized non-communicable diseases and ageing over mental health, particularly child and adolescent mental health, contributing to limited access to services and resources.

The **Department of Mental Health** was seen as having overall leadership and accountability for MHPSS with responsibility for national mental health policy, technical guidance, oversight of training and monitoring and evaluation. The multi-ministerial commission on mental health (established by law) also has a key role in national level leadership. However, to facilitate better collaboration and coordination, stakeholders recommended establishing a subcommittee for child and adolescent mental health with the authority and resources to drive action. This could include development and monitoring implementation of a multi-ministerial action plan on child and adolescent mental health. To achieve this, it was recommended that this committee should include all relevant sectors, including the BoB to support coordinated budget requests and allocation, and be chaired by a Deputy Prime Minister. Establishing a Centre for Policy Management, or similar, with a role in setting cross-sectoral indicators for implementation of a national mental health policy was also recommended.

There are some examples of multisectoral collaboration around some areas of mental health. Within child protection, the Child Protection Act (2003), Act on Promotion and Development of Children and Youth (2017) and the National Strategy on Child Protection (2017–2021) define the role of a multidisciplinary Child Protection Committee at provincial level, with committees expected to include representatives from social welfare, health, education and justice (in addition to communities, children, parents and carers) to identify and respond to child protection issues. Additionally, the recently established Centre of COVID-19 Situation Administration may provide a useful model for how a multisectoral committee can function to achieve a shared goal.

Administrative 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 administrative and implementation levels. Stakeholders noted that regulatory and administrative barriers currently make implementation planning and coordination between sectors inefficient. For example, the Department of Mental Health has a history of collaboration with OBEC which has facilitated implementation of MHPSS programmes in OBEC schools. However, the Department has limited access to certain types of schools, for example, those falling under the Local Administrative Organizations such as Bangkok Metropolitan Administration.

Lack of coordination at this level was identified as a key contributor to a weak referral system. Stakeholders described a reliance on informal networks and relationships between sectors as a result of a lack of clarity around roles, referral procedures between sectors and tools to support efficient referral. While this has had some advantages in terms of avoiding cumbersome bureaucratic requirements and barriers, coordination around referral is fragmented and there is a need for a more formal mechanism that defines clear implementation roles and accountability. This mechanism also needs to work to remove rigid approval processes and other regulatory barriers that currently make collaboration between government sectors, and between government and non-government sectors, difficult.

Lack of awareness of MHPSS-related policy and legislation at provincial and local levels also impacts on 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.

At an implementation level, there are examples of multidisciplinary approaches to support mental health that could be expanded. For example, the Mental Health Crisis, Assessment and Treatment Team is a multidisciplinary team of health professionals, social workers, emergency response teams

and local networks who respond to a community in times of crisis (humanitarian, natural disaster, violence, COVID-19) to provide screening, referral and services. The Ministry of Public Health provides an advisory role, with protocols developed by the Department of Mental Health. Similarly, Mental Health Centres, a division under the Department of Mental Health, provide 13 centres nationwide that implement community-based promotion, prevention and health services through a network of public and private providers (including schools). These facilities also provide training for community-level workers.

Existing leadership at provincial level includes the subcommittee of the National Mental Health Commission, which was identified by stakeholders as having a critical role in implementing and coordinating a multisectoral MHPSS programme at a local level. A greater role for the provincial governor of the **Ministry of Interior** was also recommended, given their responsibility for leadership of government units at this level. Improving the awareness and understanding of mental health for this level of leadership would help to facilitate greater coordination of government units. There are also some efforts to address regulatory barriers impacting on implementation. Legislation recently introduced by the Office of Decentralization to the Local Government Organization Committee will enable phased structural and organizational change for district hospitals and subdistrict primary care units that fall under the authority of Local Administrative Organizations. This will allow decentralization of administrative and financial power to communities, so they can address local needs more flexibly and effectively. However, key to the success of this initiative will be ensuring that communities and local authorities have capacity around child and adolescent mental health so that these needs and appropriate actions can be prioritized and resourced accordingly.

Towards a multisectoral governance model

Figure 17 proposes a multisectoral model of governance and coordination for MHPSS, drawn from recommendations from stakeholders. Within this model, the National Mental Health Commission (chaired by a Deputy Prime Minister) is identified as the core policy-making body at a **national level,** with authority to set a national multisectoral agenda, formulate policy, and monitor and evaluate a national response. The Office of the NESDC also has a mandate to propose mental health policies directly to the Cabinet and advocate for inclusion of mental health in the National Economic and Social Development Plan.

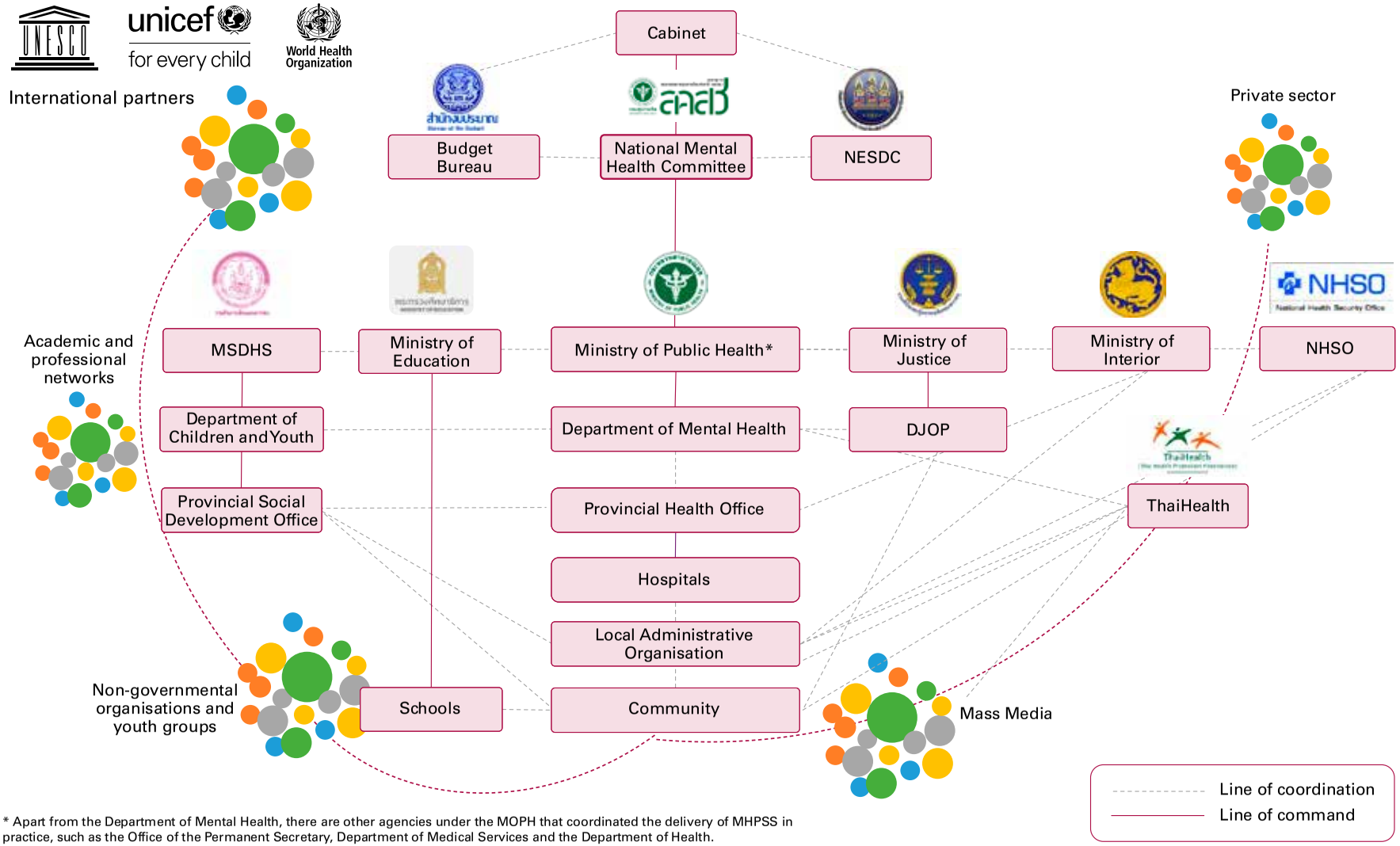
Under the Commission, the Department of Mental Health (within the Ministry of Public Health) has primary responsibility for the national mental health system and mental health programmes. Stakeholders recommend that this role be expanded to focus not only on essential service delivery, but as the core agency to provide technical leadership and facilitate coordination across the three tiers of MHPSS.

Given the current mandates and substantial role of the social welfare and education sectors in developing and implementing many MHPSS actions, the **Ministry of Social Development and Human Security** and the **Ministry of Education** were also seen to have significant leadership roles. For social welfare, this related particularly to policy and coordination of actions around child welfare and MHPSS for those at risk, while the education sector was identified as having leadership and responsibility for school-based actions. The **Ministry of Justice, through the Department of Juvenile Protection and Observation**, has responsibility for children and adolescents in conflict with the law.

Additionally, there are key roles for other agencies in supporting the implementation of MHPSS. The Thai Health Promotion Foundation (ThaiHealth) is responsible for the management of the health promotion fund supporting all sectors to carry out health promotion activities (that could include mental health). The National Health Security Office has responsibility for the management of the health security or insurance fund for providing health services. The Ministry of Interior has a critical role in providing leadership and coordination of local government units to support implementation of MHPSS.

FIGURE 17. TOWARDS A MULTISECTORAL GOVERNANCE STRUCTURE FOR CHILD AND ADOLESCENT MENTAL HEALTH

MHPSS: Towards a multi-sectoral approach by using a hybrid governance



* Apart from the Department of Mental Health, there are other agencies under the MOPH that coordinated the delivery of MHPSS in practice, such as the Office of the Permanent Secretary, Department of Medical Services and the Department of Health.

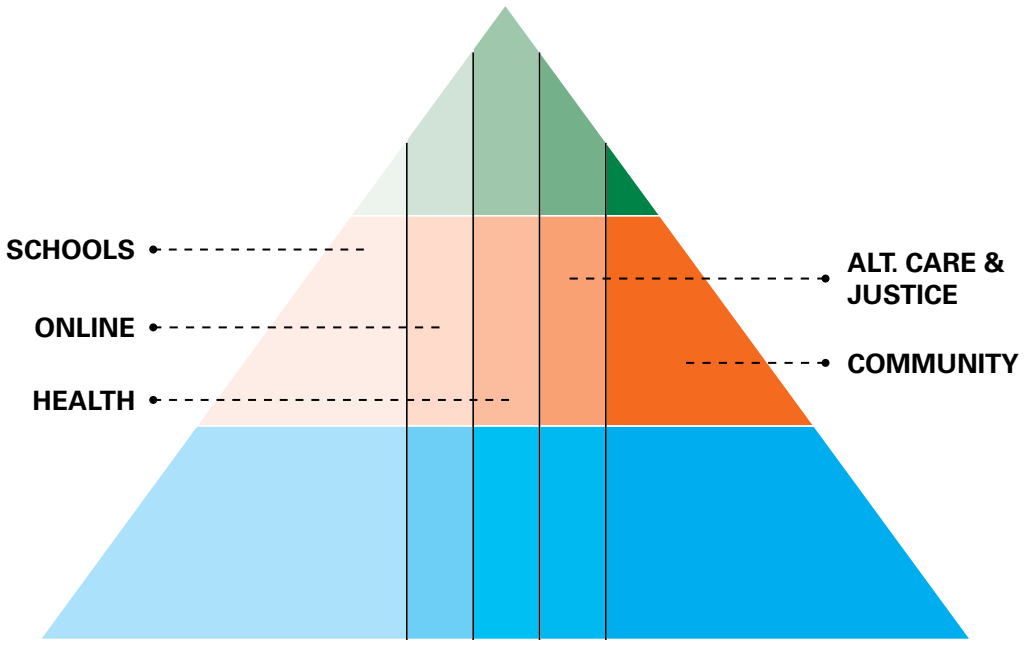
KEY RECOMMENDATIONS – LEADERSHIP AND GOVERNANCE:

- Develop a high-level, multisectoral vision for mental health and establish a national subcommittee for child and adolescent mental health to support national policy, coordination and drive action.
- Build the capacity of district and local level authorities in MHPSS to support local planning and coordination.
- Strengthen existing multidisciplinary collaborative teams to include other key sectors (such as education) to implement the priority MHPSS package.

Service delivery

Multiple platforms exist to support the delivery of MHPSS actions (see Figure 18). Within responsive care, **health facilities** (primary, secondary and tertiary level) remain an important setting to deliver screening through to specialized care. Thailand has a network of mental health hospitals and outpatient services, although availability is constrained in rural areas and there are limited services specific to children and adolescents. Within existing health service settings, further attention is needed to develop child/adolescent-centred and friendly care models, as well as **strengthen integration of mental health into primary level services** to increase accessibility. Stakeholders recommended expanding models of service delivery outside of these 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 (such as Village Health Volunteers) may be one such model for strengthening community-based delivery.

Figure 18. Platforms for delivery of MHPSS



This figure demonstrates how existing platforms 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 and targeted interventions to 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 recommended, 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 the potential to support community and school-based delivery of MHPSS. Young people in particular emphasized that adolescents and children often turn to peers first for help, who 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, mental health 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 nominated school-based delivery as essential to the effective implementation of MHPSS, with a focus on improving early identification and screening, contributing to multidisciplinary and continuing care and, most significantly, actions to build individual assets, promote positive peer relationships and create safe learning environments. The current school psychologist programme, school health programme and life skills education are important existing models for strengthening the delivery of MHPSS actions. The HERO programme was highlighted as a model of school-based delivery that could be strengthened to more effectively implement some key MHPSS actions (such as screening). The need for new mechanisms to improve the engagement of schools with parents, carers and communities was noted by some stakeholders.

The potential of **online and digital platforms** has received increasing recognition, particularly in the context of COVID-19. Young people and other stakeholders noted that several hotlines and websites for mental health currently exist, providing information, mental health literacy and referral linkages. However, these platforms are currently underutilized, with the potential to make better use of online technology to support counselling, telehealth for mental health care, interactive parenting programmes and integrating mental health into academic online education for students. Digital platforms to improve school safety (including in relation to mental health) are also currently being piloted by the Ministry of Education (MOE Safety Centre). Young people particularly highlighted the opportunity to integrate MHPSS into platforms commonly used by children and adolescents (Facebook, Twitter, Clubhouse, Tik Tok), particularly with the expansion of peer-led platforms during COVID-19. For example, approaches 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 were highlighted as actions that could be delivered through peer-led and social media platforms. Sectoral stakeholders also highlighted this potential, but noted the need for greater investment in technology and skilled expertise to support online delivery and strategies to ensure quality (particularly peer-led initiatives).

Justice settings are also important for delivery of screening, referral, targeted interventions to address risk factors (including harmful substance use) 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, such as the 'Project on Enhancing Cooperation in Protecting the Rights of Children in Conflict with the Law (CPC)'. This was initiated by the Central Juvenile and Family Court in 2015, funded by The Health Promotion Foundation (Thai Health). The project was piloted for two years in 12 provinces and was found to be an effective model for delivering child-centred care to those in contact with the justice system. In each province, the chief judge of the provincial court chaired a working committee comprising officials from relevant sectors in (mental health, social welfare, schools) to promote long-term welfare and reduce recidivism. Under the Criminal Procedural Code, psychologists are also required to support children who have been victims or witnesses of crime

during interrogation. Justice sector stakeholders also noted the significant but informal role that police and other frontline workers have in providing social welfare, and the potential to improve delivery with more formal training and support.

All sectors noted significant barriers impacting on equitable access to MHPSS. Rural and remote communities, undocumented migrants, ethnic minorities and hilltribes 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.** Stakeholders recommended further research 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 action.
- 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.

Standards and oversight

Several recommendations were made to strengthen the quality of MHPSS and oversight. At a national level, the Department of Mental Health was identified 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, oversight in relation to actions against the other tiers (prevention and promotion) is less clearly articulated.

Updated technical guidance and operating procedures are needed to reflect the changes to the Mental Health Act, specifically to address provider misconceptions that parental consent is a mandatory requirement for mental health services for adolescents under the age of 18 years. Additionally, improved tools to support early identification and screening for common mental health conditions among children and adolescents are needed, most notably for use by non-health providers. This includes locally validated tools (including for ethnic communities) and standardization across sectors about which tools should be used in which settings. As an example, the Department of Justice is collaborating with Kasetsart University to develop a validated screening tool for children in conflict with the law.

Also noted was the need for standardized protocols and procedures for referral within sectors (for example, within child protection) and between sectors (for example, from schools to health services). Unclear, inefficient and onerous administrative requirements were highlighted as key barriers to timely referral, resulting in poor access to care and reliance on informal, fragmented networks. 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.

Importantly, a national standard for counselling services is currently being developed, headed by the Director of the Department of Mental Health with the Director of CAMHRI acting as secretary. These standards will be cross-sectoral and apply to all settings where counselling services are delivered, to support accreditation, quality assurance and oversight.

Within the justice sector, several recommendations were made to revise protocols and processes for dealing with children and adolescents who come into contact with the justice system, either as victims or alleged offenders. These include strengthening protocols for judicial officers to minimize adverse impacts on child victims, including harmful impacts during trial processes (such as requirements to repeatedly recount traumatic events). Similarly, justice stakeholders recommended improved protocols and processes to support early identification, assessment and screening for mental health conditions to minimize harmful impacts on young offenders' mental health, and greater recognition of the links between mental health and behavioural problems/conflict with the law.

As noted above, stakeholders highlighted a need for greater regulation of the private sector and NGOs with respect to MHPSS.

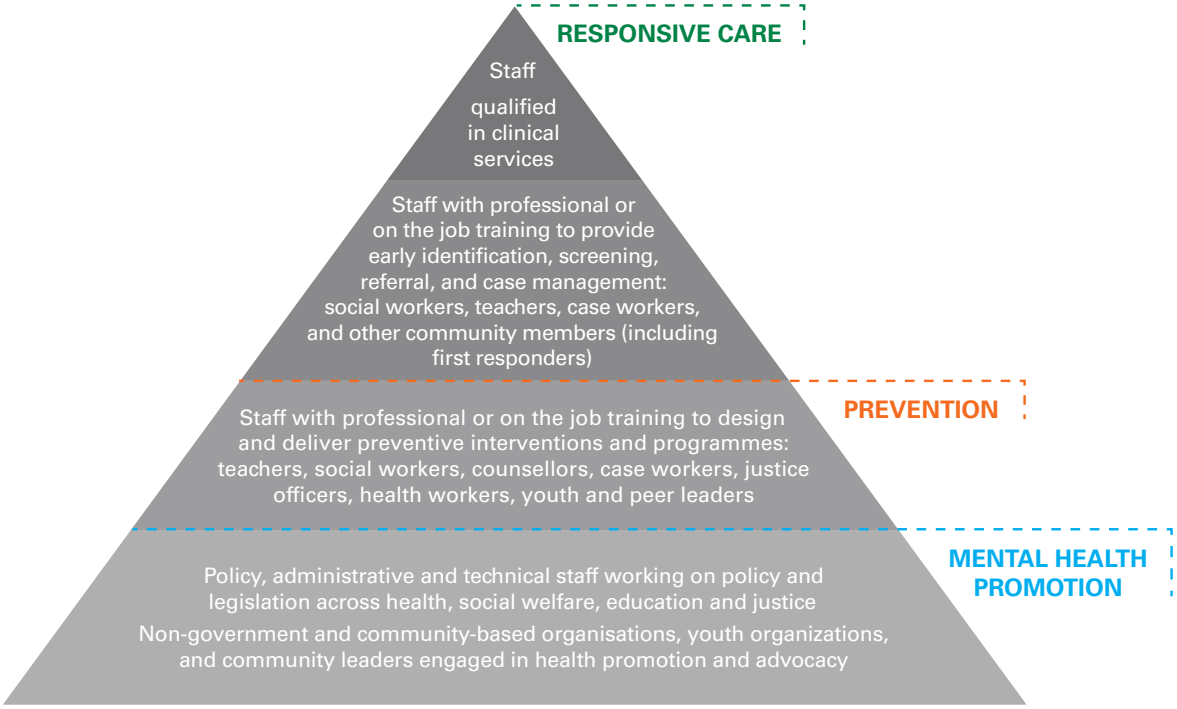
KEY RECOMMENDATIONS – STANDARDS AND OVERSIGHT:

- 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 referral (within and between sectors), with clearly defined roles and accountability of key actors.
- Develop standard operating procedures across agencies to support coordinated care of children and adolescents engaged in child protection or justice settings.
- Update 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

The multisectoral MHPSS workforce is challenging to define as it is diverse and dynamic, incorporating professional and paraprofessionals, including specialist providers whose primary roles relate to mental health, through to providers and volunteers who may be required to deliver some aspect of MHPSS but for whom this is not a primary responsibility. The three tiers of MHPSS action (responsive care, prevention, mental health promotion) can be coarsely mapped against the corresponding multisectoral mental health workforce as shown in Figure 19.

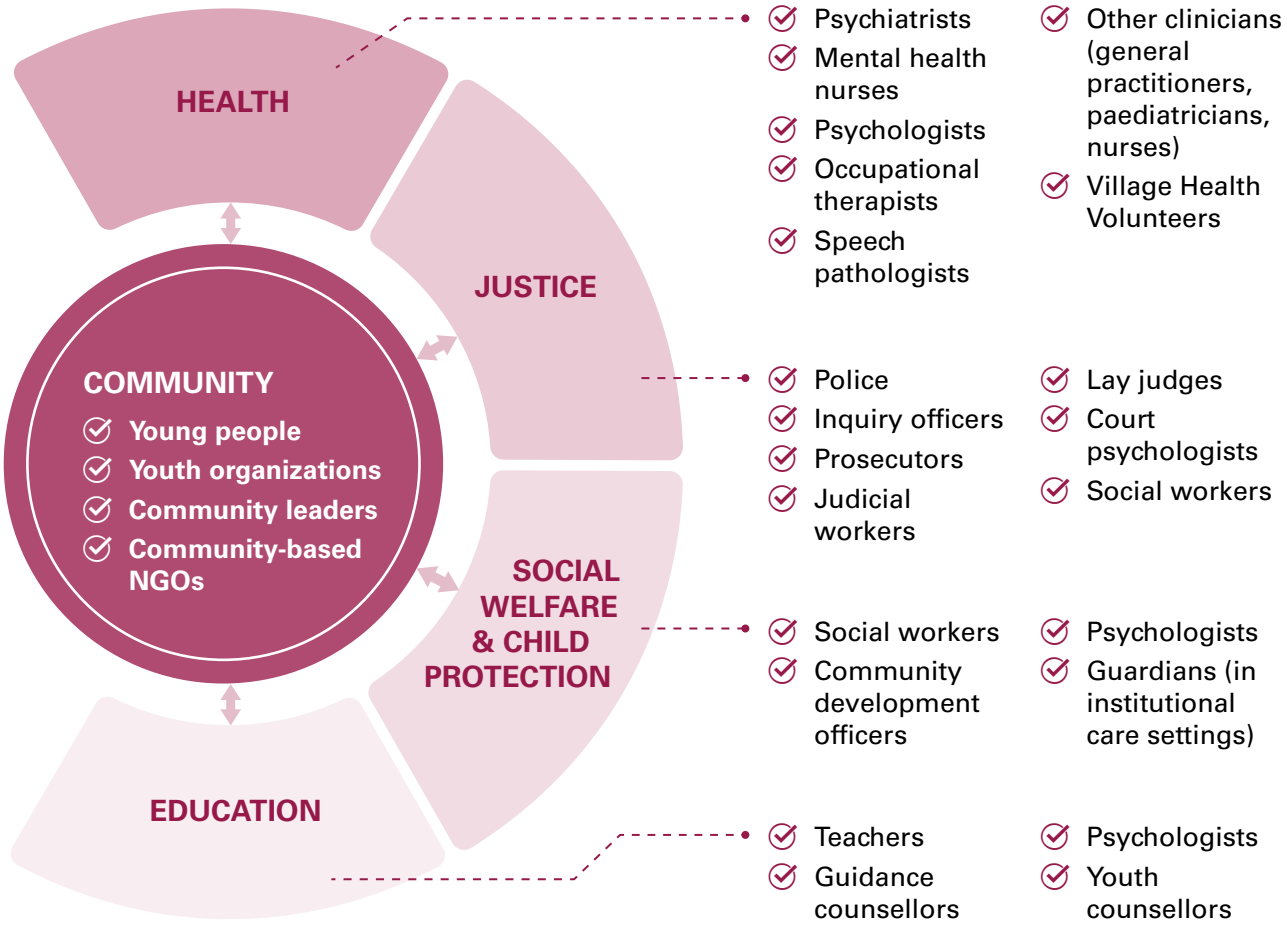
FIGURE 19. KEY TIERS OF THE WORKFORCE REQUIRED TO ENSURE MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT



The current workforce

In Thailand, the broad MHPSS workforce includes public, private and non-government actors across the health, education, social welfare/child protection, justice and community sectors (see Figure 20).

FIGURE 20. MULTISECTORAL MENTAL HEALTH WORKFORCE



All sectors identified workforce shortages as a major challenge impacting on implementation of MHPSS policy and programmes. Limited numbers of professionals trained to deliver components of MHPSS (health professionals, teachers, school counsellors and educational area psychologists, social workers and court psychologists) contribute to constraints on service delivery, very high case-loads, and over-reliance on tertiary services leading to referral bottlenecks and delayed access to care. 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, stakeholders also emphasized the need for providers with diverse gender, ethnic and cultural backgrounds so that communities have access to an appropriate and trusted provider.

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 5 outlines key recommended roles by sector.

Within the **health sector**, specialist clinicians (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. Thailand has an estimated 14.4 mental health clinicians per 100,000 population (0.99 psychiatrists, 0.75 psychologists and 6.74 mental health nurses).[30] However, resources for children and adolescents are much more limited. There are only 196 psychiatrists with specialized training in child and adolescent mental health in the country.[13] Other studies report that there are also limited numbers of other clinical professionals with the skills to provide counselling and other services to children and adolescents (such as occupational therapy and speech pathology), and those available mainly work in specialized health facilities concentrated in urban areas.[30]

To address this, stakeholders recommended strengthening collaborative care models by integrating mental healthcare into the roles of other clinicians (including those focused on physical healthcare), supported by specialist psychiatrists and tertiary facilities where needed. Integrating mental health into the roles of Village Health Volunteers was also recommended, particularly actions that could be effectively delivered at community level (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 MHPSS workforce. Teachers are expected to play a significant role in the delivery of MHPSS actions in relation to responsive care and prevention. The school-based HERO and SAFE-B-MOD programmes define the role of teachers in providing screening, referral and behavioural modification to manage uncomplicated mental health conditions in school. Many stakeholders noted the very heavy workload expected of teachers, with a significant time and administrative burden associated with conducting school-based screening, home visits and education about mental health, in addition to other academic responsibilities. Many MHPSS roles were seen by teachers as an add-on to their academic role, rather than integrated into their main role. Insufficient numbers of school counsellors and limited collaboration and supervision provided by senior-level psychologists (educational area) was also raised as a key challenge, particularly in the context of increasing mental health needs as a result of COVID-19.

To address the considerable burden on teachers (in addition to their education roles), stakeholders recommended increasing the number and capacity of psychologists and counsellors in each school, noting that these providers should have greater responsibility for whole-of-school mental health programmes and coordinating action with teachers, parents and students. Expanding the school guidance counsellor programme beyond the current focus on senior students to include junior secondary and primary level was also recommended. Increasing the role of youth counsellors (students provided with training and support) to include early identification, referral and provision of psychosocial support to peers was also recommended.

The **social service workforce,** including social workers and psychologists, encompasses a broad professional workforce in Thailand that works across multiple sectors and is employed not only by the Ministry of Social Development and Human Security (encompassing child protection), but also by the Ministry of Public Health (healthcare) and the Ministry of Justice. Many are also employed through NGOs. There are an estimated 3,008 registered social workers in Thailand, whose qualifications are recognized under the Social Welfare Promotion Act and registered with the Thailand Social Workers Professions Council, a ratio of 20.1 social workers per 100,000 children.[14] The number of other social welfare workers is not known. Social workers typically work as part of multidisciplinary teams, with almost a third of Thailand's workforce engaged in child and adolescent services and roles defined by the Child Protection and Mental Health Acts. Current roles include screening for mental health

conditions (particularly for children with high-risk exposures), case management, counselling, targeted interventions to address risk factors, programmes to support positive parenting, social security provision, and advocacy. Workforce constraints and high case-loads were reported among social workers with experience and training in child welfare, protection and mental health. Social welfare stakeholders recommended that other providers, such as youth shelter workers in juvenile justice settings, also receive mental health training to support screening and provision of care to at-risk young people. Other key challenges noted by stakeholders include difficulties attracting staff to work in social welfare institutions because only temporary contracts can be offered (rather than full civil servant contracts), lack of supportive supervision and restrictions on the licencing of clinical psychologists, particularly those working at community level.

Within the **justice sector**, stakeholders highlighted that frontline officers (police and judicial officers such as public prosecutors) are frequently called upon to provide social welfare or deal with acute mental health and behavioural concerns (particularly in the context of insufficient coverage of social workers), 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 and mental health first aid, preventive programmes (in the community as well as through linkages with schools) as well as deliver community-based programmes to promote mental health literacy and address stigma and discrimination. Health workers, Village Health Volunteers and social workers also provide MHPSS at community level.

Table 5. Overview of key MHPSS roles, by sector

Sector	Provider	Responsive care	Prevention	Promotion
Health	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 clinicians	Screening, diagnosis and management as part of a team, supported by specialists as needed	Supporting positive parenting and targeted interventions to identify and support children and families at risk Support to school-based approaches	Support mental health literacy
	Village Heath Volunteers	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

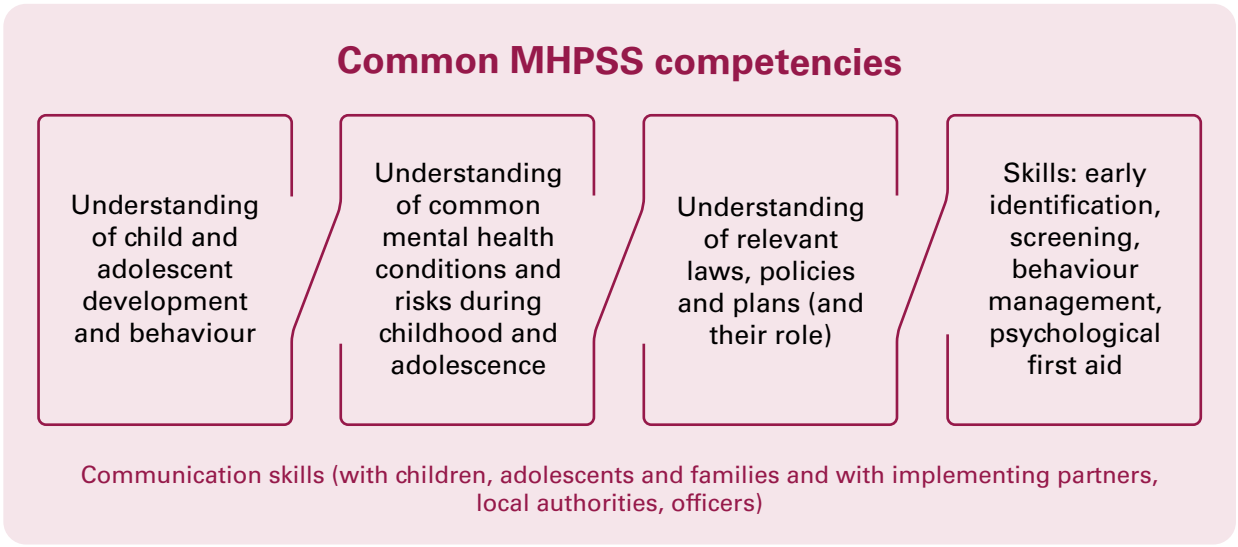
Sector	Provider	Responsive care	Prevention	Promotion
Education	Teachers	Early identification, screening and referral Behaviour modification for uncomplicated cases Support continuity of care and ongoing education	Support social and emotional learning, skills and resilience; promote positive peer relationships (curriculum-based and participation in whole-of-school approaches)	Supporting mental health literacy and anti-stigma through greater engagement with families and school communities
	Guidance 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	
	Education office 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	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 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 prosecutor, 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 skills training for young offenders)	

Sector	Provider	Responsive care	Prevention	Promotion
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

Stakeholders identified common competencies that are required of the multisectoral MHPSS workforce (see Figure 21). Particular emphasis was placed on improving understanding of child and adolescent mental health and related behaviours, as well as specific skills in relation to screening, managing difficult behaviour and dealing with crisis (including psychological first aid).

FIGURE 21. COMMON CROSS-SECTORAL MHPSS COMPETENCIES



There are four child and adolescent psychiatry training centres in Thailand, overseen by the Royal College of Psychiatrists of Thailand.[101] While this has been important in building a specialized **healthcare** workforce, some limitations in current training have been noted. A recent study found that child and adolescent psychiatrists tended towards over-reliance on pharmacological treatment and under-use of psychotherapy, especially classical and psychodynamic methods.[101] 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 Mental Health** should have an overall coordinating responsibility for the development and implementation of training, not only of clinical health personnel but also 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 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 teachers and educators, social workers, police and justice officials with an emphasis on improving understanding of child and adolescent mental health, and skills to recognize and manage mental health conditions.

For the **education sector**, limited teacher training in mental health and well-being was described as contributing to a lack of recognition of mental health conditions and behavioural problems. The HERO and SAFE-B-MOD programmes were noted examples of multisectoral collaboration to support teacher training in mental health. Within the education sector, the **Office of the Teacher Civil Service and Educational Personnel Commission** reporting to the **Ministry of Education** was identified as the main agency with responsibility for workforce planning, with coordination with the Provincial Education Office for planning in relation to school psychologists. The Educational Service Area Office is responsible for the training of guidance counsellors and teachers; however, not all Educational Service Areas currently have programmes in place. While programmes such as HERO have been positive, some stakeholders stated that two days of training was insufficient, particularly for building skills in managing difficult behaviours, and that teachers required ongoing training and support. Education sector stakeholders recommended training for all teachers in supporting children with developmental disorders, learning difficulties and other needs. Improved training for youth counsellors was also identified as a priority. Prior to COVID-19 the training programme relied on face-to-face approaches, with plans to now develop alternative platforms for training. New manuals to support the programme (for school principals and teachers, youth leaders and youth counsellors) are currently under review and counselling training for guidance counsellors and teachers will also be delivered to support the programme. It was noted that the numbers of students engaged in the programme as counsellors has also been decreasing, with efforts under way by the Ministry of Education to improve training, support and supervision, and retention.

Within the **social welfare sector,** mental health is included in undergraduate education for social workers through the Social Administration Faculty. Six universities currently offer social work degrees; however, currently only two provide a mental health education and training programme. The Social Work Professions Act (2013) requires licencing and qualification with a relevant degree for entry-level social work positions. However, many social workers employed prior to 2013 hold alternate degrees in less related fields, or have only a diploma or certificate.[14] Social worker licences can also be obtained by those with alternative qualifications provided that they have worked in social work or a related field for one year. The Thailand Association of Social Workers is also engaged in developing national practice standards and a code of ethics governing practice. There was no information regarding the opportunities for social workers, community development officers or others engaged in the social welfare sector to receive skills-based mental health training through placements or other supports for ongoing education.

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. In collaboration with the Department of Health, the Department of Justice also operates a centre based in Samut Prakan that supports training of psychiatrists (in addition to the care of children and adolescents with mental health needs). In addition to pre-service training, stakeholders across sectors also highlighted the need for continuing training and support to maintain quality, motivation and awareness of new policies and plans.

There were also some recommendations for actions to improve support and supervision of the mental health workforce. These included establishing multidisciplinary teams, increasing the numbers and role of school psychologists to support teachers and school guidance counsellors, and improving the salary and remuneration of social workers 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 sharing of knowledge, experience and support and as a platform for identifying and supporting programmes (schools, communities) in need. 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, particularly at community level. This includes clearer guidance for teachers, social workers, youth counsellors and primary-level health providers who constitute local multidisciplinary teams, and clear protocols for managing and referring children and adolescents with mental health conditions. Attention to the mental health needs of providers is also important, reflecting the often stressful and sometimes distressing roles that are required. Overall, greater coordination across sectors to map the mental health workforce, roles and competencies is required 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:

- Undertake further detailed mapping of the multisectoral mental health workforce and existing mental health competencies to identify gaps (numbers, skills, distribution) across the health, social welfare, justice and education sectors.
- Integrate and strengthen pre-service mental health training for health, education, social welfare (social workers and para-social workers) and justice sector providers, coordinated by the Department of Mental Health in collaboration with relevant sectoral agencies.
- Strengthen job aids, tools and protocols to support key MHPSS roles (screening, referral, behaviour management and mental health first aid).
- More explicitly integrate MHPSS actions into the defined roles and performance indicators of key cadres (teachers, counsellors, social workers and justice officers).
- Establish mechanisms for ensuring supportive supervision, including access to MHPSS for providers.

Budget and financing

Thailand has achieved near-universal health coverage through various health and social insurance initiatives. Mental healthcare provided through some clinical settings (such as hospitals) is included in the UCS package and several related medicines are included in the National List of Essential Medicines. However, there are some important gaps. Undocumented migrants and children who have migrated from rural to urban areas are not covered by the UCS if they are not registered as a local resident, except under emergency conditions. The justice sector, for example, described significant delays in accessing non-emergency mental healthcare for migrant children in conflict with the law, as the court is expected to pay for mental health services that are not covered by the UCS, and this approval process can be time-consuming. The need for authorized referral from a primary health provider to receive UCS-covered care was also noted as a barrier for locally registered residents, particularly for long-term care where multiple referrals and lack of available UCS-covered facilities in the local area contribute to delays and/or out-of-pocket expenses.

Government expenditure on mental health from 2014 to 2017 was estimated to be between 0.3–2.4 per cent of total government health sector expenditure, of which more than half was spent on mental health hospitals.[13,16,102] There are limited available data on other sector spending on MHPSS-related services and programmes. However, stakeholders across sectors emphasized that current budgets were insufficient to support implementation, particularly with increasing demand for MHPSS as a result of COVID-19. Additionally, stakeholders noted that budget processes are complex and cross-sectoral coordination is limited, leading to a lack of cross-sectoral planning and budgeting. Some MHPSS-related programmes are not adequately costed or budgeted for (for example, educational area psychologists), or are only funded as short-term or pilot projects without a long-term budget to support programmes. A key challenge is the ability to accurately apportion the human and other resources required to implement MHPSS, particularly for programmes, services and supports provided outside of the health sector, in the absence of a detailed and costed multisectoral mental health plan that clearly defines the roles and responsibilities of each sector.

Thailand's budgeting approach is largely driven by high-level, long-term strategies, as reflected in the 20-year National Strategy (Level 1 Plan) and the related Master Plan (5-year plan) and the National Economic and Social Development Plan. There are four key actors with respect to public financial management at a national level. The BoB, under the Office of the Prime Minister, is the central agency responsible for budget policy, planning and implementation, including developing an annual budget strategy aligned with the milestones set out in the 20-year Strategy and related plans. The

Fiscal Policy Office, within the Ministry of Finance, has responsibility for revenue forecasting and the country fiscal sustainability framework. The Bank of Thailand, in coordination with the BoB and NESDC, provides economic analysis and advice. The Office of the NESDC, also under the Office of the Prime Minister, is the lead agency for formulating the five-year National Economic and Social Development Plan, with a mandate to provide recommendations to the Cabinet. The NESDC has a critical role in advocating for, and putting forward, new policies for inclusion in the National Economic and Social Development Plan, which is informed by sectoral ministry proposals and advocacy.[103] Together, these agencies have overall responsibility for determining the overall budget envelope, total expenditure and the size of the fiscal balance, and how to finance this gap.

The budget preparation of each government unit is undertaken one year in advance due to long approval processes. Line ministries are responsible for assembling budget requests from all units and submitting them to the BoB. Budget review specialists from the BoB are organized according to the ministries. For example, all public schools under the Ministry of Education submit their annual budgets to this ministry, and public hospitals to the Ministry of Public Health (or local government). Schools affiliated with the local government submit their annual budget to the local government, and then to the Ministry of Interior. The primary consideration of the budget is its consistency with the BoB's annual budget strategy, in alignment with the 20-year National Strategy and related Master Plan (5-year), the National Economic and Social Development Plan, and major government policies and priorities. Each line ministry prioritizes budget requests, and the BoB analyses past budget reimbursement performance (for existing programmes) and reprioritizes the budget proposal as needed. The BoB will then propose a budget bill to the Cabinet for approval with the drafted Budget Act. This is then considered by the House of Representatives (first reading) and Senate (second reading), and once approved, is published in the Royal Gazette. In this context, line ministries have an important role in putting forward new policies to the Cabinet for approval and inclusion in the annual budget strategy.

The process of budget setting and allocation across multisectoral operations is a notable challenge. Different aspects of MHPSS delivery are incorporated into the annual budgets of different units and ministries, including budgets in relation to infrastructure and human resources. Although the BoB recognizes agenda-based budget frameworks with the annual budget strategy, budget requests and planning remain the function of each line ministry. Budget development and allocation are aligned with ministry units, and not agenda-based or coordinated across units by a common goal or objective in relation to MHPSS. Therefore, there is limited coordination across units and sectors during budget development, with gaps in MHPSS inclusion within individual unit budgets submitted to the BoB. Competing interests and priorities and differing levels of awareness and perceived responsibility for mental health contribute to a lack of coordination. Within the BoB itself, large workloads and lack of cross-sectoral review processes and expertise in mental health contribute to limited alignment during budget allocation and the inefficient use of resources. Improving monitoring and evaluation to support evidence-based budget prioritization was identified as a key step to improve budgeting for MHPSS. Although the new Budget Act requires a four-year Medium Term Expenditure Framework, the BoB currently will not commit to a budget for four years as the approval process as per the Budget Act remains an annual process.

Some stakeholders also noted challenges in budget planning at subnational level. Several described activities or responsibilities included in MHPSS-related policies as not being costed and that no specific budget was provided at provincial or district level for implementation. For example, it was reported that educational area psychologists do not have a specific budget for their role or to support activities outlined in related policies, and teachers are required to personally cover the costs of conducting activities such as after-hours home visits specified in school mental health initiatives. For the mental health workforce, permanent officers of the Government receive a salary and benefits, but a salary is provided only for temporary and project-based staff. Budgets for training and capacity building are also limited.

In addition to government budgets, other sources of funding for mental health include charitable organizations, international and local NGOs, United Nations agencies (such as UNICEF) and public organizations (such as the Equitable Education Fund). UNICEF, Save the Children and the Thai Health Foundation provide funding, technical assistance and a professional network for child and

adolescent-related projects delivered by both NGOs and government units. Private firms were reported by stakeholders to provide a small amount of funding, career training and job opportunities as part of corporate social responsibility programmes.

Clinical health services in relation to the management of mental disorders in public facilities are included in universal health coverage and other social insurance schemes. Inpatient care, some outpatient services and some mental health-related medicines are provided free of charge to the population that is covered by these programmes. However, some marginalized groups (such as undocumented migrants) are excluded from these schemes.[104] Fees for other services such as counselling through private organizations and NGOs are charged in some settings.

Stakeholders made a number of **recommendations** to improve budgeting for MHPSS. The first was to include a national mental health plan or goal in the upcoming 13th National Social and Economic Development Plan (2023–2027) through the Office of the NESDC. The second was to establish MHPSS as a cross-sectoral budget programme (there are currently 25 such programmes) with a focal point (or host stipulated in law) with responsibility for administration, monitoring and supervision of the agencies involved in action plans for MHPSS. An example is the Equitable Education Fund, which has a long-term budget and multisectoral engagement to achieve clear education objectives. Third, it was recommended that a national, cross-sectoral body for mental health be established to support agenda-based budgeting processes that would be better aligned with MHPSS objectives; and greater sectoral collaboration in budget planning. Additionally, the national security local fund managed by the Local Authority Administration was identified as another potential source of local level resourcing for MHPSS. To support budgeting, it was also recommended that a minimum-service package for child and adolescent mental health (that could encompass the tiered actions defined in the framework) be developed to allow these components to be more accurately costed.

Public financial resources were identified as the main source of funding for MHPSS. However, there was a recommendation to consider how a public fund, such as the Thai Health Promotion Foundation, could provide resources to support research and implementation activities, similar to the current fund for primary prevention and health promotion as part of the budget of the Ministry of Public Health and Thai Health. This could include funding for pilot programmes with a robust evaluation framework to support scale-up of effective programmes. Charitable funds and financial support from agencies such as UNICEF were also identified as important for supporting research and new innovations/programmes.

KEY RECOMMENDATIONS – BUDGET AND FINANCIAL RESOURCES:

- Expand mental health services included within UCS.
- Include a national mental health plan/goal in the 13th National Social and Economic Development Plan.
- 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 (including defining the infrastructure, human resources and service-delivery resources required by sector).
- Establish a national, cross-sectoral planning body and cross-sectoral budgeting committees for MHPSS to support efficient and coordinated budget requests and processes, and consider developing a mid-term expenditure framework.
- Develop a financing strategy for MHPSS (through a cross-sectoral budget line or revolving fund).
- Consider establishing a public fund, such as the Thai Health Promotion Foundation, to provide additional funding for prevention, promotion, research and innovation with respect to mental health.

Participation

Mental health-related stigma and discrimination and lack of mental health literacy are major barriers to seeking support and services. Stakeholders reported that terms like 'mental health' or 'psychiatry' have negative connotations, and mental health stigma remains a significant challenge in society. It was 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. International studies have also reported high rates of stigma relating to major depressive disorder, and this has contributed to low rates of help-seeking and undertreatment.[105] A recent study found that 12 per cent of Thai patients with major depressive disorder experienced significant stigma, with younger ages more likely to experience stigma.[67]

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, including those with lived experience of mental health conditions, to participate in setting high-level priorities and designing policies and programmes is critical – as is building the capacity of youth advocates and leaders. Recent initiatives to decentralize planning and budgeting to Local Administrative Organizations will also give greater autonomy to communities to respond to local priorities, although the need to increase the capacity of local authorities in MHPSS was noted.

At an implementation level, young people themselves were identified as important implementation partners. Specifically, providing opportunities for training and capacity building for youth leaders, 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 more formally establishing roles for youth volunteers through schools (OBEC), the Police Bureau, and the Department of Health Service Support. It was also recommended that provincial subcommittees of the National Mental Health Commission should include youth representatives, or that an adolescent task force be established drawing on members of the Children and Youth Council. Many stakeholders also noted that there was a need for more formal mechanisms for linking government agencies directly with communities to identify needs and support the implementation of community-based actions.

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. The Department of Mental Health currently provides an 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, while consideration should also be given to providing a more child and adolescent-friendly system for feedback.

KEY RECOMMENDATIONS – PARTICIPATION:

- Build capacity and increase opportunities for young people and youth organizations to participate in MHPSS policy and planning.
- 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 youth volunteers.
- Include youth representatives in provincial level National Mental Health Commission subcommittees and/or establish an adolescent task force with members of the Children and Youth Council.
- Strengthen mechanisms for feedback and complaints, including for feedback on non-health settings and in more child and adolescent-friendly formats.

Data, health information and research

Several needs relating to data and information 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 are 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 and reported by the Department of Mental Health (such as suicide rates). 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.

Several stakeholders highlighted the need to include mental health indicators in the routine data collection of other sectors outside of health, and improved sharing of data within sectors and between sectors to support planning and implementation. For example, better 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. Scaling up initiatives like the 'Child Shield' surveillance system would also support early identification of children and families at risk and link them with appropriate services. Other key data sources include the School Health HERO database, the Child Protection Information System, the One Stop Crisis Centre database, and the Department of Corrections – all of which could be better linked and shared with other sectors to identify mental health needs and the children and communities most at risk.

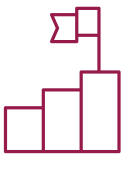
Improved access to data describing the multisectoral system was also a noted priority, including up-to-date information about the multisectoral workforce, MHPSS service availability and distribution, coverage and use of services such as hotlines, and data about non-government actors in MHPSS. To support this, it was recommended that the National Mental Health Plan include a minimum set of harmonized indicators 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 so there could be 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, 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 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.

KEY RECOMMENDATIONS – DATA, INFORMATION AND RESEARCH:

- Integrate child and adolescent mental health indicators into the routine information systems of the education, social welfare and justice sectors.
- 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 effective implementation models.



Key recommendations and conclusions

Children and adolescents aged 0–18 years in Thailand experience a high burden of poor mental health and unmet needs for services and support to respond to mental health conditions, prevent poor mental health, and ensure safe and enabling environments for psychosocial well-being. Thailand has made important efforts to address child and adolescent mental health. National policy and legislative frameworks are broadly supportive, recognizing, at least in part, the specific needs and considerations for this age group and adopting a national, multisectoral approach to mental healthcare, prevention and promotion. While a large focus of the current response 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, assessment and multidisciplinary management, as well as programmes in schools, child protection and justice settings to address risk factors.

Despite this progress, this analysis has identified some important gaps in the current MHPSS response. These include the accessibility and availability of child- and adolescent-friendly and multidisciplinary care for mental health conditions (particularly outside of specialized tertiary and institutional settings), comprehensive and coordinated whole-of-education approaches to mental health promotion, a national (and targeted) approach to support nurturing and responsive care provided by parents and carers, and coordinated programmes to support healthy peer relationships and address peer victimization. There are also important gaps in relation to programmes reaching marginalized, out-of-school and migrant children and adolescents.

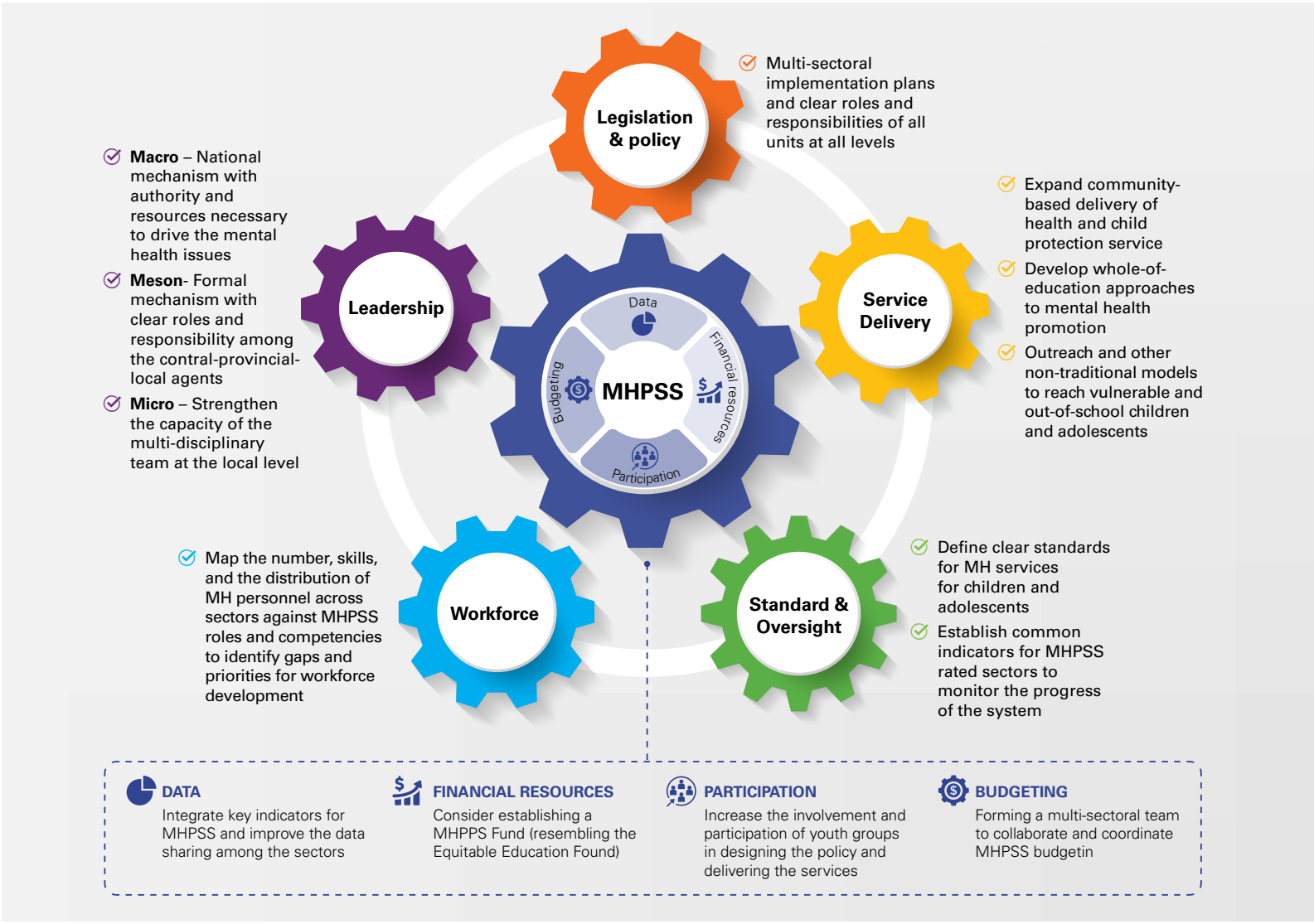
There are also some critical cross-cutting challenges impacting on implementation of MHPSS. While mental health and well-being are integrated to some degree in the sectoral plans of education, social welfare and justice, these generally focus narrowly on specific actions (such as mental health screening or the 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 have contributed to limited coordination across sectors. 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 the health and social welfare sectors, and time-consuming referral from other sectors such as education. Administratively complex and 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, there are a number of overarching recommendations to improve the implementation of MHPSS for children and adolescents in Thailand. These are summarized in Figure 22 and described below.

FIGURE 22. OVERARCHING RECOMMENDATIONS TO STRENGTHEN THE MULTISECTORAL MENTAL HEALTH SYSTEM



1. At national level, strengthen the National Mental Health Plan and Mental Health Act to more clearly articulate the specific considerations and protections for children and adolescents, and develop a multisectoral plan (and structure) for implementation of MHPSS, including cross-sectoral performance indicators.
2. Establish a national multisectoral council or subcommittee for child and adolescent mental health with responsibility for coordinating implementation.
3. At provincial, district and subdistrict levels, strengthen the role of subcommittees of the National Mental Health Commission and coordination with Ministry of Interior and Local Administrative Organizations (including through capacity building of subnational leadership in mental health) to develop local, multisectoral implementation plans, resource allocation and coordination.
4. Strengthen national, standardized protocols for child and adolescent health across government agencies, including validated screening tools and guidance on use, referral procedures, non-specialist management, and management of children and adolescents engaged in the child protection and justice sectors. Develop national standards for child and adolescent mental health services across sectors.
5. Increase government budget investment in child and adolescent mental health across the tiers of care, prevention and promotion. To support this, the BoB, with recommendation from the NESDC, should propose MHPSS as a new, agenda-based budget framework (led by the Ministry of Public Health) as part of the annual budget for consideration by the Cabinet. Also, establish MHPSS as a cross-sectoral budget programme with a focal point (host) (such as the Department of Mental Health/National Mental Health Commission) designated for administering the budget and monitoring and supervising other agencies involved in the action plans.
6. Strengthen the multisectoral mental health workforce through further in-depth mapping to identify key roles across sectors (health, education, social welfare and justice) against the MHPSS priority actions and the required competencies and training needs to support these roles. Furthermore, improve the integration of child and adolescent development and mental health into the pre- and in-service training of health professionals, social welfare workers, justice sector workers, teachers and other school-based staff in alignment with the roles and responsibilities with respect to MHPSS.
7. Improve the collection, use and accessibility of data at national and subnational levels – including data to identify mental health needs, support planning and implementation, and track progress. Develop a minimum set of MHPSS-related indicators harmonized across sectors, including performance indicators related to multisectoral collaboration. Develop user-friendly platforms (such as a data dashboard) to improve the access of service providers and communities to mental health data.
8. Increase opportunities for children and adolescents 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). Improve child- and adolescent-friendly mechanisms for providing feedback on MHPSS programmes and mental health services.
9. 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).

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Appendix A:

Workshop agenda, Prioritization Tool and Interview Guide

COUNTRY-LEVEL CONSULTATION WORKSHOP ON THE MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES IN EAST ASIA AND THE PACIFIC REGION

Programme outline

Day one

Time	Activity	Facilitator
Session A: Introduction		
9:00 – 9:15	Welcome remarks and introductions	UNICEF / Country TAG chair
9:15 – 9:30	Overview and objectives of the project and workshop	Burnet
Session B: Overview of the conceptual framework for MHPSS		
9:30 – 10:15	The conceptual framework for MHPSS *Presentation of the framework* *Questions and discussion*	Burnet to provide overview Country partner / UNICEF to help facilitate discussion
Session C: Prioritizing actions and sectoral roles		
10:15 – 10:30	Introduction to the proposed actions of the conceptual framework *Presentation of the actions against each tier* *Introduction to potential sectoral roles*	Burnet to provide overview
10:30 – 10:45	Overview of the prioritization tool and tasks *Introduction to the online tool and tasks to be completed before the next meeting*	Burnet to provide overview
10:45 – 11:00	Questions and next steps	UNICEF / Country TAG

Participants to complete the online tool in preparation for the second workshop

DAY TWO

Time	Activity	Facilitator
Session A: Introduction and recap		
9:00 – 9:15	Welcome and recap	UNICEF / Country TAG chair
Session B: Defining a minimum-services package for MHPSS		
9:15 – 9:30	Presentation of the key findings from the online tool *Outline of the actions prioritized for the minimum-services package*	Burnet
9:30 – 10:30	Discussion and agreement on the minimum-services package *Breakout rooms by sector to discuss:* • Agreement on actions included • Any actions missing or need modification • Agreement on timeframe Each group feedback	Country partner / UNICEF / Country TAG chair
10:30 – 10:45	Break	
Session C: Identifying sectoral roles		
10:45 – 11:00	Presentation of the key findings from the online tool *Recommendations for sectoral roles for key actions*	Burnet
11:00 – 12:00	Discussion and agreement on sectoral roles *Breakout rooms by sector to discuss:* • Agreement on lead sector • Recommended roles for other supporting sectors *Each group feedback*	Country partner / UNICEF / Country TAG chair
12:00 – 12:15	Questions and next steps	UNICEF / Country TAG

Example of the online prioritization tool

MHPSS Prioritisation Tool

Thank you for participating in this online consultation.

In brief, this prioritisation tool seeks your feedback on a series of actions to strengthen mental health and psychosocial support services (MHPSS) for children and adolescents in your country. We will collate all responses and discuss these at our workshop to define a key package of actions (a minimum-services package). You can find more information on the aim of the project and the framework of actions here:
https://www.dropbox.com/sh/vp3odcso41p7r20/AADXuS7HzXWqlzuy1ykVSAV1a?dl=

This tool will present you with a series of actions in three groups: actions to ensure an enabling and safe environment for mental health promotion; actions for prevention of mental health problems in the immediate social context ; and actions to ensure accessible and responsive services for mental health problems.

For each action, please indicate what priority you believe it is for your country. For actions that are rated as high and medium priority, we will then ask some brief questions about sectoral roles and timing of implementation. We will also ask for any additional actions that should be included.

Your responses will be anonymous and confidential. You can save and return to this tool at any time, but please complete it by the end of today so that your responses can be included in the key findings presented at the next workshop.

** If possible, please complete this form in one sitting. You can also save and return to it but clicking the button 'save and return' at the bottom of the page. It will ask for your email address- this will only be used to send you a link and will not be saved with your responses.

For any further info or clarification please contact A/Professor Peter Azzopardi on Peter.azzopardi@burnet.edu.au

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Demographics

Which country do you work in?
* must provide value

- ○ Malaysia
- ○ Papua New Guinea
- ○ Philippines
- ○ Thailand

reset

What sector do you mainly work in?
* must provide value

- ○ Health
- ○ Education
- ○ Social Welfare
- ○ Justice
- ○ Other (specify)

reset

What organisation do you represent?
* must provide value

- ○ Government
- ○ Non-government and civil society organisations
- ○ UN agency
- ○ Private sector
- ○ Professional associations (such as psychiatry, social work)
- ○ Youth-focused organisations
- ○ Other (please specify)

reset

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Domain	Subdomain	Recommendation
Accessible and responsive services for mental health problems (clinical and sub clinical disorders)	Screening and early identification of needs	Screening for those at risk of poor mental health

Specific action required

Routine mental health screening of children and adolescents with high-risk behaviours (e.g. harmful use of alcohol and other substances, sexual risk behaviours)

Priority for including this action in minimum package for MHPSS in your country:
* must provide value

- (●) High
- ( ) Medium
- ( ) Low

reset

Who should be the lead sector?

- ( ) Health
- ( ) Education
- ( ) Social Welfare
- ( ) Justice
- ( ) Other

reset

What other sectors should play a role in this action?

- [ ] Health
- [ ] Education
- [ ] Social Welfare
- [ ] Justice
- [ ] Other

Is this action already being implemented?

- ( ) Yes
- ( ) No

reset

What is your suggested timeline for implementation?

- ( ) Next 2 years
- ( ) 2-5 years
- ( ) 5 years plus

reset

Any challenges or considerations in implementing this action?

Expand

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Country-level validation workshop on the mental health and psychosocial support services in east asia and the pacific region

Programme outline

Time	Activity	Facilitator
13.00 – 13.10 [10 mins]	Welcome, overview and updates on the study	General Director's remarks TAG member introduction (K.Sirirath)
13.10 – 13.15 [5 mins]	MHPSS framework	(Dr.Elissa Kennedy)
13.15 – 13.55 [40 mins]	Key findings	Current response (by sector) (Dr.Tawanchai) Priority MHPSS actions (by sector) (Dr.Bhubate) MHPSS implementation (Dr.Napaphat)
13.55 – 14.35 [40 mins]	Discussion 1 in 3 break-out groups (1) Health, (2) Education and Youth, and (3) Justice and Social Welfare	Discussion agenda: Report validation 1. What specific mechanisms or structures are needed to improve multisectoral coordination for child and adolescent mental health 2. Within each sector, what specific training and other supports are needed to strengthen the workforce who are expected to deliver MHPSS
14.35 – 14.45 [10 mins]	Break	
14.45 – 15.45 [60 mins]	Discussion 2 in 3 breakout groups: (1) Health, (2) Education and Youth, and (3) Justice and Social Welfare	Discussion agenda: priority action areas: 1. Screening, referral and child/ adolescent-friendly care 2. Mental health promotion schools 3. Supporting responsive and nurturing parenting/ caregiving 4. MHPSS for children and adolescents at higher risk (child protection, justice sector, etc.) 5. Way forward & recommendations
15.45 – 16.30 [45 mins]	Reflection from the breakout group discussion and Closing	IPSR presentation General Director's closing remarks

Implementing mental health and psychosocial support services in East Asia and the Pacific

Key informant interview

**Note that sector-specific question guides were also developed and are available on request*

Interviewer ID:		Date (dd/mm/yy):	
Start time:		End time:	
Participant ID:		Sector / organization:	
Current designation / role of participant:			
How is this role related to MHPSS?			
Has the participant had a previous role related to MHPSS? Please describe			
Age of participant		Gender of participant:	
Consent obtained?	YES / NO		

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

Today we will be asking for your views and opinions about how to improve mental health and psychosocial support services (MHPSS) for children and adolescents. This includes your thoughts about the mental health needs of children and adolescents, what role your sector currently plays in delivery of support services, and the challenges and opportunities to improve the delivery of mental health and psychosocial support services.

The session today will take approximately 60 to 90 minutes.

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

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

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

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

Question guide:

Theme	Questions
Mental health needs of children and adolescents	I would like to start by asking what you think the main mental health needs or problems are of children and adolescents in [YOUR COUNTRY]? • Children (<10 years) • Adolescents (10–18 years) • Are there particular groups of children or adolescents who have worse mental health than others, or are at increased risk? Why? **What do you think are the main factors that contribute to poor mental health or well-being of children and adolescents?** • Individual-level • Family-level • Peer • Community • Society **What factors promote good mental health and well-being?** **What impact do you think COVID-19 has had on the mental health and well-being of children and adolescents?**
MHPSS policies and national plans	**I would like to ask you about what is currently being done by your sector / organization to address the mental health and well-being of children and adolescents.** **Are you aware of any government policies, plans or initiatives that relate to mental health of children and adolescents?** • Can you briefly describe these – what sectors do they relate to, what plans or actions do they include for child or adolescent mental health? • To what extent do you think these sectoral plans or policies are being implemented? **What national standards, guidelines, or other tools currently exist to support the delivery of mental health services or programmes?** *If the participant identifies specific policies, please ask them if they would be happy to be contacted by the research team at a later date to help us access these documents for the desk review*

Theme	Questions
Current role in providing MHPSS	**I would like to ask you about the different mental health and psychosocial support services that are provided by your sector/ organization. I will refer to this as 'MHPSS' – which broadly includes services, supports and programmes to respond to children and adolescents with mental health problems, to prevent mental health problems (addressing risk factors), and to promote good mental health.** **Could you talk me through what specific MHPSS for children and adolescents your sector/organization currently provides? We are interested in understanding what services or programmes are provided, who they are for, and how they are delivered** **Which groups of children and adolescents are these MHPSS for? Are any programmes targeted and, if so, to who?** **To what extent are these initiated or led by the Government** • Which ministries? • By non-governmental organizations? • By private sector? • Where they are led by non-government or private sector agencies, what role has the Government had? **Were there any MHPSS that had been implemented your sector/ organization previously but are no longer provided? Why?** **Are there any new MHPSS that are being planned or developed?** *Additional prompts:* **Services** • What MHPSS does your sector/organization provide for children or adolescents who have mental health problems **(responsive care)**? • What MHPSS does your sector/organization provide that address specific risk factors to prevent mental health problems **(prevention)**? • What MHPSS does your sector/organization provide to promote good mental health and well-being **(enabling environment)**? – For example, programmes to address harmful norms or attitudes towards mental health, stigma or discrimination related to mental health, to protect children and adolescents from harm (violence, exploitation, abuse, neglect etc) **Delivery** • Through what mechanisms, systems or platforms are these MHPSS provided? Community-based – Facility-based (health, education, residential care, other) – Online or digital – *[explore what services are provided through which platforms]*

Theme	Questions

	• Who provides MHPSS within your sector/organization and what role(s) do they have in supporting MHPSS?
	  – Who (professional, paraprofessional, volunteer) and what role or tasks do they have in delivering MHPSS?
	  – What training and other supports do they receive with respect to mental health of children and adolescents?
	  » pre-service or in-service
	  » accredited (diploma, degree, etc) or informal
	  » who provides this training
	  – Who is responsible for supervision of these MHPSS roles?
	  – Are these MHPSS workers supported by a professional association?
	  – How are these roles licenced, accredited or regulated? Is there specific regulation with respect to MHPSS roles?
	Linkages
	• Is there any current engagement between your sector/organization and communities to address norms and attitudes related to mental health, stigma, care-seeking behaviour, or other factors that influence mental health?
	• What linkages are there with other supports provided in other sectors (health, social welfare, education, justice)?
	  – What linkages exist with NGOs? The private sector?
	  – How are these linkages coordinated?
	  – For children and adolescents who are identified as having mental health problems, how are referrals coordinated to:
	  » health services
	  » social welfare
	  » or other community-based supports
	  » Are there regulations, guidelines to support these referral systems?
	• To what extent have adolescents, children and parents/carers been involved in designing, delivering or evaluating mental health supports or services in your sector/organization? Is there a process for children, adolescents and parents/carers to provide feedback?

Theme	Questions
Barriers and enablers providing current MHPSS	**I would like to ask now about what has been working well, and what some of the challenges have been delivering MHPSS for children and adolescents** • What do you think is currently being done well to address the mental health of children and adolescents by your sector/organization? • What could be improved or strengthened? • What are the gaps (what specific areas of mental health and well-being aren't being addressed)? • What are the main challenges currently impacting on the delivery of MHPSS through your sector/organization? For example: – Lack of understanding or prioritization of mental health – Community/parent attitudes and norms/social taboos – Funding and other resources for MHPSS – Existence of nationally mandated programmes that include MHPSS – Mental health worker training and education – Linkages and coordination with other sectors (social welfare, education, health services, NGOs, etc) – Information sharing within your sector/organization and across sectors/ organizations
What role *should* the social welfare sector have in implementing MHPSS and minimum-services package	**I would like to ask you now about what roles and responsibilities your sector/organization should have in MHPSS for children and adolescents** • Broadly speaking, what do you think the role of your sector/ organisation should be in implementing MHPSS? How is this different to the current roles we have already discussed? • Reflecting on the different 'tiers' of MHPSS what role should your sector/organization have in: – Responsive care for children and adolescents with mental health problems – Prevention of mental health problems – Creating an enabling environment to promote good mental health *You can refer to Figure A1 and Table A1 in the conceptual framework* **I would like to ask you now about the specific MHPSS actions or services that your sector/organization should have responsibility for. This minimum-services package for MHPSS has been proposed by stakeholders across different sectors in [YOUR COUNTRY]** • Are there any actions that you think are missing? • What actions do you think your sector/organization should have primary responsibility for, and why? • Which of these would be feasible for your sector/organization to deliver, and why?

Theme	Questions

	• How could they be delivered?
	  – What mechanisms currently exist to support implementation of these MHPSS actions? (what existing programmes or services could MHPSS be integrated with, what existing workforce could deliver MHPSS actions?)
	  – Do new delivery mechanisms or systems need to be developed?
	• What actions do you think your sector/organization could contribute to (if not primary responsibility), and how (linkages with other sectors etc)?

Challenges and considerations for implementation of a minimum-services package and strengthening a multisectoral mental health system	**I would like to ask you about how the MHPSS actions proposed in the minimum-services package could be effectively implemented. In particular**
	I would like to ask about what frameworks, structures, resources or supports your sector/organization would need to strengthen implementation
	Legislation and policy
	• What additional policies are needed to support the delivery of MHPSS?
	• What legislation or regulation changes are needed?
	• [consider: sector-specific policies to enable delivery of MHPSS, multisectoral mental health policies that clearly define sectoral roles]
	Governance and leadership
	• What government or non-governmental agency(ies) should have primary responsibility for implementation of MHPSS?
	  – Planning
	  – Implementation
	  – Monitoring
	• What role in leadership or governance do you think your sector/organization should have, and why?
	• How could coordination be improved within your sector/organization (planning, implementation, monitoring)?
	• How could coordination with other sectors (health, education, justice, social welfare) and with NGOs and private sector be improved?
	• What role should other sectors have in implementation of MHPSS?
	• What role should UNICEF have in supporting MHPSS?
	• What role should the private sector have in supporting or delivering MHPSS?
	• What role should NGOs have in supporting or delivering MHPSS?

Theme	Questions
	Services • How could MHPSS be integrated with existing services or programmes for children and adolescents? • What new services or programmes might be needed? • Are there systems or structure changes needed within this sector/ organization to take on these roles and implementation of MHPSS? • What tools, resources or supports would be needed? • Is there an opportunity for online or digital delivery of MHPSS? • What actions are needed to ensure that children, adolescents and parents/carers have access to these services/supports? What actions are needed to reach the most underserved children and adolescents? **Standards and oversight** • What national standards, guidelines, or other tools currently exist to support the delivery of MHPSS? How could these be improved? What additional guidance is needed? [Consider: new procedures, SOPs, programmes, referral mechanisms, etc] • What further actions are needed with respect to accreditation or certification of workers who are engaged in delivering MHPSS? • How should quality of MHPSS be monitored and assessed? By who? **Resources** *Financial* • How are current (or planned) MHPSS delivered by your sector/ organization currently funded? – If government organization: » Are national policies or programs that relate to MHPSS costed? » What is the source of the budget (through a specific program, specific budget line, etc)? » To what extent does the budget include contributions from user fees, sponsor contributions, in-kind contributions, private sector / local business support? » Are MHPSS funded through national or district/local government? » How are the staff who deliver MHPSS funded? » How is infrastructure for MHPSS funded? – If non-governmental/private/UN » Are MHPSS plans or programmes costed? » What is the source of budget for these? » To what extent does it include user fees, private sector support, government funding, other? • What additional financial resources would be required to support MHPSS? Where should these come from?

Theme	Questions
	Workforce • What additional human resources are required for MHPSS? • What 'types' of MHPSS providers are needed in your sector/ organization? With what competencies? • Can MHPSS be integrated into existing roles, and/or are new roles needed? • What additional training is needed? For who? Who should provide this? • How could linkages with other MHPSS providers (health workers, teachers, social workers) be improved to support delivery of MHPSS? **Participation** • What role should children, adolescents and parents/carers have in designing or developing MHPSS policy, programmes and services? • What role should they and the community have in monitoring and evaluating MHPSS? What mechanisms are needed to enable feedback? • What mechanisms are there or could be developed to support the participation and engagement of young people? **Data and information** • What data or information do you think is needed to support the implementation of MHPSS? – For design and delivery of services/support programmes – For monitoring and quality assurance – For evaluating outcomes and impact – For financing MHPSS • Are there existing systems (routine data collection, population or household surveys, etc) that do, or could, include mental health? How? • What systems are needed (or could be strengthened) to improve reporting, use and communication of mental health data? How is or could this information be shared (within your sector/organization, across different sectors, with NGOs and the private sector)? • What do you think are some important knowledge and evidence gaps with respect to child and adolescent mental health? I.e. what further research would help support MHPSS?
Any other issues?	Any other comments or suggestions you would like to raise that we have not yet covered today? I will go over a summary of what we have discussed, if you would like to add or change anything you have said please let me know.

Appendix B:

Development of the Regional MHPSS Conceptual Framework

The approach to development of the project regional conceptual framework was consultative and iterative, and included the following:

Synthesis of the available evidence

An important foundation to this work is the framing of mental health and well-being in UNICEF's 2021 State of the World's Children report.[2] A core recommendation is to consider the 'spheres of influence' that shape mental health and well-being from an early age, with key spheres including '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:[106] mental health promotion largely targets the social determinants of health which impacts on the world of the child, with preventive 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; [107–110] WHO guidelines related to mental health;[23,111–114] the Lancet Commissions on Global Mental Health and Sustainable Development, and on Adolescent Health and Well-being;[115,116] UN guidance on social and emotional learning;[117,118] available country-level operational guidance on implementation of MHPSS from both high and middle-income[119–121] and available guidance from focal countries for this project (Thailand and the Philippines).[41,102,122–124] 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 of 2021. All members of the TAG provided feedback and subsequently endorsed the conceptual 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 role 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

Each online workshop (in Thailand, the Philippines, Papua New Guinea and Malaysia) was held with key stakeholders and implementation partners across health, education, social welfare and youth advocacy representing government and non-governmental organizations, the private sector and UN agencies. Feedback was gathered through facilitated discussion and an online prioritization tool completed by individuals. The feedback from across all countries was collated to inform a cross-cutting regional framework, in addition to identifying specific priorities within each country.

Appendix C:

National level data on mental health outcomes and risks

Thailand mental health outcomes

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of depressive disorders (%)	Female	5 to 9	0.06	0.06	0.06	GBD	2019
	Male	5 to 9	0.04	0.04	0.04		
	Both	5 to 9	0.05	0.05	0.05		
	Female	10 to 14	1.01	1.01	1.01		
	Male	10 to 14	0.68	0.68	0.68		
	Both	10 to 14	0.84	0.84	0.84		
	Female	15 to 19	2.45	2.45	2.45		
	Male	15 to 19	1.88	1.88	1.88		
	Both	15 to 19	2.17	2.17	2.17		
Prevalence of bipolar disorder (%)	Female	10 to 14	0.10	0.10	0.10	GBD	2019
	Male	10 to 14	0.10	0.10	0.10		
	Both	10 to 14	0.10	0.10	0.10		
	Female	15 to 19	0.35	0.35	0.35		
	Male	15 to 19	0.35	0.35	0.35		
	Both	15 to 19	0.35	0.35	0.35		
Prevalence of inability to sleep due to worry so much most of the time or always in the past 12 months (%)	Female	13 to 17	19.6	21.2	18.1	GSHS	2021
	Male	13 to 17	12.8	15.3	10.8		
	Both	13 to 17	16.4	17.4	15.5		
Prevalence of anxiety disorders (%)	Female	1 to 4	0.14	0.14	0.14	GBD	2019
	Male	1 to 4	0.09	0.09	0.09		
	Both	1 to 4	0.12	0.12	0.12		
	Female	5 to 9	1.70	1.70	1.70		
	Male	5 to 9	1.01	1.01	1.01		
	Both	5 to 9	1.35	1.35	1.35		
	Female	10 to 14	4.08	4.08	4.08		
	Male	10 to 14	2.48	2.48	2.48		
	Both	10 to 14	3.28	3.28	3.28		

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of anxiety disorders (%)	Female	15 to 19	5.06	5.06	5.06		
	Male	15 to 19	2.99	2.99	2.99		
	Both	15 to 19	4.03	4.03	4.03		
Prevalence of conduct disorder (%)	Female	5 to 9	0.84	0.84	0.84	GBD	2019
	Male	5 to 9	1.55	1.55	1.55		
	Both	5 to 9	1.20	1.20	1.20		
	Female	10 to 14	2.59	2.59	2.59		
	Male	10 to 14	4.37	4.37	4.37		
	Both	10 to 14	3.48	3.48	3.48		
	Female	15 to 19	1.30	1.30	1.30		
	Male	15 to 19	2.69	2.69	2.69		
	Both	15 to 19	1.99	1.99	1.99		
Prevalence of idiopathic developmental intellectual disability (%)	Female	1 to 4	0.87	0.87	0.87	GBD	2019
	Male	1 to 4	1.62	1.62	1.62		
	Both	1 to 4	1.25	1.25	1.25		
	Female	5 to 9	1.00	1.00	1.00		
	Male	5 to 9	1.76	1.76	1.76		
	Both	5 to 9	1.39	1.39	1.39		
	Female	10 to 14	0.91	0.91	0.91		
	Male	10 to 14	1.66	1.66	1.66		
	Both	10 to 14	1.29	1.29	1.29		
	Female	15 to 19	0.83	0.83	0.83		
	Male	15 to 19	1.52	1.52	1.52		
	Both	15 to 19	1.17	1.17	1.17		
Prevalence of schizophrenia (%)	Female	10 to 14	0.01	0.01	0.01	GBD	2019
	Male	10 to 14	0.01	0.01	0.01		
	Both	10 to 14	0.01	0.01	0.01		
	Female	15 to 19	0.08	0.08	0.08		
	Male	15 to 19	0.10	0.10	0.10		
	Both	15 to 19	0.09	0.09	0.09		

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of autism spectrum disorders (%)	Female	1 to 4	0.20	0.20	0.20	GBD	2019
	Male	1 to 4	0.67	0.67	0.67		
	Both	1 to 4	0.44	0.44	0.44		
	Female	5 to 9	0.20	0.20	0.20		
	Male	5 to 9	0.65	0.65	0.65		
	Both	5 to 9	0.43	0.43	0.43		
	Female	10 to 14	0.18	0.18	0.18		
	Male	10 to 14	0.62	0.62	0.62		
	Both	10 to 14	0.40	0.40	0.40		
	Female	15 to 19	0.17	0.17	0.17		
	Male	15 to 19	0.57	0.57	0.57		
	Both	15 to 19	0.37	0.37	0.37		
Prevalence of attention-deficit/ hyperactivity disorder (%)	Female	1 to 4	0.28	0.28	0.28	GBD	2019
	Male	1 to 4	0.72	0.72	0.72		
	Both	1 to 4	0.51	0.51	0.51		
	Female	5 to 9	2.40	2.40	2.40		
	Male	5 to 9	6.04	6.04	6.04		
	Both	5 to 9	4.26	4.26	4.26		
	Female	10 to 14	3.07	3.07	3.07		
	Male	10 to 14	7.83	7.83	7.83		
	Both	10 to 14	5.46	5.46	5.46		
	Female	15 to 19	2.37	2.37	2.37		
	Male	15 to 19	5.88	5.88	5.88		
	Both	15 to 19	4.12	4.12	4.12		
Prevalence of suicidal attempt one or more times in the past 12 months (%)	Female	13 to 17	18.5	21.0	16.3	GSHS	2021
	Male	13 to 17	12.1	15.3	9.5		
	Both	13 to 17	15.5	17.6	13.7		
Mortality rate due to self-harm (deaths per 100,000 population)	Female	10 to 14	0.45	0.70	0.26	GBD	2019
	Male	10 to 14	0.57	1.05	0.32		
	Both	10 to 14	0.51	0.77	0.33		
	Female	15 to 19	2.47	3.65	1.54		
	Male	15 to 19	9.41	14.88	5.48		
	Both	15 to 19	6.00	9.02	3.90		

Mental health risks

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of lifetime marijuana use (%)	Female	13 to 17	3.1	4.2	2.2	GSHS	2021
	Male	13 to 17	11.2	14.8	8.3		
	Both	13 to 17	6.9	8.8	5.4		
Prevalence of lifetime amphetamines or methamphetamines use (%)	Female	13 to 17	1.7	2.2	1.3	GSHS	2021
	Male	13 to 17	6.2	9.0	4.2		
	Both	13 to 17	3.9	5.3	2.9		
Prevalence of having been bullied on at least one day in the past 12 month (%)	Female	13 to 15	29.8			GSHS	2021
	Male	13 to 15	39.2				
	Both	13 to 15	35.2				
Prevalence of being physically attacked one or more times in the past 12 months (%)	Female	13 to 17	16.70	19.30	14.40	GSHS	2021
	Male	13 to 17	36.70	41.30	32.20		
	Both	13 to 17	26.20	29.20	23.30		
Prevalence of loneliness most of the time or always in the past 12 months (%)	Female	13 to 17	21.3	23.9	19.0	GSHS	2021
	Male	13 to 17	16.9	19.9	14.2		
	Both	13 to 17	19.2	20.7	17.9		
Prevalence of suicidal ideation in the past 12 months (%)	Female	13 to 17	23.1	25.5	20.8	GSHS	2021
	Male	13 to 17	11.3	14.0	9.1		
	Both	13 to 17	17.6	19.5	15.8		
Prevalence of suicidal plan in the past 12 months (%)	Female	13 to 17	21.5	23.9	19.3	GSHS	2021
	Male	13 to 17	9.5	11.3	8.0		
	Both	13 to 17	15.9	17.7	14.3		
Proportion of children aged 2 to 4 years for whom household members engaged in four or more activities that promote learning and school readiness during the last three days (%)	Both	2	91.80			MICS	2019
	Both	3	93.20				
	Both	4	92.00				
	Female	2 to 4	94.20				
	Male	2 to 4	90.50				
	Both	2 to 4	92.30				
	Both	2 to 4	95.30				
	Both	2 to 4	90.60				

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Proportion of children under age 5 left alone or under the supervision of another child younger than 10 years of age for more than one hour at least once in the past week (%)	Both	0 to 1	2.90			MICS	2019
	Both	2 to 4	5.50				
	Female	<5	3.60				
	Male	<5	5.50				
	Both	<5	4.50				
	Both	<5	4.70				
	Both	<5	4.40				
Proportion of children aged 1 to 14 years who experienced any violent discipline in the past month (%)	Both	1 to 2	51.40			MICS	2019
	Both	3 to 4	65.00				
	Both	5 to 9	63.00				
	Both	10 to 14	51.50				
	Female	1 to 14	54.60				
	Male	1 to 14	60.50				
	Both	1 to 14	57.60				
	Both	1 to 14	52.90				
	Both	1 to 14	60.60				

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