Helping Adolescents Thrive Toolkit

Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours

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Contents

Foreword

Promoting mental well-being, preventing mental health conditions, and reducing self-harm and other risk behaviours among adolescents.

Most of us remember our teenage years. The excitement that comes with the first flashes of independence as we are given more freedom, develop new relationships and often receive our first pay packet. Likely we also remember feelings of uncertainty, and perhaps anxiety, as the pressure to do well in exams builds and the reality of soon having to make our own way in the world hits home.

During the last year, as we have lived through the COVID-19 pandemic, many of us have watched with concern as young people navigate their way through an environment that was not at all what they expected, an environment where physical contact with friends, family and teachers has been largely replaced by a voice and a face on a screen, when tensions at home have often come to the fore due to illness or financial worries and when job prospects look more uncertain than ever.

Many young people have really struggled to cope with the pressure; some have slid into depression and anxiety; tragically some have even taken their own lives.

We must do everything in our power to support young people, and to equip them with the skills and knowledge to cope even in the most challenging circumstances.

The Helping Adolescents Thrive programme, jointly conceived by the World Health Organization and UNICEF, focuses on the promotion of mental well-being among adolescents and the prevention of mental health conditions.

The Helping Adolescents Thrive toolkit, the latest material of the programme to be released, provides programmatic guidance for people working in the health, social services, education and justice sectors on how to implement mental health promotive and preventive interventions that are appropriate to local needs and the contexts where adolescents live. The toolkit covers the legal foundations required for such programmes to succeed, the features of environments that are conducive to the well-being of adolescents, what support should be provided to parents and other caregivers, and psychosocial interventions that work.

The complementary Teacher's Guide and Comic Book can be used in schools as part of mental health promotion programmes to facilitate understanding and discussion of mental health issues.

Now, more than ever, WHO and UNICEF are committed to improving the mental health of adolescents, and indeed all young people. Ensuring their mental well-being is critical not only for their future, but for all our futures.

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Acronyms and abbreviations

AA-HA!	Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation
ABCD	Ask–Boost–Connect–Discuss
AGEP	Adolescent Girls Empowerment Program (Zambia)
ART	Antiretroviral therapy
ARV	Antiretroviral
CAMH	Child and adolescent mental health
CATS	Community adolescent treatment supporters (Zimbabwe)
CBO	Community-based organizations
CBT	Cognitive behavioural therapy
CHAMPS	Collaborative HIV Prevention and Adolescent Mental Health Programme
CRC	(United Nations) Convention on the Rights of the Child
CRPD	(United Nations) Convention on the Rights of Persons with Disabilities
CSI	Caregiver Support Intervention
DoI	Declaration of interest
EASE	Early Adolescent Skills for Emotions
EQUIP	Ensuring Quality in Psychological Support
ERG	Evidence Review Group
ESPS	Enhancing Resiliency Among Students Experiencing Stress–Prosocial
FGM	Female genital mutilation
GAMA	Global Action for Measurement of Adolescent Health
GDG	Guidelines Development Group
GRADE	Grading of Recommendations Assessment, Development and Evaluation
HAT	Helping Adolescents Thrive
HIC	High-income country
HIV	Human immunodeficiency virus
LGBTQI	Lesbian, gay, bisexual, transgender, questioning (or: queer), intersex
LMICs	Low- and middle-income countries
MHC	Mental Health Curriculum
mhGAP	Mental Health Gap Action Programme
M&E	Monitoring and evaluation
MMAP	Measurement of mental health among adolescents at the population level
NCD	Noncommunicable disease
NGO	Nongovernmental organization
PICO	Population, Intervention, Comparator, Outcome
PLH	Parenting for Lifelong Health
PTSD	Post-traumatic stress disorder
RCT	Randomized controlled trial
SCTP	Social National Unconditional Cash Transfer (Malawi)
SDGs	Sustainable Development Goals
SEL	Social emotional learning

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Key definitions

Adolescence	is the phase of life between childhood and adulthood, from ages 10 to 19 years. It is a unique stage of human development, encompassing rapid physical growth and sexual maturation combined with emotional, social and cognitive development. It is an important time for laying the foundations of good health.
Adolescents	are individuals in the 10–19 years age group.
Caregivers	refers to those responsible for the care of children, and may include mothers and fathers, grandparents, siblings and others within the extended family network, as well as other child caregivers outside of the family network.
Community	can be defined as a network of people who share similar interests, values, goals, culture, religion or history – as well as feelings of connectedness and caring among its members.
Mental health	is an integral and essential component of health. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.
Mental health and psychosocial support	is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being.
Mental health care	refers to services devoted to the treatment of mental health conditions and the improvement of mental health in people with mental disorders or problems.
Mental health conditions	refer to a wide range of disorders that affect an individual's cognition, emotion and/or behaviour and interfere with the individual's ability to learn and function in the family, at work and in society. In many circumstances, many of these conditions can be successfully prevented and/or treated. They include mental and substance-use problems, severe psychological distress, intellectual disabilities and suicide risk.
Mental health law	is the specific legal provisions that are primarily related to mental health. It typically focuses on issues such as quality care and services, civil and human rights protection, professional training and service structure.
Mental health plan	is a detailed scheme for action on mental health. It usually includes setting principles for strategies and establishing timelines and resource requirements.
Mental health promotion	involves actions that improve psychological well-being. This may involve creating an environment that supports mental health.

Mental health policy	is an official statement of a government that conveys an organized set of values, principles, objectives and areas for action to improve the mental health of a population.
Mental health services	are the means by which effective interventions for mental health are delivered.
Mental health treatment	can involve psychological therapy, medication and various supports in the community, as well self-help strategies. Mental health treatment can take place in a variety of settings.
Participation	refers to the processes and activities that allow affected people to play an active role in all decision-making processes that affect them. Real participation includes all groups, including the most vulnerable and marginalized. It enables people and communities to take part in decision-making processes and to be involved in actions on issues that are of concern to them. It is a way of recognizing dignity, identifying and mobilizing community resources, and building consensus and support. Participation is a right and is voluntary
Prevention	in mental health aims to reduce the incidence, prevalence and recurrence of mental health disorders and their associated disability. It may involve universal, targeted or indicated preventive strategies.
Psychosocial	denotes the interconnection between psychological and social processes and the fact that each continually interacts with and influences the other.
Psychosocial distress	refers to unpleasant feelings or emotions that can have an impact on a person's level of functioning and ability to navigate and participate in social interactions. It is psychological discomfort that interferes with a person's activities of daily living. Psychosocial distress can result in negative views of the environment, of others and of the self. Sadness, anxiety, distraction, disruption in relationships with others and some symptoms of mental illness are manifestations of psychological distress.
Psychosocial interventions	promote positive mental health and prevent mental health conditions, helping adolescents to learn techniques to influence their behaviour, thoughts, feelings and social interactions positively.
Referral	is the process of directing a client to another service provider because the client requires help that is beyond the expertise or scope of work of the current service provider.
Resilience	is the ability to overcome adversity and positively adapt after challenging or difficult experiences. Children's resilience relates not only to their innate strengths and coping capacities but also to the pattern of risk and protective factors in their social and cultural environments.

Well-being	describes the positive state of being when a person thrives. The five domains of adolescent well-being are: good health and optimum nutrition; connectedness, positive values and contribution to society; safety and a supportive environment; learning, competence, skills and employability; and agency and resilience.
Whole-of-government	approach is an approach in which public service agencies work formally and informally across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. The approach aims to achieve policy coherence in order to improve effectiveness and efficiency. This approach is a response to departmentalism that focuses not only on policies but also on programme and project management.
Whole-of-society	acknowledges the contribution of, and important role played by, all relevant stakeholders – including individuals, families and communities, intergovernmental organizations, religious instituions, civil society, academia, the media, voluntary associations and, as appropriate, the private sector and industry – in support of national efforts and recognizes the need to further support the strengthening of coordination among these stakeholders in order to improve the effectiveness of these efforts.

Executive summary

Adolescence is a period of rapid development during which individuals experience profound physical, social and psychological changes and during which the maturing brain is highly susceptible to environmental influences *(1).* As such, adolescence offers great potential for health promotion and preventive interventions to influence health and developmental outcomes *(2),* and to influence young lives positively in the short and long term, and into the next generation *(3).*

A renewed focus on creating a supportive environment that enables positive mental health for adolescents is urgently needed. By effectively implementing a comprehensive set of strategies to support adolescent mental health, young people will enjoy improved well-being and will be able to realize their potential and participate meaningfully in their communities *(4).*

Overview

Helping Adolescents Thrive

Helping Adolescents Thrive (HAT) is a joint WHO-UNICEF initiative to strengthen programming and policy responses for adolescents, to promote positive mental health, prevent mental health conditions, and prevent self-harm and other risk behaviours. The vision of HAT is a world in which all adolescents, their caregivers, civil society and communities unite with governments to protect and promote adolescent mental health. This means taking action routinely to implement and monitor evidence-informed and human rights-based strategies for improving mental health, and to prevent and reduce mental health and substance use conditions in adolescents in order to improve lifelong well-being *(5).* This is in support of the Sustainable Development Goals (SDG) Target 3.4, namely: "to reduce by one third premature mortality from noncommunicable diseases through prevention

and treatment and promote mental health and well-being" and, within this target, to reduce suicide mortality (indicator 3.4.2) by 2030. This is also in line with the Comprehensive Mental Health Action Plan 2013–2020 *(6)* and the Global accelerated action for the health of adolescents (AA-HA!): Guidance to support country implementation *(7).*

Approach

The HAT toolkit

This guidance document, the HAT toolkit, has been developed to improve programming for adolescent mental health promotion and prevention and to support the implementation of the WHO HAT guidelines on mental health promotive and preventive interventions for adolescents. The toolkit describes evidence-informed approaches for promoting positive mental health, preventing mental health conditions, and reducing engagement in self-harm and risk behaviours.

The HAT toolkit is informed by the social ecological model, highlighting the importance of addressing risk factors at individual, family, community and societal levels to promote and protect adolescent mental health, with due attention to sociocultural contexts and care systems. The toolkit describes core principles that should guide programming efforts – including ensuring that responses are equitable and inclusive, gender-sensitive and gender-responsive, developmentally appropriate and guided by adolescents' evolving capacities, and that they actively involve both adolescents and their parents/caregivers in the planning, design, implementation and evaluation of programming, and not only as beneficiaries. It is critical to plan for large-scale implementation beginning from the planning phase for roll-out of the HAT strategies.

Actions: The HAT strategies and cross-cutting activities

The HAT toolkit describes four interlinked strategies and two implementation approaches. These include implementation tools to support the work of programme managers. Country implementation case examples are also provided.

The four strategies are:

Strategy 1

Implementation and enforcement of policies and laws provides guidance on, and examples of, laws and policy provisions to improve adolescent mental health outcomes, embracing a whole-of-government and whole-of-society approach.

Strategy 2

Environments to promote and protect adolescent mental health focuses on actions to improve the quality of environments in schools, communities and digital spaces. This strategy seeks to enhance adolescents' physical and social environments, where indicated, through a range of evidence-based activities such as school climate interventions, adolescent safe spaces in communities, and teacher training.

Strategy 3

Caregiver support refers to interventions to: build caregivers' knowledge and skills for promoting adolescents' mental health; strengthen caregivers' and adolescents' relationships; and support caregivers' own mental health and well-being.

Strategy 4

Adolescent psychosocial interventions focuses on evidence-based psychosocial interventions for universal, targeted and indicated promotion and mental health prevention.

For each of these strategies, a rationale is provided, followed by a description of various evidence-informed approaches, considerations for implementation and relevant resources.

The two implementation approaches are:

Multisectoral collaboration

describes how to develop collaboration between multiple sectors and stakeholders – public, private and civil society – at national and local levels to support the development and implementation of preventive and promotive mental health programming for adolescents.

Monitoring and evaluation

provides a breakdown of how to develop a monitoring and evaluation system which can provide policy-makers and programme managers with critical information on whether programmes and policies are being implemented as intended and are having their intended impact.

For both activities, an overview section is provided, followed by specific considerations for adolescent mental health programming, a step-by-step process for implementation, and links to relevant resources.

Finally, the HAT toolkit provides an essential resource guide to support the implementation of a whole-of-society approach as a means to achieving the goal of ensuring that all adolescents, including those living in situations of vulnerability, benefit from evidence-informed strategies to promote their positive mental health, prevent suicide and the development of mental health conditions, and reduce engagement in risk behaviours such as self-harm, substance use, and aggressive, disruptive and oppositional behaviours.

Strategies

Implementation approaches

Strategy 1

Implementation and enforcement of policies and laws

Strategy 2

Environments to promote and protect adolescent mental health

Strategy 3

Caregiver support

Strategy 4

Adolescent psychosocial interventions

Activity 1
Multisectoral collaboration

Activity 2
Monitoring and evaluation

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Introduction

Adolescence is a period of rapid development during which individuals experience profound physical, social and psychological changes, and during which the maturing brain is highly susceptible to environmental influences *(1)*. As such, it offers great potential for health promotion and preventive interventions to influence health and developmental outcomes *(2),* and to influence young lives positively in the short and long term and into the next generation *(3)*.

On the other hand, the impact of negative experiences can be intensified and have a long-lasting influence into adult life *(4)*. Many adolescents are exposed to complex family, cultural, societal, economic and environmental factors that have potential adverse effects on their cognitive, social and emotional development. These include violence, poverty, conflict, forced migration, gender inequality and humanitarian emergencies *(3)*.

Exposure to these risks during this period of developmental sensitivity has contributed to nearly one in every seven young people globally experiencing a mental disorder, with self-harm being the third leading cause of global disability-adjusted life years in this age group *(5, 6)*. Approximately half of all mental disorders begin before the age of 14 years and, if left untreated, the effects can persist throughout the life course and have serious implications *(5)*. Substance use, physical violence, self-harm and risky sexual behaviours endure into adulthood *(7, 8)*. Poor mental health has negative impacts on a number of aspects of a person's life, such as interpersonal relationships, school performance and later productivity at work *(9–11)*.

A renewed focus is urgently needed to create conditions whereby positive mental health for adolescents is enabled. By effectively implementing a comprehensive set of strategies to support adolescent mental health, young people will enjoy improved well-being, be able to realize their potential and can participate meaningfully in their communities *(12)*.

Helping adolescents thrive (HAT): the vision

The HAT vision is a world in which all governments, with the strong participation of adolescents, civil society and communities, routinely implement and monitor evidence-informed and human right-based strategies to improve mental health and to prevent and reduce mental health and substance use conditions in adolescents in order to improve lifelong well-being. Taking action to improve the conditions of daily life during adolescence provides opportunities both to improve population mental health and to reduce the risk of those mental health conditions that are associated with social inequalities *(4)*. Action across the whole of society should be consistent with needs in order to promote equality in health outcomes *(4)*.

The HAT toolkit reinforces the provisions of UN Committee on the Rights of the Child (CRC) General Comment No. 20 on the implementation of the rights of the child during adolescence, which urges States together with non-State actors to:

Recognize that adolescents require particular attention in all measures taken in respect of legislation, policies and programmes;

Fulfil their obligations for the realization of the rights of adolescents;

Promote adolescents' mental health by adopting a comprehensive multisectoral response based on a public health and psychosocial support approach *(13)*.

The HAT toolkit reflects the urgent need to reduce the burden of mental health problems now and for the future in order to enable the full development of adolescents globally. HAT intends to support countries and communities towards achieving the Sustainable Development Goals (SDG) Target 3.4 to "reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being" and, within this target, to reduce suicide mortality (indicator 3.4.2) by 2030.

HAT toolkit scope and development process

The HAT toolkit has been developed to improve programming for adolescent mental health promotion and prevention and to support the implementation of the HAT guidelines on mental health promotive and preventive interventions for adolescents *(14)*. It describes evidence-informed approaches for promoting positive mental health, preventing mental health conditions, and reducing engagement in risk behaviours through the use of four interlinked strategies and two additional cross-cutting activities. Implementation tools and country implementation case examples are provided to support the work of programme managers and others.

The content of the HAT toolkit is informed by reviews of peer-reviewed and grey literature, consultations with experts, practitioners and key stakeholders, and focus group discussions with young people in low- and middle-income countries (Belize, Kazakhstan, Nepal, South Africa).

The four HAT strategies and two implementation approaches

The HAT toolkit focuses on four interlinked strategies:

**Strategy 1
Policies and laws**

to support the implementation and enforcement of laws and policies to protect and promote adolescent mental health.

**Strategy 2
Environments to promote
and protect adolescent mental health**

to create supportive, healthy and safe environments in which adolescents live, study, work and socialize.

**Strategy 3
Caregiver support**

to ensure that caregivers are supported to promote and protect adolescent mental health.

**Strategy 4
Adolescent psychosocial**

to ensure that adolescents benefit from evidence-informed psychosocial interventions.

Additionally, HAT includes two key implementation approaches:

**Activity 1:
Multisectoral
collaboration**

describes how to develop collaboration between multiple sectors and stakeholders – public, private and civil society – at national and local levels to support the development and implementation of preventive and promotive mental health programming for adolescents.

**Activity 2:
Monitoring
and evaluation**

provides a breakdown of how to develop a monitoring and evaluation system which can provide policy-makers and programme managers with critical information on whether programmes and policies are being implemented as intended and are having their intended impact.

Who is this toolkit for?

The HAT toolkit is intended for use as operational guidance and as a resource toolkit for policy-makers and programme managers in ministries of health, education, social welfare and other relevant ministries, not-for-profit organizations such as nongovernmental organizations (NGOs), community-based organizations (CBOs), international NGOs and United Nations (UN) agencies. However, other stakeholders, such as funding bodies, academics and advocates who support and implement interventions on adolescent mental health and well-being, may also find it useful.

How does the HAT toolkit complement and link to other WHO/UNICEF frameworks and resources?

The HAT toolkit aligns with and complements WHO's Guidelines on promotive and preventive mental health interventions for adolescents – Helping Adolescents Thrive (HAT) *(15)*. The guidelines provide evidence-based recommendations on psychosocial interventions with adolescents and/or families to promote adolescents' mental health, prevent mental health conditions and reduce self-harm and substance use. The HAT toolkit provides operational guidance and resources to facilitate operationalization of the guidelines' recommendations. Furthermore, the toolkit articulates a broader whole-of-government and whole-of-society approach in order:

1) to promote enabling environments for adolescents and their families; and

2) to address the socioeconomic determinants of adolescents' well-being and other cultural and structural factors that have an impact on adolescents' cognitive and socio-emotional growth or their access to opportunities for participation and to mental health supports.

The HAT toolkit provides strategic actions as well as resources to operationalize the implementation of the Comprehensive Mental Health Action Plan 2013–2020 and the Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation *(15)*. Furthermore, HAT strategies are aligned with the Partnership for Maternal, Newborn & Child Health and WHO's adolescent well-being framework *(16)*. However, the toolkit does not do everything (Box A.1).

Box A.1

What the HAT toolkit does not do:

- The HAT toolkit does not provide detailed guidance on the implementation of strategies and interventions. The toolkit offers a description of evidence-informed strategies for promotive and preventive mental health programming for adolescents, along with implementation considerations and examples of available resources and implementation tools. It does not provide ready-to-use intervention manuals and training materials.

- The HAT toolkit does not include an exhaustive list of all evidence-supported interventions and innovations that are underway globally. Evidence-based approaches and interventions are constantly being adapted, implemented and tested across regions and countries. The HAT toolkit does not attempt to describe all of them. Instead, it highlights selected evidence-informed or evidence-based examples of interventions from across different regions.

The HAT toolkit and the social ecological model

The HAT toolkit is informed by the social ecological model, highlighting the importance of addressing risk factors at individual, family, community and societal levels to promote and protect adolescent mental health, with due attention to sociocultural contexts and care systems (Figure A1).

Strategy 1
Policies and laws

Strategy 2
Environments

Individual

Family

Community

Society

Strategy 3
Caregivers

Strategy 4
Psychosocial
interventions

Policies and laws
Children and adolescent mental health policies
Disability laws and policies
Social protection systems
Trust in government

Quality education
School retention
School-level policies for adolescent well-being
Teacher support and supervision
Counselling
Health promoting schools
School connectedness
Positive social and gender norms
Safe communities
Community acceptance
Community cohesion

Parental support
Positive family functioning
Mother's education
Quality home environment
Parental mental health
Social security
Parent skills training and support
Employment and financial security

Interpersonal skills
Emotional regulation skills
Higher-order thinking skills
(i.e. decision-making, problem-solving skills etc)
Self-esteem
Coping styles
Ability to nurture and access good social support

Figure A.1 An overview of the HAT toolkit strategies

Guiding principles

The implementation of interlinked strategies and implementation approaches is likely to be influenced in different settings by specific features of local contexts – such as available resources, cultural values, existing health service delivery systems, and other positive or negative factors. In all contexts, however, the implementation of HAT strategies should be guided by a set of core principles in order to maximize progress towards the goal of promoting and protecting the mental health of all adolescents.

Reach all adolescents and tailor strategies to meet the needs of adolescents exposed to vulnerabilities

1

Programming should be designed in a manner that ensures that the implementation of the HAT strategies reaches all adolescents, including the most marginalized. Strategies that can be employed to promote equity in implementation include:

targeting programme delivery to vulnerable groups (including the removal of barriers to participation);

delivering programming in a way that is sensitive to different cultures and contexts;

capacity-building of service providers to reach disadvantaged groups;

disaggregation of data to track trends in access and to improve accountability mechanisms.

Programme delivery should not discriminate on the basis of belonging to any of the most marginalized groups, or on the basis of adolescent age, ethnicity, sex, language, religion, political affiliation, health status or disability. Programmes should consider and identify which groups are marginalized in their country or context. All adolescents should have equal opportunities to be involved in HAT programming and to benefit from its implementation. Furthermore, programmes should include strategies for identifying adolescents and caregivers who may benefit from targeted approaches and/or more intensified support (for instance, because of exposure to vulnerabilities or for those experiencing mental health problems).

Contextualize strategies 2

Programme strategies and interventions should be adapted to countries' sociocultural environments and care systems, including human resource capacity across sectors. The planning, implementation and evaluation of the programme strategies should take a contextualized approach that involves careful consideration of the impact of multiple intersecting inequalities on demand for and access to mental health promotion and prevention in the local context. This information will support the definition and/or adaptation of inclusive and tailored approaches to reach all children and adolescents, including those who are more likely to experience vulnerability, marginalization and/or poor mental health – such as children living in poverty, those with disabilities, out-of-school adolescents or those in institutions, orphans, minority groups, those who are lesbian, gay, bisexual, transgender, questioning (or: queer) or intersex (LGBTQI), and those exposed to violence and humanitarian emergencies.

Ensure that programmes 3 are gender-responsive and gender-transformative

Programmes should be delivered in a way that is gender-responsive and gender-transformative in order to promote and protect adolescent mental health. Gender inequality negatively influences health outcomes for girls and has an impact on the well-being of all adolescents. Adolescent girls are vulnerable to gender inequality through limited opportunities to access education and other opportunities, child marriage, gender-based violence and female genital mutilation. Adolescent boys are also affected as norms around masculinity promote risk behaviours, do not allow for displays of certain emotions and do not promote health or help-seeking behaviour. LGBTQI adolescents are often marginalized and discriminated against on the basis of their sexuality and/or gender. This has direct consequences for mental health and substance use and for self-harm/suicide.

It is important to address gender socialization as early as possible. Adolescence is a critical period for intervention as gender norms are often reinforced during this time and patterns formed during adolescence often last a lifetime (17). Gender issues should be mainstreamed across the HAT responses in countries; the implications of all strategies on

adolescent females, males and gender-nonconforming populations should be considered during implementation in order to ensure that all are able to benefit equally.

Strategies to promote gender equality and address gender norms in programming include:

ensuring that all adolescents, regardless of gender identity, benefit from opportunities to access HAT programming;

acknowledging and addressing the situation when groups are less able on the basis of gender to access services that promote and protect their mental health;

addressing harmful norms and promoting gender equality as a part of programming in different contexts;

involving and engaging caregivers in gender-related issues;

disaggregating and reporting data by gender.

Ensure that programmes are developmentally appropriate   4

HAT implementation should be **developmentally appropriate and take into account adolescents' evolving capacities.** Adolescence is a period of rapid and complex transition. It is often thought of in phases – i.e. early adolescence (10–14 years) and late adolescence (15–19 years) – underscoring the significance of the changing priorities and preferences of adolescents as they grow into adulthood.

Important considerations include:

Implementation of HAT strategies should be designed around the mental health needs of adolescent beneficiaries in a given context, taking into account relevant social and cultural factors rather than rigidly applied uniformity in all settings.

Programmes designed for adolescents should recognize that the capacity of adolescents to understand matters affecting their life will change with age and maturity. Programmes should therefore promote autonomy and provide adolescents with opportunities for self-determination to enable them to take responsibility for decisions affecting their lives, commensurate with evolving capacity. Programmes should promote a balance between protection and autonomy that is in the best interests of the adolescent.

Programmes should also be delivered through platforms that are most accessible to adolescents.

Actively involve adolescents and their caregivers in a meaningful way   5

Adolescents have great potential to be agents of change in their communities, countries and globally *(18)*. In order to harness this transformative energy, it is important to provide facilitative platforms in which adolescents can engage and participate meaningfully as well as lead efforts to promote and protect their mental health. **Adolescents should act as partners** in the planning, design, implementation and evaluation of programming, as opposed to just being beneficiaries. Meaningful adolescent and youth engagement is defined as *"an inclusive, intentional, mutually-respectful partnership between adolescents, youth, and adults whereby power is shared, respective contributions are valued, and young people's ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms, and organizations that affect their lives and their communities, countries, and world" (18)*. Adolescent participation in different stages of the response can promote adolescent well-being and can increase engagement with and ownership of programming.

Participation in HAT implementation can be advanced by the following:

It should be recognized that adolescents are a diverse group with different needs, priorities and preferences, which means that adolescent representatives need to be drawn from different settings and communities *(18)*.

Formal systems and mechanisms are required to institutionalize adolescents' participation in different processes across relevant sectors.

Monitoring and evaluation efforts and accountability mechanisms should be designed to take stock of adolescent feedback, including from marginalized groups.

Additionally, caregivers play a central role in the mental and behavioural development of young adolescents *(19, 20)*. Warm and affectionate relationships promote adolescent mental health *(21)*. Positive parenting can buffer the effects of community violence and other negative influences *(22)*. Caregivers/guardians are often gatekeepers for their adolescent children and can facilitate access to mental health programming and care. Caregiver support improves adolescent mental health outcomes *(23)*. For these reasons, supporting caregivers is one of the four key strategies of the HAT toolkit.

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Strategy 1
Implementation and enforcement of policies and laws

Objective

Ensure the implementation and enforcement of policies and laws to protect and promote adolescent mental health and to reduce engagement in risk behaviours.

Rationale

Adolescence is a life stage with increasing opportunities, capabilities and ambitions, but also significant vulnerability. Governments have obligations to take measures, including policy and legislative measures, to ensure that adolescents are respected, protected and can exercise their rights. However, the potential of adolescents is widely compromised because the policies and laws (Figure 1.1) needed to protect and promote their mental health have been neither developed nor implemented in many parts of the world.

According to the WHO *Mental health atlas* in 2017, 46% of 78 responding countries, stated they had a plan or strategy for child and adolescent mental health *(1)*. Data disaggregated by age, sex and disability are not available in most countries in order to inform policy, identify gaps and support the allocation of appropriate resources for adolescents. Other factors have also been proposed which contribute to the lack of policy development and implementation (Figure 1.2).

"The costs of inaction and failure are high: the foundations laid down during adolescence in terms of emotional security, health, sexuality, education, skills, resilience and understanding of rights will have profound implications, not only for their individual optimum development, but also for present and future social and economic development." (3)

A **mental health law** is...

- the specific legal provisions that are primarily related to mental health.
- typically focused on issues such as quality care and services, human rights protection, professional training and service structure.

A **mental health policy** is...

- an official statement of a government that conveys an organized set of values, principles, objectives and areas for action to improve the mental health of a population.

A **mental health plan** is...

- a detailed scheme for action on mental health.
- usually includes setting principles for strategies and establishing timelines and resource requirements.

Figure 1.1 Definitions based on the WHO *Mental health atlas, 2017 (1)* and *WHO's Child and adolescent mental health policies and plans, 2005 (2)*

relatively new knowledge in adolescent mental health

lack of developmental perspective

stigma, discrimination

fragmented advocacy

reluctance of professionals to debate

Lack of policy development and implementation for adolescent mental health

Figure 1.2 Factors contributing to a lack of policy development and implementation based on Wei Zhou et al. (2020) *(4)*
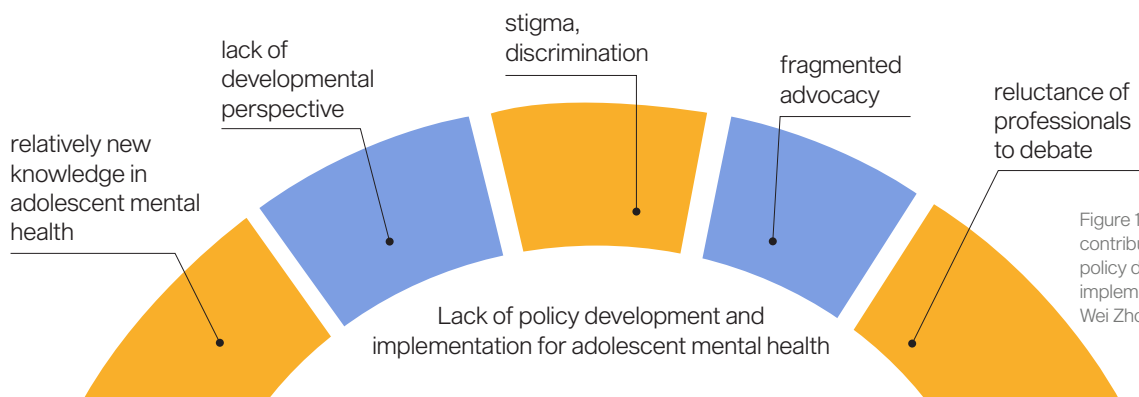
Approaches

The HAT toolkit Strategy 1 on *Implementation and enforcement of policies* and *laws* comprises two frameworks. The first refers to international frameworks that protect adolescents and that State Parties have made commitments to implement under the United Nations Convention on the Rights of the Child (UNCRC) as well as UN governing bodies' action plans to which countries have committed.

The second framework includes national legislative frameworks that protect and promote adolescent mental health, reducing suicide and engagement in risk behaviours suchas substance use.

Framework 1: International frameworks   1

■ UN Convention on the Rights of the Child (CRC)

All States have an obligation *"to implement measures for the prevention of mental health conditions and the promotion of mental health of adolescents"* and *"to ensure that health facilities, goods, and services, including counselling and health services for mental health, of appropriate quality and sensitive to adolescents' concerns are available to all adolescents"* (5).

This includes the CRC General Comment on the implementation of the rights of the child during adolescence and the CRC General Comment on adolescent health and development in the context of the Convention on the Rights of the Child (Box 1.1).
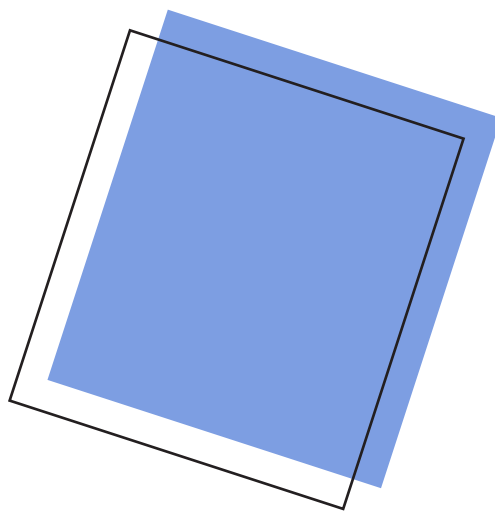
Box 1.1

What is the UN Convention on the Rights of the Child (CRC)?

The Convention contains 54 articles that cover all aspects of a child's life and describe the civil, cultural, economic, political and social rights that all children are entitled to.

For more information see here.

For a simplified version by UNICEF see here.

What is the UN Convention on the Rights of the Child General Comment on the implementation of the rights of the child during adolescence?

This general comment provides guidance on the legislation, policies and services needed to promote comprehensive adolescent

development consistent with the realization of their rights.

For more information see here.

What is the UN Convention on the Rights of the Child General Comment on adolescent health and development in the context of the Convention on the Rights of the Child?

This general comment provides guidance ensuring the respect for, and protection and fulfilment of, the rights of adolescents, including through the formulation of specific frameworks for developing policies and laws. The Committee on the Rights of the Child, which consists of 18 independent experts and monitors implementation of the CRC

by its State Parties, calls on States Parties to develop and implement – considering adolescents' evolving capacities – legislation, policies and programmes to promote the health and development of adolescents.

For more information see here.

Of note, adolescents' evolving capacities refers to an "enabling principle that addresses the process of maturation and learning through which children (and adolescents) progressively acquire competencies, understanding and increasing levels of agency to take responsibility and exercise their rights" (3).

The Optional Protocols on the sale of children, child prostitution and child pornography (see here) and on the involvement of children in armed conflict (see here) are also relevant.

Many of the CRC articles contain important obligations which contribute to the protection and promotion of adolescent mental health, including:

- the right to non-discrimination;

- civil rights and freedoms;

- respect for the views of the adolescent;

- legal and judicial measures and processes;

- protection from all forms of violence, abuse, neglect and exploitation;

- a safe, nurturing and enabling environment (school, families, communities, workplace);

- the right to information, skill development, counselling and health services.

The CRC also contains obligations concerning:

- the protection of children from cruel, inhuman or degrading treatment or punishment and capital punishment, and

- sexual abuse and exploitation.

All of the above contribute to the protection and promotion of adolescent mental health.

■ UN Convention on the Rights of Persons with Disabilities (CRPD)

Adolescents with intellectual disabilities and adolescents living in institutions are vulnerable to rights violations, and a higher prevalence of mental conditions are found among these adolescents *(6)*. States Parties have an obligation to take measures, including policy and legislative measures, to protect and fulfil their rights. Within this, it is important to ensure that coercive strategies – such as forced admission, forced treatment, seclusion, physical, mechanical and chemical restraints – are eliminated. For more information, refer here to the CRPD Article 7 – Children with Disabilities.

The CRC and the CRPD are mutually reinforcing in how they incorporate elements of key human rights standards in the protection of the rights of children with disabilities, including psychosocial disabilities. They put a focus on the removal of barriers that prevent children from full inclusion in society and on access to support and services that enable children to reach their full potential.

■ WHO's Comprehensive mental health action plan 2013–2020 (which has been extended to 2030) provides a framework for achieving mental health for all across the life course *(7)*.

■ Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation *(8)* offers strategies to guide the planning and implementation of country-level actions to improve the health of young people, within the framework of the Global Strategy for Women's, Children's and Adolescents' Health *(9)*.

Framework 2: National frameworks   2

The second framework includes national legislative and policy frameworks protecting adolescents from mental health conditions, promoting positive mental health, and reducing suicide and risk behaviours. All policies and laws formulated as part of this framework must be aligned with human rights instruments.

Legal provisions on adolescent mental health are often included in laws related to mental health, suicide prevention, substance use and alcohol, adolescent health and other concerns. Examples of relevant legislation include limiting adolescent access to and use of alcohol, banning access to firearms, and banning highly hazardous pesticides – thereby addressing key risk factors for suicide *(10)*.

Policies for promotion and protection of adolescents' mental health guide the development of systems of care, training programmes for practitioners, public health monitoring and research. Such policies set mental health promotive and preventive interventions and services for adolescents and caregivers on an integrated multisectoral platform, while addressing the wider context of developmental and mental health risk/ protective factors and socioeconomic determinants.

Table 1.1 provides an overview of domains/areas of action relating to policies and laws that are relevant to adolescent mental health promotion and prevention. Also see Boxes 1.2–1.5.

More detailed information by WHO on how to address suicide prevention, including in national strategies, can be found here.

For more information on national alcohol and drug prevention policies, refer to:

https://www.who.int/data/gho/data/themes/topics/ topic-details/GHO/alcohol-control-policies, (accessed 28 April 2021)

and

https://www.unodc.org/documents/prevention/ standards_180412.pdf, (accessed 28 April 2021).

Table 1.1 Example domains related to policies and laws for promotion and prevention in adolescent mental health

Domains	Examples of policies and laws
Financing	Investment in family benefits, child benefits and social benefits.
	Investment in education.
	Financing of community-based mental health services.
	Investing in services and supports for families (e.g. parenting programmes and services).
Intersectoral collaboration	Financial incentives for interagency collaboration.
	Participation of adolescents in programming and monitoring.
Human rights	Promotion of sexual health and reproductive rights.
	Identification, protection and support of vulnerable adolescents (e.g. adolescents with disabilities, children involved in armed conflict, refugees and migrants, orphans, adolescents in detention and/or with incarcerated caregivers).
	Policies and laws to prevent coercive practices, including forced admission and treatment as well as seclusion and restraint.
	Policies and laws on universal provision and access to education.
	Provision for all adolescents to access mental health promotion and care services.
	Consent and assent (e.g. removal of requirement for parental or guardian consent when an adolescent is seeking counselling and advice services; flexible policies to allow specific groups of adolescents to be considered "mature minors").
	Provision for all adolescents to have the right to express their views and have them taken seriously in accordance with their age and maturity.
Advocacy and social media	Mental health awareness-raising and stigma reduction.
	Awareness-raising for suicide prevention.
	Advocacy for decriminalization of suicide.
	Responsible media reporting.

Table 1.1 Example domains related to policies and laws for promotion and prevention in adolescent mental health

Domains	Examples of policies and laws
# Information systems	Surveillance of mental health outcomes, suicide and suicide attempts, and substance use.
# Research	Priorities for research investment.
# Organization of services	Multisectoral collaborative care for mental health.
	Selective and indicated access to mental health promotion and prevention programmes for adolescents exposed to vulnerabilities and risks.
	Tiered needs-based access to mental health promotion, prevention and care interventions.
	Integration of mental health promotion and prevention with management of chronic health conditions such as HIV.
	Promotion of maternal and perinatal mental health through maternal and child health services.
	Early identification and management of mental health problems and hazardous and harmful substance use.
# Mental health promotion and prevention interventions	Universal youth development and life skills training programmes.
	Universal substance use psychoeducation.
	Mental health and psychosocial support for adolescents exposed to humanitarian emergencies.
# Quality improvement	Standards for quality care services for adolescents and their caregivers.
	Confidentiality of communication and identity.
	Responsive assessment and referral systems for early detection and early treatment of mental health problems and mental health conditions.

Table 1.1 Example domains related to policies and laws for promotion and prevention in adolescent mental health

Domains	Examples of policies and laws
Safe enabling environments	Restriction of harmful use of alcohol and substance abuse.
	Provisions for secure housing.
	Access to open green and blue spaces.
	Legislation on child protection and protection from child exploitation, forced labour, trafficking, and sexual and other forms of gender-based violence.
	School-based bullying prevention.
	Gang and stress violence prevention.
	Promotion of mental health in the workplace.
	Restriction of access to means of suicide.
	Environmental interventions to prevent suicide by jumping.
	Advertising and product placement restrictions and warning and consumer labels that act to protect adolescents from substance use.
Structural sociocultural factors / socioeconomic determinants	Minimum-salary wages.
	Cash transfers.
	Legislative safeguards in relation to early marriage and harmful traditional practices.
	Gender transforming education.
Human resource development and training	Workforce training and support, including for reducing access barriers for LGBTQI adolescents and other groups of adolescents that may experience discrimination.

Table 1.1 Example domains related to policies and laws for promotion and prevention in adolescent mental health

Box 1.2

Restricting access to the means of suicide: the New Zealand amendment to the Arms Act

In 1992, New Zealand introduced more restrictive firearms legislation *(11)* which included bans on certain firearms, licensing for dealers and firearm owners that required passing training tests, police assessments of the applicant and the applicant's home, and interviews with family members.

The national suicide data was examined for 8 years before this legislation was introduced, and for 10 years afterwards *(12)*. This study showed that after legislation the average annual rate of firearm-related suicides decreased by 46% for the total population, 66% for young people (aged 15–24 years) and 39% for adults (≥ 25 years).

In conclusion, legislative restriction of access to firearms had a substantial impact on firearm-related suicide in the population, including in young people.

Box 1.3

Legislating for universal provision and access to education: Universal inclusive education policy, India

Sarva Shiksha Abhiyan (SSA) was introduced by the Indian government in 2001–2002. SSA is a national elementary educational programme for 6- to 14-year-olds and is aligned with the Right of Children to Free and Compulsory Education Act of 2009. The goals of the SSA include enrolment and

retention of all children, the bridging of gender and social class gaps in education, and the improvement of learning achievement levels of children.

As of 2015–2016, 97.9% of all male and 100% of all female children were enrolled in primary education and 88.7% of all male and 97.6% of all female children were enrolled in upper primary education *(13)*.
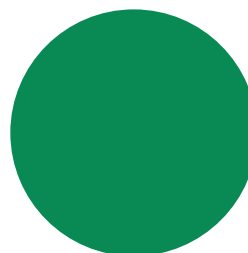
Box 1.4

Restricting access to the means of suicide: law to ban paraquat (a hazardous pesticide), Republic of Korea

In the Republic of Korea, self-poisoning with pesticide – predominantly paraquat – accounted for 20% of suicides between 2006 and 2010 *(14)*. Paraquat is a herbicide which is associated with high lethality when consumed. There is no antidote or effective treatment for paraquat poisoning yet it was identified as the most commonly employed pesticide. Paraquat was also associated with almost 80% of the fatality rate and accounted for just over a third of all poisoning cases in the Republic of Korea *(15)*.

In 2011, the government of the Republic of Korea cancelled the registration of paraquat and banned the pesticide's sale from November 2012. These actions resulted in an immediate and clear decline in suicide related to pesticide poisoning in all age groups, all genders and in both urban and rural areas.

A study investigated long-term trends in pesticide suicide rates in the Republic of Korea using registered death data *(16)*. Results of this study showed that, following the paraquat ban, there was a significant decrease in pesticide suicide.

Box 1.5

Restricting the harmful use of alcohol and other psychoactive substances: policies that prevent alcohol use in adolescents, USA

Xuan and colleagues (2015) investigated the alcohol policy environment and young people's drinking in the United States *(17)*. The alcohol policy environment included the combined effectiveness and implementation of several existing alcohol policies, including both youth-oriented alcohol policies and population alcohol policies (i.e. those that are not youth-specific, such as alcohol taxes). Data from 1999–2011 on secondary school students from grades 9–12 were included in the sample.

The authors found that a stronger policy environment was associated with an 8% reduction in the odds of young people drinking alcohol and a 7% reduction in heavy episodic drinking. This study demonstrated that stronger alcohol policies – whether focused on the general population or on young people – related to a decreased probability of adolescent alcohol use in the United States. It suggests that efforts to reduce young people's drinking should incorporate population-based policies to reduce harmful use of alcohol among adults as part of a comprehensive approach to preventing alcohol-related harms.

Example policy and law approaches at-a-glance

Table 1.2 provides four examples of relevant policy and law approaches. Note that these are a selection only and do not cover all the policy provisions and laws that would be required to support the well-being and mental health of adolescents.

Table 1.2 Law and policy approaches at-a-glance

Laws to prevent adolescent access to all firearms	These laws provide stricter licensing requirements for all firearms, combined with targeted enforcement to prevent illegal access.	**Potential outcomes** ■ Reduced suicide ■ Reduced gun-related violence and injuries	**Law example** New Zealand Arms Regulations 1992
Policies to ensure inclusive adolescent education free from discrimination	These policies prohibit exclusion of adolescents from educational settings and include the prohibition of discrimination based on caregiver status (e.g. adolescent parents), health status (e.g. HIV, psychosocial disability), gender or sexual orientation.	**Potential outcomes** ■ Improved educational achievement ■ Improved mental well-being ■ Reduced anxiety and depression	**Law example** India National Policy of Education
Laws to ban highly hazardous pesticides	These laws require bans of highly hazardous pesticides, and strict licensing requirements for pesticides combined with targeted enforcement to prevent access to hazardous pesticides.	**Potential outcomes** ■ Reduced pesticide suicide ■ Reduced self-harm	**Law example** Republic of Korea Pesticide Control Act Korea *(using Korea Legislation Research and Law Translation Center)*
Laws to prevent harmful substance use by adolescents	These laws aim to reduce harmful use of alcohol by regulating commercial marketing of alcohol (including associating alcohol with sports), by increasing the price, by establishing a minimum age for purchase, by limiting times and days of sale, and by reducing the density of outlets	**Potential outcomes** ■ Reduced risk of cognitive and mental health problems associated with harmful use of alcohol during adolescence ■ Reduced risk behaviours	**Law and policy example** United States of America Minimum Drinking Age Act 1984.

Table 1.2 Law and policy approaches at-a-glance

What works best when...

Efforts to implement this strategy may be more likely to have the intended impact when the following are in place:

1

A human rights approach is adopted in all policy, planning, legislation and service development.

2

Action is across the whole of society and is proportionate to the need to level the social gradient in health outcomes *(18)*.

3

A systemic approach towards mental health promotion and prevention is adopted in policy planning and implementation and the socioeconomic determinants of adolescents' mental health are addressed along with more proximal factors.

4

Policies are informed by a context-driven understanding of health inequalities, vulnerabilities and experiences of well-being and distress within their relational contexts.

5

Stand-alone mental health policy for adolescents (or children and adolescents) is available in addition to having adolescent mental health promotion and prevention covered in policies related to education, social welfare, disability, general health, mental health and other relevant areas.

6

Mechanisms for multisectoral collaboration are established.

7

National and local stakeholders throughout government and civil society, including adolescents and their caregivers, are fully engaged in the process of developing policies and plans using a coordinated approach.

8

Policies are supported by adolescent mental health legislation and a policy budget, which includes an accurate costing of infrastructure or services, and allocation of sufficient resources with long-term planning and sustainability strategies.

9

The role of research and researchers is reinforced in the policy development process.

10

Measures to monitor and evaluate implementation are in place, ensuring that data are disaggregated so that adolescents' age and gender are visible and the impact of policies on equity is assessed.

11

The roles of duty-bearers and rights-holders are clearly defined. For example, the primary duty-bearers may be the government and its agents (social workers, judges, police, health-care workers, teachers etc.) while the rights-holders are adolescents.

12

There are clear consequences if policies and laws are not put into action.

Focus exercise

Before moving to the specific approaches and programmes for implementing this strategy, take a moment to reflect on your setting, your goals, what is already happening and what you wish to change.

The purpose of this exercise is to help you focus on your priorities as you read more about the evidence-supported approaches and programmes for this strategy. Adolescents and their caregivers from your setting should be included when you complete this exercise.

What do you see as the biggest problem(s) in your country related to the promotion and prevention of adolescent mental health?

What policies and laws exist to address these problems? What is missing, what should stay, and what should change?

What do you see as the biggest problem(s) related to the reduction of self-harm and suicide?

What policies and laws exist to address these problems? What is missing, what should stay, and what should change?

Are existing laws functional and operating at all levels? Are laws being implemented and enforced by the relevant sectors? Is the application and compliance by service providers, communities and families being implemented? If not, what do you see as the obstacles to effective implementation and enforcement?

Are policies and laws reviewed for their impact on adolescents and caregivers? Are they reviewed for their impact on social and health inequalities?

Are most people aware of the laws that are relevant to adolescents and mental health? Is there public support for implementing the types of laws that promote and prevent mental health conditions in adolescents?

Is there widespread understanding of, and agreement with, the rights of adolescents? What are some of the human rights challenges faced by adolescents?

Implementation considerations

Policies for the promotion and protection of adolescent mental health can be part of a mental health policy, an adolescent health policy, an adolescent mental health policy or other relevant policies.

The development of a policy for promotion and prevention in adolescent mental health requires a phased approach involving:

1) gathering of information and data;

2) engaging and consulting with stakeholders, including adolescents and caregivers;

3) defining the vision, values, principles and objectives of the policies;

4) determining areas of action; and

5) defining the major roles and responsibilities of stakeholders and sectors and the strategies for multisectoral coordination *(19).*

Once the policy is available, the next steps are:

- to disseminate the policy;

- to develop a plan for promotion and prevention in adolescent mental health, which defines strategies and time frames, indicators and targets, and major activities along with related costs and budget;

- to generate political support and funding;

- to establish coordination and monitoring and evaluation mechanisms;

- to develop a supportive structure with involvement of experts and empowerment of providers and advocates;

- to set up pilot projects in demonstration areas.
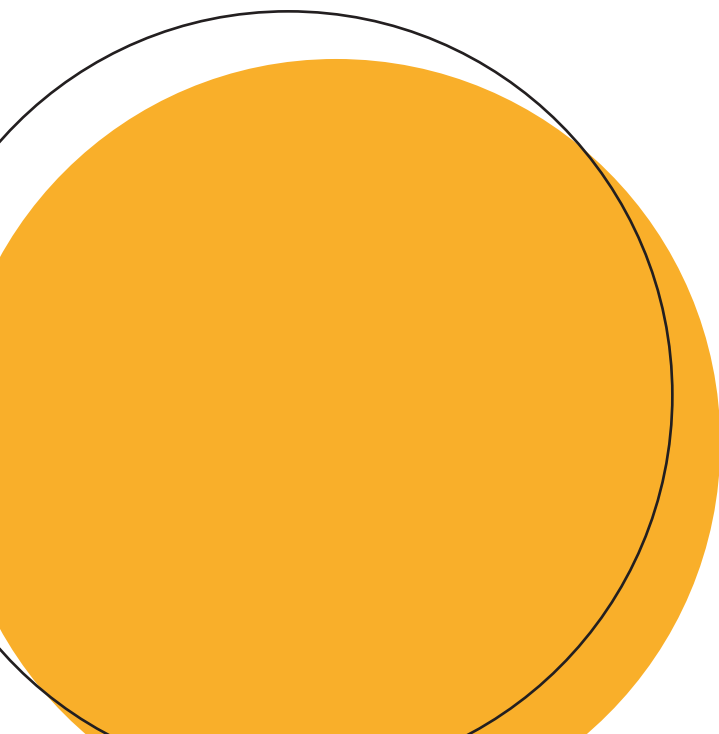
Resources

General

WHO – The WHO mental health policy and service guidance package

https://www.who.int/mental_health/policy/essentialpackage1/en/
(accessed 11 March 2021).

WHO – Child and adolescent mental health policies and plans. WHO mental health policy and service guidance package – module 11

https://www.who.int/mental_health/policy/services/essentialpackage1v11/en/
(accessed 11 March 2021).

WHO – Promoting rights and community living for children with psychosocial disabilities

https://www.who.int/mental_health/publications/promoting_rights_and_community_living/en/
(accessed 11 March 2021).

WHO – QualityRights materials for training, guidance and transformation

(These guidance and training materials build capacity of national stakeholders to integrate human rights into policy, planning, legislation and practice)

https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools
(accessed 11 March 2021).

WHO – MiNDbank: More Inclusiveness Needed in Disability and Development

http://www.mindbank.info/
(accessed 11 March 2021).

WHO – Mental Health ATLAS

https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/
(accessed 11 March 2021).

Suicide prevention

WHO – National suicide prevention strategies: progress, examples and indicators

https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/
(accessed 11 March 2021).

WHO – INSPIRE: Seven strategies for ending violence against children

https://www.who.int/publications/i/item/inspire-seven-strategies-for-ending-violence-against-children
(accessed 11 March 2021).

UN Treaties, Treaty Monitoring Bodies and General Comments

Rights of the Child

United Nations – Committee on the Rights of the Child: Convention on the Rights of the Child (CRC)
https://www.ohchr.org/en/professionalinterest/pages/crc.aspx
(accessed 11 March 2021).

UNICEF – Simplified version of the Convention on the Rights of the Child
https://www.unicef.org.au/Upload/UNICEF/Media/Our%20work/childfriendlycrc.pdf
(accessed 11 March 2021).

United Nations – Comitee on the Rights of the Child (CRC): General Comment on the implementation of the rights of the chid during adolescence (2016)
https://www.ohchr.org/_layouts/15/WopiFrame.aspx?sourcedoc=/Documents/HRBodies/CRC/GC_adolescents.doc&action=default&DefaultItemOpen=1
(accessed 11 March 2021).

United Nations – Committee on the Rights of the Child (CRC): General Comment No. 4 (2003) on Adolescent health and development in the context of the Convention on the Rights of the Child (2003)
https://www.refworld.org/docid/4538834f0.html
(accessed 11 March 2021).

United Nations – Committee on the Rights of the Child (CRC), General Comment No. 3 (2003) on HIV/AIDS and the Rights of the Child, 17 March 2003
https://www.refworld.org/docid/4538834e15.html
(accessed 11 March 2021).

United Nations – Committee on the Rights of the Child (CRC), General Comment No. 13 on the right of the child to freedom from all forms of violence
https://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf
(accessed 11 March 2021).

United Nations – Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict
https://childrenandarmedconflict.un.org/tools-for-action/optional-protocol/
(accessed 11 March 2021).

United Nations – Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography
https://www.ohchr.org/en/professionalinterest/pages/opsccrc.aspx
(accessed 11 March 2021).

Rights of Persons with Disabilities

Convention on the Rights of Persons with Disabilities (CRPD)
https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html
(accessed 11 March 2021).

United Nations – Convention on the Rights of Persons with Disabilities (CRPD) Article 7: Children with disabilities
https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-7-children-with-disabilities.html#:~:text=States%20Parties%20shall%20take%20all,2
(accessed 11 March 2021).

United Nations – Convention on the Rights of Persons with Disabilities, General Comment No. 3, Article 6: Women and girls with disabilities
https://www.refworld.org/docid/57c977344.html
(accessed 11 March 2021).

Others

WHO – The WHO mental health policy and service guidance package

https://www.who.int/mental_health/policy/essentialpackage1/en/ (accessed 11 March 2021).

United Nations – International Covenant on Civil and Political Rights

https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (accessed 11 March 2021).

United Nations – International Covenant on Economic, Social and Cultural Rights

https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx (accessed 11 March 2021).

United Nations – Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

https://www.ohchr.org/en/professionalinterest/pages/cat.aspx (accessed 11 March 2021).

International Convention on the Elimination of All Forms of Racial Discrimination

https://www.ohchr.org/en/professionalinterest/pages/cerd.aspx (accessed 11 March 2021).

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

https://www.ohchr.org/EN/ProfessionalInterest/Pages/CMW.aspx (accessed 11 March 2021).

United Nations – Convention on the Elimination of All Forms of Discrimination Against Women

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United Nations – General discussion on violence against children

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Strategy 2
Environments to promote and protect adolescent mental health

Objective

Ensure that all adolescents live, study, work and socialize in supportive, healthy and safe environments that promote and protect their mental health and reduce their engagement in risk behaviours.
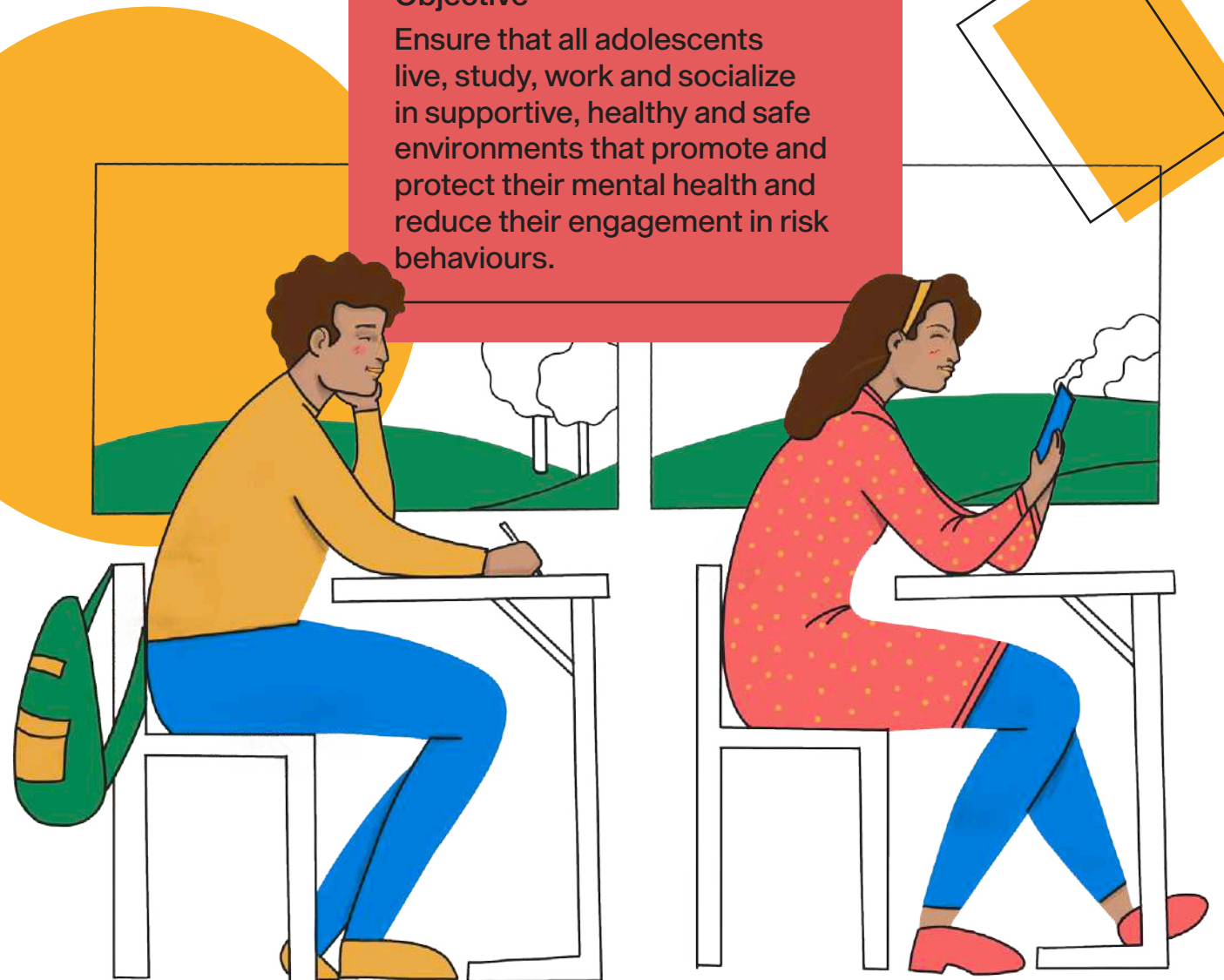
Rationale

Mental health-promoting environments allow individual and collective mental health to flourish *(1)*. They share a common set of factors that place value on children's, adolescents' and adults' right to mental health. During adolescence, these environments are particularly important for a number of reasons. Adolescence is a time of developmental transition during which individuals may increasingly seek approval from their peers and may make decisions about seeking novel experiences. Modifying young people's social environments can mitigate the impact of risk factors on their mental health. Mental health-promoting environments can enhance mental health outcomes directly, as well as facilitate access to resources and support systems.

The environments in which adolescents live are profoundly influenced by social and political factors *(2)* including socioeconomic status, physical and mental health, employment and employment conditions, access to education, community safety and cultural norms. Efforts to develop and implement mental health-promoting environments for adolescents should take place within efforts to address poverty, inequality and violence, and to promote access to critical services for adolescents – such as education, social protection, skills development, safe recreational spaces and health services (including HIV, sexual and reproductive health, and mental health services) *(2)*.

This chapter focuses on three environments in which adolescents may spend considerable time: their schools, their communities and the Internet. In addition, work conditions and their influence on the mental health of young people are briefly discussed (Box 2.1).
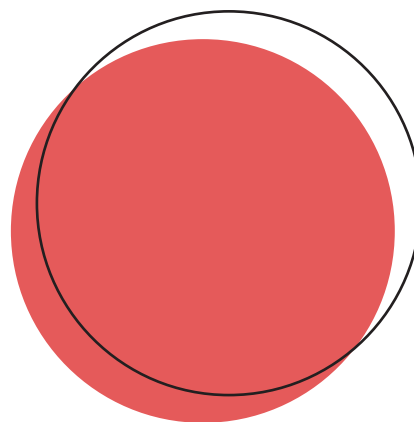
Schools

Schools are important spaces for addressing adolescent mental health. Apart from being structures for academic learning, schools are places where many adolescents spend most of their time – places where they interact with peers and develop their social and emotional skills *(3)*. Educators, school support staff and peers are well-placed to identify and respond to risk factors and emerging mental health conditions in adolescents, and/or connect adolescents to additional resources. The school climate is defined as the "pattern of students', parents', and school personnel's experience of school life [that] reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures" *(4)* and can have a significant impact on adolescent health outcomes. Poor school climates have been associated with worse academic performance, increased violence, risky sexual and reproductive health behaviours, tobacco use and higher levels of problem behaviour *(5–9)*. However, developing a positive school climate, such as through the Health-Promoting Schools approach, creates conditions that are conducive to better health and educational outcomes and influences health behaviours to the benefit of students, school personnel and the broader community *(10).*

Communities
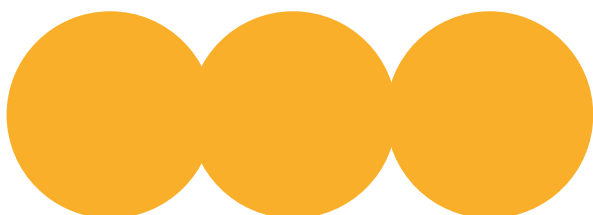
Communities are the broader environments in which adolescents participate or belong. These may include living spaces and neighbourhoods, and also the activities that adolescents engage in outside of school or work, such as sports teams, extracurricular communities or youth groups.

The communities in which adolescents engage can be important spaces for facilitating well-being, safety and social and emotional development. Communities can serve as a platform to foster neighbour and friendship networks, providing sources of social support that promote positive mental health outcomes *(11).* Mental health-promoting communities offer increased opportunities for youth engagement, which can be a powerful influence as adolescents transition to adulthood and discover a stronger sense of identity and participation *(12).*

◼ Internet use

Internet use has a link with adolescent well-being, although the direction of the causal relationship is not always clear. Adolescents engage with the Internet in different ways, with wide variation in access as well as user patterns, and different risks and benefits associated with different types of activities *(13)*. Low self-regulation, low self-esteem and depression have all been linked to high levels of use, while low levels of depression, aggression and other externalizing behaviours have been associated with moderate use *(14, 15)*. On one hand, the Internet can provide a positive, supportive space that bolsters adolescent well-being and advances civic engagement *(16)*. For instance, social media use can improve socialization, communication and perceived social support, enhance learning opportunities, and increase access to health information *(17, 18)*.

On the other hand, the negative effects of social media use include impacts on adolescent self-esteem, body image and identity *(19)*. Gaming also has both both positive and negative influences: it can improve working memory and attention but it is also associated with poorer educational outcomes and peer problems *(20)*. Overall, the negative impact of Internet use might be particularly marked in adolescents as compared to adults since the developing brain is typically more unstable and self-regulatory processes and control are still developing *(21, 22)*. Overall, it has been shown that adolescents with protective personality traits (e.g. happiness, high purpose in life) are less likely to involve themselves in negative online behaviours *(19)*. While causal relationships are difficult to define, it appears that adolescents who are already at risk of poor mental health outcomes are rendered even more vulnerable by negative online experiences.
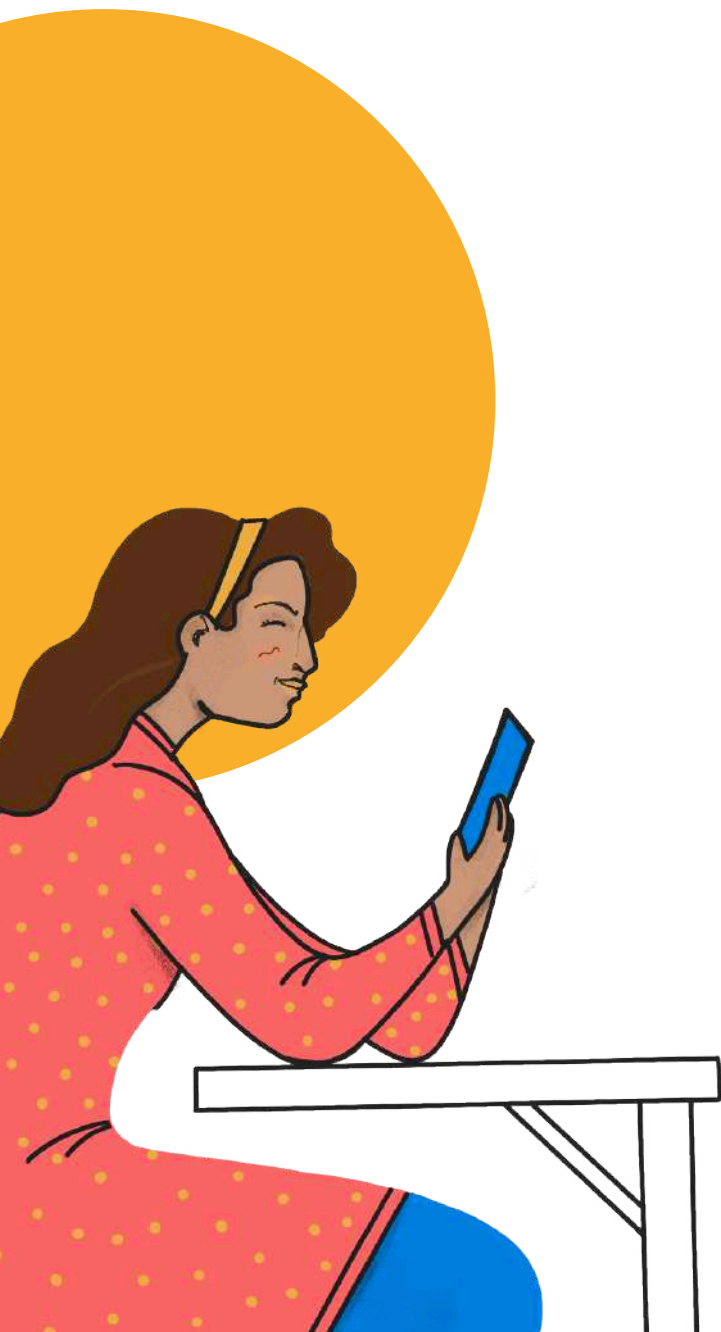
Box 2.1

Young people, mental health and work

In the transition to adulthood, work begins to have an influence on the lives of many adolescents. Work, including working conditions, can therefore be a key social determinant of mental health among adolescents. Unemployment, the work environment and work organization can have a significant impact on the mental health and well-being of people who work.

International standards for the minimum working age in countries is 15 years (13 years for light work), and the minimum age for hazardous work is 18 years (or 16 years under strict conditions). In countries where education and the economy are less well developed, the minimum working age is set at 14 years (12 years for light work) *(23)*.

Engaging in work which does not affect their health and education can be beneficial to adolescents' development and participation in society. However, many adolescents below and within the above–mentioned ages are at risk of child labour – work which harms their physical and mental health, safety, morality, dignity, development and education – including the worse forms of child labour *(24)* and hazardous child labour *(25)*.

An estimated 88 million adolescents aged 15–17 years are working, with almost half in child labour conditions and almost half of those working in hazardous conditions *(26)*. This form of labour not only poses a risk to mental health but also increases the likelihood of exploitation, discrimination and mistreatment at work due to age or sociodemographic status. For the migrant population, discrimination and mistreatment amplify the likelihood of poor mental health *(27)*.

The majority of child labour is in the agricultural sector and many young people work in informal employment. This poses challenges for utilizing the work setting to implement interventions for mental health promotion and prevention since such workers may not benefit from social protection, thus impeding their access to care.

Where the risks to health and development in working conditions cannot be improved or mitigated, strategies should be in place to facilitate the removal of adolescents from hazardous work and to ensure provision of transitional support services and the opportunity to find decent work *(26)*.

Young people should benefit from promotion of their mental health, prevention of risks to their mental health (including access to evidence-based psychosocial prevention; management, removal or mitigation of psychosocial risk factors in the workplace, with consideration of the risks specifically faced by younger workers; and access to staff who are trained in management practices and in supporting staff in distress) and access to mental health services and return to work support where needed.

There is a substantial knowledge gap in understanding the needs of young workers in different sectors and in identifying risks which affect their mental health in this working population. This gap must be filled in order to better support young people as they transition to adulthood and enter the workforce.

Approaches

This section outlines evidence-informed approaches that can be used in these environments.

School environment

Adolescent mental health programmes are often delivered through schools due to high levels of enrolment (although these diminish with age), low programme attrition rates, efficient use of resources and the existing adolescent-focused workforce and structures in place. Improving the school environment can be an effective way to address structural barriers to engagement in health programming *(28).* There is good evidence that there are links between school-related variables and mental health and that intervening through schools can improve adolescent mental health *(3)* (Figure 2.1).

The Health-Promoting Schools model uses six strategies to promote good health: school-level policies, the physical environment, the social environment, the health curriculum, and linkages to community and health services. The WHO and UNESCO initiative *Making Every School a Health Promoting School* aims to build the capacity of the education sector to promote health and well-being through a whole-school approach *(33).* Eight global standards for health-promoting schools have been established, including one standard that is focused on creating a safe social-emotional environment for students *(34)* (Table 2.1).

1

Mental health literacy

Positive interpersonal relationships

School safety

School connectedness

Positive mental health

Reduced mental health conditions

Reduced risk behaviour
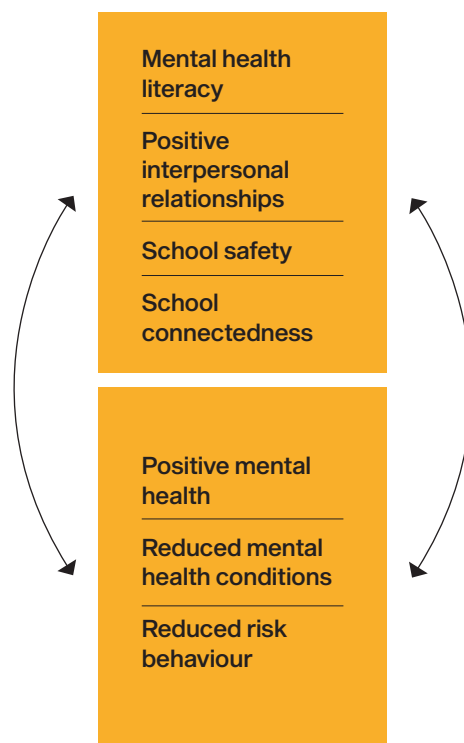
Figure 2.1 Relationships between school climate and student mental health *(3, 29–32).*

Table 2.1 Global standards and standard statements for health-promoting schools

1   **Government policies and resources**

There is whole-of-government commitment to and investment in making every school a health-promoting school.

2   **School policies and resources**

There is commitment to a whole-school approach to being a health-promoting school.

3   **School governance and leadership**

There is a whole-school model of school governance and leadership to support being a health-promoting school.

4   **School and community partnerships**

There is engagement and collaboration within the school community, including with students and between the school and local communities for health-promoting schools.

5   **School curriculum supports health and well-being**

The school curriculum supports physical, social-emotional and psychological aspects of student health and well-being.

6   **School social-emotional environment**

The school has a safe and supportive social-emotional environment.

7   **School physical environment**

The school has a healthy, safe, secure and inclusive physical environment.

8   **School health services**

All students have access to comprehensive school-based or school-linked health services that address their physical, emotional, psychosocial and educational health-care needs.

Examples of strategies for improving the school environment to promote mental well-being across a diverse range of evidence-based programmes are described in more detail below.

■ Improving the school climate

School climate refers to how students, teachers, parents and other members of the school community experience the school environment. It includes the norms and values of the school, relationships within the school environment, teaching and learning activities, school policies and management structures *(35)*. Fostering a positive and supportive school climate has the potential to influence a wide range of health outcomes, including improving adolescent mental health *(35)* (Box 2.2).

Box 2.2

Strengthening the evidence base on school-based interventions for promoting adolescent health programme (SEHER)

The SEHER programme aims to improve the school climate as a means to influence adolescent health outcomes. A core part of the programme uses whole-school activities which are designed to focus on selected health-related themes each month over the duration of project implementation. Activities included: the establishment of a School Health Promotion Committee comprising students, teachers, parents and school management; awareness-raising activities; a suggestion and complaints box; a wall magazine; competitions; and the adaptation and adoption of policies on bullying and substance use. These activities took place in conjunction with other group and individual activities. The intervention was evaluated in a randomized controlled trial in Bihar, India. This showed that the intervention improved the school climate and had a significant positive impact on depression symptoms, bullying, violence and a number of other health-related outcomes for 13- to 14-year-old students, when delivered by lay counsellors, compared either to controls or to a teacher-delivered version of the same intervention. It was the first study from a LMIC assessing the effectiveness of a whole-school intervention to improve the school climate and adolescent health outcomes *(35)*.

◼ Improving school safety

School safety can be improved through the reduction of violent behaviours within the school environment. As an example, anti-bullying programmes focus on reducing negative behaviours and promoting positive behaviours *(36)* and can include components such as discipline planning, teacher training, caregiver engagement and improved supervision. These programmes are most successful when they use a multilevel approach that reaches – and targets behaviour change in – students, teachers and school leadership *(37)*. The development of governance-level policies can outline minimum standards for the school environment and how they can be implemented and monitored, together with accountability mechanisms. These programmes address various behaviours that threaten well-being at school – including violence, drug abuse and sexual harassment – as well as addressing elements of infrastructure to improve well-being within schools (e.g. classroom layout, recreational activities) (Box 2.3).

Box 2.3

Improving school safety: ViSC Social Competence Program

The ViSC was delivered to secondary schools in Austria with the aim of reducing levels of aggressive behaviour and victimization. In addition to targeting the individual behaviour of students, the programme aimed to initiate change processes at the school level by improving knowledge and competence among teachers. The programme focused on the responsibility of the school as a whole to prevent violence in schools. It was delivered through in-school teacher training sessions, delivered by ViCSC coaches, and a class project (including a manual) delivered to students through teachers. The programme included content on aggressive behaviour, problem-solving skills and assertiveness training. It was evaluated through a cluster randomized controlled trial which found that the programme effectively reduced levels of victimization *(38)*.
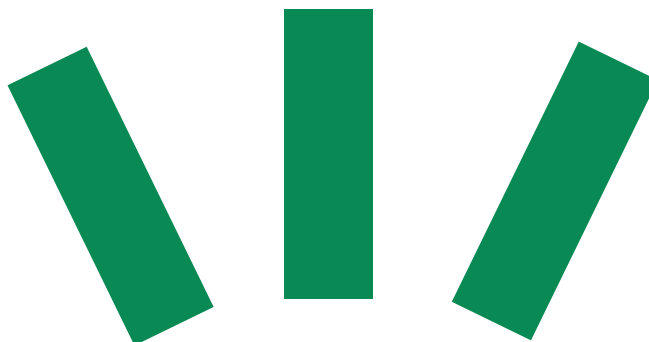
■ Promoting teacher well-being

Another key strategy is to deliver programmes to teachers in school settings to promote teacher well-being *(39)*. These programmes can improve the mental health of teachers, which has previously been found to be associated with higher social and emotional well-being in students *(40)*. This can have an indirect beneficial effect on the well-being of students by teaching teachers how to engage more effectively with students in the classroom or employ constructive classroom management techniques (Box 2.4).
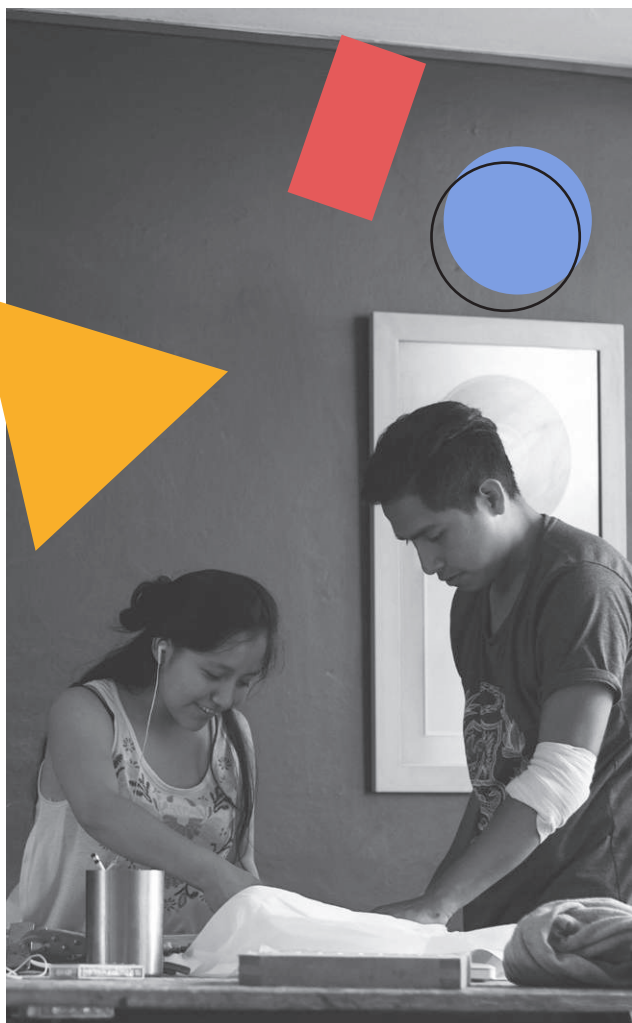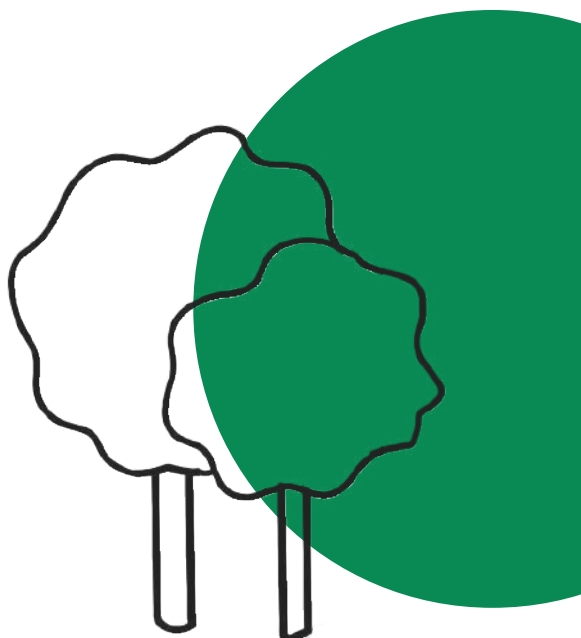
Box 2.4

Improving teacher well-being: Well-being in Secondary Education (WISE)

The WISE programme focused on supporting teachers' mental health and trained them in supporting student mental health. The programme offered support services to teachers through the formation of peer support groups that were led by nominated teachers. These teachers received training on adolescent mental health and how to recognize signs and symptoms of distress. The impact of the intervention programme was assessed through a cluster randomized controlled trial in England and Wales, which found that the programme was successful in improving knowledge, attitudes and confidence in supporting others *(41)*.

■ **Promoting adolescent participation in school interventions**

Using peers as delivery agents in school-based programmes can improve healthy behaviours and reduce risk behaviours in adolescents. Adolescents often react better to programmes delivered by peers as they find these more engaging and credible than adults in education and skills training *(42)*. These programmes provide participants with the opportunity to model positive behaviour in order to improve health-related outcomes. Peer leaders demonstrating positive behaviour (e.g. prosocial behaviour) can increase the reach of positive behaviour through adolescent social networks (Box 2.5) *(43)*.

Box 2.5

Promoting adolescent participation in interventions: Source of Strength (SOS)

SOS is a global school-based programme that aims to improve positive norms relating to suicide prevention (e.g. seeking help from an adult), social connectedness and use of positive coping skills. SOS is delivered through peer leaders from diverse social groups, including at-risk adolescents, who received training in changing the norms and behaviours of their peers through well-defined messaging activities. Peer leaders modelled and encouraged other students to:

1) identify a "trusted adult" in order to improve youth–adult communications;

2) reinforce the idea that adolescents should ask for help from a trusted adult when identifying a suicidal peer; and

3) identify and use interpersonal and formal coping resources.

The effect of SOS was evaluated through a cluster randomized controlled trial in the USA. Results show that the programme was significantly successful in increasing the perception of adult support in suicidal adolescents and the acceptability of seeking help *(43)*.

Community environment

2

Community-based interventions have the benefit of being able to reach all adolescents, irrespective of whether they are attending school or not. Adolescent participation in extracurricular activities – such as sports, drama and art groups, youth clubs or religious groups – has consistently been associated with improved mental health and well-being *(44)*. Community services can also play an important role in promoting mental health awareness, reducing stigma and discrimination, supporting social inclusion and preventing mental health problems *(45)*. In contrast, adolescents living in communities with high levels of adversity or with low levels of resources are more likely to have poor mental health outcomes *(46)*. Adolescents living in poor neighbourhoods are more likely to be exposed to adverse life events compared to those living in high-income communities *(47)*.

They have a higher risk of being exposed to violence, either as victim or perpetrator, which can be detrimental to adolescent mental health *(48)*. Research has found that living in a community that experiences high levels of adversity and violence is associated with an increase in depressive symptoms, anxiety and externalizing behaviour *(49, 50)*. Common strategies for improving the community environment are described in more detail below *(35)*.

■ Adolescent-friendly spaces

This strategy refers to the creation of alternative safe spaces where adolescents can engage in everyday activities (Box 2.6). Adolescent-friendly spaces typically provide adolescents with a safe and supervised environment where they can engage in a range of recreational, psychosocial and learning activities *(51)*. These require specific developmentally appropriate considerations, as compared to child-friendly spaces, such as opportunities for adolescents to attend and run programmes, and can promote adolescents' physical and mental health and educational performance *(52)*.

Box 2.6

Creating safe spaces for adolescents: adolescent-friendly spaces in post-earthquake Nepal

Following the 2015 Nepal earthquake, an initiative to set up child- and adolescent-friendly spaces was taken up by Plan International. The aim of these 88 friendly spaces was to provide a physically and emotionally safe environment where those affected by the earthquake could receive immediate life-saving information, protection, and educational and psychosocial support. More structured activities such as life skills and sexual and reproductive health sessions were gradually integrated. Adolescents reported that the friendly spaces contributed to their psychosocial well-being and provided them with the space to share their experiences with others (51).

■ Improving the built environment

Promote sustainable urban planning and transport adapted for safe cycling, walking and protecting children from ambient air pollution (e.g. removing waste sites around schools). Enhance development, improvement and maintenance of infrastructures, including schools, housing and the physical environment (e.g. facilities and spaces within and surrounding school grounds and playgrounds) to ensure safe and healthy physical and social environments for adolescents. This includes preventing exposure to environmental and developmental hazards such as high levels of air pollution, both indoor and outdoor, reducing exposure to pesticides, avoiding toxic chemicals in buildings and cleaning/maintenance products (e.g. lead paint, asbestos) and ensuring access to ultraviolet shade areas *(53–55)*.

Green spaces, such as parks that provide environments for relaxation and sports and reduce exposure to noise and air pollution, should be prioritized by policy-makers and urban planners in order to protect the mental health of populations, particularly in urban areas *(53)*. Access to natural environments can also facilitate involvement in physical exercise *(54)*. Communities with green spaces such as parks and playgrounds are associated with better positive mental health outcomes in adults *(55)*, although data on children and adolescents are limited *(56)*.

Online environment   3

Adolescents engage with the Internet in different ways, with wide variation in access and user patterns and with different risks and benefits associated with different types of activities *(13)*. By taking part in online activities, however, adolescents are exposed to a specific set of risks which may undermine their mental well-being *(17)*. For instance, the reach of cyberbullying (harassment of others using digital platforms) extends further than traditional bullying, with the potential for messages to be transmitted at any time. Cyberbullying can involve the often anonymous sharing of personal and private information *(60)*. It has been linked with a number of negative mental health outcomes for both perpetrators and victims, while protective factors against perpetration include empathy and academic performance, and against victimization include self-esteem and social skills *(61)*. There is also a risk of increased exposure to developmentally inappropriate content online. On one hand, social media can provide space for adolescents to express themselves and have opportunities to explore and develop their identity, including gender identity and sexual orientation. On the other hand, adolescent engagement in sexual behaviours such as sexting and cybersex may be detrimental if they do not have a fully developed understanding of the risks. Adolescents are also at risk of increased exposure to cyberstalking, revenge pornography and grooming by adults *(62)*. Viewing of violent pornography is linked to perpetration of sexual violence *(19)*. Specific types of advertising targeting adolescents online are another growing concern. In particular, unregulated alcohol marketing and pro-alcohol messages and images can increase brand awareness and alcohol use *(63)*.

Unlike other environments, it is difficult to change the online environment directly. However, a number of different approaches can be employed to promote safe and healthy use of the Internet through targeting adolescents, parents and teachers. These approaches improve knowledge and behaviours around Internet use, develop skills to maintain healthy use of the Internet, and create virtual walls to protect adolescents from unsafe activities or people online *(19)*.
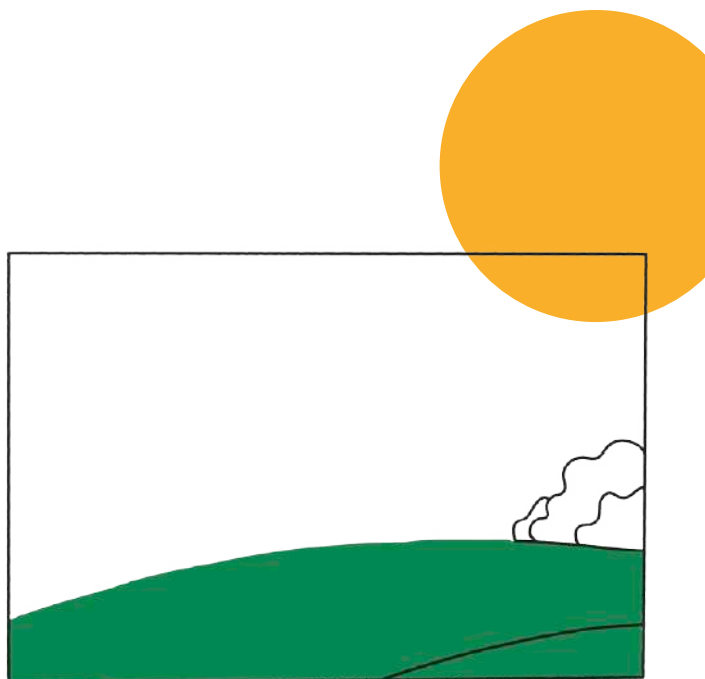
■ Adolescent training programmes

Social and emotional learning programmes can be used to develop skills to use the Internet responsibly and safely, reduce Internet-related risk exposure, educate on cyberbullying, and promote safety online, cyber citizenship, cybersecurity and law enforcement in addition to reducing cyberbullying and victimization (Box 2.7).

Box 2.7

Adolescent training to reduce cyberbullying: the Asegúrate Program

The Asegúrate Program is a Spanish school-based intervention programme that aims to prevent and reduce cyberbullying, cyber-victimization and cyber-aggression. The intervention programme consists of eight sessions delivered by teachers who have received training in the didactic Asegúrate package.

The intervention focuses on communication, self-regulation skills, social networks, online behaviour, establishing safe online friendships, and abuse through the Internet. The intervention was evaluated through a quasi-experimental design with two data points – pre-test and post-test. The results show a significant decrease in cyberbullying, cyber-victimization and cyber-aggression in the intervention group *(64)*.
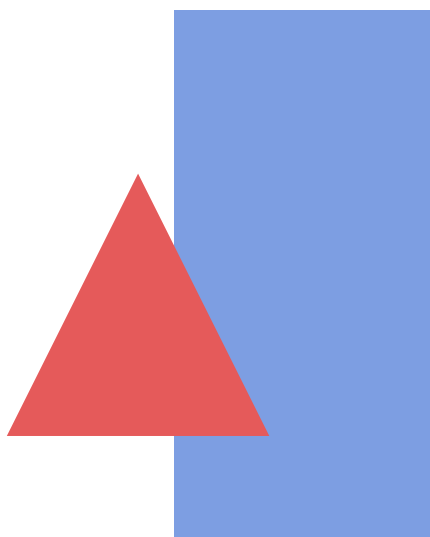
■ Parent training programmes

Parenting programmings support caregivers to develop skills in communication, setting limits, family routines and respecting the adolescent's privacy. These programmes can also have an additional focus on training caregivers on how to promote their adolescent's safe use of the Internet, including active intervention to protect adolescents from severe risks (such as monitoring or keeping the device in a shared space), developing family media plans (e.g. appropriate rules regarding Internet use, limits for social media use), but also promoting adolescents' skills to engage online responsibly and to maintain privacy. These programmes work best when they combine a number of different skills, including active monitoring, but also support adolescents to develop skills in how to use the Internet responsibly, co-using media with adolescents *(65)* and encouraging Internet use that supports social interaction *(18, 66)*. Engaging caregivers has been identified as critical in anti-cyberbullying programmes with significant outcomes *(67)*.

■ Technological tools

This strategy refers to the use of applications or websites that promote online safety by using filtering and blocking software *(68)*. There is a variety of different types of tools – such as mobile applications that include caregiver controls (through monitoring, restriction and active mediation), adolescent self-regulation tools (through self-monitoring, impulse control and risk-coping) *(69),* and language screening systems that identify and flag abusive language. Many social media sites include systems where adolescents and other users can report abuse and harassment. Other emerging approaches include artificial intelligence-driven reporting systems that identify specific mental health-related language, although there remain a number of concerns about how these programmes are monitored and how the information is used *(69)*. Table 2.2 gives an overview of the different types of interventions, their targets and their potential outcomes.

Example environment approaches at-a-glance

These approaches represent evidence-based, prudent or promising practice in enhancing the quality of environments for promotion and protection of adolescent mental health.

Table 2.2 Interventions at-a-glance

School-based	Programmes to improve school climate, school safety, teacher well-being, adolescent engagement.	**Targeted at** School students, teachers, school management	**Potential outcomes** Improved positive mental health (empathy, social skills, communication, coping skills), reduced mental health conditions (depression, anxiety), reduced risk behaviours (including violence and bullying), improved social and emotional competencies in teachers, improved teacher-student relationships
Community-based	Programmes to improve environments where adolescents live and socialize (including adolescent-friendly spaces), improvements to the built environment, access to healthy extra-curricular activities	**Targeted at** Adolescents	**Potential outcomes** Improved positive mental health (e.g. coping skills, self-efficacy), improved social, emotional, and cognitive competencies (e.g. resilience, coping, problem-solving, relationships, communication skills), individual functioning
Online	Programmes to improve how adolescents manage risk exposure related to Internet use (including through adolescent and caregiver training programmes), and use of technological tools to reduce exposure to negative online influences	**Targeted at** Adolescents and their caregivers, legislators	**Potential outcomes** Improved mental health (self-esteem, empathy, social skills, communication, coping skills), improved knowledge of online safety, digital citizenship, cybersecurity, legal issues, limited exposure to risks (reduced time spent online, contact with online threats)

Table 2.2 Interventions at-a-glance

What works best when...

Efforts to implement this strategy may be more likelyto have the intended impact when:

1
The policy and legislative framework is supportive of initiatives to promote and protect adolescent mental health.

2
A whole-of-government or whole-of-society approach is used, in which different sectors are engaged in specific roles under an established coordinating mechanism.

3
Different sectors are sensitized to the needs of adolescents, especially where services are designed more specifically to address the needs of younger children or adults.

4
There are sufficient financial resources available across sectors to ensure the successful development, implementation and sustainability of interventions to transform adolescents' environments. Resources should be allocated equitably to ensure cover for marginalized adolescents. Ensuring adequate resource allocation should be the responsibility of the government in partnership with others such as development banks, finance institutions and the private sector *(71)*.

5
Efforts are designed to be sustained over time: interventions of longer duration are more effective than short-term efforts.

6
Interventions are designed to be scaled up at the initiation stage, and not restricted to limited locations, in order to ensure extended reach in the longer term.

7
Adolescents are consulted and involved in efforts to improve their environments.

Focus exercise

Take a moment to reflect on the environment
that you wish to modify, what activities are already
underway and what you would like to change.

**Where do adolescents spend most of their
time in this setting?**

**In which environments are they most exposed
to risk that might influence their mental health
negatively or positively?**

**What aspects of the environment,
or the way that adolescents engage
with it, affect adolescent mental health?**

**Are these aspects of the environment
modifiable? In order to modify them,
what activities need to take place?**

**What technical support or other capacity
exists in this setting?**

**In order to implement these changes,
which partners need to be involved?
Which of these partners has not already
been actively engaged?**

**How might you engage community
stakeholders, including adolescents
themselves, in improving environments
to promote and protect adolescents
mental health?**

**What are the roles of other sectors? How
might multisectoral action for improving the
environment be initiated and sustained?**

**What training, supervision and other capacity
needs exist in order to implement changes to
the selected environment?**

**On which outcomes are you able to
have an impact by improving or enhancing
these elements?**

**How will you measure the impact
of the programme?**

Implementation considerations

- Transforming environments to promote and protect mental health is complex and depends on engagement with stakeholders from many different backgrounds and sectors with diverse sets of priorities. It is therefore important to invest efforts in developing a shared vision and outcomes from the start *(72)*.

- Interventions should be implemented at multiple levels and in multiple settings, using different approaches to reinforce efforts and to ensure a comprehensive response *(73)*.

- Interventions should be implemented within contexts where adolescents' civil, political, economic, social and cultural rights are upheld *(72)*.

- Effective modification of environments relies on collective action by a range of stakeholders. In many instances, in a given context there will be existing practices and traditions in place which support mental health, even if they are not identified as doing so *(72)*. It is important to ensure that efforts to change environments are contextually and culturally appropriate and equitable *(73)*.

- There should be long-term investment in sustaining the intervention and evaluating its impact *(73)*.

For more information on Implementation Approaches, see page 126.
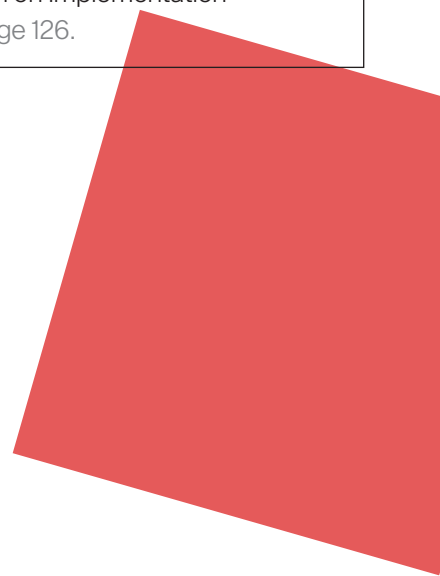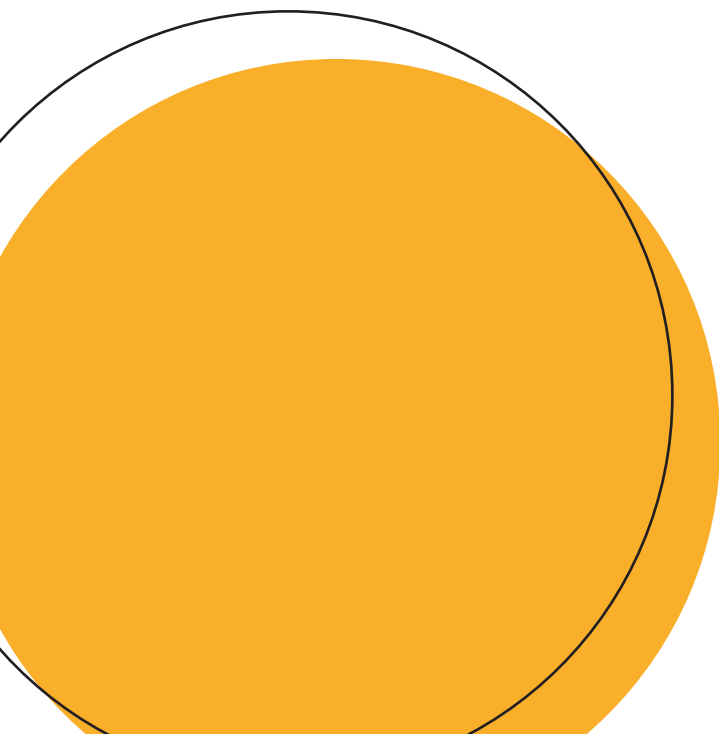
Resources

WHO – Promoting mental health: concepts, emerging evidence, practice: a summary report

https://www.who.int/mental_
health/evidence/en/promoting_
mhh.pdf
(accessed 7 March 2021).

Department of Health, Scotland – Making it happen: a guide to delivering mental health promotion

http://www.
mentalhealthpromotion.net/
resources/makingithappen.pdf
(accessed 7 March 2021).

Center for Addiction and Mental Health – Best practice guidelines for mental health promotion programmes for children and youth

https://www.porticonetwork.ca/
documents/81358/128451/Best+
Practice+Guidelines+for+Mental
+Health+Promotion+Programs+-
+Children+and+Youth/b5edba6a-
4a11-4197-8668-42d89908b606
(accessed 7 March 2021).

WHO – School and youth health resource page

https://www.who.int/school_
youth_health/gshi/hps/en/
(accessed 7 March 2021).

WHO – Information series on school health

https://www.who.int/school_
youth_health/resources/
information_series/en/
(accessed 7 March 2021).

Children in Emergencies – Toolkit

https://childreninemergencies.
org/2016/07/14/example-
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Strategy 3
Caregiver support

Objective

Ensure caregivers are supported to promote and protect adolescent mental health and reduce their engagement in risk behaviours.

Rationale

Caregiving of adolescents is a complex undertaking that requires continued adjustment to meet the needs of adolescents as they mature and acquire more autonomy. Despite the shift in roles and relationships, caregivers maintain a primary role in promotion and protection of adolescents' wellbeing. Positive relationships with caregivers during adolescence can have a profound influence on adolescent development and mental health outcomes that is sustained into adulthood and even across generations *(1)*.

Caregivers and adolescents, and the caregiving relationship, are greatly influenced by a range of interlinked and mutually reinforcing environmental, social and political factors *(2)*. These include poverty and inequality, gender norms, access to education and health services, and exposure to violence and conflict. Caregivers can act as a protective buffer against negative influences in adverse contexts *(2)*. However, caregivers living in conditions of adversity often experience high levels of stress themselves and require support *(3)*.

A strong evidence base demonstrates that interventions to support caregivers can promote and protect adolescent mental health *(4)*. Parenting support programmes can improve caregiver well-being, increase caregiver mental health literacy, and provide opportunities for caregivers to strengthen parenting skills, practice new ones and be empowered to use them *(4)*. Such programmes also provide opportunities to improve family environments for adolescents, strengthe social support and address gender-specific risk factors. All caregivers (and their adolescent children) benefit from this kind of support, but not all caregivers require the same level or intensity of intervention, and needs may fluctuate and evolve over time.

Approaches

Interventions can be defined as:

Universal Interventions   1

when they are intended to
benefit all caregivers

Targeted Interventions   2

when they are designed to reach
and benefit at-risk caregivers or
caregivers of at-risk adolescents

Indicated Interventions   3

when they are for caregivers
of adolescents with symptoms
of mental health conditions (Figure 3.1)

Psychosocial interventions to support caregivers
in their capacity to promote adolescents' mental
health may vary in content and delivery approaches
depending on the specific constellation of protective
and risk factors caregivers and adolescents are
exposed to, parenting styles and practices, gender
and age of the adolescents as well as the availability
of other mental health resources in the local setting.

However, it is possible to identify a few common
targets of caregiver psychosocial interventions for
promoting adolescent mental health. Key factors
that are associated with improved mental wellbeing
and reduced risk behaviours in adolescents include:

**Caregiver–adolescent relationship
and communication**

Caregiver mental wellbeing

**Positive parenting skills including positive
discipline strategies**

Family cohesion

Family social network *(5–7)*

Interventions for adolescents' caregivers that aim to
promote or improve adolescent mental health should
include one or some of the components described in
Table 3.1. It is important to ensure that such caregiver
support and parenting programmes give priority to
strenghting caregivers' competencies, building on
their skills and strengths *(8–10)*.

Universal	Targeted	Indicated
All caregivers	Caregivers of adolescents with known risk factors; caregivers exposed to risks or vulnerabilities (at individual, family or community level)	Caregivers of adolescents with symptoms of mental health conditions

Figure 3.1 Beneficiaries of universal, targeted and indicated caregiver support interventions

Table 3.1 Evidence for components in caregiver psychosocial interventions.

Psychosocial component	Evidence
Support to promote nurturing family environments	Caregivers play a critical role in helping to ensure adolescents feel loved, heard, valued and supported in decision making, and that they experience a sense of belonging and acceptance within the family. Interventions that promote increased caregivers' involvement in parenting, increased time spent in joint pleasant activities and that promote strategies for providing structure, limits, supervision and monitoring in ways that are appropriate to the adolescent's developmental stage can positively influence adolescent mental health outcomes *(6)*.
Skills to strengthen caregiver–adolescent communication and relationship	Interventions that improve caregiver communication skills and adolescent–caregiver communication skills have been shown to improve the caregiver–adolescent relationship, as well as positively influencing adolescent mental health outcomes – including improved self-esteem *(11)* and self-worth *(12),* better social functioning *(13)* and fewer mental health problems *(12)*. When the caregiver–adolescent relationship operates with demonstrated warmth and affection, adolescent mental health and caregiver outcomes improve *(14)*.
Skills to strengthen positive parenting skills and protect adolescents from exposure to violence, including harsh discipline	Caregiving interventions can strengthen and improve consistency in use of positive parenting strategies: enhance skills for setting limits and rules, promote praise and positive reinforcements and reduce harsh punishment. These skills mediate improvements in self-efficacy, positive wellbeing and reduced risk behaviours in adolescents and can contribute to reducing exposure to violence and abuse *(9, 14, 15)*.

Psychosocial component	Evidence
Knowledge to increase caregivers' understanding of mental health and adolescent development	When caregivers better understand adolescent development – including the psychological, social and physical (including sexual) changes that happen during adolescence – they are better able to help their adolescent cope with changes and are better equipped to support their mental health *(14)*. Caregiver knowledge and perceptions of adolescent mental health problems, together with positive caregiver attitudes to seeking professional help, are associated with increased likelihood of service utilization by adolescents *(16)*. More research is needed on self-harm and suicide, but there is some evidence that caregiver training can lead to increased knowledge of suicide (suicide literacy) although not detection of suicide risk *(17)*.
Skills to promote caregivers' mental health and wellbeing	Interventions to reduce caregiver stress and support caregiver mental wellbeing have the potential to positively influence adolescent mental health outcomes *(18)* in addition to caregiver psychosocial wellbeing *(19)*. Interventions may include teaching caregivers to engage in self-care practices, including effective coping strategies *(20)* and may use a behavioural, cognitive, or multimodal approach *(19)*. For caregivers experiencing significant difficulties with their own mental health or substance abuse conditions, access to their own independent treatment, as recommended in the World Health Organization mhGAP Intervention Guide is essential *(21)*. Providing support to caregivers experiencing difficulties with their own mental health conditions, to ensure they can adequately supervise and monitor their child, has also been identified as an important protective intervention factor *(22)*.
Support family social networks	The promotion of social support and community connectedness emerges as an important element of caregiver support programmes, with benefits on caregivers' mental health, caregiving skills and adolescents' mental wellbeing *(10)*.

Table 3.1 Evidence for components in caregiver psychosocial interventions.

Universal interventions

1

Universally delivered programmes are primary prevention tools, designed for all caregivers regardless of risk status. This means that resources to ensure effective targeting based on risk exposure are not required. Universal interventions (Box 3.1 and 3.2) can help improve knowledge and skills for all caregivers, can influence social norms and can improve community support for providing caregiving to adolescents.

Box 3.1

Improving caregiver–adolescent relationships: the Strengthening Families Programme (SFP)

SFP is an evidence-based family skills training programme that was developed in the USA *(23)*. SFP aims to improve the quality of caregiver–adolescent relationships, reduce caregiver-perpetrated harsh punishment, increase the use of positive behaviour management, and improve family functioning. It can be delivered in the community by trained and supervised nonspecialist providers through 12 weekly sessions for adolescents and 12 weekly sessions for caregivers. SFP caregivers' intervention components include creating warm and loving relationships, setting clear and firm boundaries (rules against antisocial behaviour, including drug and alcohol use), and monitoring their children's emotional well-being and activities. SFP has been evaluated in nine randomized controls in Australia, Canada, Italy, Netherlands, Spain, Sweden, Thailand, the United Kingdom and the USA, and with migrant families. The programme has been linked with increased quality of the caregiver–adolescent relationship, increased family functioning and reduced harsh discipline *(16)*.

More information can be found here: https://strengtheningfamiliesprogram.org/ (accessed 8 March 2021).

Box 3.2

Training both caregivers and adolescents: Parenting for Lifelong Health (PLH) for caregivers and teens

PLH Teen is a caregivers training programme for caregivers and adolescents aged 10–17 years of age. The programme seeks to establish nurturing of caregiver–teen relationships and reduce the risk of violence against teens in and outside the home. It also aims to strengthen the ability of caregivers to provide a protective environment and ensure the health and well-being of their adolescent through positive parenting techniques. Caregivers are taught alternative parenting strategies to reduce adolescent problem behaviours and to avoid harsh disciplining techniques at home. The programme is delivered by trained community workers and volunteers. PLH intervention components include learning to establish quality time for caregivers and adolescents, delivering specific and immediate praise, dealing with stress and anger, establishing rules, accepting responsibilities and responding to crises, as well as budgeting, risk identification and conflict management. PLH uses a collaborative learning approach, with activity-based learning, role-plays and home practice. It is delivered in community settings with home visit consultations and peer support, with 10 joint weekly caregiver and teen sessions and separate sessions for caregivers and for teens.

The programme has been implemented in several countries, including Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Haiti, Kenya, Lesotho, Malawi, Philippines, South Africa, South Sudan, Swaziland, United Republic of Tanzania, Uganda and Zimbabwe.

PLH outcomes include: reduced abuse and corporal punishment; improved positive caregiving, involvement and monitoring; reductions in adult and child substance use; reduction in caregiver stress, depression, financial stress and caregiver endorsement of corporal punishment; and cost-effectiveness per case of abuse prevented.

More information can be found here: https://www.who.int/violence_injury_prevention/violence/child/PLH_parents_teens/en/ (accessed 8 March 2021).
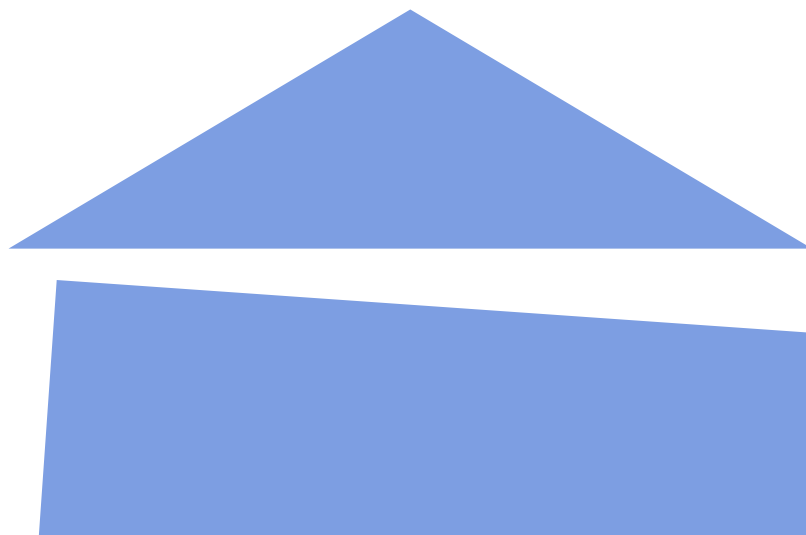
Targeted interventions   2

Targeted interventions are designed for specific groups of caregivers who may benefit from tailored support – such as caregivers of adolescents with known risk factors, or caregivers who themselves have higher exposure to risks. Examples of adolescents with known risk factors include those affected by HIV, pregnant or parenting adolescents, or adolescents of incarcerated caregivers. Caregivers may experience difficulties that may have negative impacts on their caregiver role if they are living in humanitarian settings, are victims or survivors of violence or abuse, have a mental health or substance abuse condition or another chronic illness. Adverse environmental, social and political factors – such as poverty, racism, discrimination, gender norms and exposure to conflict – have a profound impact on communities and families and may simultenously influence caregivers and their adolescents.

Targeted programmes can allow resources to be focused on those at highest risk. However, in some settings resources may be required to identify who is eligible to participate in these programmes. In addition, programmes must be implemented in ways that do not perpetuate stigma towards families who participate.

■ Caregivers of adolescents exposed to violence [and caregivers exposed to violence]

Both caregivers and adolescents affected by violence are at risk of mental health difficulties, including post-traumatic stress disorder and depression *(24)*. Additionally, adolescents within families who experience harsh punishment and family violence are more likely to engage in similar forms of behaviour later with their own children, in turn placing them at risk for negative outcomes.

Example of approach

It is important for caregiver interventions to target the reduction of family violence and support caregivers' own mental health and psychosocial well-being, in addition to promoting positive caregiving skills.

Improved caregivers' avoidance of alcohol and other psychoactive substances and family economic strengthening can also mediate reduced violence against adolescents *(25)*.

■ Caregivers of adolescents exposed to poverty
[and caregivers exposed to poverty]

Individuals exposed to poverty are more vulnerable to poor mental health *(26),* which means that adolescents and their caregivers are both at risk.

**Example
of approach**

Unconditional cash transfer programmes (Box 3.3) have been associated with improved adolescent mental health outcomes along with reduced caregiver stress *(27)* and have been evaluated in Malawi *(28)*, Kenya *(29)* and South Africa *(30)*.

Box 3.3

**Structural intervention example: Malawi's
National Unconditional Cash Transfer Programme**

Malawi has a Social National Unconditional Cash Transfer Programme (SCTP) which provides monetary support and guidance without conditions to very poor households. An evaluation of its impact on young people's mental health showed that the SCTP significantly improved adolescent mental health outcomes and, when gender differences were examined, adolescent females were shown particularly to benefit. Worries about food, education, health, caregiver's stress levels, life satisfaction, perceived social support and participation in hard and unpleasant work were shown to explain at least half of the impact of SCTP *(31).*

■ Caregivers of adolescents in humanitarian settings [and caregivers in humanitarian settings]

Caregivers and adolescents exposed to stressors related to war, armed conflict or natural disasters are vulnerable to mental health conditions *(32)*. The impact of these stressors on caregiver well-being, and how it can influence caregiving behaviours and child mental health, has been well-documented *(32, 33)*.

Example of approach
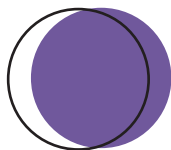
Caregiver interventions to improve caregiver psychosocial well-being and to strengthen parenting skills may be beneficial for adolescents in humanitarian settings (Boxes 3.4, 3.5) *(34, 35)*. Given difficulty to access and reach this population, novel dissemination methods which are brief, low-cost and low-intensity should be considered.

Box 3.4

Caregiver and adolescent psychosocial intervention: Strong Families, Afghanistan

Strong Families, a family training programme in Afghanistan, aims to strengthen family functioning and child behaviour *(35)*. The intervention takes place over seven sessions, including three sessions for caregivers, two for children and adolescents, and two family sessions. The total contact hours *(5)* are spread over 3 weeks.

Topics covered in the caregiver sessions include common caregiver stressors, managing caregiver stress, showing love, enforcing limits, listening to children, encouraging good behaviour and reducing misbehaviour. Adolescents are taught how to deal with stress, and discuss rules, responsibilities, future aspirations and their relationship with their caregivers. In the family sessions, stress management is covered, along with communication skills, shared family values and gratitude.

A pilot study tested the feasibility of the implementation and effectiveness of Strong Families. Female caregivers and their children aged 8–12 years were recruited through schools and drug treatment centres. Most caregivers (over 90%) reported experiencing war/armed conflict in their past. Seventy-two families in the programme were enrolled with strong retention throughout the duration of the programme. Caregiver-reported child behavioural and emotional difficulties significantly decreased and parenting/family functioning improved post-intervention.

Box 3.5

Caregiver Support Intervention – North Lebanon

The Caregiver Support Intervention (CSI) aims to reduce caregiver stress, improve psychosocial well-being and enhance the quality of caregiving skills *(36, 37)*.

The CSI is a nine-session psychosocial group intervention delivered by nonspecialist providers and has been designed for all adult primary caregivers of children and adolescents

(aged 3–12 years) in communities in high-adversity settings. The nine sessions include techniques related to stress reduction (i.e. breathing), anger management, visualization and grounding. Nonspecialist providers receive 6 days of training, onsite support and weekly supervision prior to delivery of the intervention. The CSI is currently undergoing evaluation in a randomized controlled trial with Syrian refugee families in North Lebanon.

■ Caregivers living with HIV and caregivers of adolescents living with HIV

Caregivers living with HIV are at increased risk for mental health conditions, and mental health conditions can affect adherence to antiretroviral therapy (ART), harming their physical health. Consequently, caregivers may need additional support to perform their caregiver role. Caregivers living with HIV may have specific worries about their capacity to care for their adolescent in the future, and this may negatively influence their current practices. In cases where their adolescent child has perinatally acquired HIV, caregivers may be experiencing guilt, fears about the future, adolescent blame and associated familiar tensions *(37)*.

Example of approach

Caregiver interventions should include focus on skills for conducting sensitive and supportive conversations between caregivers and adolescents on topics such as illness, treatment, bereavement, sexual and reproductive health education and HIV prevention *(39)*.

Box 3.6

Caregiver and adolescent psychosocial intervention for adolescents positive with HIV: the Collaborative HIV Prevention and Adolescent Mental Health Programme (CHAMPS) – South Africa, Thailand and USA

CHAMP was initially designed to prevent HIV among at-risk young people and their caregivers in the USA. It was then adapted for testing in other countries, including South Africa and Thailand *(40, 41)*. The modified version, CHAMP+, is an intervention for HIV-positive children and adolescents and their adult caregivers. It includes 11 cartoon-based sessions delivered over 6 months. Sessions cover:

1) caregiver–child communication and decision-making;

2) caregiver supervision and involvement;

3) family support; and

4) child and adolescent problem-solving skills.

CHAMP+ was pilot-tested in a randomized controlled trial in Thailand. Caregiver–child dyads were recruited from four HIV clinics and randomized to receive the intervention (CHAMP+) or treatment as usual. Data were collected from participants with measures across three timepoints – baseline, 6 months (post-intervention) and 9 months – on outcomes that included mental health, treatment adherence, caregiver factors, HIV knowledge and communication.

There was a 100% adherence and retention rate for all participants allocated to the intervention. The intervention group significantly improved across most measures across the timepoints.

■ Caregivers of pregnant adolescents/adolescent caregivers

Pregnant adolescents and adolescent caregivers are more likely to experience mental health conditions than adults, and are more at risk of long-term negative outcomes in terms of socioeconomic status, education and health. They are at particular risk of experiencing stigma and feeling unsupported and disempowered *(42)*. Positive caregiving and familial relationships have been found to play a protective role in supporting pregnant adolescents and young parents *(43)*.

Example of approaches	Interventions should strengthen caregivers' skills for supporting their adolescent children during the signficiant changes that take place as they enter parenthood. These include building awareness of particular mental health challenges that young parents might face, such as perinatal depression *(44),* and linking adolescents to critical support and services. Interventions should also empower caregivers to conduct sensitive and supportive conversations with adolescents on topics such as sexual reproductive health education *(14)*.

Indicated interventions   3

Indicated programmes are focused on supporting caregivers of adolescents with existing or emerging mental health needs *(45)*.

■ Caregivers of adolescents with emotional problems (i.e. existing symptoms but no existing diagnosis)

Involving caregivers in interventions to prevent mental health conditions in adolescents experiencing emotional problems is likely to be of benefit, particularly with regard to anxiety problems *(46, 47)*.

Example of approaches	In the WHO Early Adolescent Skills for Emotions (EASE) intervention *(45),* caregivers have three group sessions independent of their adolescents. In these sessions, caregivers are informed about the strategies being taught to their children in separate sessions, caregivers learn strategies to reduce harsh punishment, and they are also encouraged to take care of their own well-being by learning self-care skills.

■ Caregivers of adolescents with existing disruptive or oppositional behaviour problems (i.e. existing symptoms but no diagnosis)

Caregiver training and involving caregivers in interventions for adolescents with aggressive, disruptive and oppositional behaviours are effective strategies for reducing these behaviours and improving adolescents' mental health *(48)*.

Example of approaches

Group-based caregiving programmes (Box 3.7) can improve childhood behaviour problems and the development of positive parenting skills in the short-term, while also reducing caregiver anxiety, stress and depression *(49)*. Strengthening caregivers' communication is an important programme component in parenting interventions for adolescents with behavioural problems *(5)*.

Box 3.7

Brief two-session psychoeducation for caregivers in post-war Burundi

Jordans and colleagues (2012) conducted a pilot study of a brief caregiver psychoeducation programme in Burundi *(50)*. The intervention consisted of two sessions delivered to groups of caregivers with young adolescents. The intervention group was evaluated using measures of child aggression and depression symptoms and family social support. The intervention had a positive effect on reducing conduct problems among the young people although no effect was detected on depression symptoms or family social support. Caregivers indicated that the intervention was useful in learning positive caregiving and discipline strategies.

Example psychosocial approaches for caregivers at-a-glance

These approaches represent evidence-based, prudent or promising practice in supporting carevigers for promoting mental wellbeing, preventing mental health conditions and reducing self-harm and other risk behaviours in their adolescent children. They should be part of a comprehensive plan. Table 3.2 includes eight examples.

Table 3.2 Psychosocial interventions for caregivers

		Potential outcomes	Example
Interventions for all caregivers	Information and skill-building may be delivered through community settings or as part of other educational, health or social programmes – such as life skills or economic strengthening programmes.	■ Reductions in depression ■ Reductions in self-harm and suicide ■ Reductions in alcohol and drug use ■ Improved mental well-being ■ Improved relationships	■ Parenting for Life Long Health, South Africa ■ Strengthening Families Programme, Thailand
Interventions for caregivers of adolescents with known risk factors	Information and skill-building may be delivered as part of a psychosocial intervention for adolescents, with sessions offered for caregivers independently or in combination, or both.	■ Improved family and caregiver outcomes ■ Reduced emotional difficulties ■ Improved mental wellbeing ■ Reduction in depression and anxiety ■ Reduction in alcohol and drug use	■ National Unconditional Cash Transfer Programme, Malawi (exposure to poverty) ■ Strong Families, Afghanistan (exposure to humanitarian setting) ■ Caregiver Support Intervention, North Lebanon (exposure to humanitarian setting) ■ CHAMPS, Thailand (adolescents with HIV)
Interventions for caregivers of adolescents with existing symptoms	Information and skill-building may be delivered as part of a psychosocial intervention for adolescents, with sessions offered for caregivers independently or in combination, or both. Participants will need to undergo screening to enter the programme.	■ Reductions in existing symptoms of depression and anxiety, or aggressive, disruptive, oppositional behaviours	■ Early Adolescent Skills for Emotions (EASE) ■ Brief caregiver psychoeducation, Burundi

Table 3.2 Psychosocial interventions for caregivers

What works best when...

It is suggested that interventions to support caregivers are more likely to have the intended impact when:

1

They involve caregivers, community groups and leaders in programme design and delivery strategies. This includes: participating in advisory boards (providing input across the programme cycle, identifying local champions who can become the drivers of change in their communities), together with planning, budgeting, implementing and monitoring activities in order to improve engagement in, and ownership of, the programme.

2

They strengthen and support community platforms for delivering caregiver interventions. These include faith-based and community organizations such as women's groups and initiatives involving community health workers.

3

They plan for and implement national communication strategies. These should inform and empower communities and families to engage in caregiver interventions.

4

They are tailored to address the needs of families by incorporating local caregivers' beliefs, practices and priorities. They are informed by an understanding of cultural and socioeconomic environments and identification of the range of resources and stressors affecting caregivers, adolescents and their relationships.

5

They offer support appropriate to the age and development of the caregiver's adolescent.

6

They provide caregivers with opportunities to practice new skills and receive feedback through role-playing, observation and/or nonjudgemental coaching, and include strategies to support relationships between adults (and other children) in the family if needed.

7

They reach marginalized groups of caregivers and engage all involved caregivers (both female and male) by overcoming barriers to participation.

8

They integrate caregivers' interventions with the interventions to address inequalities and socioeconomic determinants at family and community levels – and in particular anti-poverty and/social protection programmes.

9

They ensure that referral pathways and services are identified in advance. This includes, for instance, identifying resources for the referral of caregivers for mental health treatment, or income and economic strengthening efforts, or support for survivors of interpersonal violence.

Focus exercise

Before moving to the specific approaches and programmes for implementing this strategy, take a moment to reflect on your own setting and what you wish to change. You can do this exercise individually or in a group.

In your context, what are caregivers' attitudes and practices regarding mental health (their own and of their adolescents)? How much do most caregivers in your setting know about mental health?

What are caregivers' attitudes and beliefs about parenting adolescents?

What stressors and vulnerabilities are caregivers and families exposed to? What are the socioeconomic determinants of poor mental health?

What do you see as the main goal of caregiver and family support?

What strategies will support specific groups of caregivers and adolescents exposed to risks?

If caregiver support is already provided in your context, has it been evaluated? What is working? What could be improved? What strategies can be used to engage communities in supporting caregivers?

Caregiver participation is often described as a barrier. How can you overcome these barriers or increase participation and outreach? If appropriate, consider solutions for reaching marginalized groups of caregivers.

On the basis of your reflections above, define your goal for strengthening the caregiving support strategy in your setting.

Implementation considerations

Delivery approaches

- **Involvement of caregivers and adolescents in psychosocial interventions**

  Some caregiver programmes have sessions with both caregivers and adolescents, either together or separately depending on the overall aims of the programme and the content of the individual sessions. Caregiver psychosocial interventions may be provided independently or at the same time as adolescents are receiving a psychosocial intervention.

- **Delivery setting**

  Community-based group caregiver interventions have been shown to be cost-effective in high-income country settings when accounting for the future costs of mental health conditions *(50)*. Home visiting and the integration of interventions into existing health-care settings are also feasible alternatives.

- **Implementers**

  There is limited evidence about who is best placed to deliver caregivers' programmes *(5)*. However, in most settings, particularly in low- and middle-income countries (LMICs), service providers are likely to be nonspecialized providers – otherwise called community health workers or lay health workers. Most evidence-based caregiving programmes in high-income countries rely on professionals such as psychologists or social workers to facilitate caregiving interventions. Programmes delivered by non-specialized providers in low-resource settings, such as Parenting for Lifelong Health, have also been shown to be effective *(14)*.

  The selection, training and supervision of service providers must be carefully planned at the design stage in order to ensure the quality and effectiveness of the programme. Service providers need to understand child and adolescent development as well as being skilled at facilitating adult learning and interacting effectively with families. Confidentiality rules and boundaries for service providers involved in delivering caregiver and adolescent interventions need to be established and communicated clearly prior to commencement.

  For additional resources for scaling up the quality delivery of psychological and psychosocial support interventions, refer to the WHO's Ensuring Quality in Psychological Support (EQUIP) at https://www.who.int/mental_health/emergencies/equip/en/ (accessed 8 March 2021).

- **Overcoming barriers to caregiver attendance**

  It is critical that caregivers are reached, and that they participate in a sufficient proportion of the intervention.

  There are many known barriers to participation in community programmes, including issues of access, child care, transportation, the opportunity costs of lost work time (particularly for caregivers in the informal sector) and caregiver stigma towards mental health and health-seeking *(51)*. It is important to assess barriers in each setting and to identify local solutions, particularly making sure that access is made possible for the most disadvantaged caregivers.

  There is evidence to suggest that the provision of transport and a focus on positive and involved parenting can result in higher caregiver attendance, while caregivers with higher rates of alcohol and substance use, or who are employed may have lower attendance *(52)*.

  Caregiver interventions address sensitive and personal issues, including adolescent behaviour, family dynamics, adolescent sexuality, gender roles and caregivers' own childhood experiences. As such, it is essential to respect privacy, withhold judgement, and focus on caregiver strengths and capacity for change in order to encourage and support caregivers' participation and engagement.

Resources

**WHO – Parenting
for Lifelong Health for
Parents and Teens
(PLH for parents and teens)**

https://www.who.int/violence_
injury_prevention/violence/child/
PLH_parents_teens/en/
(accessed 8 March 2021).

UNODC Strong Families

https://www.unodc.org/
documents/drug-prevention-
and-treatment/Strong_families_
Brochure.pdf
(accessed 28 April 2021).

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Strategy 4

Adolescent psychosocial interventions

Objective

Ensure that adolescents benefit from evidence-informed psychosocial interventions

Rationale

Psychosocial interventions to promote positive mental health and prevent mental health conditions help adolescents to learn techniques to positively influence their behaviour, thoughts, feelings, and social interactions. Such interventions are wide-ranging and could include, for instance, life skills training in schools, group-based psychological interventions, family-based approaches, online programmes for prevention of anxiety and depression and social interventions *(1)*.

Psychosocial interventions with adolescents provide the foundational cognitive emotional and social skills at a time when many health-related behaviours are acquired or are consolidated. Hence, these interventions can promote positive youth development, prevent mental health conditions and positively influence risk behaviours such as bullying, self-harm and substance use, and several other health outcomes such as sexual and reproductive health *(2)*.

Promotive and preventive mental health interventions target adolescents individually or in groups, often with the involvement of their caregivers and families. Interventions could be centred on the school, community (including in humanitarian contexts such as refugee camps), health centre or home. They could also be online, digital or combinations of all the above. A range of persons such as teachers, health and non-health professionals, community workers, lay workers and peers can deliver the interventions.

Interventions can be designed to reach all adolescents or selected groups. Universally delivered interventions are designed to benefit every adolescent and are often delivered in schools. Targeted interventions focus on individuals or communities at risk of developing mental health problems or engaging in risk behaviours due to factors such as poverty, exposure to violence, health status (including HIV and pregnancy) or migration status. Indicated interventions are programmes for adolescents who are already experiencing emotional or behavioural symptoms.

The HAT guidelines provide evidence-informed recommendations on psychosocial interventions to promote mental health, prevent mental disorders, and reduce self-harm and other risk behaviours among adolescents *(1)*. Table 4.1 contains a summary of the recommendations.
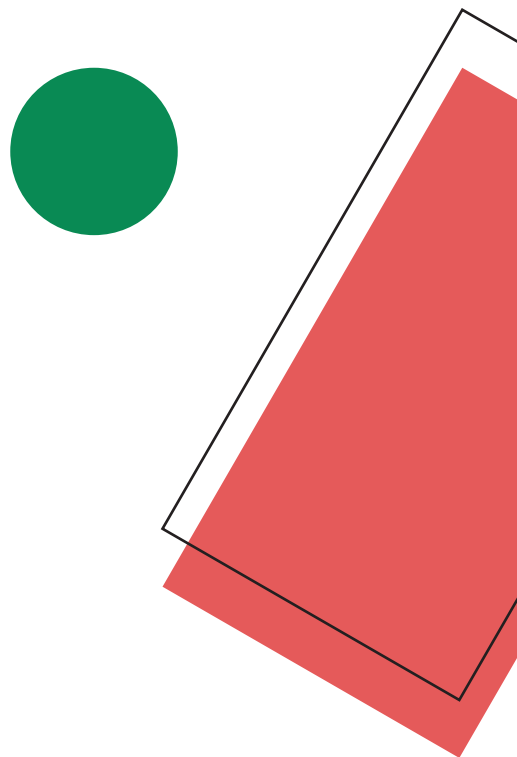
Recommendation	R
Good practice statement	GP
Best practice statement number	BP

Table 4.1 Summary of WHO Guideline recommendations on adolescent mental health promotive and preventative psychosocial interventions

Type of Intervention	Population	Recommendations (in italic) and key considerations
Universal promotion or prevention	**All, regardless of risk status**	*Universally delivered psychosocial interventions should be provided for all adolescents. These interventions promote positive mental health, as well as prevent and reduce suicidal behaviour, mental disorders (such as depression and anxiety), aggressive, disruptive and oppositional behaviours, and substance use.*
		Interventions should cover social and emotional learning, which may include components such as: emotional regulation, problem-solving, interpersonal skills, mindfulness, assertiveness and stress management *(2)*.
		Self-harm and suicide prevention can be integrated as part of universal intervention programmes.
		Universal interventions in schools may be easier to implement and may be less likely to cause stigmatization.
Targeted prevention	**Adolescents exposed to humanitarian emergencies**	*Psychosocial interventions should be provided for all adolescents affected by humanitarian emergencies.*
		Available evidence indicates that stress management, relaxation strategies and care for the implementer's well-being are the intervention components most associated with effectiveness.
		For adolescents with high levels of trauma exposure, trauma-focused cognitive behavioural therapy (CBT) has shown positive effects on reducing symptoms of depression, anxiety and stress *(3, 4)*.
		Group-based CBT interventions have shown positive effects on the symptoms of other adolescents exposed to stressful events *(5)*.

Type of Intervention	Population	Recommendations (in italic) and key considerations
	Pregnant adolescents and adolescent caregivers	*Psychosocial interventions should be considered for pregnant adolescents and adolescent parents, particularly to promote positive mental health (mental functioning and mental well-being) and improve school attendance.*
		Cognitive behavioural skills-building programmes may be considered for pregnant adolescents and adolescent mothers *(6)*.
Indicated prevention	**Adolescents with emotional problems**	*Indicated psychosocial interventions should be provided for adolescents with emotional symptoms.*
		Group-based CBT may be considered for adolescents with emotional symptoms *(7)*.
	Adolescents with disruptive/ oppositional behaviours	*Indicated psychosocial interventions should be provided for adolescents with disruptive/oppositional behaviours.*
		Effective psychosocial interventions for adolescents at risk of, or diagnosed with conduct disorder, often include: training for caregivers; and social, cognitive, problem-solving and interpersonal skills training for the adolescents. They may also include multimodal interventions based on a social learning model for adolescents and their caregivers *(8)*.

Table 4.1 Summary of WHO Guideline recommendations on adolescent mental health promotive and preventative psychosocial interventions

The HAT recommendations on evidence-based psychosocial interventions can benefit all adolescents or groups of adolescents exposed to risks and vulnerabilities, including adolescents exposed to humanitarian emergencies, pregnant adolescents and adolescent caregivers, and adolescents with existing symptoms of emotional or behavioural problems.

In addition to the groups covered in the HAT guidelines, there are several other groups of adolescents exposed to known risk factors or vulnerabilities who may benefit from tailored approaches for mental health promotion and prevention. These include, for example: adolescents living with chronic health conditions and disabilities; those living with parents with mental health and substance use conditions; those in contact with the criminal justice system; lesbian, gay, bi, trans and intersex adolescents; migrants and refugees; and adolescents recruited into armed forces.

There is complementary evidence that is relevant to the promotion of positive mental health and well-being, the prevention of mental health problems and the reduction of risk behaviours among these groups of adolescents. Decisions on content and delivery of psychosocial intervention can be guided by a number of related WHO guidelines as shown in Tables 4.4–4.7 (on adolescents exposed to violence), Tables 4.9–4.12 (on adolescent pregnancy or adolescent caregivers) and Tables 4.13 and 4.14 (on adolescents living with HIV).
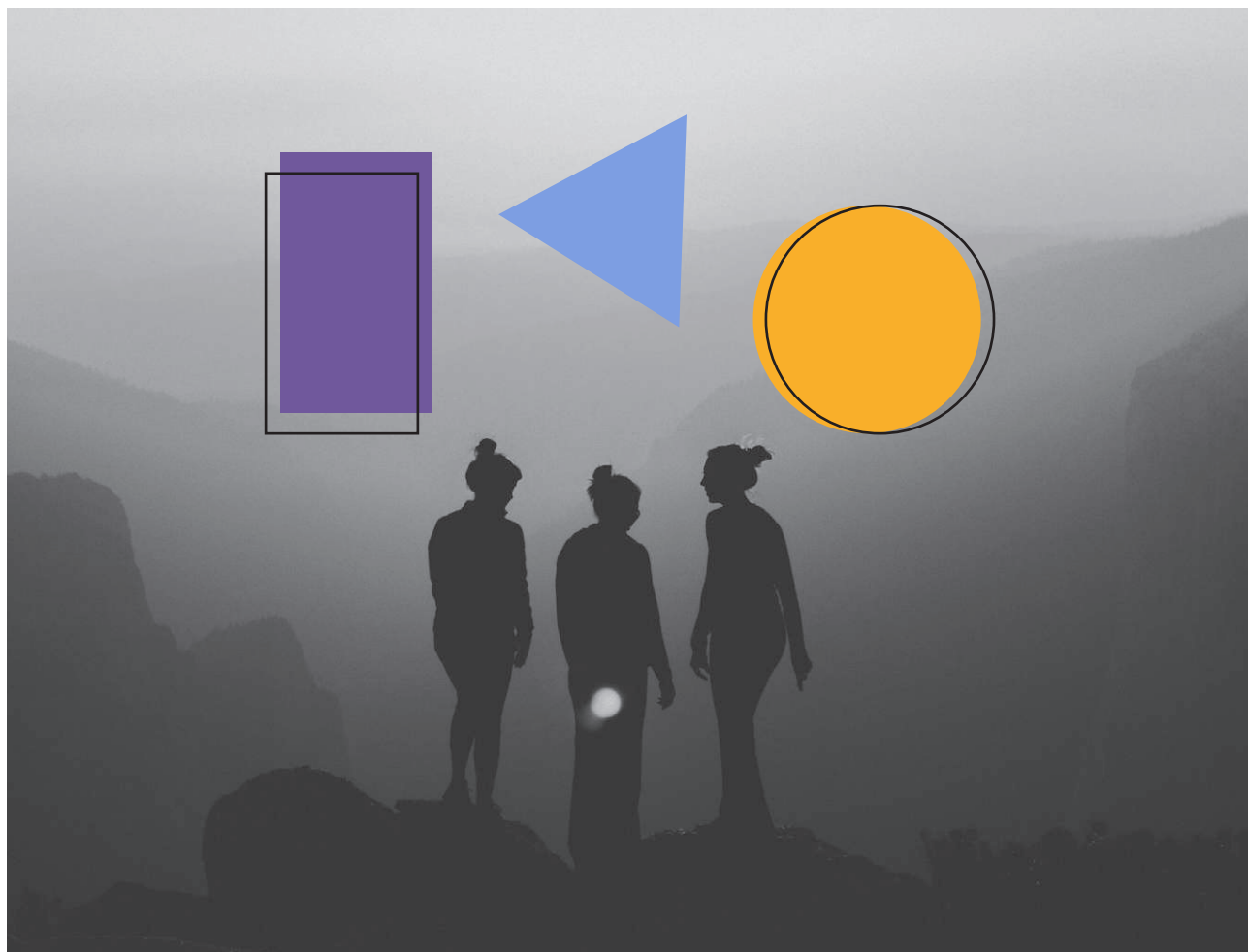
Approaches

Approaches for promotion and prevention in mental health can be broadly classified as universal, targeted or indicated, as described in Figure 4.1.

Universal	Targeted	Indicated
All adolescentst	Adolescents with known risk factors	Adolescents with symptoms of mental health

Figure 4.1 Categories of mental health promotive and preventive psychosocial interventions and their beneficiarie

Universal interventions

1

The WHO HAT guidelines recommend that universally delivered psychosocial interventions should be provided for all adolescents to promote positive mental health, to prevent mental health conditions, self-harm and suicide, and to reduce risk behaviours (1). Advantages of universally delivered interventions include less stigma than other types of interventions in some contexts (and even increased participation as a result), higher levels of public awareness and support, and simpler implementation that does not require risk assessment or screening to identify potential beneficiaries (9).

Universally delivered psychosocial interventions should encompass social and emotional learning, or the skills that adolescents need to set goals, manage behaviour, build relationships, and process and remember information (2, 10). These are essential skills needed across the life course to enjoy good health and success in school, work, home and the community (10).

Universal interventions are commonly implemented in schools because of the potential for wide reach. Universal school-based programmes for promotion and protection of adolescent mental health and reduction of risk behaviours are typically multicomponent. Core programme components span across the cognitive, social, emotional and physical domains and may include emotional regulation, problem-solving, interpersonal skills, mindfulness, assertiveness, stress management, as well as drug and alcohol education and gatekeeper training (2, 11). Gatekeeper training involves training teachers and other school personnel to recognize the risk of suicide behaviour in students, and to enhance their communication skills to motivate and help students at risk to seek professional care (12). Promotion of health diets and physical activity, as part of recreation and leisure (play, games, sports or planned exercise) and physical education, improve school performance and other cognitive outcomes and reduce symptoms of depression among adolescents (13, 14). Table 4.2 describes components of universally delivered psychosocial interventions that contribute to positive programme effects. Table 4.3 provides WHO guidelines' recommendations on physical activity and sedentary behaviours.

Table 4.2 Definitions of social emotional learning (SEL) universal psychosocial intervention components

Domain	Component	Intervention includes:
Emotion	**Emotion regulation**	Techniques to improve one's ability to manage and respond to emotions effectively.
	Stress management	Techniques to control levels of stress – especially chronic stress that interferes with everyday functioning.
	Mindfulness	Activities to enhance the individual's ability to "pay attention in a particular way: on purpose, in the present moment, and nonjudgmentally" *(15)*.
Cognitive	**Problem-solving**	Techniques to identify and act on a solution to a challenge/difficult problem.
	Drug and alcohol knowledge	Education about the use of drugs/alcohol, or the effects of drugs/alcohol on development, lifestyle (including harm minimization approaches) and beliefs/perceptions about drugs/alcohol.
Social	**Interpersonal skills**	Improving skills to develop or improve close, strong, positive relationships with other people.
	Assertiveness	Improving skills to communicate one's viewpoint, needs or wishes clearly and respectfully.
Physical	**Physical activity**	Opportunities to engage in sports and/or physical activity, either individually or in teams.

Table 4.3 Summary of WHO Guideline recommendations on physical activity and sedentary behaviour for adolescents *(31)*

The guidelines focus on physical activity and sedentary behaviour in children, adolescents and adults.

WHO Guideline recommendations

It is recommended that:

R Children and adolescents should do at least an average of 60 minutes per day of moderate- to vigorous-intensity, mostly aerobic, physical activity, across the week.

R Vigorous-intensity aerobic activities, as well as those that strengthen muscle and bone, should be incorporated at least three days a week.

R Children and adolescents should limit the amount of time spent being sedentary, and particularly the amount of recreational screen time.

Developmental and gender-responsive perspectives are important to ensure that intervention content and strategies align with adolescents' evolving needs and resources, including their evolving gender roles *(15, 16)* and autonomy. Social emotional learning in schools should be considered as one element of a multipronged strategy for implementation of school mental health promotive policies and as closely linked to other school health services and referral mechanisms *(17, 18)*. Box 4.1 describes an example of an evaluated school-based universal prevention intervention that is delivered face-to-face.

Box 4.1

The Youth Aware of Mental Health programme (YAM)

YAM is a universal prevention intervention designed to improve mental health literacy, enhance coping skills, improve stress management skills and reduce suicidal behaviours in students aged 13–17 years. In YAM, young people are invited to role-play and discuss everyday situations that are important to them. The topics range from relationships with peers and adults and changes in mood to feeling sad or facing a stressful situation. As a group, the students reflect on how they might feel if faced by such events and discuss how to handle challenging real-life situations. Emphasis is placed on peer support and information is given on how and where to find professional help if needed.

It is a manualized intervention of 5 hours, including 3 hours of student role-play, and two 1-hour interactive teaching sessions. A booklet is provided, as are six educational posters that are used in classrooms.

YAM was developed and evaluated for the Saving and Empowering Young Lives in Europe (SEYLE) study conducted in 2009–2010 *(11)*. The SEYLE sample consisted of just over 11 000 students (average age 15 years) who were invited to participate from almost 170 schools in 10 countries in Europe.

Results from the SEYLE study showed that YAM was effective in preventing suicide attempts, reducing severe suicidal ideation and preventing depression.

Box 4.2 provides an example of an evaluated school-based digitally-delivered universal prevention intervention in Australia, while Box 4.3 describes an evaluated school-based universal prevention intervention in Nicaragua.

Box 4.2

Climate Schools Combined, Australia

Climate Schools Combined is an online universal school-based intervention focused on preventing substance use, depression, and anxiety in adolescence.

The Climate Schools Combined programme incorporates two evidence-based interventions: the Climate Schools Substance Use course, shown to reduce the uptake of heavy alcohol use and increase alcohol and cannabis use knowledge *(19),* and the Climate Schools Mental Health course, shown to reduce anxiety and depressive symptoms significantly *(20).*

The Climate Schools Combined programmes are accessed by students online, and a story with cartoon characters and interactive features is used to enhance engagement and ensure fidelity *(21).* In addition to the story, there are classroom activities and lesson summaries to consolidate student learning.

Testing of the Climate Schools Combined programme was conducted in Australia. Students aged 13–14 years attending secondary school were invited to participate in the study. The results of this study showed a significant increase in knowledge related to alcohol and cannabis use, improved mental health literacy, reduced anxiety symptoms, reduced likelihood of any alcohol use and reduced likelihood of binge drinking.
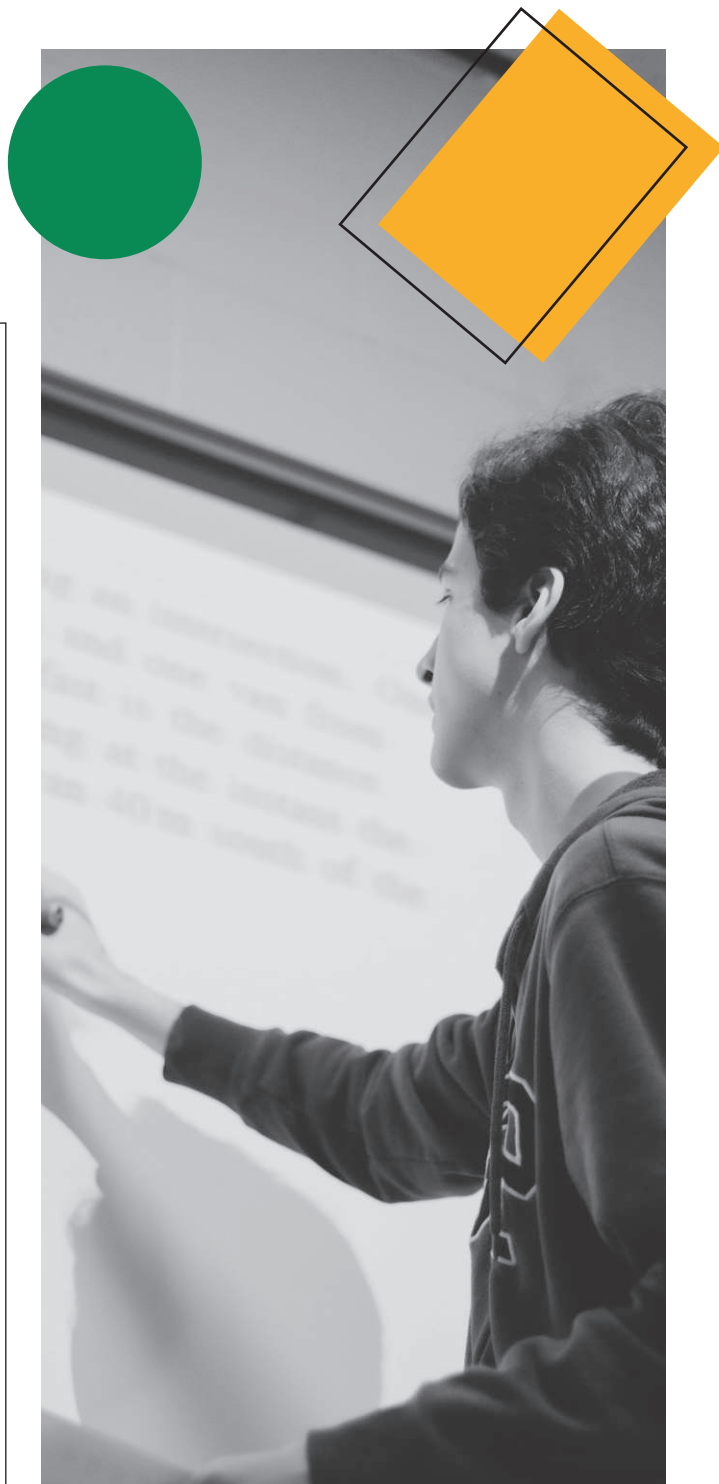
Box 4.3

The Mental Health Curriculum, Nicaragua

The Mental Health Curriculum (MHC) was first developed in Canada for 15- to 24-year-olds *(22)*. It showed self-reported improved student mental health literacy and help-seeking, and reductions in stigma towards mental health conditions *(23)*. MHC has been subsequently implemented in the United Republic of Tanzania and Malawi with benefits shown on teacher-related outcomes *(24, 25)*.

For the study in Nicaragua, MHC was translated into Spanish and culturally adapted by a local team of experts. It was tested with 913 students from four secondary schools and eight university faculties.

The MHC intervention contains six modules on adolescent mental health literacy, a website and training materials for teacher training. The website provides supplementary articles, presentations, videos, and stories about adolescent mental health conditions and substance use.

The six modules related to adolescent mental health literacy address:

- understanding mental health and mental illness;
- information on specific mental health conditions;
- stigma related to mental health conditions;
- adolescents' experience of mental health conditions;
- strategies to address stigma and support help-seeking;
- the importance of maintaining positive mental health.

Following a 3-day training course, classroom teachers delivered twelve 1-hour weekly consecutive sessions embedded to students in Leon, Nicaragua. The sessions were embedded in the usual school curriculum.

Results from the study showed significantly improved adolescent mental health literacy and reduced negative attitudes. Secondary benefits included improved coping strategies, reduced perceived stress, improved lifestyle choices (exercise, diet, stress management, socializing) and reduced substance use *(26)*.

The WHO HAT guidelines identified 158 universal preventative studies that included adolescents *(1)*. For more information, see *Annex 6* of the guidelines.

Targeted interventions   2

Targeted interventions are delivered to adolescents who are known to be at increased risk of mental health conditions or self-harm because of exposure to specific adversities (e.g. violence, poverty, humanitarian emergency), chronic illness (e.g. HIV/AIDS) and/or life circumstances (e.g. adolescent pregnancy and/or parenthood). These adolescents may not be able to access resources for universal mental health promotion in schools and communities and may benefit from tailored approaches and more intensive psychosocial interventions.

Here below are examples of psychosocial interventions to promote and protect the mental health of adolescents and reduce engagement in risk behaviours which target specific groups of at-risk adolescents.

It is essential that all identified known risk factors and difficult life circumstances are primarily addressed using the appropriate supports as well as, or integrated with, a psychosocial intervention.

Examples include:

- For adolescents exposed to violence, their safety and protection must be secured.

- For adolescents exposed to poverty, structural interventions (i.e. cash transfers) are provided.

- For adolescents exposed to a humanitarian emergency, their safety, stability and protection must be secured.

- For adolescent caregivers/pregnant adolescents, pre-/post-natal care and infant health care are provided.
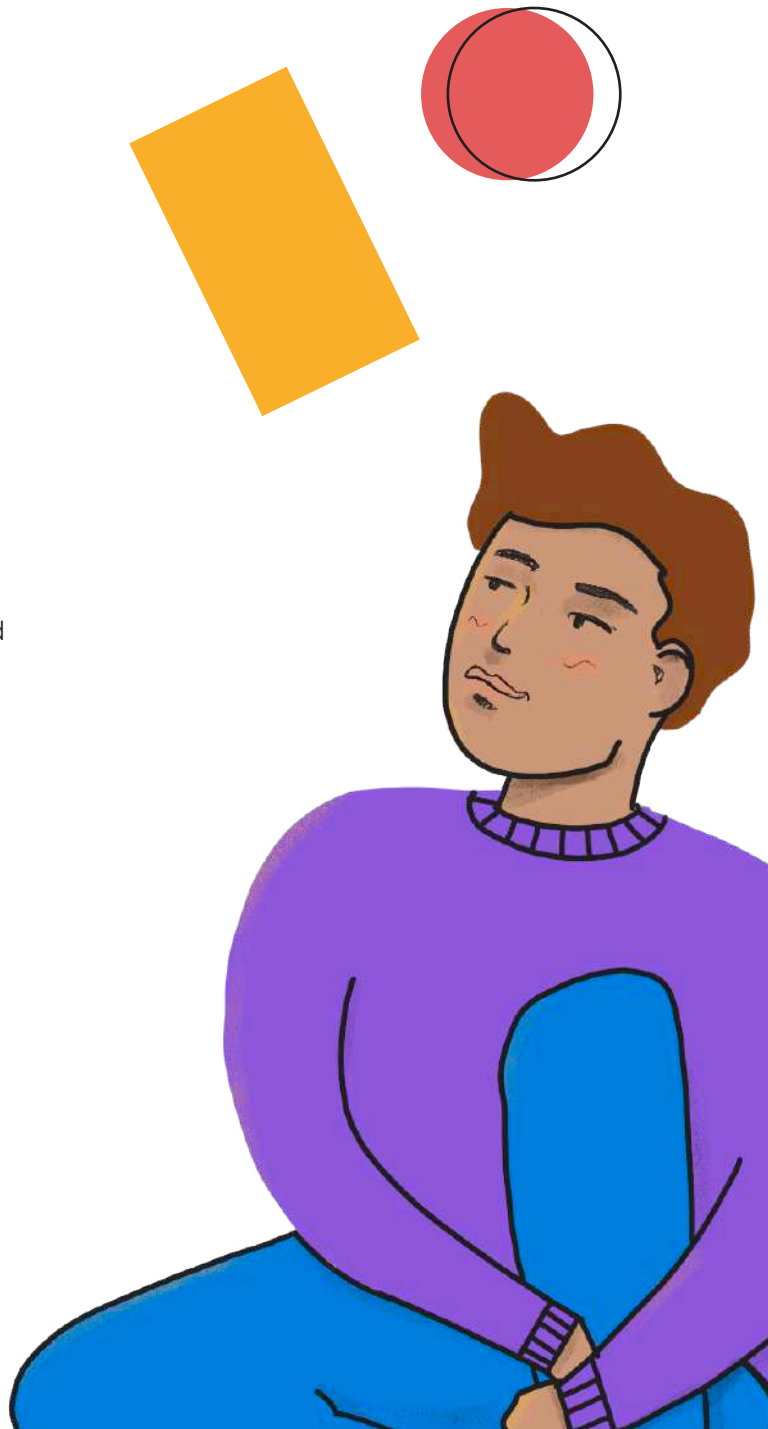
Adolescents exposed to violence

Adolescents who have experienced different types of exposure to violence, including intimate partner violence *(27)* and family violence *(28)*, can present with a wide range of mental health symptoms and conditions, including post-traumatic stress disorder (PTSD) *(29)* and depression *(30,31)*. Moreover, early exposure to violence can increase the likelihood of engaging in risk behaviours, with earlier onset of drinking alcohol and other substance use *(30, 31)*. It is important to prioritize delivery of interventions to promote the positive mental health of adolescents exposed to violence, as well as to prevent mental disorders, self-harm and suicide, and to reduce risk behaviours *(1)*.

Only a few studies assess the impact of psychosocial interventions to promote mental health and prevent mental health conditions and self-harm among adolescents exposed to violence *(1)*. However, WHO guidance is available on psychosocial interventions to improve other health outcomes in adolescents exposed to violence and on psychosocial interventions to improve mental health for adolescents exposed to violence and experiencing symptoms of mental health conditions. WHO has guidelines that provide guidance on responding to: child maltreatment; sexual abuse in children and adolescents; and intimate partner violence and sexual violence against women (Tables 4.4, 4.5, 4.6, 4.7).

Based on this complementary body of evidence, key considerations for planning and delivering psychosocial support to adolescents exposed to violence include the following:

- It is important that adolescents exposed to violence receive immediate, private and confidential first-line support by a health-care provider, along with information on how to manage and cope with stress, referral to other local resources, and the possibility to come back for further support.

- Psychological interventions may be considered for adolescents exposed to violence, and/or their caregivers, depending on the type of exposure, the adolescent's experience of depression, anxiety or post-traumatic stress symptoms and the possibility of involving non-offending caregivers. See Tables 4.4, 4.5, 4.6 and 4.7 for additional details on relevant WHO guideline recommendations and good practice statements.

- It is important to ensure gender-sensitive and adolescent-centred care. *Caring for women subjected to violence: a WHO curriculum for training health providers* provides competency-based training to help identify women experiencing violence and to provide first-line support using the WHO LIVES approach (Listen, Inquire, Validate, Enhance safety and Support). The curriculum emphasizes compassionate, empathetic provider-patient communication *(32)*.

- The stigma of experiencing violence, and particularly sexual violence, may prevent individuals from disclosing exposure. Therefore, these adolescents may be reluctant to seek help. Overcoming these issues needs to be considered sensitively.

Box 4.4 contains an example of a psychosocial intervention for adolescents exposed to violence in the Democratic Republic of the Congo.

Table 4.4 <u>WHO Guideline:</u> Responding to intimate partner violence and sexual violence against women *(33)*

The guideline aims to provide evidence-based guidance to health-care providers on the appropriate responses to intimate partner violence and sexual violence against women, including clinical interventions and emotional support.

WHO Guideline recommendations

R1

Women-centred care

Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. Health-care providers should, as a minimum, offer first-line support when women disclose violence.

First-line support includes:

- being nonjudgemental and supportive and validating what the woman is saying;

- providing practical care and support that responds to her concerns, but does not intrude;

- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved);

- helping her access information about resources, including legal and other services that she might think helpful;

- assisting her to increase safety for herself and her children, where needed; and

- providing or mobilizing social support.

Providers should ensure:

- that the consultation is conducted in private;

- confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting). If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

Care for survivors of intimate partner violence

R8

Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health-care systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries, is uncertain.

R9

Where children are exposed to intimate partner violence at home, a psychotherapeutic intervention, including sessions where they are with and sessions where they are without their mother, should be offered, although the extent to which this would apply in low- and middle-income settings is unclear

Clinical care for survivors of sexual assault

1. Interventions during the first 5 days after the assault

   R10   Offer first-line support to women survivors of sexual assault by any perpetrator (see also Recommendation 1), which includes:

   - providing practical care and support, which responds to her concerns, but does not intrude on her autonomy;

   - listening without pressuring her to respond or disclose information;

   - offering comfort and help to alleviate or reduce her anxiety;

   - offering information and helping her to connect to services and social supports.

2. Psychological interventions

   R21   ■ Offer support and care as described in recommendation 10.

   R22   ■ Provide written information on coping strategies for dealing with severe stress (with appropriate warnings about taking printed material home if an abusive partner is there).

   R23   ■ Psychological debriefing should not be used.

3. Psychological/mental health interventions after 5 days

   Interventions up to 3 months post-trauma

   R24   ■ Continue to offer support and care as described in recommendation 10.

   R25   ■ Unless the person is depressed, has alcohol or drug use problems, psychotic symptoms, is suicidal or self-harming, or has difficulties functioning in day-to-day tasks, apply "watchful waiting" for 1–3 months after the event. Watchful waiting involves explaining to the woman that she is likely to improve over time and offering the option to come back for further support by making regular follow-up appointments.

   R26   ■ If the person has any other mental health problems (symptoms of depression, alcohol or drug use problems, suicide or self-harm), provide care in accordance with the WHO mhGAP intervention guide, 2010.

Recommendation   **R**

Good practice statement   **GP**

Table 4.5 <u>WHO Guideline:</u> Responding to children and adolescents who have been sexually abused *(34)*

This guideline provides recommendations aimed primarily at front-line health-care providers (e.g. general practitioners, nurses, paediatricians, gynaecologists) providing care to children, including adolescents up to the age of 18 years, who have, or may have, experienced sexual abuse, including sexual assault or rape. It can also be useful for other cadres of specialist health-care providers who are likely to see children or adolescents.

WHO Guideline recommendations Good practice statements

Child- or adolescent-centred care/first-line support

GP1 Health-care providers should provide first-line support that is gender-sensitive and child- or adolescent-centred, in response to disclosure of sexual abuse. This includes:

- listening respectfully and empathetically to the information that is provided;

- inquiring about the child's or adolescent's worries or concerns and needs, and answering all questions; offering a nonjudgemental and validating response;

- taking actions to enhance their safety and minimize harm, including those of disclosure and, where possible, the likelihood of the abuse continuing, this includes ensuring visual and auditory privacy;

- providing emotional and practical support by facilitating access to psychosocial services;

- providing age-appropriate information about what will be done to provide them with care, including whether their disclosure of abuse will need to be reported to relevant designated authorities;

- attending to them in a timely way and in accordance with their needs and wishes;

- prioritizing immediate medical needs and first-line support;

- making the environment and manner in which care is being provided appropriate to age, as well as sensitive to the needs of those facing discrimination related to, for example, disability or sexual orientation;

- minimizing the need for them to go to multiple points of care within the health facility;

- empowering non-offending caregivers with information to understand possible symptoms and behaviours that the child or adolescent may show in the coming days or months and when to seek further help.

Psychological and mental health interventions in the short term and longer term

- **GP6** For children and adolescents who have recently been sexually abused, and who experience symptoms of acute traumatic stress (within the first month), health-care providers should offer/continue to offer first-line support that is gender-sensitive and child- or adolescent-centred, as described in Good practice statement 1.

- **R10** Psychological debriefing should not be used in an attempt to reduce the risk of post-traumatic stress, anxiety or depressive symptoms.

- **R11** Cognitive behavioural therapy (CBT) with a trauma focus should be considered for children and adolescents who have been sexually abused and are experiencing symptoms of post-traumatic stress disorder (PTSD).

- **R12** When safe and appropriate to involve at least one non-offending caregiver, CBT with a trauma focus should be considered for both: 1) children and adolescents who have been sexually abused and are experiencing symptoms of PTSD; and 2) their non-offending caregiver(s).

Table 4.6 <u>WHO Guideline:</u> WHO guidelines for the health sector response to child maltreatment *(35)*

The aim of the guideline is to provide evidence-based recommendations for health-care providers to provide appropriate clinical care for children and adolescents who have experienced maltreatment, in order to mitigate the negative health consequences and to improve their well-being.

WHO Guideline recommendations Good practice statements

Safety and risk assessment

GP6 Promoting and protecting the physical and emotional safety of the child or adolescent must be the primary consideration throughout the course of care. This means that, with the participation from the child and adolescent (and their non-offending caregivers, as appropriate) health-care providers need to consider all potential harms and take actions that will minimize the negative consequences for the child or adolescent, including the likelihood of the maltreatment continuing.

Assessing safety and developing a safety plan for children and non-offending caregivers includes:

- assessing the child or adolescent's physical and emotional safety needs;

- involving the child and caregivers in safety planning, where safe to do so, prioritizing the physical and emotional well-being of the child or adolescent;

- considering the risk of recurrence of child maltreatment, taking into account whether the perpetrator of sexual or physical abuse has access to the child, whether caregivers are able to protect the child, and whether the child feels safe to return home;

- considering that different types of violence, and especially child maltreatment and intimate partner violence, often co-occur in the same household and that spouses, siblings and other members of the household might also be at risk of violence;

- involving other relevant agencies, in consultation with the child or adolescent, if the child's safety is at risk. Information including contact details of relevant agencies should be made available to health-care providers. In some settings no legal mechanism may be available to separate children from perpetrators of maltreatment in their current living arrangements or removing the child or adolescent may expose them to an even less safe environment (in such situations careful and frequent follow-up by health workers will be particularly important);

- always following up on all referrals;

- making a plan for follow-up contact with the child and/or caregivers, including what will happen if the child cannot be reached.

If assessment instruments are used to determine risk:

- be aware of the many factors that influence the risk of recurrence that may not be accounted for by assessment instruments;

- treat instruments as a tool to enhance or expand clinical judgement, not as a substitute for clinical judgement.

Psychological and mental health interventions

- Psychological debriefing should not be used in an attempt to reduce the risk of post-traumatic stress, anxiety or depressive symptoms.   **R5**

- Caregiver interventions that promote nurturing caregiver–child relationships, including through improved communication skills and direct coaching of parents while they are interacting with their children, may be considered.   **R9**

Table 4.7 <u>WHO Guideline:</u> WHO guidelines on management of health complications from female genital mutilation *(36)*

These guidelines are intended primarily for health-care professionals involved in the care of girls and women who have been subjected to any form of female genital mutilation (FGM). This document also provides guidance for policy-makers, health-care managers and others in charge of planning, developing and implementing national and local health-care protocols and policies.

WHO Guideline recommendation Best practice statements

Mental health

R4 Cognitive behavioural therapy (CBT) should be considered for girls and women living with FGM who are experiencing symptoms consistent with anxiety disorders, depression or post-traumatic stress disorder (PTSD) (conditional recommendation; no direct evidence).

BP3 Psychological support should be available for girls and women who will receive or have received any surgical intervention to correct health complications of FGM (Best practice statement)

Female sexual health

R5 Sexual counselling is recommended for preventing or treating female sexual dysfunction among women living with FGM (conditional recommendation; no direct evidence).

Box 4.4

A group-based face-to-face delivered psychosocial prevention intervention for children and adolescents exposed to violence, Democratic Republic of the Congo

A pilot study evaluated a community-participative psychosocial intervention with war-affected children and adolescents living under constant threat of attack and/or abduction in the Haut-Uele Province
of northern Democratic Republic of the Congo. Some 159 children and adolescents (aged 7–18 years) and their caregivers took part in this study and 79 of them received the intervention.

The intervention, which included life skills, relaxation training and mobile cinema screenings, was delivered over eight group sessions by a supervised, local nonspecialist provider *(3)*.

Upon completion of the intervention, participants reported significantly less post-traumatic stress reactions compared to the wait-list control group; and at 3 months follow-up, participants from the intervention group reported improvements in internalizing symptoms and prosocial behaviours. Caregivers of the intervention participants reported a reduction in conduct behaviours.

The HAT guidelines review identified seven preventative studies that included adolescents exposed to violence *(1)*. See Annex 6 of the WHO HAT guidelines.

■ Adolescents exposed to poverty

Poverty places adolescents at increased risk of food insecurity and hunger, infectious diseases, exposure to community violence *(37)* and dropping out of school, and limits employment opportunities. It is linked to increased mental health problems as well as engagement in risk behaviours, including substance use and risky sexual behaviours *(38, 39)*. It is thus critically important to invest in preventing mental health problems in this group *(40)*.

Efforts should be made to ensure equity in access to universally delivered mental health promotion programmes. For instance, Box 4.5 presents the example of a universally delivered psychosocial intervention for adolescents exposed to poverty in Zambia. Adjunct structural interventions should be considered in addition to individual psychosocial interventions. More research is required to inform tailored mental health promotive and preventive strategies to benefit adolescents exposed to poverty *(1)*.

The WHO HAT guidelines review identified 13 studies that included adolescents exposed to poverty *(1)*. See Annex 6 of the HAT guidelines.

Box 4.5

The Adolescent Girls Empowerment Program (AGEP), Zambia

The AGEP intervention components included: problem-solving, conflict management, communication skills and stress management, and financial education combined with a structural intervention (a health voucher that could be used for all-purpose wellness or reproductive health services, plus an age-appropriate bank savings account). AGEP was delivered to 3515 adolescent girls in Zambia over a 2-year period in a weekly group universal intervention delivered by a trained nonspecialist female provider (a mentor from within the community).

AGEP was found to:

1) increase sexual and reproductive health knowledge after 2 years, an effect that was maintained at 4 years;

2) improve financial knowledge after 2 years; and

3) improve savings behaviour after 2 and 4 year *(41)*.

Improved self-efficacy was also found, along with reduced transactional sex after 2 and 4 years.

There was no effect of AGEP on: improving primary education outcomes, improving fertility outcomes, improving norms regarding gender equity acceptability of intimate partner violence, and there was no improvement in HIV knowledge.

■ Humanitarian settings

Programmes to prevent mental illness should give priority to adolescents exposed to humanitarian emergencies. Psychosocial interventions are particularly beneficial for preventing mental disorders (depression, anxiety and disorders related specifically to stress) and may be considered for reducing substance use in these populations *(1).*

Past and continuing support to adolescents exposed to humanitarian emergencies includes a broad range of psychosocial interventions. This reflects the heterogeneous nature of experiences involving emergency events.

The intervention components that are associated with more effective interventions are stress management, relaxation strategies and care for the implementer's well-being *(1).* In resource-constrained settings, it is suggested that these components be prioritized over others *(42).*

For adolescents with elevated levels of trauma exposure, trauma-focused CBT has shown positive effects on the reduction of symptoms of depression, anxiety and stress *(4, 43).* For other adolescents exposed to stressful events, group-based CBT interventions have shown positive effects in reducing these symptoms *(5).* Box 4.6 describes a face-to-face school-based psychosocial intervention for adolescents exposed to the 2008 Gaza conflict.

Box 4.6

A face-to-face school-based psychosocial intervention for adolescents exposed to the 2008 Gaza conflict

Enhancing Resiliency Amongst Students Experiencing Stress–Prosocial (ERASE-Stress–Prosocial [ESPS]) was designed to reduce symptoms of PTSD among Jewish-Israeli students in school grades 3 to 8 (approximately 8–12 years of age) who are experiencing ongoing war-related violence. ESPS is a teacher-delivered programme that uses cognitive-behavioural, somatic and narrative stress-reduction approaches in combination with mindfulness, compassion-cultivating strategies and prosocial skills training. It includes a focus on perspective-taking, empathy training and dealing with stereotyping and prejudice.

ESPS consists of 16 weekly classroom sessions of 90 minutes each, facilitated by students' homeroom teachers.

The programme was evaluated with a randomized controlled trial which showed significant positive impact on measures of PTSD – such as severity, anxiety, somatic complaints, and function problems – in third through sixth grade students in Israel, at the post-test taken 2 months after the intervention *(5).*

The WHO HAT guidelines review identified 26 studies that included adolescents living in a humanitarian setting *(1).* See Annex 6 of the HAT guidelines.

■ Pregnant adolescents and adolescent mothers

Pregnancy in adolescence is associated with low socioeconomic status, dropping out of school, unemployment and exposure to violence and substance use *(44–46).* Adolescents are more likely to experience perinatal depression compared to older mothers *(47).*

Psychosocial interventions should be considered for pregnant adolescents and adolescent parents, particularly to promote positive mental health (mental functioning and mental well-being) and to improve school attendance *(1).* Cognitive behavioural skills-building programmes may be considered for pregnant adolescents and adolescent mothers *(6).* Psychosocial interventions can be integrated into pre-existing maternal health programmes and early childhood development programmes. The involvement of adolescent fathers and their psychosocial needs should also be considered.

Structural interventions that address poverty, gender norms and other sociocultural factors can complement the psychosocial approach to optimize support and opportunities available to adolescent parents and to reduce the risks of poor mental health. See the example of psychosocial interventions provided in Box 4.7.

Other relevant WHO guidelines are:

■ Improving early childhood development: WHO Guideline. Geneva: World Health Organization; 2020.

■ WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016.

■ WHO recommendations on health promotion interventions for maternal and newborn health 2015. Geneva: World Health Organization; 2015.

■ Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.

For key recommendations, see Tables 4.8–4.12. To view the WHO guidelines and recommendations in full, refer to the references indicated below.

Table 4.8 <u>WHO Guideline:</u> Improving early childhood development, 2020 *(48)*

This guideline provides global, evidence-informed recommendations on improving early childhood development.

WHO Guideline recommendation

R4 Psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services.

Table 4.10 <u>WHO Guideline:</u> WHO recommendations on antenatal care for a positive pregnancy experience *(50)*

This is a comprehensive WHO guideline on routine antenatal care for pregnant women and adolescent girls. The aim is for these recommendations to complement existing WHO guidelines on the management of specific pregnancy-related complications.

WHO Guideline recommendation

R B.1.6 Health-care providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every antenatal care visit.

Please note, in this table the term "women" includes adolescent girls aged 15 years and older.

Table 4.9 <u>WHO Guideline:</u> WHO recommendations on the postnatal care of women and newborns, 2013 *(49)*

WHO Guideline recommendations

Assessment of the mother   **R8**
Beyond 24 hours after birth

At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. All women and their families/partners should be encouraged to tell their health-care professional about any changes in mood, emotional state and behaviour that are outside the woman's normal pattern.

At 10–14 days after birth, all women should be asked about resolution of mild, transitory postpartum depression ("maternal blues"). If symptoms have not resolved, the woman's psychological well-being should continue to be assessed for postnatal depression and, if symptoms persist, evaluated.

Psychosocial support   **R12**

Psychosocial support by a trained person is recommended for the prevention of postpartum depression among women at high risk of developing this condition.

Health professionals should provide an opportunity for women to discuss their birth experience during their hospital stay. A woman who has lost her baby should receive additional supportive care.

Please note, in this table the term "women" includes adolescent girls aged 15 years and older.

Table 4.11 <u>WHO Guideline:</u> WHO recommendations on health promotion interventions for maternal and newborn health 2015 *(51)*

The recommendations set forth will help countries to establish if the single intervention should be part of a broader package to reach the objectives to increase individual, family and community capacity to contribute to maternal and newborn health improvements and to increase use of skilled care during pregnancy, for childbirth and after birth.

WHO Guideline recommendation

Community mobilization through facilitated participatory learning and action cycles with women's groups.

R9 The implementation of community mobilization through facilitated participatory learning and action cycles with women's groups is recommended to improve maternal and newborn health, particularly in rural settings with low access to health services.

Please note, in this table the term "women" includes adolescent girls aged 15 years and older.

Table 4.12 <u>WHO Guideline:</u> Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries *(52)*

The guideline aims to improve adolescent morbidity and mortality by reducing the chances of early pregnancy and its resulting poor health outcomes.

WHO Guideline recommendations

Outcome 1: Reduce marriage before the age of 18 years.

R Implement interventions to inform and empower girls, in combination with interventions to influence family and community norms, to delay the age of marriage among girls under 18 years of age.

Outcome 2: Reduce pregnancy before the age of 20 years

R Advocate for adolescent pregnancy prevention among all stakeholders through interventions such as: information provision, sexuality and health education, life skills building, contraceptive counselling and service provision, and the creation of supportive environments.

Outcome 4: Reduce coerced sex among adolescents

Implement interventions to enhance adolescent girls' abilities to resist coerced sex and to obtain support if they experience coerced sex by: **R**

- building their self-esteem;

- developing their life skills in areas such as communication and negotiation; and

- improving their links to social networks and their ability to obtain social support.

The above interventions should be combined with interventions to create supportive social norms that do not condone coerced sex.

Implement interventions to engage men and boys to critically assess gender norms and normative behaviours (e.g. gender transformative approaches) that relate to sexual coercion and violence. Combine these with wider interventions to influence social norms on these issues. **R**

Please note, in this table the term "women" includes adolescent girls aged 15 years and older.

Box 4.7

A face-to-face school-based psychosocial intervention for pregnant adolescents and adolescent mothers

Pregnant Mexican-American adolescents and adolescent mothers (age 14–19 years) were recruited to a cognitive-behavioural school-based intervention group (total n = 85). The cognitive-behavioural group intervention comprised eight weekly 1-hour sessions delivered with the help of a detailed treatment manual. The manual was based on the use of a

five-step problem-solving process to identify goals and carry out specific tasks towards each goal. The first two of the eight sessions were used to establish the group structure and to learn the process for goal and task identification. Each participant used each of the four subsequent sessions to develop a personal goal as well as two specific tasks towards the goal.

On completion of the intervention, participants reported improved coping skills and improved school grades and attendance, and these improvements were maintained at the 30-day follow-up *(6)*.

Box 4.8

Ask–Boost–Connect–Discuss (ABCD) – a co-developed targeted intervention for adolescent mothers living with HIV, South Africa

Ask–Boost–Connect–Discuss (ABCD) for adolescent maternal mental health is an adolescent co-developed mobile-enhanced tool adapted from WHO's Thinking Healthy programme.

The tool aims to help adolescent and young mothers living with HIV to access basic maternal depression care through screening (ASK), evidence-based CBT-informed mental health support (BOOST), help with accessing services (CONNECT), and the provision of ongoing supervision and self-care (DISCUSS). The approach involves training youth HIV-positive peer-supporters.

ABCD is undergoing effectiveness-testing in six southern African countries *(53)*.

The WHO HAT guidelines review identified 17 studies that included pregnant adolescents and/or adolescent mothers *(1)*. See Annex 6 of the HAT guidelines.

■ Adolescents living with and affected by HIV

Adolescents living with HIV experience negative impacts on their physical health, including pubertal and neurodevelopmental delays and unique psychosocial challenges such as stigma, orphanhood, impoverishment and difficulty managing medications *(54)*. The disclosure of HIV status is also an area of concern with implications for the adolescents' experiences with establishing romantic and sexual relationships. These stressors put adolescents living with HIV at heightened risk for developing mental health conditions and engaging in health–related risk behaviours *(55)*.

The mental health of adolescents living with HIV affects other domains of their health and well-being, particularly their adherence to antiretroviral therapy (ART) *(56, 57)*.

The evidence on psychosocial interventions to improve mental health and to reduce self-harm and substance use among adolescents was considered by the members of the WHO Guidelines Development Group (GDG) in the context of the development of the HAT guidelines recommendations.

The GDG reached consensus on the following:

- It is important to give priority to the delivery of interventions to promote positive mental health among adolescents living with HIV, as well as to prevent mental disorders, self-harm and suicide, and to reduce risk behaviours.

- Because of lack of evidence, it was not possible to offer any specific recommendation on psychosocial interventions to promote positive mental health among adolescents living with HIV.

There is an urgent need for high-quality research to assess the effect of psychosocial interventions that seek to promote mental health and prevent mental disorders, self-harm and risk behaviours among adolescents living with HIV.

A complementary body of evidence is available on the impact of psychosocial interventions in adolescents living with HIV when a broader perspective on potential health outcomes is considered, including improved adherence and retention in ART care *(58)*. In relation to this, complementary WHO guidance is available to support the inclusion of psychosocial support in HIV care *(59)*. See Tables 4.13 and 4.14 for additional information.

In addition to offering individual psychological support, adjunct structural interventions such as microfinance should be considered *(60)*. See the example of psychosocial interventions provided in Box 4.9, 4.10, 4.11 and 4.12.

Table 4.13 <u>WHO guideline</u>: WHO Consolidated guideline on sexual and reproductive health and rights of females living with HIV *(60)*

This guideline aims to provide evidence-based recommendations and good practice statements for the sexual reproductive health and rights of women living with HIV.

WHO Guideline recommendations Good practice statements

R ■ Adolescents should be counselled about the potential benefits and risks of disclosure of their HIV status to others and empowered and supported to determine if, when, how and to whom to disclose.

GP ■ Psychosocial support interventions, such as support groups and peer support, provided by, with and for women (including adolescents aged 15 years and older) living with HIV, should be included in HIV care.

Table 4.14 <u>WHO guideline:</u> Updated recommendations on service delivery for the treatment and care of people living with HIV *(61)*

The guideline that this recommendation was based on benefits from ART adherence and other HIV outcomes (not on mental health outcomes).

WHO Guideline recommendation

Psychosocial interventions should be provided to all adolescents and young people living with HIV.   **R**

Box 4.9

Peer support for adolescents living with HIV in Zimbabwe

Ninety-four HIV-positive adolescents aged 10–15 years and on antiretroviral therapy participated in the study.

The psychosocial intervention utilized community adolescent treatment supporters (CATS) in weekly home visits with the aims of treatment adherence,

improved psychosocial well-being (including self-esteem, quality of life and self-confidence), improved referrals and linkages to service, and supported retention in care *(62)*.

The participants reported improved psychosocial well-being, improved treatment adherence, more referrals and linkages to services, and longer retention.

The WHO HAT guidelines review identified 17 studies that included pregnant adolescents and/or adolescent mothers[1]. See Annex 6 of the HAT guidelines.

[1]HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf, accessed 20 March 2021).

Indicated interventions

Indicated psychosocial interventions are delivered to adolescents who present with early signs and/or symptoms of mental health problems but do not have a formal diagnosis of a mental health condition. It is important to consider carefully strategies to identify the adolescents who may benefit from indicated mental health prevention as this can potentially lead to increased stigma. Indicated prevention interventions aim to avert the onset of a diagnosable mental health condition in high-risk adolescents identified as already experiencing mild-to-moderate symptoms *(1)*. Such interventions are often more tailored to individual needs than universal interventions. This approach may enhance sustainability (Box 4.10) *(63)*.

■ Adolescents with emotional problems (i.e. psychological symptoms but no diagnosis)

Indicated psychosocial interventions should be provided for adolescents with emotional symptoms *(1)*. The use of group-based CBT may be considered for adolescents with emotional symptoms *(7)*.

A group format and a session with briefer contact time was found to be cheaper to implement compared to individual, long-term interventions but was just as effective *(63–65)*. Using self-help, digital-based tools may reduce requirements over the longer term *(1)*. Box 4.10, 4.11 and 4.12 provide examples of programmes that include strategies to benefit adolescents with emotional distress.

Box 4.10   3

SHINE – a school-based multicomponent programme including an indicated intervention for emotional and behavioural problems, Egypt, the Islamic Republic of Iran, Jordan, Pakistan

The School Health Implementation Network in the Eastern Mediterranean Region (SHINE) is a regional collaboration developed to address the challenges of implementing school-based child mental health programs. A manualized school mental health programme was developed for this purpose and then adapted for implementation through a digital platform.

The enhanced School Mental Health Program (eSMHP) includes an online training course to train teachers and a chatbot to aid the programme implementation in real-world settings.

The intervention contents include modules on:

- teachers' well-being;
- addressing problems of children with learning difficulties; and
- demonstration videos on identifying and managing low-intensity mental health problems of children in school settings.

A cluster-randomized implementation effectiveness trial with 960 children aged 8–13 years enrolled in 80 Pakistan schools is currently underway to evaluate the programme in reducing socio-emotional difficulties in school-going children and adolescents *(66, 67)*.

For more information, see: https://www.shineformentalhealth.org/research/ (accessed 28 April 2021).

Box 4.11

WHO Early Adolescent Skills for Emotions (EASE) for young adolescents with emotional distress

WHO has developed a manualized psychological intervention – EASE – for 10- to -14-year-old adolescents with high emotional distress. EASE intervention components include psychoeducation, emotion regulation, problem-solving and behavioural activation.

EASE has been designed to be delivered to groups of adolescents who are living in adversity by trained and supervised nonspecialist facilitators, with separate delivery of the intervention to their caregivers *(68, 69)*.

There are seven group sessions for adolescents and three sessions for caregivers. EASE is currently undergoing randomized controlled trial testing at sites in Jordan, Lebanon, Pakistan and the United Republic of Tanzania in different settings (school, refugee camp and community).

Box 4.12

Scalable Technology for Adolescents to Reduce Stress (STARS) – a digitally-delivered psychosocial intervention for adolescents with emotional distress

WHO has developed STARS, a digital self-help indicated psychological intervention that incorporates evidence-based techniques, for 15- to -18-year-old adolescents with high emotional distress and impaired functioning.

STARS delivers content through an engaging chatbot (a pre-programmed conversational agent). The intervention components include psychoeducation, goal-setting, emotion regulation, behavioural activation, thought-challenging, social support and problem-solving. STARS consists of 10 sessions, each lasting 10 minutes. The STARS intervention was developed using a human-centred design to create an intervention which is responsive to the needs of adolescents. Testing in randomized controlled trials is planned.

For more information, see: https://www.who.int/mental_health/management/stars/en/ accessed 28 April 2021.

The WHO HAT guidelines review identified 70 studies that included adolescents with emotional symptoms *(1).* See Annex 6 of the HAT guidelines.

■ **Adolescents with existing disruptive or oppositional behaviour problems (i.e. existing psychological symptoms but no diagnosis)**

Indicated psychosocial interventions should be provided for adolescents with disruptive/oppositional behaviours. They reduce aggressive, disruptive and oppositional behaviours, prevent mental disorders (depression and anxiety) and promote positive mental health. Caution should be adopted in delivery of these interventions which may increase substance use among adolescents with disruptive and oppositional behaviours (Box 4.13) *(1)*.

The intervention components should focus on social and cognitive problem-solving and interpersonal skills training, or multimodal interventions based on a social learning model for both adolescents and caregivers *(8)*.

The inclusion of caregiver training based on social learning approaches is recommended *(8)*. Older adolescents (≥ 14 years) are likely to benefit more from structured CBT in mixed-gender groups, whereas younger adolescents may benefit more from a single-sex group *(65)*.

Box 4.13

A psychosocial intervention for adolescents with existing aggressive behaviours, Nigeria

Students aged 9–14 years from two public schools in Nigeria were rated by their teachers on aggressive behaviours *(70)*. Twenty students with the highest scores from each school were then randomly allocated to receive the intervention (six twice-weekly group-based sessions) or to the waiting list control group. The intervention included problem-solving skills, calming strategies and attribution reframing. It was delivered by a clinical psychologist in the local language to groups of 10 students.

At the end of the study, the students who received the interventions were reported to have significantly less teacher-rated and student-rated aggressive behaviours.

The WHO HAT guidelines review identified 22 studies that included adolescents with existing disruptive or oppositional behaviour symptoms *(1)*. See Annex 6 of the HAT guidelines.

Example adolescent psychosocial interventions at-a-glance

These approaches represent evidence-based, prudent or promising practice in promoting positive mental health and in preventing mental health conditions, reducing self-harm, suicide and risk behaviours in adolescents, and should be part of a comprehensive plan. Table 4.15 shows examples.

Table 4.15 Psychosocial interventions for adolescents

Psychosocial interventions for all adolescents	These interventions may normally be delivered in a school setting, or in another community setting where adolescents spend time – such as a workplace or as digital interventions.	**Potential outcomes** ■ Reduction in depression and anxiety ■ Reductions in self-harm and suicide ■ Reductions in substance use ■ Improved mental well-being	**Example** ■ The Youth Aware of Mental Health programme (YAM) ■ Climate Schools Combined, Australia ■ Climate Schools Combined, Australia
Targeted psychosocial interventions for adolescents with known risk factors	These interventions are for adolescents exposed to individual or family-level vulnerabilities or can be offered to at-risk neighbourhoods or populations. They can be delivered through the health sector (e.g. services for HIV/AIDS), the education sector, social services, child welfare and juvenile justice systems or other community-based service for adolescents. Online or combinations of in-person and online strategies are possible. Stigma must be carefully considered.	**Potential outcomes** ■ Improved mental wellbeing ■ Reduction in depression, anxiety and disorders related specifically to stress ■ Reduction in substance use ■ Improved school retention ■ Improved adherence to HIV treatment for adolescents living with HIV ■ Reductions in risky sexual behaviour ■ Improved caregiving by adolescent caregivers ■ Improved (adolescent) maternal outcomes and newborn/child outcomes in the offspring	**Example** ■ A group-based face-to-face delivered psychosocial prevention intervention for children and adolescents exposed to violence, Democratic Republic of the Congo ■ The Adolescent Girls Empowerment Program (AGEP), Zambia
Indicated psychosocial interventions for adolescents with emotional symptoms or disruptive or oppositional behaviours	These interventions may be delivered individually or in groups through health services, in school or other community settings. Screening and assessments for the identification of adolescents experiencing symptoms of mental health conditions can also be offered within health, schools or community. Stigma must be carefully considered.	**Potential outcomes** ■ Reduction in emotional symptoms ■ Reduction in aggressive, disruptive, oppositional behaviours ■ Improved school attendance ■ Reduction in depression and anxiety ■ Improved mental well-being	**Example** ■ SHINE – a school-based multicomponent programme including an indicated intervention for emotional and behavioural problems, Egypt, Iran, Jordan, Pakistan ■ WHO Early Adolescent Skills for Emotions (EASE) for young adolescents with emotional distress

What works best when...

Efforts to implement this strategy may be more likely to have the intended impact when:

1

They engage the adolescent target group for the intervention and encourage and facilitate adolescent participation in developing, adapting or implementing the intervention.

2

They are integrated into national or district-level workforce development and education policy, curricula and provider training, including providers in community settings (work, juvenile justice).

3

They take a whole-of-community or whole-of-school perspective and seek cultural changes in these settings, including dynamics between adolescents and authority figures as well as among adolescents themselves.

4

They fit with broader change of norms and with actions to address socioeconomic determinants, inequality and other stressors, including violence.

5

They consider and address issues regarding hierarchy, status, and cultural and social norms in relation to gender and encourage reflection and consciousness-raising on gender identity and sexual minorities *(71)*.

6

They engage communities, caregivers, school governing boards, teachers and staff in critical reflection on their values, beliefs and experiences related to inclusion, violence and the promotion of adolescent well-being and autonomy *(72)*.

7

They are adapted to the local cultural context, using good practice for adaptation of evidence-based interventions with fidelity and maintain quality with competent facilitators.

9

They ensure links and referrals to other health, education and social services for adolescents and families.

8

They take account of the age and developmental stage of adolescents, including:

- The content of the intervention needs to be suitable for the adolescents' ages and stages of development.

- Transition periods need to be considered (e.g. from primary to secondary school, from school to higher education, training or work).

- Older adolescents may have additional/alternative commitments such as work, examinations, family or caregiving responsibilities which need to be considered.

- The autonomy and living circumstances of the adolescent must also be supported.

Focus exercise

Before moving to the specific approaches and programmes for implementing this strategy, take a moment to reflect on your own setting and what you wish to change. You can do this exercise individually or in a group.

Determine community attitudes and norms regarding mental health, and particularly those of adolescents and caregivers.

Do a needs assessment/situational analysis to understand what existing research has shown about the mental health needs of adolescents and the numbers of adolescents in the setting.

Determine which risk factors (such as poverty, exposure to violence, HIV, adolescent pregnancy or others) exist in your setting.

Understand what is currently happening – at the system level and within individual communities or schools – to promote mental health and improve social and emotional skills.

Determine whether existing service providers, schools and teachers 1) have the guidance, knowledge and skills to respond appropriately to adolescents who need more support or may be at imminent risk of suicide and 2) understand the support services available for referral.

Identify evidence-based interventions that may be suitable to meet the needs of your context (see examples provided in this chapter).

Identify interventions that are being implemented. If any are found, investigate how these interventions were chosen and whether they are aligned with the evidence.

Based on your reflections above, what is your goal for introducing or strengthening a psychosocial intervention in your setting?

Implementation considerations

Planning for introducing new mental health promotive and preventive psychosocial interventions for adolescents in your context will involve six steps (Figure 4.2).

In many settings, there are existing psychosocial interventions for adolescents that are aligned with HAT. In other settings, it may be necessary to initiate a new programme.

To assess an existing programme, it is important to consider:

- the theory of change or logic model that underlies its design;

- the evidence base for the intervention;

- the content (in terms of developmental level, style of delivery and relevance for different groups of adolescents);

- how it is delivered (including alignment with standards for quality care for adolescent services *(72);* and

- the overall acceptability and feasibility of the programme.

In some cases, it may be worthwhile to adapt an intervention from another setting. This requires careful consideration of context-specific factors. Some interventions may be implemented in a new setting and remain effective with minor changes; however, others may be ineffective or even cause harm without adaptation. It is important to make changes that do not affect the core elements of the intervention or the mechanisms mediating positive changes. Adolescents and caregivers play an important role in the co-design, adaptation and evaluation of interventions.

The psychosocial intervention should be considered along with other structural interventions to address the socioeconomic and environmental stressors which have an impact on adolescents' mental health in a specific context.

1 Involve adolescents and caregivers

2 Engage other stakeholders and community members

3 Select the best approach and intervention

4 Carry out any adaptation or translation to meet the developmental needs

5 Determine the selection, supervision and quality assurance of service providers

6 Determine the identification, screening, assessment and referral process

Figure 4.2 Planning steps needed to assist in introducing a new psychosocial intervention to your setting

■ Key implementation issues to be considered at a planning stage include:

Use a staged approach in provision of promotion, prevention and care services to ensure a continuum of care.

Ensure linkage and referral to mental health treatment services and other support, including acute and community mental health services, child protection and other family services.

Screening, detection and identification

of adolescents must be carefully and sensitively planned, especially when identifying adolescents with existing psychological symptoms, and should always be accompanied with psychoeducation and psychosocial support.

Strategies to avoid stigma,

such as training, and supervision of assessors and providers must be conducted. Internalized stigma experienced by the adolescents who are offered these interventions must also be carefully considered and addressed as part of the intervention.

Community-based detection and identification

of adolescents can be conducted to support identification and referral of adolescents who may benefit from an indicated psychosocial intervention. For example, the Community Case Detection Tool (CCDT) van den Broek et al., (submitted, 2020) has been developed and evaluated in the Palestinian territory to improve community detection of child and adolescent emotional problems (also known as internalizing disorders) and disruptive/oppositional problems (also known as externalizing disorders) *(73)*.

■ Delivery approaches for universal interventions

Universal interventions can be delivered face-to-face (e.g. in schools or community settings), digitally, or using a combination of both approaches.

Most interventions (70%) evaluated in the evidence review that informed the WHO HAT guidelines were implemented in schools *(1)*. Since a universal intervention aims to reach the whole population, this delivery approach may be well-suited to many contexts where most (although not all) adolescents may be engaged.

Intervention duration and instructional components

Face-to-face delivery

For face-to-face programmes, there is no evidence of a difference in effect sizes between programmes of long duration (more than 16 hours) and those of shorter duration. The exception to this is for programmes targeting positive mental health, where longer programmes predict smaller effect sizes *(61)*.

It is suggested that implementers use participatory or active strategies, including modelling and group discussion, as they are more likely to engage and thus benefit adolescents *(61)*.
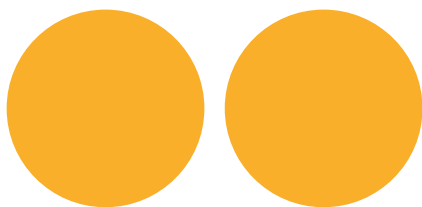
Digital delivery

For digital interventions, the duration of programmes does not typically predict effect sizes[1]. The exception to this is violence prevention programmes, where a longer duration appears to be associated with higher effect sizes. Three digital components (standardized content, tailored content and push notifications) predict larger effect sizes. Standardized content and push notifications predict larger effect sizes for violence-related outcomes, and tailored content for substance use. Personalized feedback (digital) and additional professional assistance (digital) to support online interventions do not predict effect sizes across any outcome *(61)*.

More than 16 hours of intervention duration are suggested when targeting violence prevention through digital strategies *(2)*.

Modelling and group discussion were shown to predict larger effect sizes, while the use of rehearsal and role-play did not predict effect sizes in either direction. Modelling was shown to be important in digital delivery and group discussion was important in face-to-face delivery *(61)*.

Implementers:

Implementers include a range of individuals such as teachers, mental health professionals, lay workers and peers. However, when teachers are implementers, clear roles and boundaries must be respected. Supervision and quality control mechanisms for implementers do not consistently predict larger effects, although these components are often not well reported

(61). In the global mental health field, where mental health interventions are increasingly developed for and implemented by nonspecialist health workers, supervision is recognized as an important strategy for programme success *(74)*. Previous research in this area has indicated that supportive supervision and programme monitoring can improve programme outcomes *(75)*.

Resources required:

Universal interventions tend to be conducted in settings that naturally capture the entire population (e.g. schools), resulting in low attrition rates. These settings are also associated with efficient use of resources as there is no need for screening tools or screening personnel since teachers are an existing human resource in the setting who

can be trained and supervised to deliver an intervention. However, there are also substantial costs to providing the intervention to a full population, depending on scale. There may be substantial differences between digital and face-to-face interventions, between countries and schools.

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[1] Effect size: the strength of relationship between two variables, the larger the effect size, the stronger the relationship.

Implementation considerations for adolescents exposed to known risk factor(s)

Delivery setting

Face-to-face, group school-based, refugee camp-based, individual home-based or web-based, or multiple-based interventions can be considered.

Consider alternative delivery settings such as the workplace or other community settings to ensure that adolescents out of school can be reached.

Implementers   1

Mental health professionals, social workers, nonspecialized providers, teachers or other school personnel may all be used to deliver the intervention.

Training and ongoing supervision must be provided.

A train-the-trainer model can be adopted where there are experienced nonspecialized providers, teachers or other school personnel with knowledge and practice.

Specific implementation considerations for humanitarian settings

Delivery setting

Adolescents exposed to humanitarian emergencies are less able to access care for their physical and mental health and are often no longer in school *(30)*.

Novel delivery strategies may need to considered where access to interventions is difficult because of ongoing conflict or other emergency.

Implementers   2

Care for implementers' well-being is important and must be supported as part of training and regular supervision.

Teachers, nonspecialized providers and mental health providers have all been used to implement these programmes.

Specific implementation considerations for pregnant adolescents and adolescent mothers

Delivery setting

Psychosocial interventions to support maternal mental health should be integrated into maternal and early childhood health and development services *(48)*.

Home visiting is a particularly useful strategy for engaging high-risk, hard-to-reach pregnant adolescents living under adverse circumstances. However, barriers to attrition must be overcome if the population is mobile.

Implementers   3

Nonspecialized providers may be better positioned to reach young caregivers and pregnant adolescents than health providers based in stationary clinics. However, these types of interventions deserve additional attention to strengthen retention and sustainability.

Specific implementation considerations for adolescents living with and affected by HIV

Delivery setting

Health centres and participants' homes may be used.

Mental health support should be integrated into health-care management for HIV. This needs to take a gender-sensitive and life-course approach, considering changes that occur from early adolescence to older adolescence and beyond.

Further research is needed to investigate the use of web-based interventions in this population.

Implementers

Given the sensitivity around the topic of HIV, it is both important and necessary to commit time and resources to training the workforce *(1)*.

3

Implementation considerations for adolescents with emotional problems (existing psychological symptoms but no existing diagnosis)

Delivery setting

Digital, face-to-face and combined approaches are feasible and effective options for delivery.

Delivering interventions using digital media could mitigate stigma.

Implementers

Nonspecialized providers in a school setting may be less intimidating.

Potential stigma of delivering interventions to selected groups of adolescents in schools, health or community settings should be carefully considered.

There is some evidence that indicated school-based interventions delivered by school staff are not effective *(76)*.

4

Implementation considerations for adolescents with existing disruptive or oppositional behaviour problems but with no existing diagnosis

Delivery setting

Digital and face-to-face approaches (in schools, community and health settings) to intervention delivery have been evaluated and show promise for the setting.

Caution should be exercised about using group approaches because adolescents may learn new oppositional or disruptive behaviours from each other, and/or may have their behaviours reinforced by observing and interacting with other adolescents with oppositional or disruptive behaviours.

5

Resources

WHO – Global standards for quality health-care services for adolescents.

https://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/
(accessed 4 March 2021).

UNICEF – Caring for the caregivers during the Covid-19 crisis

https://www.unicef.org/media/84131/file/CFC-COVID-19.pdf
(accessed 14 March 2021).

WHO – Guidelines on promotive and preventive mental health interventions for adolescents – Helping Adolescents Thrive (HAT)

https://apps.who.int/iris/handle/10665/336864
(accessed 14 March 2021).

WHO – HAT, EASE, STARS

https://www.who.int/mental_health/maternal-child/adolescent/en/
(accessed 14 March 2021).

WHO – STARS

https://www.who.int/mental_health/management/stars/en/
(accessed 14 March 2021).

YAM – Youth Aware of Mental Health

https://www.y-a-m.org
(accessed 14 March 2021).

AGEP – the Adolescent Girls Empowerment Program

https://www.popcouncil.org/research/adolescent-girls-empowerment-program
(accessed 14 March 2021).

Climate Schools Australia

https://www.climateschools.com.au/
(accessed 14 March 2021).

WHO – INSPIRE: Seven strategies for ending violence against children Education and Life Skills

https://www.who.int/publications-detail/inspire-seven-strategies-for-ending-violence-against-children
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Key implementation approaches

Multisectoral collaboration

Engaging diverse sectors through a whole-of-society approach is necessary to build a comprehensive response to promote and protect adolescent mental health *(1)*. Successful delivery of evidence-based strategies depends on well organized, ongoing collaboration between multiple sectors and stakeholders – public, private and civil society – at national and local levels. Multisectoral collaboration is the process of organizing and coordinating multiple stakeholders, within and external to the health sector, to work towards the common goal of promoting and protecting adolescent mental health *(2)*.

Key considerations in implementing HAT strategies within a multisectoral response include:

A range of sectors can play roles in promoting and protecting adolescent mental health

These sectors may contribute to promoting mental health and preventing mental health conditions through their usual service delivery which addresses risk factors for developing a mental health condition (e.g. provision of education or poverty alleviation). The sectors can also ensure that their policies and programmes are not harmful to mental health, and that they advance a mental health-promoting environment.

Different sectors can provide alternate delivery platforms for service provision

and increase access to adolescent promotive and preventive interventions (such as school- or workplace-based programming). As adolescents grow older, they often have reduced contact with health services and are increasingly difficult to reach through traditional delivery platforms. It is critical to be able to target adolescents through diverse entry points to which they are connected in their everyday lives, such as education, employment and social channels (3).

Different sectors can integrate gender and mental health in adolescent promotive and preventive interventions

Understanding adolescent girls' and boys' unique and common vulnerabilities to mental health risks, including the impacts of harmful gender norms and the factors that can protect and enhance their mental health and well-being, are crucial when developing interventions.

Multisectoral collaboration can be an effective way to strengthen service delivery collectively

for adolescent mental health promotion and prevention across a range of platforms. It may be possible for gaps faced by one sector to be filled by complementary services in another sector *(2)*.

Sectors may approach adolescent mental health in different ways, using different terminology and tools

Agreeing on a shared understanding of the issue is an important step towards ensuring that multisectoral action can be founded on best practices while also building on existing modes of improving mental health in young people *(4)*.

Natural disasters, disease outbreaks, conflict and other humanitarian emergencies can provide an impetus for collaborative efforts to promote and protect mental health

including for adolescents, and can provide opportunities to "build back better" mental health services (5).

Steps to implement HAT strategies

This section outlines essential steps for planning and implementing HAT strategies.

Establish a coordinating mechanism   1

To plan and oversee the development and implementation of a multisectoral response, a coordinating body should be convened at national, district and local levels (depending on the level of HAT implementation) *(2)*. The coordinating body, usually led by the Ministry of Health, should have political support and should be sufficiently resourced to plan for and implement the response while being able to hold partners accountable *(6)*. Its role is to oversee the development of the vision, leadership and governance, and to plan for implementation *(7)*.

Identify multisectoral partners   2

A number of partners should be involved in a multisectoral response – including government departments, civil society organizations including adolescent leaders, and academic and research partners. A diverse set of stakeholders is needed to fill essential but complementary roles, including technical expertise, programmatic expertise, research and knowledge generation, and oversight, planning and support. A detailed list of potential sectors is included in Table 5.1 *(8)*.

Foster political will and support   3

Senior leaders within each sector should be engaged and committed to the response. This includes fostering political will and leadership around adolescent mental health, mobilizing and allocating funds, and creating a sense of ownership and accountability within their sectors *(2)*.

Align partners' understandings of key issues   4

In developing the response, it is critical to create a shared understanding of adolescent mental health and the issues that influence it in a given context. It is also important that partners agree upon important principles of implementation, such as commitment to protecting the human rights of adolescents, promoting their participation in programming, and using gender-responsive programming. Working from a common framework facilitates communication as well as the design, implementation and evaluation of multisectoral responses *(9)*.

Complete a situation analysis and map of current activities   5

It is essential to assess the current environment and to identify existing mental health promotion and prevention activities, resources and needs (Box 5.1) *(10)*. Different stakeholders and sectors may already be engaging in activities to promote and protect adolescent mental health. It is important to identify what activities are already taking place, which stakeholders are involved (including adolescents and caregivers), what barriers to implementation exist, which factors facilitate successful programme delivery and whether there are equity issues, and to document other lessons learned. The mapping should determine the level of available resources (human, information, financial) and the current monitoring and evaluation frameworks *(10).* The mapping should also identify gaps in programming and opportunities for implementation of HAT strategies.

Box 5.1

Situation analysis and map of current activities

For **Strategy 1 (Policies and laws)**, the situation analysis should consider the current implementation and enforcement of current laws and policies that impact adolescent mental health promotion and prevention, through standards, protocols and mechanisms. These include laws and policies on pesticide and firearms control, injuries and violence, alcohol and other substance use, adolescent pregnancy, and HIV/sexually transmitted infections. The mapping should also include identification of areas where HAT strategies can contribute to strengthening existing policies and strategies for key health and well-being needs.

For **Strategy 2 (Environments),** one should consider the prevailing situations or conditions in which most adolescents live, work, study and socialize. The mapping would include the risk and protective factors for mental health within these environments, the extent to which relevant sectors and stakeholders are sensitized to issues relating to adolescent mental health, and existing programmes to improve environments (even if not termed as mental health promotion), including their level of sustainability and scale.

For **Strategy 3 (Caregivers)** and **Strategy 4 (Psychosocial interventions)** the situation analysis should cover: information on existing mental health services and resources; referral networks and pathways for adolescents and/or their caregivers; information on barriers to, and facilitators of, participation in existing programmes for adolescents and/or their caregivers; existing data about adolescents and/or caregiver mental health and risk and protective factors; data from past evaluations of adolescent and/or caregiver interventions; and opportunities for expanding programming.

Develop cost and implementation Plan   6

The implementation plan should be based on the situation analysis and developed together with all partners *(10)*. Developing a clear plan involves deciding on and establishing the overall goals and priority interventions for HAT implementation. The action plan should include a clear description of activities and targets, matched with appropriate indicators and data collection tools and systems to monitor implementation progress. The plan should describe opportunities for participation and leadership from adolescents and their caregivers and communities, resource needs (human, information, financial) and plans for mobilization of resources at national, district and local levels. The selected interventions and implementation plan will differ according to the context, depending on local priorities and resources and the conditions under which HAT implementation is taking place (e.g. a standalone initiative or part of a wider approach to health systems strengthening) (Box 5.2).

Box 5.2

Selecting interventions

For **Strategy 1 (Policies and laws),** when selecting key interventions, consider: priorities within the current legal and policy framework; the feasibility of changing policies and laws; the changes that are likely to gain support from decision-makers; and how changes to policies and laws fit within the overall plan to promote and protect adolescent mental health.

For **Strategy 2 (Environments),** consider: the existing evidence base for proposed environment-level interventions; the feasibility and acceptability of making changes to the adolescent environment; the extent to which a range of partners are able to contribute to efforts; and the extent to which interventions can be delivered equitably.

For **Strategy 3 (Caregivers)** and **Strategy 4 (Psychosocial interventions)** consider: the existing evidence base for proposed interventions; the feasibility and acceptability of programming by target caregivers, adolescents and providers; and whether it is possible to build on existing programmes or if it is necessary to initiate a new response.

Depending on the selected interventions, the plan should describe the roles and responsibilities for each sector according to its strength and area of expertise *(8)*. Table 5.1 gives examples of sectors and their potential roles in HAT.

Table 5.1 Potential roles of different sectors

Sector/partner	Potential role for sector
Education	Policies and programmes for mental health in schools and tertiary education, including for social and emotional learning and school climate interventions (including anti-bullying)
	Equitable access to counselling and referral
	Training and support programmes for educators
Social welfare/ Social development/ Child protection	Policies and programmes to prevent violence against adolescents
	Policies and programmes to support parents of adolescents
	Ensuring inclusion of adolescents in social protection programmes
	Policies and programmes to prevent child marriage
Labour	Policies and programmes for workplace mental health for young people and reduction of abuse associated with child labour
Constitutional/ legal affairs	Laws that protect adolescents from discrimination
Local/district government and municipalities	Provision of basic services to promote and protect mental health, e.g. safe living environments, basic services and sanitation facilities
	Provision of adolescent mental health programmes in municipal health services
Communications	Provision of Internet access to promote access to education, information and employment
	Media campaigns (including those aimed at adolescents) to improve knowledge about adolescent mental health
	Policies and programmes to promote safe Internet use and protect adolescents online

Sector/partner	Potential role for sector
Justice and law enforcement	Early identification and referral of young offenders and promotion of rights-focused approaches
	Policies and programmes for the prevention of violence against adolescents
Justice and law enforcement	Home/State affairs
Youth	Policies and programmes to promote the health, well-being and development of young people that integrate prevention of mental health conditions
Sport	Promotion of healthy recreational activities
Transport	Provision of safe and effective public transport system to increase access to school, work, recreational activities and public services
Research and academic partners	Identification of challenges facing adolescents in accessing information and services for mental health needs (structural as well as social, economic, behavioural)
Adolescent leaders	Provision of safe and effective public transport system to increase access to school, work, recreational activities and public services
Foundations and funders	Prioritizing initiatives to promote good mental health and creation of funding opportunities for diverse stakeholders
Research and academic partners	Assessment and mapping of local contexts, identification of an evidence base for best-suited policy and programming, partnerships with programme managers to evaluate responses
	Dissemination and knowledge translation of materials to broad audience

Table 5.1 Potential roles of different sectors

The HAT strategies should be implemented by the relevant partners, implementation monitored on an ongoing basis using the monitoring framework devised for the implementation plan. As interventions are implemented, partners should proactively document progress and any adaptations to the implementation plan as they occur *(10)*. Feedback should be gathered from key stakeholders, including adolescents, caregivers and communities, as the strategies are implemented. More information about Monitoring and evaluation is included in the next section (page 136).

There should be ongoing and regular mechanisms to sustain the multisectoral response. Partners can convene through planning boards, strategic advisory committees, task forces, think tanks or other kinds of committees. Holding different sectors to account for their actions, systems and standards should be established. These can include reporting requirements, public participation processes, public access to data and information, and engagement in mental health tribunals and ombudsman procedures *(9)*. Simultaneously, collaboration between sectors to promote and protect mental health should be encouraged and incentivized *(6)*.

The coordinating body and partners should regularly evaluate the implementation and impact of the HAT strategies to determine if and how targets have been met and to identify areas for improvement *(10)*. More information about the analysis and dissemination of findings is included in the following section on Monitoring and evaluation, see page 136.

Resources

WHO – Multisectoral Action for Mental Health

https://www.euro.who.int/__data/assets/pdf_file/0014/413015/Multisectoral-action-for-mental-health-Brief.pdf
(accessed 3 March 2021).

WHO – Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region

https://www.euro.who.int/__data/assets/pdf_file/0005/371435/multisectoral-report-h1720-eng.pdf?ua=1
(accessed 3 March 2021).

Community toolbox – Developing multisector collaborations

https://ctb.ku.edu/en/table-of-contents/implement/improving-services/multisector-collaboration/main
(accessed 3 March 2021).

UNICEF – Programme Guidance for the Second Decade: Programming with and for adolescents

https://www.unicef.org/media/57336/file
(accessed 3 March 2021).

UNICEF – National Multi-sectoral Coordination Framework for Adolescent Girls

https://www.unicef.org/uganda/reports/national-multi-sectoral-coordination-framework-adolescent-girls
(accessed 3 March 2021).

Monitoring and evaluation

Monitoring and evaluation (M&E) refers to two interlinked and complementary systems to collect, analyse and disseminate programme-related data *(11)*. M&E systems track whether programmes are being implemented as designed and are having their intended impact. Monitoring data, which are collected continuously during programme delivery, can help programme managers to plan and improve the implementation of promotive and preventive adolescent mental health interventions. Evaluation data, which are collected at specific time points, can help programme managers to assess the impact or effectiveness of interventions.

Effective M&E systems can also provide essential information on service delivery, service gaps, equity of implementation, cost-effectiveness and allocation of resources. Data from these systems can improve accountability and generate lessons to guide future programming. They can also be used to grow the evidence base *(11)*. This is essential for adolescent mental health, particularly in LMICs where there is limited evidence about what works to promote adolescent mental health and prevent mental health conditions and risk behaviours among young people.

Designing and implementing effective M&E systems requires detailed planning, including clear objectives, specific indicator frameworks, identified responsible persons or agencies, time frames and budget and resource allocations. Careful consideration should be given to M&E systems in the planning and implementation of HAT strategies in countries. To improve equity it is important to ensure that data are disaggregated by age and gender and in ways that enable monitoring of benefits and impacts on those adolescents who may be marginalized or exposed to vulnerabilities.

Types of information

M&E systems are designed around indicators which define the desired output, outcome or impact to be measured (Table 5.2). Different types of indicators provide different types of information for policy-makers and programme managers *(11)*.

Table 5.2 Types, definitions and examples of indicators

Type of indicator	Definition	Example question	Example indicator
Inputs	Financial, human and material resources	How much was spent on training teachers in the HAT programme?	Budget amount for HAT training sessions
Processes	Tasks through which inputs are converted to outputs	How many training sessions were held?	Number of training sessions held
Outputs	Direct result of processes	How many schools have at least one HAT-trained teacher on their staff?	% of schools with at least one HAT-trained teacher
Outcomes	Short- and medium-term changes	How has the programme changed	% reduction in new cases of and/or symptoms of depression, anxiety and suicide ideation in adolescents after taking part in HAT, compared to baseline
Impact	Long-term effect	What has the impact of HAT been on the mental health of the adolescent population?	% adolescent population with improved mental health compared to baseline

Considerations for M&E systems for adolescent mental health programming include:

- Different types of data from varied sources can be used to track adolescent mental health outcomes. These include routine data such as administrative data from both within and external to the health sector (including services delivered through the education, social development or child protection sectors, as well as nongovernmental programmes). Non-routine data, such as research data from school-based surveys or nationally representative surveys, can answer important questions relating to impact *(11)*. Smaller quantitative and qualitative studies looking at issues relevant to HAT can also be useful to answer specific questions in a given context.

- WHO's *Global accelerated action for the health of adolescents (AA-HA!):* guidance to support country implementation details critical considerations for the monitoring and evaluation of adolescent health programmes *(7).* These include the importance of:

collecting a range of data on inputs, processes, outputs, outcomes and impact to answer different questions about service delivery;

disaggregating data by age and biological sex of adolescents;

linking M&E plans to indicators in the *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (12)* and the SDGs;

involving adolescents in programme monitoring, evaluation and research, taking into account their developmental stage and relevant ethical considerations.


- WHO's *Comprehensive mental health action plan 2013–2020* (which has been extended to 2030) *(13)* provides considerations for the monitoring and evaluation of mental health programmes across the life course. These include the following:

Information systems should gather and report data on:

1) the extent of the problem (the prevalence of mental health conditions and identification of major risk factors and protective factors for mental health and well-being);

2) coverage of policies and legislation, interventions and services;

3) health outcome data (including suicide rates at the population level as well as individual- or group-level improvements related to clinical symptoms, levels of disability, overall functioning and quality of life); and,

4) social/economic outcome data.

Data should be collected through ad hoc periodic surveys in addition to existing data (such as those collected through the routine health information system or information from the reports submitted to treaty-monitoring bodies).

Data should reflect the diverse needs of subpopulations, including individuals from geographically diverse communities (e.g. urban versus rural) and vulnerable populations.
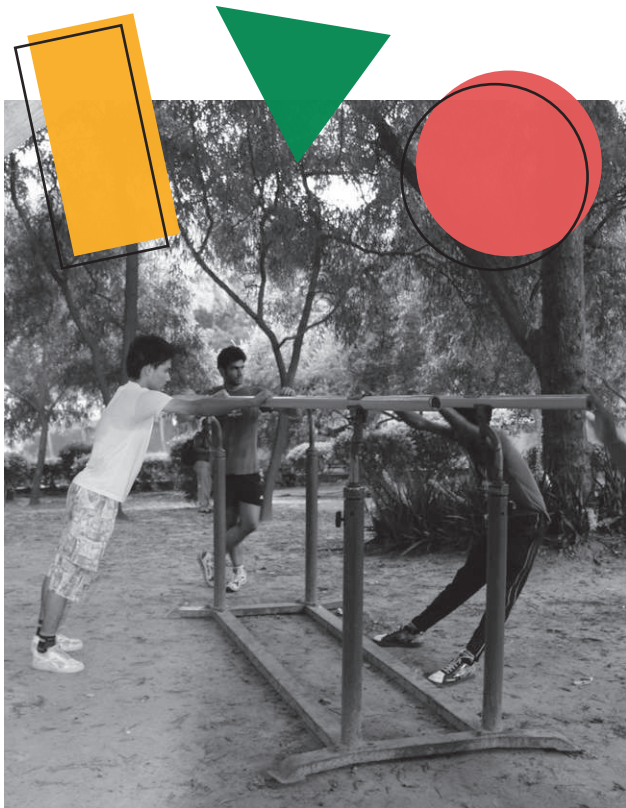
Steps to plan and implement an M&E system

This section outlines essential steps for planning and implementing HAT M&E systems. It is adapted from *Monitoring and evaluation of mental health policies and plans (11).*

Commit to guiding principles

Step 1

In developing the guiding principles of the new system, consider:

How will the M&E system protect the human rights of HAT participants and ensure that their personal data are provided voluntarily and kept confidential?

How will participation of adolescents and their caregivers in HAT and the M&E system be promoted and sustained?

How can the system be integrated within existing M&E and reporting systems and build on existing resources and capacities?

How can capacity development in M&E be integrated more broadly into HAT activities (e.g. through training all HAT stakeholders in M&E)? How can M&E system development be linked to broader capacity development in promotive and preventive programming for adolescent mental health (i.e. using M&E strengthening as an entry point for strengthening the HAT response)?

How can the findings from the M&E processes be used for accountability purposes to the benefit of participants? How can findings be used to monitor health outcomes and inequities?

Decide on the purpose and scope (linked to specific HAT strategies)

Step 2

Monitoring and evaluating the implementation, effectiveness and impact of HAT may differ in different contexts, depending on whether the full package or selected strategies are being implemented, and whether programme managers are focused on implementation or impact-related questions, or both. For instance, if HAT programme managers focus on the caregiver support aspects of HAT (Strategy 3), indicators tracking changes in the adolescent–caregiver relationship will be critical.

Before developing an M&E system for HAT implementation in a given context, consider:

Which HAT strategies will be implemented?

What is the goal of implementing the strategies in this context?

Who are the target participants?

Identify what information is needed

Step 3

Map the relevant inputs, processes, outputs, outcomes and impacts against the intended programme design to create an M&E framework. Programme managers should:

Define specific indicators based on the information that is required and is feasible to obtain.

Ensure that indicators are tailored to the target group, approach and context.

Develop an operational plan for data collection

Step 4

In developing an operational plan for data collection, consider:

Are there existing data sources available that could be used as part of the M&E plan?

Are there sufficient resources for M&E activities, especially when non-routine data are being collected?

Who is responsible for collecting, analysing and disseminating data? What is the role of each stakeholder?

When, how and how often will data be collected?

What data collection tools will be used?

How will the information flow through the system?

What training and ongoing support is required?

How can quality control mechanisms be implemented?

In selecting data collection tools for use, consider:

Do the tools measure the desired outcomes?

Are the tools relevant, age-appropriate and gender-sensitive?

Have the tools been validated in the given context or in a similar context?

Are there any copyright issues with using the tools?

What training do personnel need to administer the tools?

Manage ethical issues for adolescents and their families

Step 5

Collecting data about — and/or from — adolescents and their families requires careful consideration and additional emphasis on child protection. Programme managers should consider all processes in the system in terms of their impact on adolescent participants and their families, and how these persons can be protected from harm. The processes include:

selection, training and management of M&E staff;

procedures to obtain informed consent/assent (including with caregivers);

use of measurement tools that are appropriate in terms of context, age and developmentally,

methods of data collection;

implementation of referral (including emergency) procedures and follow-up checks.

Plans for data collection from adolescents and their families, or from other participants such as teachers or youth workers, should be submitted to and approved by an accredited Ethics Review Committee in the given context.

Collect the data   Step 6

For data collection, the roles and responsibilities of the various stakeholders should be clearly defined. Data collection procedures should be in accordance with a protocol regarding the mechanisms for monitoring data and for subject safety. The protocol should include information on how participants' identities will be kept confidential, how data will be stored securely and for how long, and who is able to access it.

Analyse the data   Step 7

At the analysis stage, disaggregation of data can provide useful information about specific groups enrolled in programming and whether they can access and benefit from HAT equitably. Depending on the context, data should be disaggregated in terms of age, gender, ethnicity, disability status, identity status and whether or not the adolescent is in or out of school.

Disseminate   Step 8
the results

A comprehensive dissemination plan should be designed with the support of the communications team involved in the process. Dissemination of the results could include feedback to adolescents, their families, HAT facilitators, M&E staff and other local stakeholders (administration, schools, community leaders, civil society etc.). No data on individuals should be disseminated. All results and findings should be aggregated before sharing and will be strictly limited to the M&E framework and for programme evaluation or accountability purposes. Data may also be shared on request for research/ evidence purposes.

Resources

Global Health Learning Centre – M&E fundamentals

https://www.globalhealthlearning.org/course/m-e-fundamentals
(accessed 3 March 2021).

International Federation of the Red Cross and Red Crescent Psychosocial Centre – Monitoring and Evaluation Framework indicator guide

https://pscentre.org/?resource=monitoring-and-evaluation-framework-indicator-guide
(accessed 3 March 2021).

International Federation of the Red Cross and Red Crescent Psychosocial Centre – Monitoring and Evaluation Framework toolkit

https://pscentre.org/?resource=monitoring-and-evaluation-framework-Toolkit
(accessed 3 March 2021).

Iner-Agency Standing Committee – A common Monitoring and Evaluation framework

https://interagencystandingcommittee.org/system/files/iasc_common_monitoring_and_evaluation_framework_for_mhpss_programmes_in_emergency_settings_english.pdf
(accessed 3 March 2021).

WHO – Mental health information systems

https://www.who.int/mental_health/policy/services/12_info%20sytem_WEB_07.pdf?ua=1
(accessed 3 March 2021).

WHO – Monitoring and Evaluation of mental health policies and plans

https://www.who.int/mental_health/policy/services/14-monitoring%20evaluation_HKprinter.pdf?ua=1
(accessed 3 March 2021).

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2. Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region. Copenhagen: World Health Organization Regional Office for Europe; 2018.

3. Baltag V, Servili C. Adolescent mental health: new hope for a "Survive, Thrive and Transform" policy response. J Public Ment Health. 2016;15(1):63–70.

4. Lo S, Das P, Horton R. A good start in life will ensure a sustainable future for all. Lancet. 2017;389(10064):8–9.

5. Coronavirus disease (COVID-19) preparedness and response. UNFPA Interim Technical Brief. Gender equality and addressing gender-based violence (GBV) and coronavirus disease (COVID-19) prevention, protection, and response [press release]. New York (NY): United Nations Population Fund; 2020.

6. The INSPIRE handbook. Action for implementing the seven strategies for ending violence against children Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/272996, accessed 3 March 2021).

7. Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/255415/9789241512343-eng.pdf, accessed 3 March 2021).

8. Skeen S, Kleintjes S, Lund C, Petersen I, Bhana A, Flisher AJ et al. 'Mental health is everybody's business': roles for an intersectoral approach in South Africa. Int Rev Psychiatry. 2010;22(6):611–23.

9. World Health Organization discussion paper. Intersectoral action on health: a path for policy-makers to implement effective and sustainable intersectoral action on health. First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, Moscow, 28–29 April 2011 (https://www.who.int/nmh/publications/ncds_policy_makers_to_implement_intersectoral_action.pdf, accessed 3 March 2021).

10. Implementation Guidance for Health Promoting Schools, Draft 2, September 2020. Melbourne: Centre for Adolescent Health, Murdoch Children's Research Institute; 2020.

11. Monitoring and evaluation of mental health policies and plans. Geneva: World Health Organization; 2007.

12. Every Woman Every Child. Global Strategy for Women's, Children's and Adolescents' Health 2016–2030. New York (NY): United Nations; 2015.

13. Comprehensive mental health action plan 2013–2020. Geneva: World Health Organization; 2013.

Annex. HAT indicators

These are examples of indicators that will need to be selected and tailored to meet the specific needs of the country. Below are examples from

The *Measurement of mental health among adolescents at the population level (MMAP) (1);*	1
The *WHO Global Health Observatory (2);*	2
The *WHO Comprehensive Mental Health Action Plan 2013–2020 (3)* (which is being extended to 2030); and	3
The *Global Action for Measurement of Adolescent Health (GAMA) (4).*	4

For all indicators, data should be collected for 10–14 years of age and 15–19 years of age, together with reported gender preference.

MMAP   1

Indicators from MMAP are currently under validation. Below is a preliminary list *(1):*

Prevalence of depression and anxiety among adolescents

- Number of adolescents aged 10–19 years reporting symptoms of depression and/or anxiety at a clinical threshold.

Functional limitations due to anxiety or depression

- Number of adolescents aged 10–19 years reporting symptoms of depression and/or anxiety reporting functional limitations.

Suicidal thoughts and behaviours

- Number of adolescents aged 10–19 years reporting suicidal thoughts in the last 2 weeks.

- Number of adolescents aged 10–19 years reporting suicidal attempt in the last 2 weeks.

Mental health care and psychosocial support

- Number of adolescents aged 10–19 years reporting symptoms of depression and/or anxiety reporting contact with someone (health professional or counsellor) about difficult feelings and experiences.

- Number of adolescents aged 10–19 years reporting symptoms of depression and/or anxiety reporting having no contact with someone (health professional or counsellor) about difficult feelings and experiences.

- Number of adolescents aged 10–19 years reporting they talk to someone either most or all of the time when they have a problem or worry relating to difficult feelings and experiences.

- Number of adolescents aged 10–19 years reporting that in the last 30 days their caregiver (parent or other guardian) understood their problems or worries most or all of the time.

The WHO Global Health Observatory   2

provides indicators relevant to adolescent mental health *(2).* For example*:*

Mental health policy

- Existence of officially approved mental health policy.

Mental health legislation

- Existence of dedicated mental health legislation.

Adolescent substance use

- Heavy episodic drinking is defined as the proportion of adults (15+ years) who have had at least 60 g (approximately six standard alcoholic drinks) or more of pure alcohol on at least one occasion in the past 30 days.

Substance use prevention programmes

- Existence of programmes for the prevention for alcohol or drug use for special population groups such as for children and adolescents, children and families at risk, etc.

Environments: school

- Number of schools with anti-bullying policies.

- Number of adolescents who report, in the last 30 days, that they feel a sense of belonging at their school.

- Number of adolescents who report, in the last 30 days, that they feel safe at school.

- Number of reported incidents of violence/bullying at school in the last 30 days.

Environments: community

- Number of adolescents who report they can trust people in the area where they live.

- Number of adolescents who report that their neighbourhood is a place where neighbours help each other.

- Number of adolescents who report that social disorder in their neighbourhood is "a very big problem" or "a fairly big problem".

- Number of adolescents who report feeling safe, in the last 30 days, while travelling to school.

- Number of adolescents who report feeling safe, in the last 30 days, going to access food or recreation.

- Number of adolescents reporting, in the last 30 days, witnessing violence in communities/gangs/drug deals.

- Number of adolescents who report there are places to spend free time in the area where they live.

Environments: online

- Number of adolescents reporting online interaction with unknown person in the past 12 months.

- Number of adolescents reporting face-to-face meetings with persons first met online, in the past 12 months.

- Number of adolescents reporting having experienced in the past 12 months being disturbed due to cyberbullying/cyberstalking/hacking of personal data/online data.

The *WHO comprehensive Mental Health Action Plan 2013–2020 (3)* (which is being extended to 2030)

3

proposes core indicators for monitoring progress towards set targets. These include:

- Existence of a national policy/plan for mental health that is in line with international and regional human rights instruments.

- Existence of a national law covering mental health that is in line with international and regional human rights instruments.

- Functioning programmes of multisectoral mental health promotion and prevention in existence.

- Number of suicide deaths per year.

- Core set of mental health indicators routinely collected and reported every 2 years.

Global Action for Measurement of Adolescent health (GAMA) (4)

4

See here proposed indicators for adolescent mental health and well-being, which include:

Policies, programmes and laws

- Existence of national policy exempting adolescents (10–19 years) from user fees for specified health services in the public sector, by type of service (including mental health, HIV-testing and counselling).

- Existence of a legal age limit for married and unmarried adolescents (10–19 years) to provide consent, without spousal/parental/legal guardian consent, for specified adolescent health services by marital status and type of service (including mental health, HIV-testing and counselling).

Health outcomes and conditions

- Number (or percentage) of adolescents (10–19 years) with depression and/or anxiety seeking mental health care or psychosocial support, by age group (10–14, 15–19 years) and sex.

Adolescent well-being

- Number (or percentage) of adolescents (10–19 years) with a positive connection with their parent/caregiver or guardian, by age group (10–14, 15–19 years) and sex.

References

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2. Vardell E. Global health observatory data repository. Med Ref Serv Q. 2020;39:67–74 https://doi.org/10.1080/02763869.2019.1693231, accessed 6 March 2021).

3. Comprehensive mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/handle/10665/150159, accessed 24 February 2021).

4. Guthold R, Moller AB, Azzopardi P, Ba MG, Fagan L, Baltag V et al. The Global Action for Measurement of Adolescent health (GAMA) initiative – rethinking adolescent metrics. J Adolesc Health. 2019;64:697–9. https://doi.org/10.1016/j.jadohealth.2019.03.008, accessed 6 March 2021).
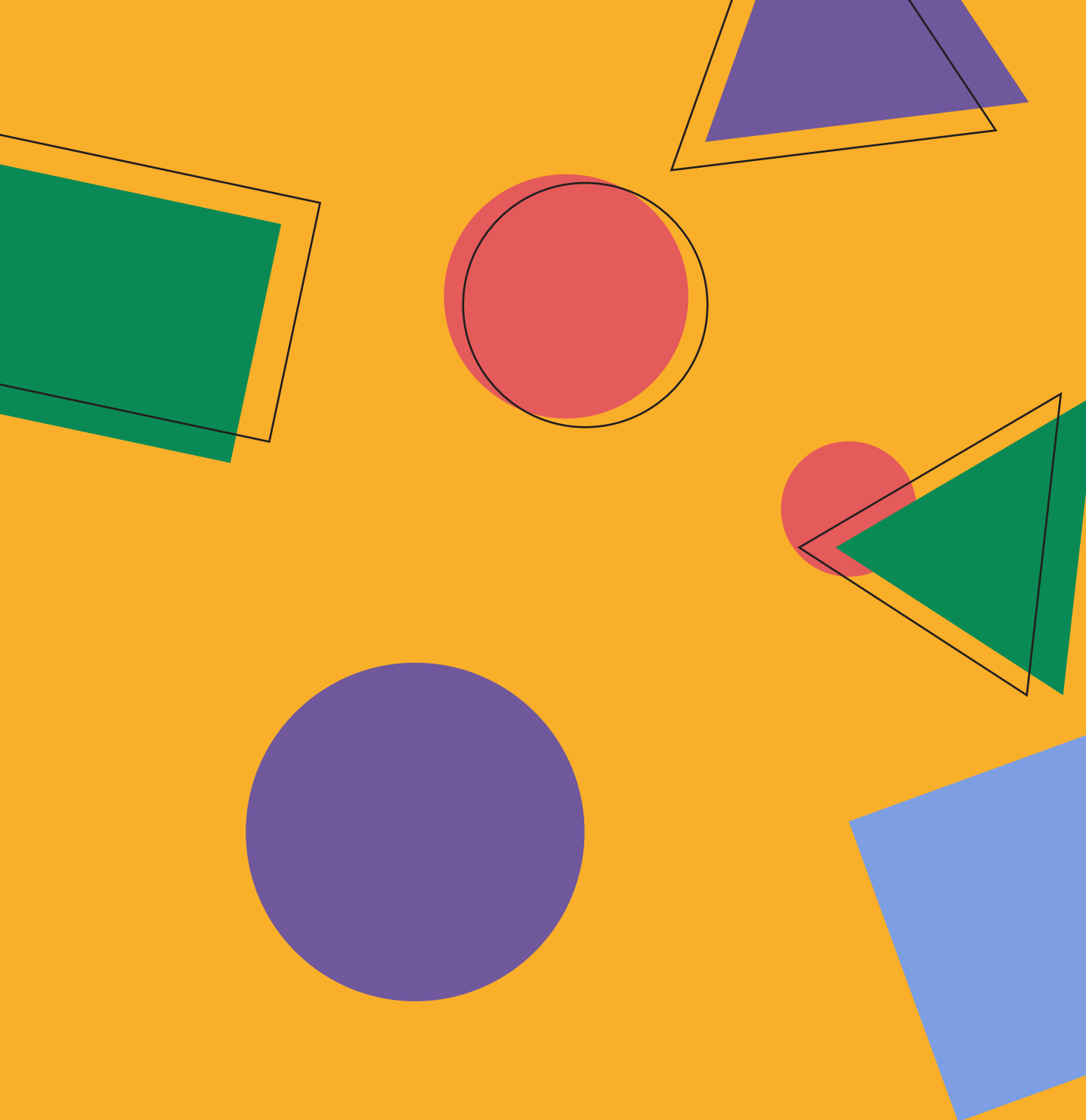
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