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MINISTRY OF HEALTH MALAYSIA

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STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SYSTEMS AND SERVICES

for children and adolescents in East Asia and Pacific Region

MALAYSIA

COUNTRY REPORT
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Prepared for UNICEF East Asia and the Pacific Regional Office and UNICEF Malaysia by:

Institute for Clinical Research (ICR), Institute for Health Behavioural Research (IHBR) and Institute for Health Management (IHM),
National Institutes of Health (NIH)
Ministry of Health Malaysia
National Institutes of Health (NIH), No.1, Jalan Setia Murni U13/52, Seksyen U13, 40170 Shah Alam, Selangor Darul Ehsan, Malaysia
603-3362 7700
https://www.crc.gov.my/
https://iptk.moh.gov.my/
https://ihm.moh.gov.my/

MINISTRY OF HEALTH MALAYSIA

Burnet Institute
85 Commercial Rd, Melbourne, Victoria, Australia
+61 3 9282 2111
www.burnet.edu.au

Burnet Institute
Medical Research. Practical Action.

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UNICEF East Asia and the Pacific Regional Office
Phra Athit Road, Bangkok, Thailand 10200
Email: eapro@unicef.org
www.unicef.org/eap/

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National Institutes of Health Malaysia
Norizan Rosli
Aimi Nadiah Jamel
Nur Ain Zahidah Zainudin
Nur Alia Mohammad Rihan
Tasneem Basir
Nur Khalisah Kaswan
Ainul Asyhikin Tan Ahmad Farid Tan
Syahirah Farhana Mohd Saleh
Anis Suraya Muhamad Nawawai
Lai Wei Hong
Juhanah Gimbo
Leow Mei Lian
Nik Nur Eliza Mohamed
Malini Shanmuganathan
Chong Kai Loon
Shirin Tan Hui
Lee Kun Yun
Nadia Hani Jahaya
Zaikiah Mohd Zin
Nurashma Juatan
Abu Bakar Rahman
Sheikh Shafizal Sheikh Ilman
Mohamad Zaidan Bin Zulkepli

Burnet Institute
Elissa Kennedy
Peter Azzopardi
Miika Coppard
Vinay Menon

Nisaa Wulan
Julie Hennegan
Murdoch Children's Research Institute
George Patton
Monika Raniti
Monash University
Jane Fisher
Consultant Psychiatrists, Ministry of Health Malaysia
Salina Abdul Aziz
Nazariah Aiza Harun
Nor Rahidah Abdul Rahim
Mohd Affendi Hashim
Centre for Mental Health And Well-being, HELP University
Marc Archer

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Regional TAG	Malaysia Country TAG
Janelle Babb (UNESCO)	Sarah Norton Staal
Roshni Basu (UNICEF)	Feisul Idzwan Mustapha
Francisco Benavides (UNICEF)	Noor Ani Ahmad
Michelle Dynes (UNICEF)	Nurashikin Ibrahim
Akihiro Fushimi (UNICEF)	Andrew Mohanraj
Zeinab Hijazi (UNICEF)	Amer Siddiq Amer Nordin
Jennifer Hall (WHO)	Aida Syarinaz Ahmad Adlan
Kunihiko Chris Hirabayashi (UNICEF)	Izzatul Shima Md Thahir
Jo Lucas (Oxford Policy Management UK)	Azmaini Isa
Natia Partskhaladze (GSSWA)	Nor Hisham Ismail
Cassie Redlich (WHO)	Mohd Pilus Abdullah
Hugh Salmon (GSSWA)	Alexius Cheang
Martin Vandendyck (WHO)	Susheela Balasundaram
Natia Partskhaladze (GSSWA)	Anita Abu Bakar
Christina Popivanova (UNICEF)	Atirah Haizir

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Abbreviations

COVID-19	Coronavirus disease 2019
CRC	Convention on the Rights of the Child
DALY	Disability-adjusted life year
DSW	Department of Social Welfare
EAPRO	Regional Office for East Asia and the Pacific (UNICEF)
GBD	Global Burden of Disease
GSHS	Global School-Based Student Health Survey
GSSWA	Global Social Service Workforce Alliance
HEADSS	Home and Environments, Education and Employment, Activities, Drugs, Sexuality and Gender, Suicide, Self-harm, Safety and Spirituality
MHPSS	Mental health and psychosocial support
MICS	Multiple Indicator Cluster Survey
NCMW	National Coalition for Mental Wellbeing
NGO	Non-governmental organization
NHMS	National Health and Morbidity Survey
TAG	Technical Advisory Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

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

Despite this burden, there is a substantial unmet need for mental health and psychosocial support (MHPSS) for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of the total health expenditure[5] despite accounting for 7 per cent of the total burden of disease.[6] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescent is <0.5 per 100,000 population, and there are fewer than two outpatient facilities for child and adolescent mental health per 100,000 population.[5]

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

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

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

This report documents the application of the conceptual framework in Malaysia and provides country specific recommendations for strengthening the provision of MHPSS for children and adolescents.

Children and adolescents aged 0–18 years in Malaysia experience a high burden of poor mental health. Around 1 in 8 adolescents aged 10–19 and 1 in 20 children aged 5–9 years are estimated to have a mental disorder (including developmental disorder). Suicide is the second leading cause of death among adolescents aged 15–19. Risk factors for poor mental health – including exposure to violence, peer victimization and bullying, loneliness and social isolation particularly in the context of COVID-19 – are also prevalent.

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

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

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

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

1. At national level, the Mental Health Act should be strengthened to more clearly articulate the specific considerations and protections for children and adolescents, including those within the mental health system. Consideration should also be given to developing a specific multisectoral child and adolescent mental health strategy that more clearly articulates the MHPSS actions across the three tiers of responsive care, prevention and promotion, and details a multisectoral plan (and coordination structure) for implementation, including cross-sectoral performance indicators and clear roles, responsibilities and accountabilities of key sectors.
2. The Government should strengthen legislative protections for children and adolescents (including prohibiting corporal punishment, decriminalizing suicide, addressing discrimination and increasing protections within justice and institutional settings), and address legislative barriers to accessing MHPSS (such as mandatory parental consent and barriers for undocumented migrants).
3. Under the leadership of the Ministry of Health, a national, multisectoral steering committee for child and adolescent mental health should be established, with responsibility for coordinating policy, implementation and accountability.

4. Under the Ministry of Health, a cross-sectoral, independent monitoring body should be established to assess quality, compliance and performance of MHPSS programmes and services.
5. At district level, the state government should support district offices to develop local, multisectoral implementation plans, resource allocation and coordination for MHPSS. To support this, consider establishing district-level, multisectoral subcommittees for mental health and provide capacity building for district-level decision-makers in mental health.
6. The Ministry of Health, in consultation with other sectors and technical partners, should strengthen national, standardized protocols for child and adolescent health across agencies, including:
    a. Early identification protocols and validated screening tools for this age group and detailed guidance on their use in different settings (including consideration of the potential harms of screening);
    b. Referral procedures across sectors;
    c. Non-specialist management;
    d. Case management of children and adolescents engaged in the child protection and justice sectors.
    e. Greater protections for children in conflict with the law and child victims within the justice system; and
    f. National, quality service standards for child and adolescent mental health services across sectors.
7. The Government should include mental health services (including outpatient services) within the national health insurance programme and increase public resource allocation for mental health across the tiers of care, prevention and promotion. To support this, consideration should be given to including mental health as a primary programme, and a minimum-services package (based on the regional framework) should be defined and costed, with budget allocations and responsibilities clearly defined across key sectors. The Government could also consider establishing a national cross-sectoral body or cross-sectoral budget committee on MHPSS to support coordinated and comprehensive budget requests that align with national MHPSS goals.
8. The Government, with support from professional associations, training institutions and development partners, should strengthen the multisectoral mental health and psychosocial support workforce through:
    a. Further in-depth mapping to identify key roles across sectors against the MHPSS priority actions, and the required competencies and inter-sectoral training needs to support these roles;
    b. Development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for key providers across sectors;
    c. Integration of child and adolescent development and mental health into the pre-service training of health professionals, the social service workforce, justice sector workers, teachers and other school-based staff in alignment with the roles and responsibilities with respect to MHPSS;
    d. Strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers), social service workers, justice sector workers, teachers and education staff that is competency-based and aligned with expected MHPSS roles;
    e. Training provided to relevant ministry-level staff from the health, education, social welfare and justice sectors to support planning and development of the workforce as well as broader MHPSS programmes;
    f. Expansion of the number of posts at national and subnational levels; and
    g. Improved supervision and support for MHPSS providers across sectors, including establishing provider support networks and multidisciplinary teams, improved remuneration, job security and career pathways, and attention to the mental health needs of providers themselves.

9. The Ministry of Health, in consultation with other key sectors and academic and development partners, should improve the collection, use and accessibility of data at national and subnational levels – including data to identify mental health needs, support planning and implementation, and track progress. This should include the development of a minimum set of MHPSS-related indicators harmonized across sectors, including performance indicators related to multisectoral collaboration, and development of user-friendly platforms (such as a data dashboard) to improve the access of service providers and communities to mental health data.
10. The Government, development partners and non-governmental organizations (NGOs) should increase opportunities for children and adolescents to participate in MHPSS policy and programming, including establishing more formal roles for young people such as representation on the National Coalition for Mental Wellbeing (NCMW) or national steering committee. The Ministry of Health should also improve child- and adolescent-friendly mechanisms for providing feedback on MHPSS programmes and mental health services.
11. The Government, development partners and NGOS should expedite the process of systematic decentralization of mental healthcare to community-based MHPSS by expanding national and community-based programmes to address mental health- related stigma and discrimination and improve mental health literacy (particularly targeting children, adolescents and parents/caregivers).
12. The Government, development partners and NGOs should focus on expanding inter-agency collaboration and monitoring and evaluation of implementation, outcomes and the impact of mental health programmes, including improved data and information sharing through digital platforms.

Introduction

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

Malaysia has more than 9 million children and adolescents aged 0–18 years, making up approximately 28 per cent of the country's population.[2] Children and adolescents in Malaysia experience a substantial burden of poor mental health. Modelled estimates from the Global Burden of Disease (GBD) Study 2019 indicate that mental disorders and self-harm account for 19 per cent of the total burden of disease among 10–19-year-olds, with suicide the second leading cause of death for 15–19-year olds.[1] The COVID-19 pandemic has heightened the need for MHPSS, with significant impacts on education, social connectedness, family stressors, inequality and disruption of essential services.

BOX 1. DEFINITIONS OF MENTAL HEALTH

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

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

Adapted from *The State of the World's Children 2021,* UNICEF, 2021.

Poor mental health can have profound impacts on the health, learning and participation of children and adolescents, limiting opportunities for them to reach their full potential. This age spectrum encompasses a time of critical brain growth and development when social, emotional and cognitive skills are formed, laying the foundations for mental health and well-being into adulthood. In addition to mental disorders, many risk factors for future poor mental health also typically have their onset during this developmental stage.[4,5] Poor mental health during the first two decades of life also has broad implications for communities and societies. The lost human capital from mental disorders during childhood and adolescence in East Asia and the Pacific is estimated to be US$74.68 billion a year (expressed in terms of purchasing power parity dollars) – the highest of any region.[2]

Despite this burden, there is a substantial unmet need for MHPSS for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of total health expenditure[6] despite mental health disorders accounting for 7 per cent of the total burden of disease.[7] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescents is <0.5 per 100,000 population, and there are fewer than two outpatient facilities for child and adolescent mental health per 100,000 population.[6] There

are also many gaps and missed opportunities to prevent poor mental health and promote well-being, with approaches often fragmented and small-scale. In addition to inadequate human and financial resources, lack of coordination between sectors and substantial stigma remain significant barriers to ensuring that children, adolescents and their families have access to quality services and support.[2,8]

BOX 2. DEFINITION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

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

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

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

Malaysia has made important efforts to address child and adolescent mental health through the provision of mental health services, parenting programmes and policy and legislation to protect children from violence and other forms of harm. However, access to services is still far from universal and unmet need is prevalent. A greater understanding of how to effectively implement MHPSS for children and adolescents across multiple sectors is needed to address these gaps.

To ensure the mental health and psychosocial well-being of children and adolescents, there is a need for a holistic and tiered approach to MHPSS that includes actions to:

- Promote well-being;
- Prevent poor mental health by addressing risks and enhancing protective factors; and
- Ensure quality and accessible care for those with mental health conditions.

This requires the mobilization of all sectors – including health, education, social welfare and justice – as well as engagement with communities, schools, parents, service providers and children and adolescents themselves. This multisectoral approach is at the core of UNICEF's East Asia and Pacific Regional Conceptual Framework on MHPSS and the Global Multisectoral Operational Framework for mental health and psychosocial support of children, adolescents and caregivers across settings.[9,10]

Project aims, objectives and approach

Aims and objectives

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

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

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

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

BOX 3. OUTLINE OF THIS REPORT

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

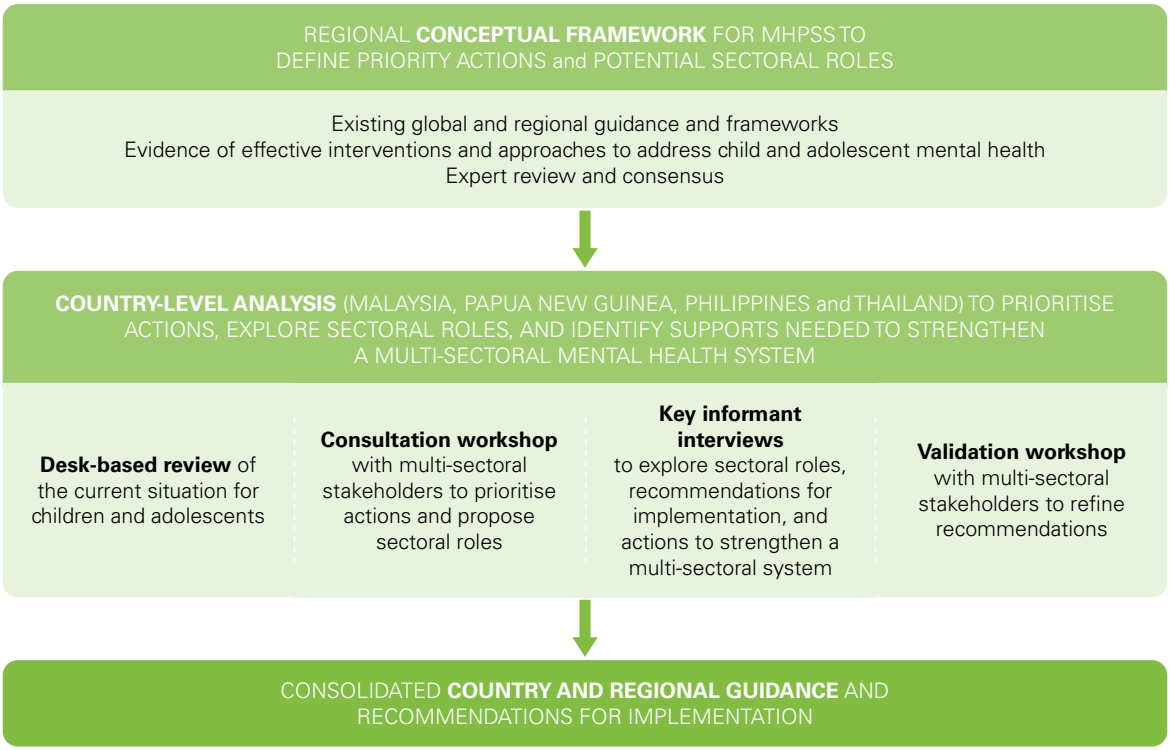
1. **Mental health and psychosocial well-being of children and adolescents: the current situation (mental health needs, and policy and programming responses);**
2. **Priority package of MHPSS actions;**
3. **Recommended sectoral roles; and**
4. **Recommendations for strengthening the multisectoral mental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

Overview of the approach

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

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

FIGURE 1. OVERVIEW OF THE PROJECT APPROACH



Country-level analysis

Country-level analysis was co-led by Burnet Institute and the National Institutes of Health Malaysia, supported by the UNICEF Country Office and the Country TAG, with oversight by the UNICEF East Asia and the Pacific Regional Office and Regional TAG.

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

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

This component included four main activities:

1. Desk-based review

Synthesis and secondary analysis of existing survey data

Priority indicators describing mental health outcomes and risks for children and adolescents aged 0–18 years were identified following a mapping of existing global and regional mental health indicators. Indicators were populated using available national-level survey data (National Health and Morbidity (NHMS) 2019[11] and NHMS Adolescent Survey 2017)[12] and data disaggregated by age and sex, where possible. Where data were not available, modelled estimates were sought from the GBD Study 2019.[1]

Review and synthesis of available literature

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

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

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

Search results were uploaded to Covidence. A total of 2,054 studies were imported for screening; 659 duplicates were removed, 1,395 studies were screened and 1,204 were excluded. In total, 191 articles were included for full-text screening and extraction to the literature review as appropriate. Manual searching of reference lists from relevant articles was also conducted to identify further peer-reviewed literature or grey literature.

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

Government policies, plans, strategies and legislation were sought from relevant government websites and United Nations (UN) agencies. Relevant government ministries or departments from each sector (health, education, social welfare and justice) were first identified and websites searched using similar search terms to those above to identify potentially relevant documents relating to mental health. Documents were included if they were:

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

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

2. Country-level stakeholder consultation workshops

Two half-day, online workshops were conducted on 27 and 29 July 2021. These were attended by 72 participants, including representatives from the Government (primarily the health, education, social welfare and justice sectors), NGOs, the private sector, UN agencies, youth organizations and young people with hearing impairment. The aim of the workshops was to present and reflect on the MHPSS conceptual framework, identify priority actions for MHPSS for children and adolescents, and propose sectoral roles and responsibilities for implementation of the MHPSS package. To facilitate this, participants were invited to complete an online prioritization tool to provide feedback on each proposed MHPSS action and indicate a lead sector. Thirty-three participants completed the online tool, and findings were presented and discussed during the second workshop.

3. Key informant interviews with sector stakeholders

Key informant interviews were conducted to explore in depth:

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

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

A total of 25 interviews were conducted with stakeholders aged 18 years and over from the health (five), education (two), social welfare (10) and justice (four) sectors, including government, non-government, UN agency and four youth representatives. All interviews were conducted via Zoom due to COVID-19 restrictions. Interviews were conducted in Bahasa Malaysia or English, facilitated by experienced researchers who had completed a three-day, intensive training workshop covering the study objectives, study procedures and ethical considerations. Interviews were audio-recorded and transcribed verbatim. Transcripts were analysed thematically using a Framework Method.

All participants provided voluntary informed consent. Ethics approval was obtained from the Alfred Ethics Committee (Australia) and the Ministry of Health Medical Research and Ethics Committee (Malaysia). Approval was also obtained from the Ministry of Education Malaysia through its Educational Research Application System (eRAS 2.0).

4. Translational workshop

Following data analysis, a second, one-day workshop was conducted with 27 participants from the Country TAG and other key sectoral stakeholders. The purpose of this workshop, held in person and online, was to present and reflect on the key findings and refine the recommendations through facilitated small group discussions.

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

Limitations

The Malaysia analysis has some key limitations. First, the synthesis of peer-reviewed literature was restricted to studies published in English. However, key publications in Bahasa Malaysia relating to the criteria above were identified and reviewed by Institute for Clinical Research researchers for inclusion in the desk review. Not all policy/strategy/legislation documents were able to be accessed online – these gaps were filled through key informant interviews. Despite this, some key policies may not have been included. Additionally, the desk review was limited to national and high-level policies – specific details regarding protocols, guidelines, training programmes and standard operating procedures in relation to MHPSS were not included. Similarly, key informant interviews were limited primarily to national-level stakeholders, so some specific approaches, priorities and challenges at subnational level may not have been explored in depth. This project also focused intentionally on supply-side priorities and challenges with respect to implementing MHPSS. Representatives from youth-focused organizations and networks were included in workshops and interviews to provide perspectives on demand-side barriers, enablers and service delivery preferences. However, further research is needed to explore these issues in more depth with children, adolescents and their parents/carers (including those with lived experience).

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

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

An important foundation for this framework is the UNICEF Global Multisectoral Operational Framework for mental health and psychosocial support of children, adolescents and caregivers across settings.[10] The Global Framework defines a range of interventions to promote psychosocial well-being and prevent and manage mental health conditions, providing guidance to support planning and implementation. While the inception of this research initiative pre-dated the finalization of the Global Framework, the regional framework has sought to include and harmonize key actions for MHPSS in East Asia and the Pacific with the global guidance. The purpose of the regional framework is specifically to define the MHPSS actions that are a high priority for East Asia and the Pacific and provide detailed guidance to support implementation, with a focus on describing sectoral roles and recommendations to strengthen a multisectoral mental health system.

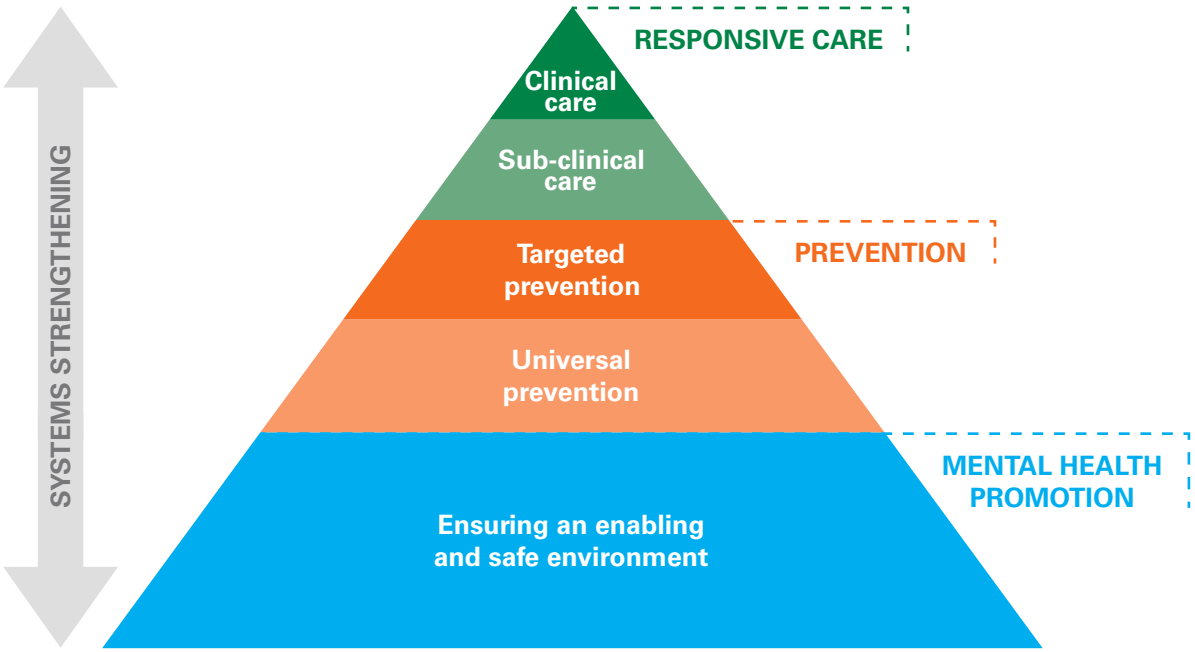
Guiding principles of the framework

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

A regional framework for child and adolescent MHPSS

The regional framework defines three key tiers of actions required to ensure the mental health and well-being of children and adolescents, with systems strengthening as a cross-cutting theme (see Figure 2).

FIGURE 2: KEY TIERS OF MHPSS ACTIONS FOR CHILDREN AND ADOLESCENTS



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

Responsive care for children and adolescents with mental health conditions

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

- ***Screening, assessment and early identification*** of mental health needs to identify children and adolescents who are at risk or have mental health conditions, with a focus on those who would most benefit from care. It also includes the referral pathways (between and within sectors) for those requiring specialized care or social support and protection, noting that screening in the absence of referral and accessible care can be stigmatizing.
- ***Management/treatment*** that is responsive to the needs of children and adolescents, including care that is developmentally appropriate, accessible, comprehensive and culturally appropriate, including for:
  - Clinical mental disorders, which refers to a clinically diagnosable disorder generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (5th edition) or the International Classification of Diseases.
  - Subclinical mental disorders and mental health conditions, when children and adolescents show the signs or symptoms of a mental or psychological disorder that is below the clinical threshold for mental disorder.

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

Prevention of mental health conditions in the immediate social context

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

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

Ensuring a safe and enabling environment to promote mental health

These actions seek to address the structural determinants of mental health and well-being in relation to where children and adolescents live, grow and learn through policy and legislation, and community engagement. The determinants of psychosocial well-being are very broad, encompassing factors such as secure housing, the environment and climate change, poverty, nutrition, social justice and equality, disaster, conflict, economic and fiscal contexts, and political contexts. Following consultation with the Regional TAG and expert advisors, this tier of the framework was narrowed to specifically focus on actions in relation to:

- ***Community engagement and participation*** – the active involvement of people from communities, including young people and those with lived experience of poor mental health, in the process of planning, delivering, monitoring and evaluating policies and programmes, and in mental health advocacy. The involvement of community members is essential to determine their own priorities in dealing with mental health conditions with respect to cultural context. Community engagement is also central to addressing harmful norms, attitudes and beliefs that contribute to poor mental health (for example, discriminatory attitudes towards non-conforming gender identity or expression), that contribute to poor care-seeking behaviours (for example, harmful norms around masculinity that discourage seeking help), and to stigma and discrimination against children and adolescents with mental health problems.

- ***Policy and legislation*** that both *enables and protects* the rights of children and adolescents with mental health conditions, protects children and adolescents from the harms and risks associated with poor mental health, and provides a clear framework for the system and sectoral roles in responding to and supporting mental health, including sufficient allocation of public resources for MHPSS. Legislation should reflect the values and principles of human rights and the Convention on the Rights of the Child (CRC), with the best interests of children and adolescents as a primary consideration. This includes, but is not limited to, the right to equality and non-discrimination, dignity and respect, privacy and individual autonomy, and information and participation.[13]

In addition to identifying what 'actions' are required within each of these tiers, the framework also describes broad roles for key sectors in implementing MHPSS for children and adolescents (see Figure 3). The specific roles and responsibilities of each sector were explored in depth during country-level analysis; however, the regional framework proposes broad overarching roles:

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

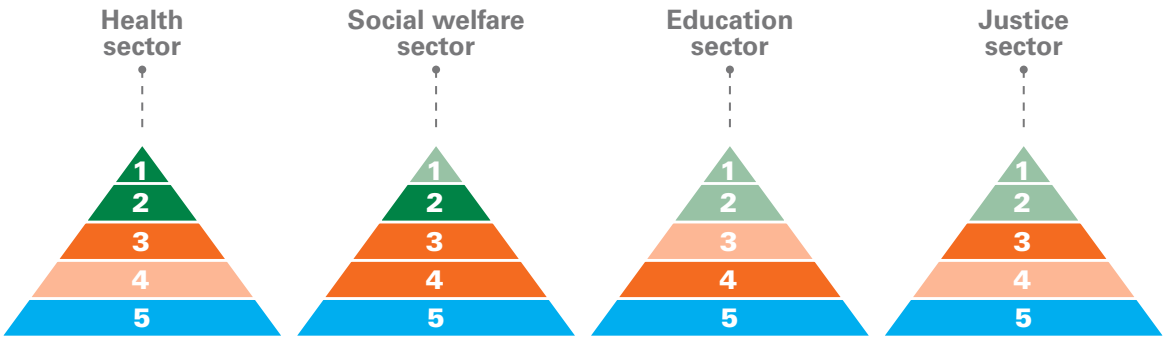
The **social welfare sector** plays a significant role in the delivery of MHPSS. The social service workforce broadly encompasses government and non-government professionals, paraprofessionals and community volunteers who not only work within social welfare or community development but may also be employed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

The **education sector** is critical for implementation of universal preventive interventions as well as ensuring that school and learning environments promote mental health and well-being. The education sector arguably comprises the biggest mental health and psychosocial support workforce as teachers, school-based counsellors and psychologists, and volunteers (such as peer counsellors) have the potential to reach large numbers of children and adolescents. In addition to delivery of curriculum-based approaches to support social and emotional learning, there is also an opportunity for schools to shape attitudes and norms around mental health and positive relationships that are an important contributor to building an enabling environment for good mental health. Teachers, school counsellors and school-based psychologists can also play a role in early identification and assessment of mental health needs, referral, behavioural management and targeted prevention. Schools furthermore have an important role to play in supporting children and adolescents with mental health needs, including through ongoing opportunities for education as well as providing alternative learning pathways.

Schools may also provide an opportunity for screening, with careful consideration; screening alone, in the absence of accessible services and support, can be stigmatizing. Additionally, lack of age, cultural and language-validated tools, limited training in their application and lack of confidentiality may contribute to misdiagnosis, pathologizing normal behaviours, and stigma.

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

FIGURE 3. SUMMARY OF BROAD SECTORAL ROLES FOR MHPSS.



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

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

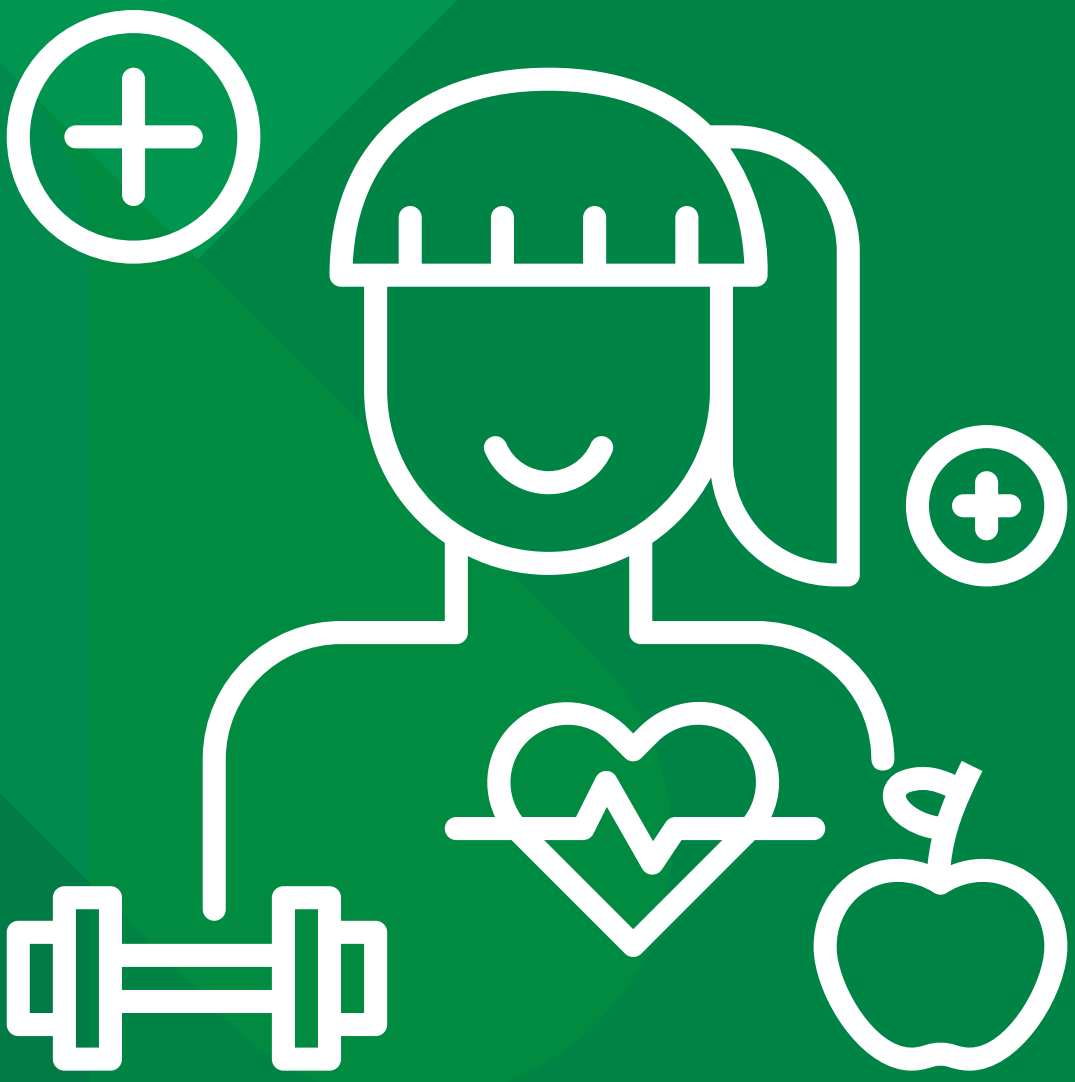
Finally, the regional framework also identifies eight pillars of **systems strengthening** that are required to enable effective and equitable implementation of these actions within and across key sectors (see Figure 4).

FIGURE 4. PILLARS OF SYSTEMS STRENGTHENING

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

Mental health and psychosocial well-being:

The current situation for children and adolescents



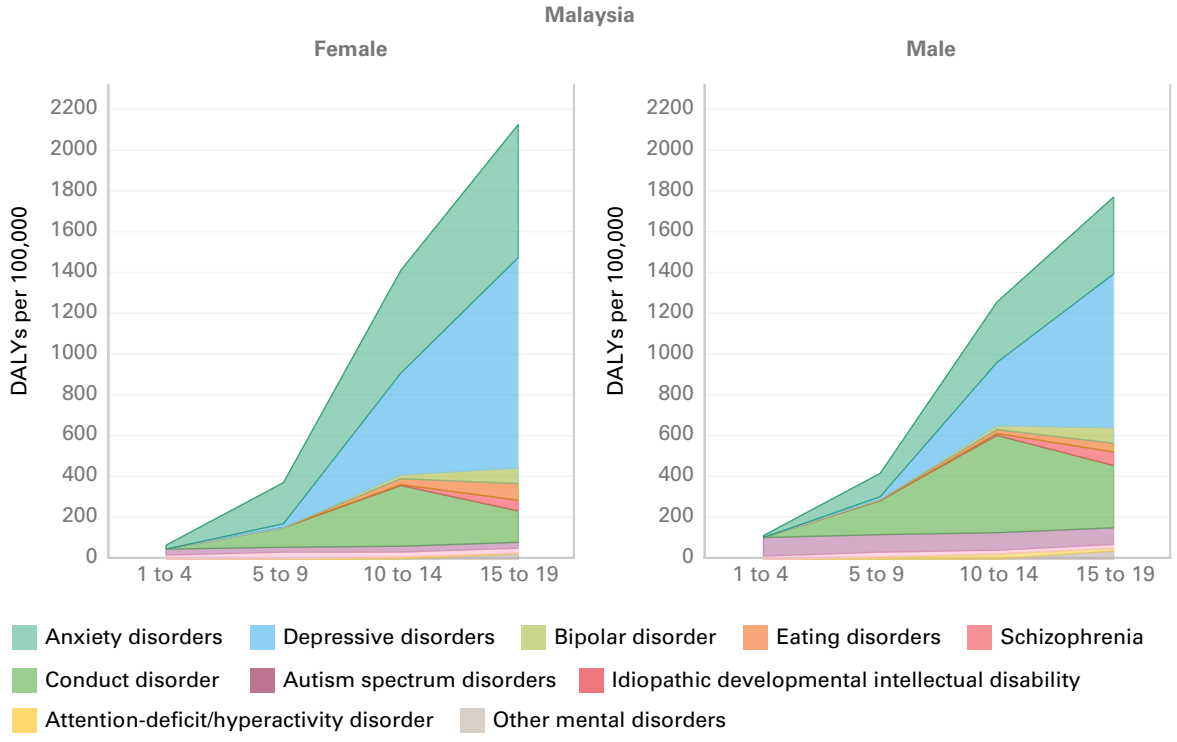
Mental health needs of children and adolescents

Mental health outcomes for children and adolescents

Children and adolescents aged 0–18 years in Malaysia experience a substantial burden of poor mental health. Modelled estimates from the GBD Study 2019 indicate that mental disorders and self-harm account for 19 per cent of the total burden of disease among 10–19-year olds.[1] Among younger adolescents and children aged 5–14 years, mental disorders are the leading cause of poor health, with conduct disorder, anxiety disorder and depression alone accounting for 12 per cent of the total burden of disease in this age group.[1] Around 1 in 8 adolescents aged 10–19 and 1 in 20 children aged 5–9 are estimated to have a mental disorder (including developmental disorder).[1]

Figure 5 shows the modelled burden of disease due to mental disorders across childhood and adolescence, reported as disability-adjusted life years (healthy years of life lost due to either disability (illness) or premature death). Several important observations can be made. First, the burden of disease due to mental disorder increases substantially during childhood and adolescence, with the greatest increases happening during later childhood and early to mid-adolescence. Second, the specific causes of poor mental health vary substantially by age: for young children, developmental disorders predominate; for young adolescents there is a sharp increase in conduct disorders and depression and anxiety; for older adolescents and young adults there is a pre-dominance of depression and anxiety, with an emergence of psychosis and eating disorders. Third, there are important differences in burden and pattern of mental disorder by gender. Girls have an overall larger burden of mental disorder that is mostly driven by excess depression and anxiety, while boys have an excess burden of conduct disorder.

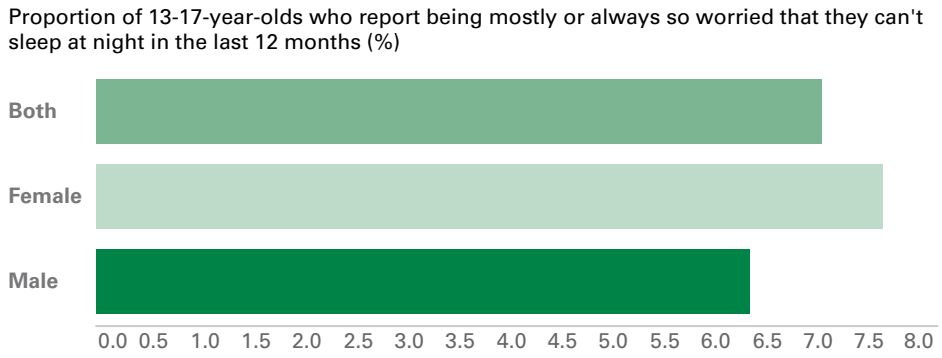
FIGURE 5: DISEASE BURDEN DUE TO MENTAL HEALTH DISORDERS ACROSS CHILDHOOD AND ADOLESCENCE IN MALAYSIA (IN DISABILITY-ADJUSTED LIFE YEARS (DALYS) – YEARS OF LIFE LOST TO EITHER CAUSE-SPECIFIC DEATH OR DISABILITY)



Source: IHME GBD 2019.

Limited primary survey data for child and adolescent mental health in Malaysia also highlight a substantial burden of needs. The most robust mental health data come from the NHMS 2019 and NHMS Adolescent Survey 2017.[11,14,15] Overall, the proportion of children aged 5–15 with reported mental health symptoms increased from 13.0 per cent in 1996 to 20.0 per cent in 2011, before falling to 12.1 per cent in 2015 and 7.9 per cent in 2019.[11,16,17] The highest reported prevalence of mental health conditions among 5–15-year-olds in the 2019 NHMS was in Perak state at 19.9 per cent, and prevalence was also higher in rural areas and in the lowest-income households.[11] The 2017 NHMS survey also found that 17.7 per cent of adolescents reported depressive symptoms,[14] while 2019 analysis of NHMS data estimated that 39.7 per cent of Malaysian adolescents experienced anxiety symptoms.[18] One in 14 adolescents reported anxiety so severe it disrupted their sleep most or all of the time (see Figure 6).[14]

FIGURE 6: PREVALENCE OF SIGNIFICANT WORRY FOR 13–17-YEAR-OLDS, MALAYSIA

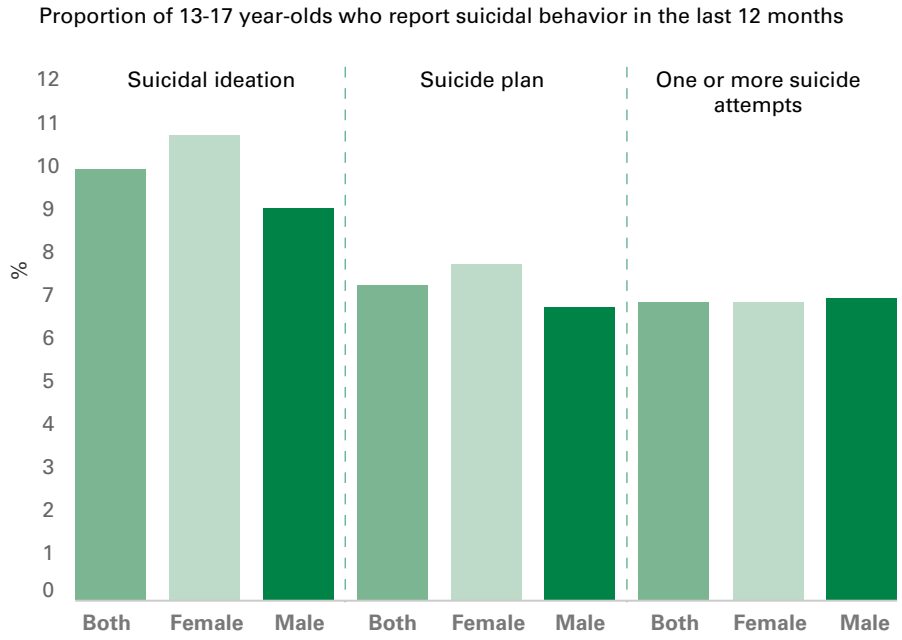


Source: NHMS 2017.

In younger age groups, the NHMS 2019 found that 15.9 per cent of children displayed conduct problems, 4.6 per cent displayed hyperactivity problems and 8.3 per cent emotional health problems.[11] A separate 2019 longitudinal study conducted in the Malaysian cities of Petaling and Klang among children aged 7–8 and 13–14 reported that between 8.5 and 9.3 per cent of children displayed emotional and behaviour problems, according to parents and teachers.[19] Both studies found significant gender differences, with boys more likely to have reported conduct and hyperactivity problems and girls more likely to have reported emotional health problems.[11,19]

Suicide is closely related to poor mental health. The proportion of adolescents reporting suicidal ideation appears to be increasing: from 7.9 per cent in the 2012 Global Student Health Survey (GSHS) to 10.0 per cent in the 2017 NHMS Adolescent Health Survey (although the two sources are not perfectly comparable).[14] The 2017 NHMS Survey also found that 7.3 per cent of adolescents reported making suicide plans and 7.0 per cent reported a suicide attempt in the previous 12 months (see Figure 7). This was higher than in comparable countries such as Indonesia and Brunei, but lower than in Thailand.[14] Girls were more likely to report suicidal ideation (10.8 per cent versus 9.1 per cent) and suicidal plans (7.8 per cent versus 6.8 per cent). Suicide attempts were similar between boys and girls at 7.0 per cent and 6.9 per cent, respectively.[14]

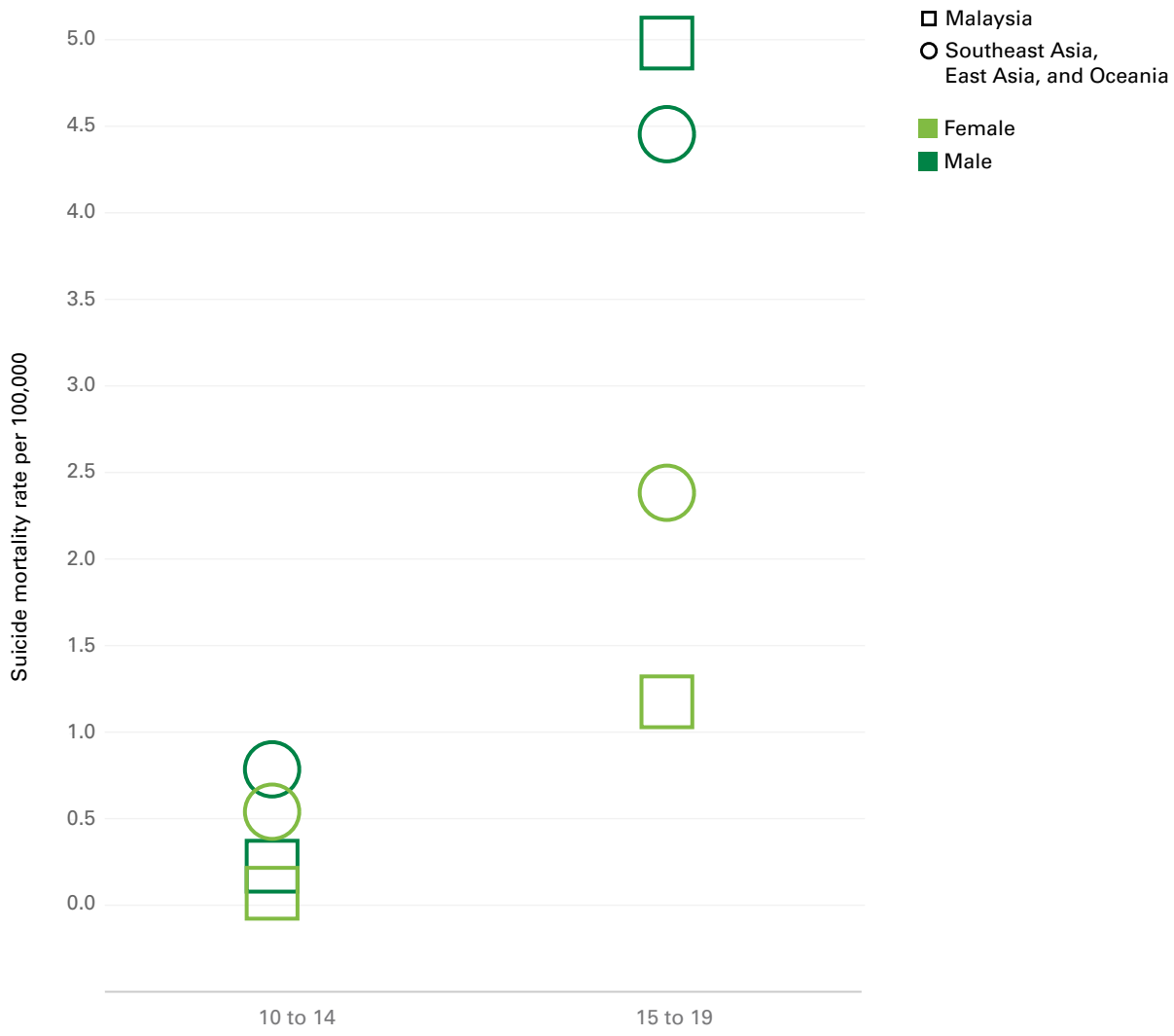
FIGURE 7: SUICIDAL BEHAVIOUR SELF-REPORTED BY ADOLESCENTS, MALAYSIA



Source: NHMS 2017.

Suicide is estimated to be the second leading cause of death for adolescents in Malaysia.[1] Direct information about suicide mortality among adolescents and children in Malaysia is sparse.[20] The National Suicide Registry Malaysia reported that in 2009 the suicide mortality rate was 1.03 per 100,000 population. This was relatively low compared to other Asian countries, and this may have been due to under-reporting related to stigma and the legal implications of suicide under Malaysian law.[20] Fifty-three young adults aged 15–24 were reported to have died by suicide,[20] making them the most represented age group in suicide figures, at 16.2 per cent.[21] More age-specific data were not provided. Risk factors for suicide were male gender and Indian ethnicity. Most adolescents who died by suicide did not have a known past history of attempted suicide, physical and mental health problems or family history of suicide.[20] There are no more recent data as the National Suicide Registry was discontinued in 2009.[22] Hospital figures are another useful data source. In 2014, there were 83 admissions to hospital for intentional self-harm, at a rate of 0.3 per 100,000 of the population.[22] This too was likely an underestimate.[23] Adjusting for missing data (e.g., deaths not reported) or misclassification of cause of death, the GBD 2019 estimated that the mortality rate due to suicide for children aged 10–14 was 0.16 per 100,000 population, and for adolescents aged 15–19 it was 3.13 per 100,000 population (see Figure 8). Adolescent boys had around four times the mortality rate due to suicide compared with girls.[24]

FIGURE 8. SUICIDE MORTALITY AMONG 10–24-YEAR-OLDS, MALAYSIA



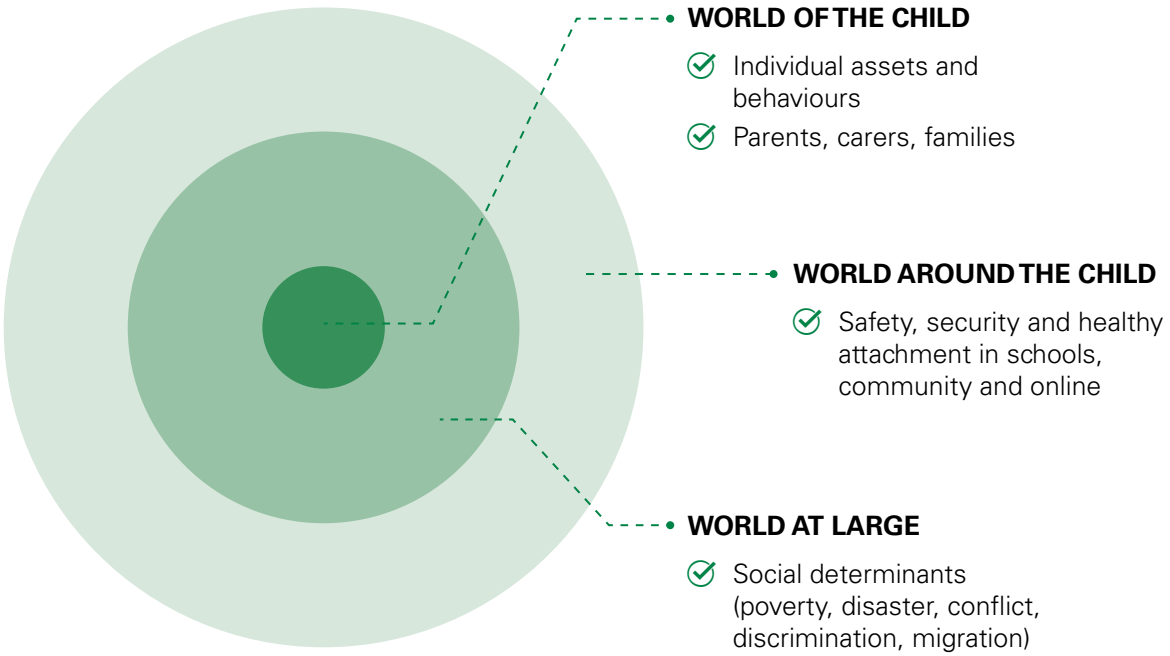
Source: IHME GBD 2019.

Available survey data and published studies of mental health needs in Malaysia most commonly relate to mental disorder. To explore broader understandings of mental health needs during childhood and adolescence, stakeholders who participated in interviews and workshops were also asked to describe their own understanding of mental health during this age period. While stakeholders from the health, education, social welfare and justice sectors identified mental disorders (depression, anxiety, personality disorder, post-traumatic stress disorder and bipolar disorder) as the most important mental health issues for this age group, young people themselves had a more holistic understanding of mental health and well-being. For young people, the focus of needs was on mental health-related stigma, neglect from parents, and mental health issues being mistaken for growing pain or phases of puberty. The health and social welfare sectors also identified self-harm and suicide as priority mental health outcomes and child and sexual abuse as key contributors to poor mental health. The justice sector highlighted substance abuse and its associated criminal implications as an important mental health need among this age group.

Risks and determinants of mental health and psychosocial well-being

UNICEF's *The State of the World's Children 2021* report defines three spheres of influence that shape the mental health and well-being of children and adolescents. These are the 'world of the child' (individual assets, parents, carers and families), the 'world around the child' (safety, security and healthy attachment in the school, community and online), and the 'world at large' (social determinants, including poverty, disaster, conflict, discrimination and migration) (see Figure 9).[2] Childhood and adolescence are periods of rapid change in social context and roles, and the timing and nature of exposures from the environment and immediate social context can powerfully shape mental health and well-being for children and adolescents across their lives. These risks and protective factors are cumulative across the life course and are often clustered – with children who experience multiple adverse childhood experiences (abuse, neglect, violence or dysfunction within families, peers or the community) having the highest risk of poor mental health.[2]

FIGURE 9. SPHERES OF INFLUENCE ON MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING



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

The world of the child

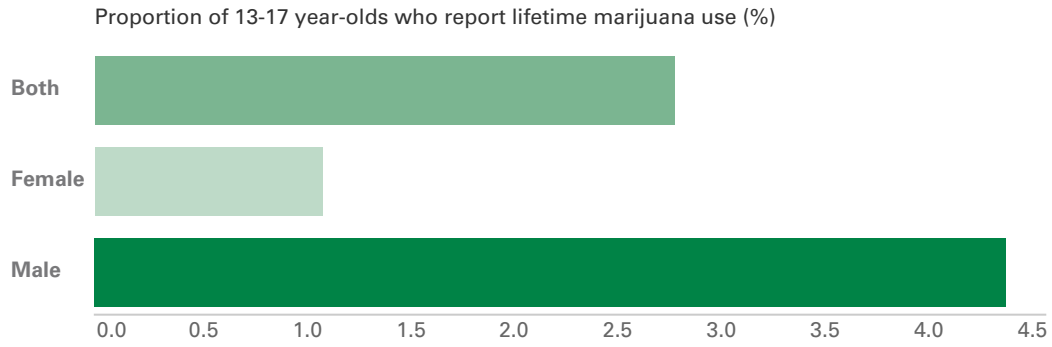
For children, ***healthy attachment with parents and other caregivers and nurturing, responsive care*** are powerful determinants of mental health and well-being. Attachment is the emotional relationship between a child and their parents or caregivers that gives a child a sense of safety and protection and fosters the development of social and emotional skills. While attachment is crucial and evolves during the course of childhood and adolescence, it is one of the defining influences on mental health and well-being during infancy and early childhood.[2] The mental health of parents and caregivers also impacts on their capacity to provide responsive care and healthy attachment, including for adolescent parents.[25]

There are currently no national-level data or subnational studies describing parental attachment, positive parenting, early stimulation or adequate supervision during childhood in Malaysia. There are, however, an estimated 13,000 children and adolescents living in approximately 90 private and 35 government-run orphanages throughout Malaysia.[26,27] A study of 287 adolescents aged 12–17 in six orphanages in the Klang Valley found that 72.5 per cent had moderate to very severe depression and 71.1 per cent had moderate to very severe anxiety. A total of 70.8 per cent and 69.2 per cent reported low self-esteem, and this was significantly associated with depression, anxiety and stress.[28]

Violence and neglect experienced within households and families are key risk factors for mental health conditions.[29,30] The 2016 NHMS reported that 71 per cent of children aged 1–14 years had experienced violent discipline by caregivers (psychological aggression and/or physical punishment). In addition, 11.8 per cent of adolescents reported recent physical abuse at home and 43.2 per cent reported verbal abuse.[14] Both physical and verbal abuse at home have been associated with suicidal ideation.[31]

For adolescents, ***substance use and misuse*** are important individual-level risk factors for poor mental health.[32] The NHMS 2017 reported that 2.8 per cent of adolescents aged 13–17 years had ever used marijuana (see Figure 10), and 2.4 per cent had ever used amphetamines or methamphetamines, with prevalence higher among boys than girls. However, there were no other data or studies describing substance use among this age group or its impacts on mental health.

FIGURE 10: MARIJUANA USE, MALAYSIA



Source: NHMS 2017.

Sedentary behaviours and screen time are also important, individual-level influences on psychosocial well-being. In the 2017 NHMS Adolescent Survey, only 19.8 per cent of 13–17-year-old school-going adolescents were physically active for at least 60 minutes five days per week, and 50.1 per cent spent at least three hours per day on sedentary activities. In the same survey, overall internet addiction prevalence was 29.0 per cent. The highest prevalence was found in the capital Kuala Lumpur at 39.2 per cent.[14] A separate study of 178 students from 56 primary schools across the Klang Valley, Selangor, found internet addiction prevalence of 23 per cent.[33] A 2019 study of 396 students in

Chinese primary schools in Johor Bahru found that excessive internet usage was associated with anxiety symptoms.[34] A study of 158 students aged 13–16 found that smartphone addiction affected 51.9 per cent of participants, and this was significantly correlated with poor mental health.[35]

Children and adolescents with chronic illness and disability may also experience a higher burden of poor mental health. While these children were noted by stakeholders during interviews as having an excess burden of poor mental health, there are currently no data available describing their mental health needs.

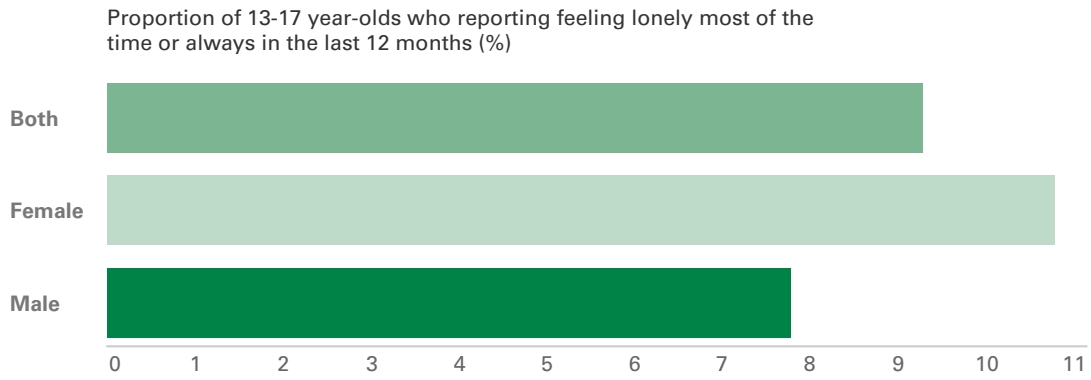
Child marriage and early pregnancy are associated with poorer mental health outcomes. In Malaysia, 5 per cent of girls aged 15–19 years are currently married, and there are 13 births per 1,000 girls in this age cohort per year.[36] While studies exploring the mental health of married Malaysian adolescents are limited, studies of maternal mental health report that young mothers (under 20 years) have a higher risk of anxiety compared with older women.[37]

Children and adolescents living in alternative care, including residential care, are also at increased risk of poor mental health and exposure to risk factors, such as violence. Residential child care is managed by the Department of Social Welfare as well as NGOs (licenced by the Department). In 2019, Department statistics reported that 6,382 children were in need of care and protection, of which 4,043 were girls. Around 1,100 children were in an institutional residential care facility.[38] There are very limited data describing the mental health needs or risks for children in residential care. Small studies have reported higher rates of behavioural problems, depression and anxiety among children in care compared to those living with parents,[39] and exposure to verbal aggression among peers and use of shame by caregivers.[40]

The world around the child

in addition to healthy parent/carer relationships, ***peer relationships and connectedness*** also influence mental health and well-being, particularly during adolescence. In the 2017 NHMS, 9.3 per cent of adolescents reported feeling lonely most of the time or always (see Figure 11), with the percentage higher among girls than boys. This represents an important target for action.

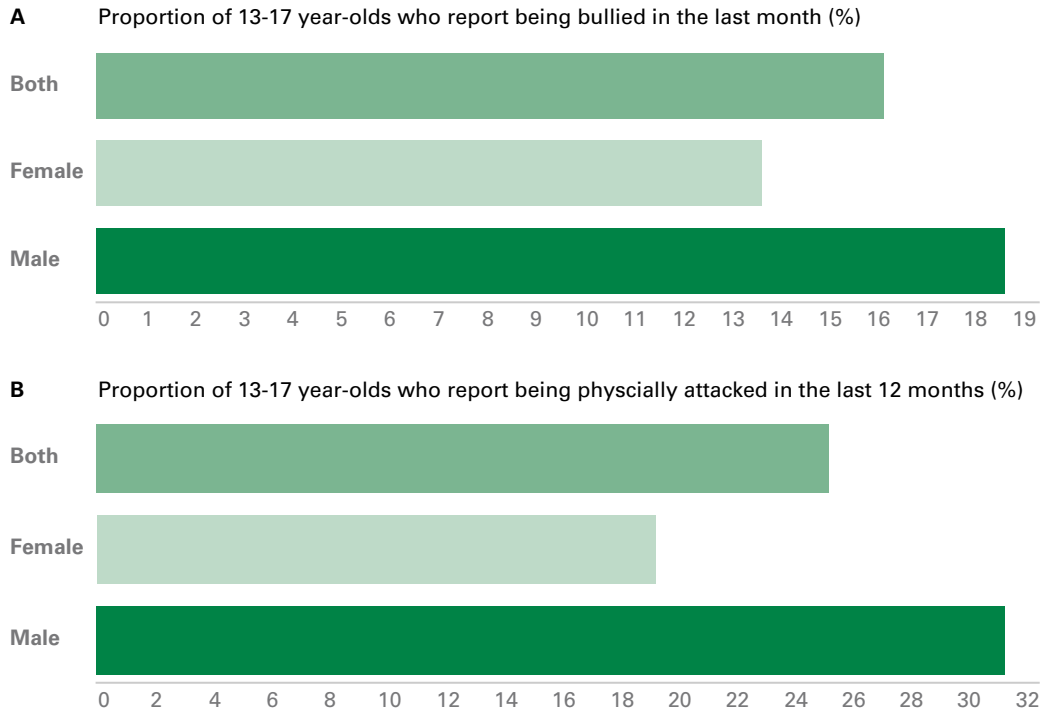
FIGURE 11. PREVALENCE OF LONELINESS AMONG 13–17-YEAR-OLDS, MALAYSIA



Source: NHMS 2017.

Exposure to bullying behaviour,[i] ***harassment and violence*** are risk factors for poor mental health and these are highly prevalent among adolescents in Malaysia (see Figure 12). In 2017, 16.2 per cent of adolescents reported having recently been victims of bullying behaviour.[14] Witnessing, perpetrating or being the victim of ***physical violence*** is also common, with more than a quarter of 13–17-year-olds reporting having been physically attacked in the last 12 months. Rates were higher among boys, with 31.4 per cent reporting being physically attacked compared with 19.3 per cent of girls (see Figure 12).[14] Adolescents who are lesbian, gay, bisexual, transgender, intersex, or queer/non-conforming also experience very high rates of peer victimization and violence in the context of substantial stigma. These adolescents have reported widespread verbal humiliation and violence. Systemic discrimination has also been significant, with reports of school expulsion of lesbian and bisexual youth, and transgender students forced to dress in clothes that did not match their gender identity.[41] Violence against transgender children at home and in school has also led to early school dropout.[41]

FIGURE 12. BULLYING (A) AND VIOLENCE (B) AMONG 13–17-YEAR-OLDS, MALAYSIA



Source: NHMS 2017.

Sexual harassment, sexual violence and intimate partner violence are also important risk factors, most notably for adolescent girls. However, national-level data reporting intimate partner violence experienced by adolescent girls in Malaysia are lacking. Around 3 per cent of adolescent girls aged 15–19 years have ever experienced sexual violence from a non-intimate partner.[36]

Safe and enabling learning environments profoundly influence mental health and well-being. Participation in early education, primary and secondary school are important protective factors. Available data indicate that the majority (99 per cent) of children in Malaysia are enrolled in organized early childhood education and primary education; however, 12 per cent of 12–15-year-olds are not attending secondary school. Out-of-school children and adolescents were identified by stakeholders as at high risk of poor mental health due to poor access to school-based MHPSS services and a

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

clustering of other risk factors (such as substance use, family conflict and violence). Children with developmental disorders or disabilities were also identified as experiencing excess risks for poor mental health in school settings, where resources to support them and their teachers are limited. Schools can also be a source of stress. Stakeholders (including young people) described academic pressures, competition, and family expectations around academic performance as contributing to high levels of psychological distress among students, particularly in secondary school.[16,42] These stresses were exacerbated during the COVID-19 pandemic due to the increased pressure of remote learning coupled with social isolation and the loss of peer support. Schools can also be a setting of violence and harassment, with high rates of bullying experienced among school students and corporal punishment and verbal abuse by teachers.

The world at large

National-level data and published studies exploring the association of social determinants with child and adolescent mental health in Malaysia are limited. However, stakeholders identified several factors that are likely to influence mental health and well-being. These include poverty and economic instability (exacerbated by the COVID-19 pandemic), and legislative and other barriers that limit access to MHPSS. Malaysia hosts over 182,000 **asylum seekers and refugees,** the vast majority from Myanmar. An estimated 44,800 are below 18 years of age.[43] Due to the lack of a domestic legal framework for management of refugees, their irregular status renders them liable to prosecution under the Immigration Act. Refugees continue to be at risk of arrest, prosecution, detention and, in some cases, deportation. This uncertainty and fear contribute to significant psychological distress,[42] which is compounded by past traumatic experiences in their country of origin. A 2021 survey of 91 refugee adolescents in Malaysia found that discrimination was pervasive and occurred in a range of settings.[44]

Stigma and discrimination are also significant determinants of mental health. Misconceptions and stigma associated with mental health are common and were noted by stakeholders as an important contributor to poor mental health and poor access to MHPSS. For adolescents in particular, stigma and discrimination experienced by those whose sexuality and/or gender identity do not conform to rigid norms also contributes to a high burden of poor mental health.[41]

A more recent threat to mental health is ***COVID-19***. Public health approaches that limit social interactions and disrupt education and employment (and the resultant isolation and increased use of social media and a potential increase in exposure to family violence and conflict) have acute impacts on mental health, while the economic uncertainties and projected socioeconomic inequalities have more long-term implications.[45] These disasters can also result in a diversion of resources away from mental health services, and combined with greater need, can lead to greater difficulties in accessing services. A recent survey of 1,163 adults found that mental health concerns increased consistently as the pandemic progressed.[46] From May 2020 to September 2020, depression symptoms increased from 20.6 per cent to 59.2 per cent of respondents, and anxiety symptoms from 32.3 per cent to 55.1 per cent. Young people aged 18–29 were more vulnerable to mental health symptoms, but children and adolescents were not included in the survey.[46]

Other risk and protective factors identified from key informant interviews with stakeholders are listed in Table 1.

Table 1. Risk and protective factors identified by stakeholders

Risk factors	Protective factors
Child abuse and neglect	Ability to cope with stress
Communication problems	Ability to face adversity
Early pregnancy	Adaptability
Substance use	Autonomy
Emotional immaturity and lack of control	Feelings of mastery and control
Exposure to aggression, violence and trauma	Feelings of security
Family conflict or family disorganization	Good parenting
Loneliness	Literacy
Low social class	Positive parent – child interaction
Personal loss – bereavement	Problem-solving skills
Reading disabilities	Prosocial behaviour
Sensory disabilities	Self-esteem
Social incompetence	Skills for life
Stressful life events	Social and conflict management skills
	Social support of family and friends
	Socioemotional growth
	Stress management

Current responses to the mental health needs of children and adolescents

Key national policies, strategies and legislation

An overview of key national-level policies and legislation relevant to mental health and MHPSS is set forth in Table 2 with key documents summarized by sector.

TABLE 2. SUMMARY OF KEY MHPSS-RELATED LEGISLATION AND POLICY

Mental health		
National mental health plan/policy/ strategy	The National Mental Health Policy for Malaysia outlines advocacy, promotion, prevention, treatment and rehabilitation. It lays out eight guiding principles for development in mental health – comprehensiveness, accessibility and equity, continuity and integration, multisectoral collaboration, community participation, human resource training, standards and monitoring, as well as research. The National Strategic Plan for Mental Health includes actions to address mental health in children and adolescents such as screening for early detection and intervention, training of students and teachers in psychological first aid, and a continuous education programme on mental health for teachers.	Psychiatric and Mental Health Services Operational policy 2011 National Strategic Plan for Mental Health 2020–2025
Age of majority	18 years	Age of Majority Act 1971
Age of consent to medical care	Based on this Age of Majority Act, children below the age of 18 years are deemed to be incapable to give consent to medical treatment. The power to give consent lies with their parents/ legal guardian. In special circumstances (outlined in Section 21 of the Child Act) a Protector or police officer may authorize the treatment of a minor. It is to be highlighted that this provision only applies to a child referred to in section 21, i.e., a child who fulfils the definition of 'a child who is in need of care and protection' under section 17.	Age of Majority Act 1971 Child Act 2001

Standards of care for child/adolescent mental health	The National Adolescent Health Plan of Action aims to encourage and ensure the development of adolescents in realizing their responsibilities for health and empower them with appropriate knowledge and assertive skills to enable them to practice health behaviours through active participation. The Plan includes the strengthening of existing mental health promotion programmes targeted to adolescents in various settings.	National Adolescent Health Plan of Action 2006–2020
Protections within mental health legislation	According to the Mental Health Act, a guardian must give consent for a minor's admission to a psychiatric hospital (Section 9) and must give consent to a minor's surgery (Section 77). In Section 2 of the Mental Health Act, a 'Guardian' is defined as a person who has lawful custody of the minor (person under 18 years). There are no special protections for minors.	Mental Health Act 2001
Prohibition of physical restraint for those with acute mental illness	There is no national legislation on the use of restraints on children and young people. However, the use of physical restraints on children and adolescents is outlined in Section 9.1.1 of the MoH Guidelines on Management of Aggressive Patients in Ministry of Health Facilities. The document states that in restraining children, behavioural approaches are preferrable; the Human Rights Act 1998 and the UN CRC 1989 must be considered; restraint is NOT allowed for children below the age of 12 years; and parents must be informed of the management.	Guidelines on Management of Aggressive Patients in Ministry of Health Facilities 2016
Right to mental healthcare for those deprived of liberty	Unclear.	
Criminalization of suicide	Whoever attempts to commit suicide shall be punished with imprisonment for a term which may extend to one year or with fine or with both (Section 309). Whoever abets the suicide of a person under 18 years of age shall be punished with death or imprisonment for a term which may extend to twenty years and shall also be liable to fine (Section 305). (Currently being revised.)	Penal Code of Malaysia 1936

Mental health and education	No visions for child and adolescent mental health or aspirations in the National Education Blueprint 2013–2025.	National Education Blueprint 2013–2025
Mental health and child protection	No mention of child and adolescent mental health (or mental health) in the National Family Policy.	National Family Policy 2010
Protection		
Rights of children and adolescents	Malaysia became a party by accession to the Convention on the Rights of the Child on 17 February 1995. Malaysia enacted the Child Act 2001 to ensure that children will be provided with necessary care, protection, and intervention, especially those children deprived of a family environment.	Child Act 2001, Sexual Offences Against Children, Act 2017 [Act 792], Domestic Violence Act 1994 and The Convention on the Rights of the Child
Age of sexual consent	16 years. Exception: sexual intercourse by a man with his own wife by marriage is not rape. Refers only to a man committing rape if he has sexual intercourse with a woman under 16 years of age (with or without her consent). Does not make the age of sexual consent for boys or the age of sexual consent for same-sex couples clear.	Penal Code of Malaysia 1936 (Section 375)
Age of marriage	**Non-Muslims:** 18 years with parental consent. But 16 years for girls if solemnization of marriage is authorized by a licence granted by the Chief Minister. **Muslims in the Federal Territories:** Boy: 18 years; Girl: 16 years. But younger if permission is granted by a Syariah Judge. **Sabah and Sarawak population:** According to the customary law (*Undang-undang Adat*) of each ethnic group. **Orang Asli (aborigines) population:** No age limit is provided under any written law. It is at the discretion of the Community Chief (*Tok Batin*).	Law Reform (Marriage and Divorce) Act 1976, (Sections 3, 10, 12); Islamic Family Law (Federal Territories) Act 1984, (Section 8); Undang-undang Adat

Prohibition of violence	Section 31 of the Child Act 2001 states that any person who, being a person having the care of a child abuses, neglects, abandons or exposes the child or acts negligently in a manner likely to cause them physical or emotional injury or causes or permits them to be so abused, neglected, abandoned or exposed or sexually abuses the child or causes or permits them to be so abused, commits an offence.	Child Act 2001
Laws on corporal punishment	Corporal punishment is lawful in the home under Sections 89 and 350 of the Penal Code. Corporal punishment of boys is lawful in schools, regulated by the Education Regulations (Student Discipline) 2006, under the Education Act 1996. Corporal punishment is lawful as a sentence for crime.	Penal Code of Malaysia 1936 Education Act 1996
Prohibition of recruitment into the armed forces	No conscription. The minimum age for voluntary recruitment is 17 years. The constitution states that all forms of forced labour are prohibited, but Parliament may by law provide for compulsory service for national purposes (Section 6).	
Minimum age of criminal responsibility	10 years (or a child above 10 and under 12 years of age, who has not attained sufficient maturity of understanding) – Chapter 4 (General Exceptions) of the Penal Code.	Penal Code of Malaysia 1936
Age of child labour	15 years. Laws to protect children under 17 years. Exceptions can apply for work in a family business or other jobs authorised by the government.	Children and Young Persons (Employment) Act 1966 (Amendment 2010)
Criminalization of same-sex consensual sex	Same-sex sexual acts between men criminalized (Section 377A).	Penal Code of Malaysia 1936
Protection for youth and families	Unclear.	

Health sector

Malaysia's key mental health laws are the Mental Health Act 2001 and Mental Health Legislation 2010.[47]

The Act provides a framework for the delivery of treatment and rehabilitation of those with mental disorders; licencing and monitoring of facilities; and the rights and protections of persons within the mental health system. While the Act defines the role of a guardian in providing consent for 'minors', it does not define special protections for children or adolescents under the age of 18 years.

The Act is supported by the Psychiatric and Mental Health Services Operational policy 2011.[23] This policy identifies the mental health of children and adolescents as a priority and defines general principles for the provision of care for this age group, including assessment and treatment through a multidisciplinary team; evidence-based and multimodal care; provision of services outside traditional hospitals or clinic settings (and the need to avoid admitting children to adult facilities); referral mechanisms; and the role of psychiatrists in reporting suspected child abuse and neglect. The policy also emphasizes the need for collaboration outside the health sector to support screening and referral and the importance of mental health promotion (including in schools), although it lacks specific details about actions or implementation. The policy additionally notes the current lack of specialist and multidisciplinary teams for child and adolescent mental health. It recognizes the rights of children and adolescents to confidential care and the need for their assent in addition to the assent of guardians. Nevertheless, there is no detailed guidance concerning the rights of adolescents to access care independently.

The National Mental Health Policy was formulated in 1998 and revised in 2012. Additionally, the Mental Health Framework was developed in 2001.[47] The National Mental Health Promotion Advisory Council was established in 2011 and includes the Minister of Health and representatives from government and non-government agencies.[47] There is no separate plan or strategy for child and adolescent mental health.[15] Of the aforementioned policies and laws, child and adolescent mental health is most explicitly targeted in the Mental Health Framework, which focuses on improving care for target groups.[47] The National Strategic Plan for Mental Health 2020–2025[48] outlines eight strategies that span the tiers of responsive care, prevention and promotion. Actions to address mental health in children and adolescents include screening for early detection and intervention, training of students and teachers in psychological first aid, and continuous education programmes on mental health for teachers. Stakeholders noted that several actions from the strategic plan, such as decriminalization of suicide and the prevention/promotion programme 'Let's Talk Minda Sihat', are currently under way. The implementation of other actions remains unclear.

The Malaysian Government has also developed policies to specifically improve adolescent health, including mental health. In 1995, the Ministry of Health established the Adolescent Health Unit within the Family Health Development Division.[14] Primary adolescent health clinics have made healthcare, including mental healthcare, more accessible and approachable for young people (see next section). The National Adolescent Health Policy and National Adolescent Health Plan of Action 2006–2020 includes mental health as one of five priority areas for adolescent health. While it encompasses broad, cross-cutting actions that are needed to support health promotion and access to services, it does not, however, include specific actions for mental health.[41]

Education sector

The focus of the National Education Blueprint 2013–2025 is on ensuring quality education and academic outcomes as well as equity of access. However, it also emphasizes a commitment to the holistic development of children and adolescents, including emotional development. While the Blueprint does not specifically address mental health, it stresses the importance of school environments and a curriculum that supports resilience, emotional intelligence, positive peer relationships and communication skills for all ages. It also defines the response of the sector to support the learning needs of children living with disability.

Social welfare sector

There is a suite of policy and legislation addressing the social determinants of mental health for children and young people in Malaysia. The Child Act of 2001, last amended in 2016, is the key legislation protecting the rights of children and adolescents who have been abused, neglected or abandoned.[41] The Act requires medical assessment, examination and access to treatment (including psychiatric care) and protections for children who are suspected of being a victim of ill-treatment, neglect or abuse. The welfare and rights of children are also protected under the Sexual Offences Against Children Act 2017, the Evidence of Child Witness Act 2007, the Domestic Violence Act 1994, the Guardianship of Infant Act 1961, the Married Women and Children Maintenance Act 1950, the Adoption Act 1952, the Registration of Adoptions Act 1957 and the Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act 2007.[41] While these do not specifically address mental health needs, these Acts provide a strong framework for the protection of child rights and the provision of a safe and enabling environment for children to thrive.

The National Policy for Children and the National Child Protection Policy also guarentee the rights of all children, including those with disabilities, to be protected from all forms of neglect, abuse, violence and exploitation. The main objectives of the Policy include increasing awareness and commitment to child protection, creating safe and child-friendly environments, encouraging organizations to develop child protection policies, protecting children from all forms of violence, enhancing support services to address neglect, abuse, violence and exploitation, and enhancing research and development.

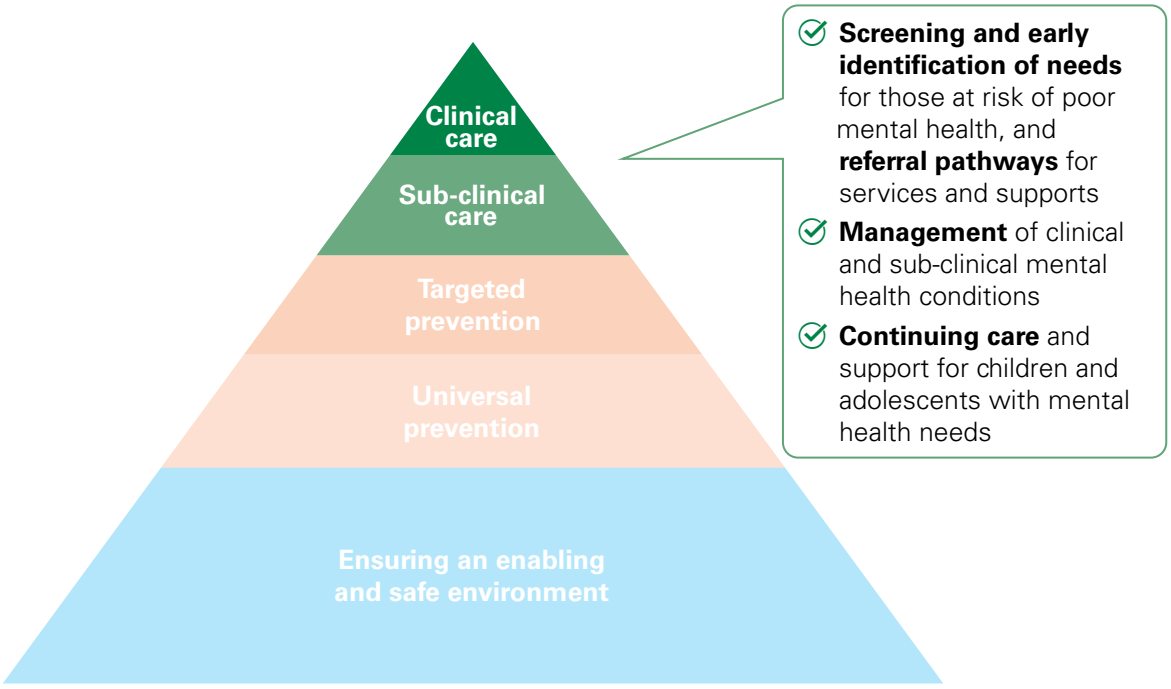
Other national plans which may improve conditions and safety for children and young people include the National Action Plan on Trafficking in Persons 2021–2025, the National Policy for Persons with Disabilities 2007, the Malaysia Plan of Action for Persons with Disabilities 2016–2022 and the National Family Policy 2010.[41]

Justice sector

The Child Act 2001 provides some safeguards for children who need care and protection. It includes requirements for medical assessment, examination, access to treatment (including psychiatric care) and protections for children who are suspected of being a victim of ill-treatment, neglect or abuse. For children in conflict with the law, the Child Act 2001 is silent on the requirements for medical assessment, examination and access to treatment. The Ministry of Health Guideline on Medical Assessment of Child Custody Cases 2018 requires the assessment of emotional and psychological needs, and defines the referral process for children undergoing custody disputes.[49]

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

Responsive care for children and adolescents with mental health conditions



The mental health system in Malaysia is coordinated and regulated nationally by the Ministry of Health. The Ministry's Medical Programme is responsible for hospital psychiatric services and the Public Health Programme is responsible for mental health in primary care.[50] The Ministry of Education and Ministry of Defence also have roles in responsive care by directly providing services in teaching and army hospitals. Currently, responsive care is primarily provided through the health sector, through clincial mental health services.

Screening and early identification of mental health needs

There is limited information about the national approach to early identification and screening of children and adolescents for mental health conditions. Psychological risk assessment of adolescents is integrated into adolescent-friendly health services. This assessment is carried out by trained health staff using the Health Status Screening Form developed by the Ministry of Health.[47] At primary healthcare facilities, there is also a programme called 'Healthy Mind', which screens for mental health using the internationally validated, 21-item Depression, Anxiety and Stress Scale (DASS-21).[47]

Since 2011, the Ministry of Health and Ministry of Education have collaborated to implement the 'Healthy Mind' mental health screening programme among 16-year-olds in schools. Students are asked to self-report using the DASS-21[22] and are referred to services as appropriate. More than 2,300 counsellors have been trained to deliver this screening programme in schools.[47] In 2015, 55.9 per cent of all students in Malaysia had been screened through this programme.[22] On average, 3.6 per cent of students were found to have severe depression.

Stakeholders from across sectors noted a lack of early identification and screening, particularly in non-health settings. Young people themselves identified schools as a potentially important setting to provide screening of students with behavioural problems or other signs of poor mental health.

Referral pathways

A 2019 study of over 2,000 referrals to psychologists across seven government hospitals found that 25.7 per cent of referrals were for children and 22.8 per cent were for adolescents.[51] The majority of referrals were for neurodevelopmental disorders, followed by depressive disorders, obsessive-compulsive-related disorders, and anxiety disorders.[51] Stakeholders acknowledged that within the health sector, there is a formal referral pathway for step-up and step-down care. Practitioners from primary care can refer cases to clinical psychologists or psychiatrists at the hospital for specialized care. Similarly, practitioners from tertiary care can refer back stable cases to primary care for care in the community. One drawback in the mechanism is that the communication happens via a physical referral letter which is the responsibility of the patients/caregivers to transport between the referring party to the referred party. Should the patients/caregivers decide not to abide by the referral, there is no mechanism in place for tracing this loss to follow-up.

Referral between sectors is most commonly communicated through referral letters provided to parents/caregivers. For example, a school counsellor can write to a psychiatrist at the specialist clinic for further care. The onus is then on the parents/caregivers to bring their child to the specialist clinic to secure an appointment. In some settings, children and their families may be physically accompanied to a specialist by a counsellor or social welfare officer. For cases needing urgent specialized care, the first point of contact with the health sector may be through the primary care clinics or directly with the tertiary care facilities via the emergency department.

Although there are no obstacles in referring, stakeholders observed that the process is usually one-way. After referring, the initial provider is not updated on the progress or management unless they hear back from the child or family themselves, creating challenges to providing follow-up and continuing care and support.

> *"For me, if we were to put it on a scale, we are now possibly at a scale of 6 on cooperation between sectors. We can cooperate because we can call for help, but how far the thing progresses, we don't know the development…* ***after referring, we don't know what happens*** *unless the client comes back to us and we ask for their feedback..."* —A social welfare sector informant

Limited availabilty of specialist services is a key challenge for referral pathways. Stakeholders noted the long waiting time to get an appointment at specialist clinics, contributing to treatment delays and/or parents/caregivers not seeking further care.

> *"…so far it is* ***difficult to get appointment dates…****when they have to wait for a long time, usually they will be fed up and end up not going to the appointment. Perhaps there's something there...perhaps* ***the linkage (referral) can be further improved.****"* —A social welfare sector informant

Management of mental health conditions and continuing care

Over the last 20 years, the Malaysian **Ministry of Health** has engaged in substantial reform of mental health services, including for children and adolescents. Prior to 2001, mental health services focused on inpatient management, which was managed separately from primary care. The 2001 National Mental Health Policy guided the integration of mental health into primary healthcare.[17] Currently, 89 per cent of all primary health clinics provide mental health services,[47] which include initial screening, diagnosis, treatment and rehabilitation. Approximately 25 per cent of primary health clinics also have family medicine specialists, who have additional (but limited) psychiatry training.[22] Complex cases may be referred to specialized outpatient clinics. Across Malaysia, there are 28 specialized psychiatry outpatient clinics specifically for children and adolescents, including for developmental disorders. Almost every state has at least one specialized outpatient service.[15] In 2015, there were a total of 38,956 child and

adolescent psychiatric clinic visits across the country. [22] In 2017, there were 83.5 child and adolescent psychiatry clinic visits per 100,000 population. [15] A technical report in Malaysia in 2015 found that 99.1 per cent of patients waited six weeks or less for a first specialist psychiatry consultation. [22]

Malaysia has approximately 49 general public hospitals with inpatient psychiatric units,[50] 38 of which can admit children and adolescents,[15] as well as four large mental health hospitals.[50] Out of 5,367 inpatient psychiatric beds across the country, 4,240 (79.0 per cent) are in the four main psychiatric hospitals.[50] For both inpatient and outpatient care, most services for children and adolescents are provided by general psychiatrists – there were fewer than 10 child psychiatrists in Malaysia as of 2015.[16] In 2017, there were 14.99 mental health-related hospital admissions per 100,000 population in Malaysia. For children and adolescents, the mental health hospital admission rate was 13.86 per 100,000.[15] In a 2011 report, 37 hospitals offered community and psychosocial rehabilitation services,[50] although data for children and adolescents were not available.

The Ministry of Health has implemented specific **adolescent health services** since 1995. These are primary care services aimed at adolescents to promote healthy lifestyles and holistic well-being,[52] and are available at mainstream health clinics and through school health units.[53] In 2018, the Ministry of Health introduced national best practices for adolescent-friendly health services.[53,54] In order to be accredited as adolescent-friendly, clinics are now assessed in terms of compliance with 12 criteria, including appealing ambience for adolescents, confidentiality of processes, integration of all services under one roof, adolescent engagement in service assessment, and training of staff in psychological risk assessment on adolescents using the HEADSS framework.[53,54] HEADSS is an adolescent psychosocial assessment that covers the domains of home, education and employment, activities and peer relationships, drug use, sexuality and gender, and suicide or self-harm. A study in the state of Kelantan found that 35 per cent of its 85 health clinics had qualified as adolescent friendly. Adolescent-friendly clinics scored significantly higher than conventional clinics in 11 out of 12 criteria for best practices.[53] In a survey, adolescents attending adolescent-friendly clinics showed significantly higher satisfaction levels compared with their peers attending conventional clinics.[53,54] However, service quality with respect to mental health was not specifically assessed.

Other sectors are also involved in supporting person-centred and continuing care. Children with disabilities are registered with the Department of **Social Welfare** on a voluntary basis. Since 2001 the Ministry of **Education** has been responsible for special education programmes for children with learning disorders.[16] There are also some examples of smaller programmes piloted in **schools.** In Pahang state, a school-based cognitive behavioural therapy (CBT) intervention known as Shine Through Any Roadblocks (STAR) was piloted.[55] Eighty-five adolescents from eight secondary schools were recruited and assigned either to an intervention group or control group. Participants showed higher depressive scores than average but did not have a psychiatric diagnosis. The intervention consisted of eight, 1-hour group sessions over two months and involved small-group seminars, hands-on activities, interactive discussions and homework to provide education on CBT principles, managing thoughts, feelings and behaviours, and improving relationships and communication skills. The intervention group was found to have significant and sustained, reduced levels of depressive symptoms and automatic negative thoughts compared to the intervention group.[55]

Private sector engagement in the delivery of mental healthcare has been limited, owing partly to the restrictions under the previous mental health legislation, and has taken the form of private nursing facilities and private specialty services. Numerous NGOs play a part in providing MHPSS, including the Malaysian Mental Health Association, the Malaysian Psychiatric Association, and the Mental Illness Awareness and Support Association, among others.

There has been a significant increase in the availability of **online or digital mental health services**. For example, the Befrienders and Talian Kasih 15999 helplines provide emotional support and counselling countrywide. During the COVID-19 crisis in 2020, UNICEF partnered with the Malaysian Government to deliver innovative psychosocial support services, including online and telephone helplines to address mental health issues, suicide and domestic violence.[56] UNICEF and the National Early Childhood Intervention Council delivered telehealth psychosocial support for over 450 children with disabilities and over 450 parents.[56] UNICEF also partnered with the Ministry of Education and local NGOs to build the capacity of school counsellors to deliver psychosocial support.[56] Other examples of digital services include:

- **Guidance for social workers and social service practitioners** Ten ideas for social workers and social service practitioners on how to undertake remote case management in order to safeguard children when face-to-face contact with them and their families is restricted due to COVID-19 containment measures.
- **WeConnect (KitaConnect)** UNICEF Malaysia established WeConnect (KitaConnect) in March 2020 to listen to and answer young people's concerns about MHPSS. The network comprises social media influencers and mental health specialists who raise awareness about mental health and provide practical advice to young people. In 2020 UNICEF reported the engagement of over 270,000 young people with this programme.[56]

Additionally, there are private helplines and online services that cater to children and adolescents, including:

- **Buddy Bear Helpline** The Buddy Bear helpline is a telephone service established by social enterprise HumanKind to assist disadvantaged populations with mental health difficulties, particularly children who wish to express their fears and concerns about the COVID-19 pandemic
- **Befrienders Kuala Lumpur** Befrienders is one of the main mental health support hotlines in Malaysia that offers emotional support to people who are distressed, despairing or struggling with suicidal thoughts. Every conversation is treated in strict confidentiality to encourage people to openly share without fear. Callers can also schedule an appointment for a face-to-face consultation.

A range of **barriers** nevertheless prevents children and adolescents from accessing quality mental health services. A 2010 study among 175 secondary school students found that none reported using primary health services for mental health problems.[52] The most common reason was a lack of awareness about the availability of mental healthcare in primary health clinics. More than half (55.4 per cent) thought their mental health issues were due to their own mistakes, 43.2 per cent were worried about confidentiality if they sought help, and 48.6 per cent were concerned about stigma from family and friends.[52] Despite government efforts in recent years, access is still a major barrier to mental healthcare, especially for the most vulnerable. A 2015 study in Penang surveyed families of children with disabilities, including learning, visual, hearing, physical or multiple disabilities. A quarter of children were in need of psychology services, among whom 63.0 per cent of needs were unmet.[57] Common reasons for unmet needs included: the place of service was too far, there was no-one to take the child for therapy, the unaffordability of therapy, and insufficient time to attend therapy.[57] People with a mental disorder and their families frequently seek traditional faith healers before consulting conventional medical staff.[58,59] A 2011 study among hospitalized patients with first episode psychosis found that 32 per cent had three or more non-psychiatric contacts before hospital admission. Almost half (48 per cent) of these individuals had sought help from traditional healers before seeking a psychiatric service.[50]

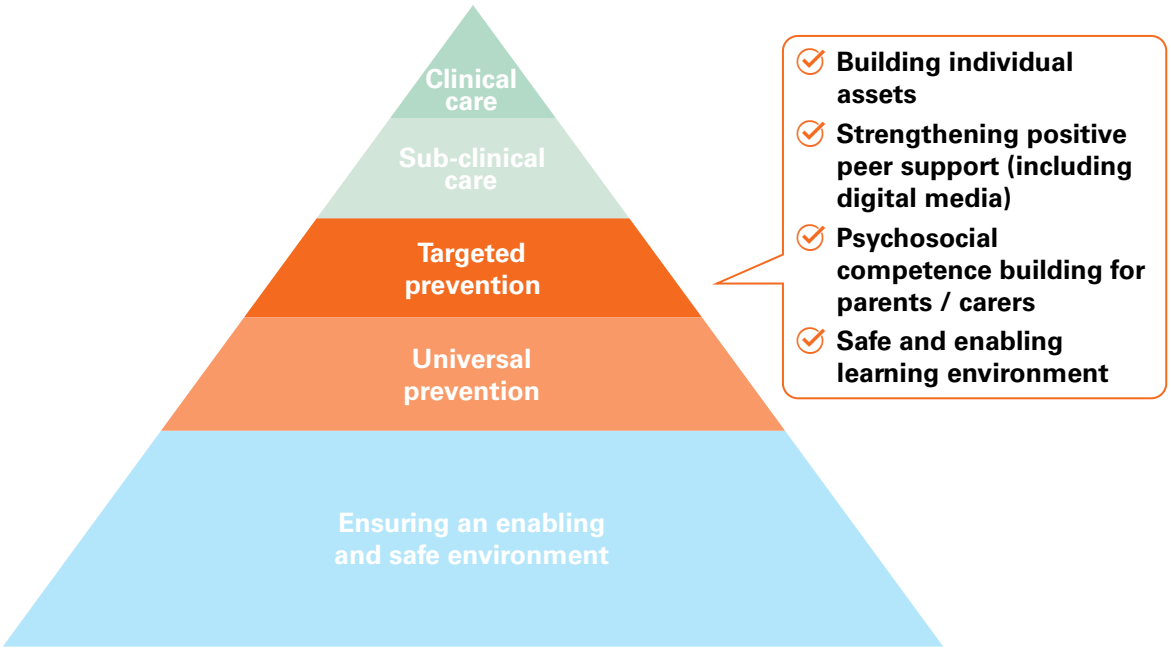
Stigma and low mental health literacy were also noted by stakeholders as key barriers impacting on access to mental health services.

> *"I think a lot of people don't understand and a lot of people actually don't believe children have mental health problems. They will say that* ***why is it that children have mental health problems?*** *It's not like they have stress." —A social welfare sector informant*

> *"The parents, they are not able to accept mental health (issues) as a problem. They think that is not a problem and they think it's something that is normal. You just go through, everybody goes through. So, there's* ***lack of knowledge and therefore lack of support*** *for the children."* —A social welfare sector informant

> *"Because what I see is when it comes to mental health, people are more comfortable talking to a non-profit organization than trained professions, because they don't want to talk and say that 'I have mental illness'.* ***It's still the stigma*** *associated with 'I have a mental health problem'".* —A social welfare sector informant

Prevention of mental health conditions in the immediate social context



Actions to prevent poor mental health by addressing risk factors and enhancing protective factors are critical to ensuring mental health and well-being. For children and adolescents, this requires a focus on factors related to where they live, grow, learn and socialize, with parents/carers, peers and learning environments a high priority. The health, education, justice and social welfare sectors, along with NGOs and youth organizations, all play key roles in supporting current mental health prevention programmes targeting the general population, school children and teachers, parents and at-risk children and adolescents.

Building individual assets

At present, activities to promote the mental health and well-being specifically of children and adolescents are aimed at: (i) equipping students with appropriate knowledge, attitude and skills about mental well-being through: (a) an infotainment approach (animation characters, e.g., Upin & Ipin, Didi & Friends) at pre-school, (b) an infotainment approach, games and contests at primary school, and (c) an e-mental health approach (social media, internet, apps) at secondary school; and (ii) empowering students toward positive mental well-being and to seek help when needed through training in emotional regulation, communication and social skills, such as the peer counsellor (Pembimbing Rakan Sebaya) programme

There are also some examples of smaller-scale or pilot programmes to build individual assets and support social and emotional learning. From 2017 to 2018 in Jerantut, Pahang, an anxiety prevention programme for primary school students was trialled, based on stimulus response theory and an information-motivation-behavioural skills model.[60] A cluster, randomized controlled trial was conducted, whereby 193 children in five schools received the intervention and 268 children in six schools received no intervention. Both groups completed questionnaires before, immediately after, and three months post intervention. However, the impact of the intervention was very small on the primary measure of anxiety, and there were no changes in regard to the secondary measures of worry, coping skills and self-esteem.[60]

From 2014 to 2015 in Klang Valley, Selangor, a Life Skills Education programme was implemented based on WHO guidance in a randomized controlled trial at eight orphanages. The trial recruited 287 adolescents aged 12–18 with mild depression, anxiety or stress.[61] The intervention group was associated with a significant increase in positive, problem-based coping skills such as using emotional support and positive reinterpretation, and a significant decrease in dysfunctional coping skills like substance abuse and self-blame, compared to the placebo programme group. However, the study could not establish a causal relationship between an improvement in coping mechanisms with decreased levels of depression, anxiety or stress.

Strengthening positive peer support

Despite the importance of promoting healthy peer relationships, addressing bullying and violence and supporting positive peer networks, few examples of programmes to strengthen peer support were identified. There were limited community activities for children and adolescents; hence, the stakeholders identified this area as a key priority.

On a small scale, a quasi-experimental study was conducted in 2010 to assess the efficacy of the Olweus **Bullying Prevention** Programme in Malaysia.[62] Almost 4,000 participants were recruited from three intervention schools and three control schools. In the intervention schools, programmes included formation of an anti-bullying committee, defining and enforcing rules within classrooms, discussions and activities to reinforce positive behaviour. Coordination with school counsellors and parents to monitor for bullying outside classroom settings were included as part of the programme. After one year, two of the three intervention schools showed significant reductions in bullying and victimization compared to the baseline, while no school in the control group showed any improvement.[62]

Psychosocial competence building for parents/carers

In Malaysia, Positive Parenting, a multifaceted parent education programme that emphasizes family wellness was set up in 2000. Positive Parenting was developed and implemented by healthcare professionals from various professional bodies, including the Malaysian Psychiatric Association, Malaysian Society of Clinical Psychology (MSCP), Malaysian Mental Health Association (MMHA), National Population and Family Development Board Malaysia (LPPKN), Nutrition Society of Malaysia (NSM), Obstetrical & Gynaecological Society of Malaysia (OGSM), Malaysian Association of Kindergartens (PTM), and Association of Registered Childcare Providers Malaysia (PPBM). Although Positive Parenting has since grown and successfully evolved in a unique way to reach out to modern-day parents with useful information on parenting through various channels, feedback from stakeholders suggested the need to intensify the dissemination of this programme, especially in rural areas.

UNICEF Malaysia, in partnership with the National Family Development Board, Parenting for Lifelong Health and University Putra Malaysia, also developed evidence-based parenting tips in an initiative, launched in in May 2020, to help parents and caregivers cope during the COVID-19 pandemic and the lockdowns. The parenting tips, covering the topics of violence prevention, self-care and psychosocial well-being, were disseminated through UNICEF's social media platforms and have since reached more than 1.2 million social media users.

A number of pilot studies or trials of parenting programmes have been conducted, aimed at families at risk. In 2020, a randomized controlled trial was launched of a supportive parenting intervention among Afghan and Rohingya refugees in Malaysia, in the context of the particular uncertainties and stress these groups face. Seventy-nine mothers were recruited through community centres and networks[63] and they were randomized to an intervention group and a control group, with a three-month follow-up assessment conducted with both groups. The intervention involved one-hour sessions weekly for eight weeks and included check-ins, small-group seminars, group discussion and role plays on topics such as improving health and emotional well-being, adjusting to a new environment, strengthening family relationships and managing child behaviour. On evaluation, the intervention group had more beneficial outcomes on several measures, including child intensity (challenging behaviours), parenting self-efficacy (confidence they can manage their child's behaviours), family intimacy, family conflict, and parental emotional distress, compared to the control group. However, there were no differences between the intervention and control groups on measures of positive parenting (reinforcing good behaviour), inconsistent discipline or poor supervision.

Safe and enabling learning environments

The National Education Blueprint emphasizes the importance of school environments and a curriculum that supports resilience, emotional intelligence, positive peer relationships and communication skills. However, there are no documented examples of whole-of-school or whole-of-education mental health promotion approaches in Malaysia. In 1963, the Education Planning and Research Division of the Malaysian Ministry of Education established a guiding and counselling section. There is now at least one full-time counsellor in every secondary school in Malaysia.[64] The role of counsellors often involves both traditional activities such as counselling, career guidance and education as well as rule-enforcement roles such as the checking of badges or instituting disciplinary action for tardiness or other infringements.[64,65] Studies have found that school counselling services are unpopular with students in Malaysia, partly due to fears of being stigmatized for using them.[64] However, there are few data formally evaluating the effectiveness of school counselling in Malaysia. A 2017 qualitative study in Perak State found that counsellors struggled with a very wide job description, insufficient opportunities for engagement with other stakeholders and schoolteachers, and a need for a much more collaborative approach to manage these issues.[64] Other than the anti-bullying pilot described above, there were no documented national programmes to address violence or harassment in schools or other education settings.

Targeted interventions for children and adolescents at higher risk

There are several programmes aimed at children and adolescents who are at increased risk for poor mental health due to risk behaviours or high-risk exposures – in particular programmes to **prevent and respond to child abuse, violence, exploitation and neglect**.

The Department of Social Welfare (DSW) Children's Division has responsibility for the administration of child protection and child justice. The DSW's responsibilities include support for neglected and abandoned children, investigating child abuse cases, implementing the National Strategy Plan in addressing the causes of child marriage, and providing protection, rehabilitation and interventions in regard to children who are involved in illegal sexual activities.[41,66] Child Protectors work in each state to coordinate prevention and response to child protection concerns. Within the DSW, the approach to child protection includes primary services (focused on raising awareness of child rights and child abuse), secondary-level services (hotlines, community care centres, crisis centres and family centres to support those at risk), and tertiary-level services (care homes, emergency services, crisis centres, and suspected child abuse and neglect teams in hospitals and police units).[67]

The DSW runs a network of nine 'Rumah Tunas Harapan' (temporary shelters) for children under protection or not living with their biological family and 15 children's homes with a capacity for 1,480 children.[68] The DSW also runs facilities for the protection and psychosocial support of children who have been exposed to forced labour, slavery trafficking or sexual exploitation.[69] For children in the juvenile justice system, the DSW also has community-based and institutional rehabilitation programmes.[68] The DSW has a 'Counselling and Psychology' division that provides some psychosocial services for children in protection and rehabilitation. Specific programmes include counselling for victims of trafficking or forced labour, counselling for children with identified psychosocial and emotional issues, and even interactive workshops for families with problematic dynamics.[66,69] A UNICEF report found that inter-agency collaboration between hospital teams and DSW on suspected child abuse and neglect cases was particularly strong in Malaysia. It was reported that child victims of serious violence had access to comprehensive and child-sensitive psychosocial, legal and medical services.[41]

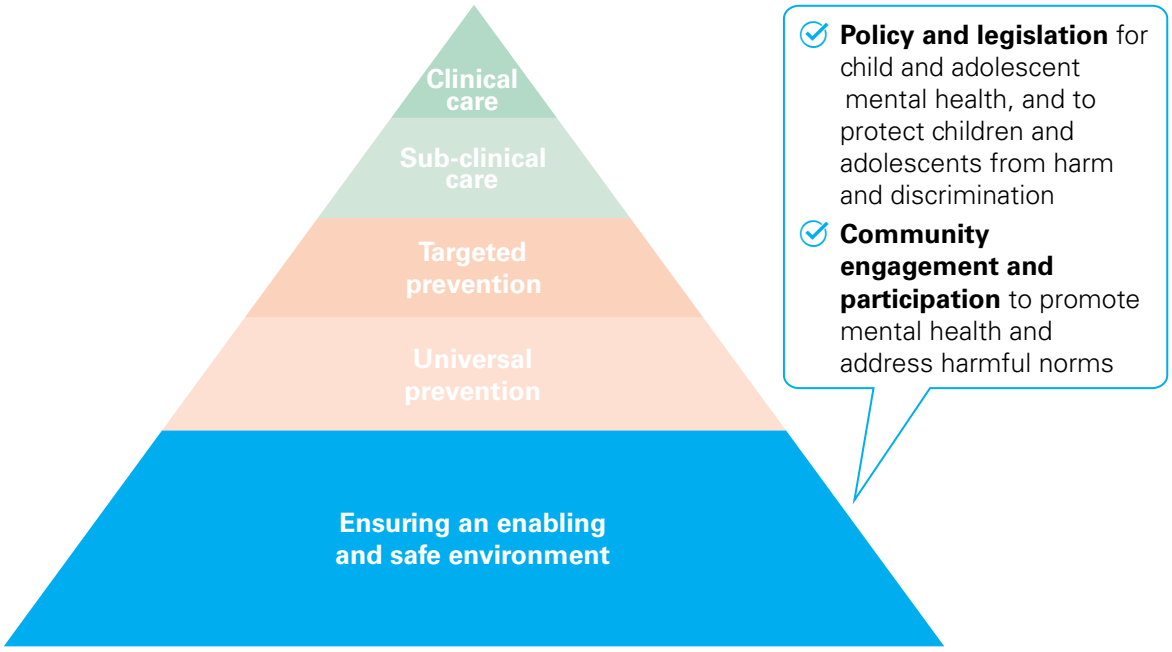
There are also some non-government programmes to support children who experience violence or neglect and that address risk factors for mental health:

- **Protect and Save the Children** Protect and Save the Children encourages children experiencing sexual abuse and exploitation to speak up, be heard, and receive help. To build safer communities and protect children's rights, it organizes frequent educational programmes, campaigns, forums and conferences for the general public. Importantly, the programme provides prevention, intervention and treatment services for children and families suffering from sexual abuse. Moreover, it fosters an environment of trust whereby children can freely speak about their experiences without fear of judgement or punishment.

- **Women's Aid Organization** Since 1982, Women's Aid Organization has been providing free crisis support and shelter to women and children facing domestic violence. In 2014, the organization started its WhatsApp hotline TINA, which stands for 'Think I Need Aid'. Currently, it offers confidential services to survivors of domestic violence, sexual abuse, rape and other forms of violence. Women's Aid Organization also provides face-to-face consultations and access to services like shelter and social work.

The DSW also implements **substance abuse** prevention programmes, such as the PINTAR programme providing education to primary school students aged 10–12, and the SHIELDS programme for at-risk adolescents aged 13–18.[68]

Ensuring a safe and enabling environment to promote mental health



In addition to key policies and legislation for MHPSS and to protect children from harm (described above), promotion of awareness about mental health has been a key stated goal in Malaysian mental health plans.[47] Since 2000, the Government has launched multiple activities for mental health promotion in the community, including World Mental Health Day commemorations and anti-stigma campaigns such as 'Stop Exclusion: Dare to Care'.[47] Multiple nationwide suicide prevention campaigns have also been implemented, including talks, media coverage, exhibitions and seminars. Since 2003, the Ministry of Health's national 'Healthy Lifestyle' campaign has incorporated messages on 'handling stress effectively' and 'enhancing a healthy mind'.[47]

Mental health promotion in the general community has grown over the last two decades in Malaysia. Several NGOs have helped to increase awareness of mental health and advocate for improved services, such as the Malaysian Mental Health Association,[16,17] Malaysian Psychiatric Association, Mental Illness Awareness and Support Association, and the Psychiatric Welfare Body.[50] These NGOs collaborate via a government body known as the Malaysian Mental Health Council.[47] There are also some subnational programmes to improve mental health literacy among communities with a higher burden of poor mental health. For example, Sabah had the highest prevalence of mental health conditions among adults in the 2015 NHMS, particularly among indigenous populations. In response, the Ministry of Health and Universiti Malaysia Sabah implemented a comprehensive programme to improve mental health literacy.[70] The intervention utilized various strategies and modalities to promote mental health literacy

in schools among children and adolescents. The Ministry of Health and Universiti Malaysia Sabah have also collaborated with the Kadazandusun Cultural Association to reach traditional healers, indigenous chiefs and village elders and with rural village associations and volunteers to engage rural indigenous populations. Another intervention involved engaging social media celebrities to reach social media users and using mental health promotional videos in native languages.[70]

Other approaches to improve mental health literacy and well-being in the general population include:

- Implementation nationwide of the 'Let's TALK Minda Sihat' campaign and Malaysia Mental Health Film Festival;
- Empowerment of NGOs and relevant community groups on mental health promotion, enhancing awareness and early detection and intervention in the community via (a) training of trainers (and echo training) for NGOs and the community, and (b) conducting campaigns and community dialogues particularly aimed at engagement with religious groups;
- Equipping and enabling workers with the appropriate knowledge, attitude and skills on mental well-being via (a) training on mental health and work life balance (e.g., Stress Management at Workplace Programme, DOSH Stress at Workplace guideline), (b) involvement in 'Healthy Communities, Building the Nation–Plus' (KOSPEN Plus) programme, and (c) promotion and advocacy of mental health to employers.

A priority package of MHPSS actions for children and adolescents

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

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

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

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

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

	Ensure sufficient allocation of public resources to implement the national policy through detailed costing, defined budget lines, and allocation and expenditure tracking across all key sectors.
	Adopt a multisectoral, national suicide-prevention plan and integrate prevention of suicide and self-harm across child and adolescent health, development and welfare programmes.
	Integrate mental health into child and adolescent health, nutrition, and maternal and child health policies and plans.
	Strengthen the integration of mental health into early childhood development, child protection/ending violence, social welfare and social protection policies and plans with clear roles and actions in relation to MHPSS.
	More explicitly integrate mental health into education sector policies and plans and develop a whole-of-education policy for mental health promotion.
	Strengthen the integration of mental health of children and adolescents into juvenile justice with clear roles and actions in relation to MHPSS.
Legislation and actions required for effective mental health services	Adopt policies that define high-quality mental healthcare for children and adolescents (minimum standards of care) that include relevant sectors and government, non-government and private providers.
	Adopt legislation and develop implementation guidance that ensures children's and adolescents' right to access mental health services in accordance with their evolving capacities and in a manner that protects confidentiality. This includes legislation supporting the right of adolescents to access care without mandatory parental consent.
	Adopt legislation that mandates access to mental healthcare for children and adolescents who are deprived of liberty, in conflict with the law or in out-of-home placements.
	Address legislation that denies access to mental healthcare for migrant, displaced or other marginalized children and adolescents.
	Remove legislation that criminalizes suicide or attempted suicide.
Legislation to protect children and adolescents within the mental health system	Prohibit physical restraint of children and adolescents with acute mental conditions in home, school, healthcare or any other settings providing services or care.
	Adopt protections (legislation, regulation, monitoring and complaints mechanisms) to ensure that deprivation of liberty, including detention for mental health purposes, is a last resort, for the shortest appropriate period, and subject to periodic review.
Policies, programmes and legislation to protect children and adolescents from harm and discrimination	Prohibit all forms of violence (physical, sexual, emotional) against children and adolescents in all settings, including home, school, online and in places of alternative care and detention, including use of corporal punishment.
	Prohibit early marriage of children under the age of 18 years.

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

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

The highest priority was given to actions related to **responsive care**. Improving early identification and screening beyond traditional healthcare settings (such as in schools, community-based services and through self-referral) is essential. However, it is critical that screening occurs in the context of a **strong referral system and accessible services** and supports. As such, stakeholders considered strengthening the referral system and increasing the availability of child and adolescent mental health services (including community-based services) among the most pressing priorities for MHPSS. Improving multidisciplinary, person-centred care was also a priority, with many stakeholders noting that the current approach focuses primarily on individual-based clinical treatment, with a significant need for services that extend beyond clinical management to include social support and care for parents and families.

The next highest priority were key actions related to **prevention**. Among these, school-based actions (from early education through to secondary education and higher) were considered central to preventing poor mental health and enhancing protective factors. High priority actions included: developing and implementing programmes to address violence and bullying; curriculum-based and other programmes to promote positive peer relationships; programmes to address the harmful use of substances; and implementing curriculum-based and other programmes (for example, strengthened life skills education) to support social and emotional learning and skills. Similarly, high importance was placed on strengthening the quality and coverage of parenting programmes to support positive parenting and improve mental health literacy and care-seeking.

Among actions related to ensuring a **safe and enabling environment**, high priority was given to campaigns and programmes to address stigma and discrimination and harmful norms, noting that stigma remains a significant barrier to seeking services and supports. The importance of engaging

young people and community leaders with training and education around mental health and supporting greater participation of young people in the planning and design of MHPSS were rated as high priorities among youth representatives. Other stakeholders across key sectors also noted the need to more explicitly integrate mental health into key sectoral policies, with clear descriptions of roles, responsibilities and accountabilities. Strengthening or amending legislation to protect children and adolescents from harm was also prioritized. Decriminalizing suicide was also identified as a priority because it is seen as a key barrier to care-seeking and a contributor to stigma. Another high priority was removing mandatory parental consent requirements as this creates a significant barrier to accessing care for adolescents.

Stakeholders also identified priority actions for the short term (within two years), mid-term (two to five years) and long term (more than five years):

FIGURE 13. ACTIONS FOR SHORT-TERM IMPLEMENTATION

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

- **Screening** those with high-risk behaviours and exposures
- Screening for pregnant and postpartum adolescent girls
- Strengthening **self-referral through helplines/hotlines/online**
- **Specialist support, case management and therapy** by multidisciplinary team
- Specialized **services and support to families** of children with complex behaviours / needs, in social services, justice settings
- **Specialist clinical** mental health **treatment and care**
- **Person-centred care** that includes social support, peer support and mental health professionals

- Establishing **peer-to-peer groups and youth clubs** for children and adolescents both in-school and out-of-school
- Implementing **selective intensive school-based and out-of-school programmes t**argeted for children and adolescents who are at risk of poor mental health. Can be packaged with counselling and referral to services

- Designing and delivering **stigma and discrimination reduction campaigns**
- **Training community** health workers, community volunteers, adolescents, religious leaders and educators to raise awareness about mental health **to address harmful social norms**
- Providing **capacity building opportunities** for adolescents, including those with lived experience, to be engaged in the planning and design of MHPSS

FIGURE 14. ACTIONS FOR MEDIUM-TERM IMPLEMENTATION

Actions given medium priority for implementation within two to five years:

- **Sensitizing school-based counsellors and social services** to identify those with mental health needs
- **Training and sensitizing frontline and community workers** to identify, support and refer
- Establishing **referral criteria and mechanisms** within the health sector and from other sectors/settings
- Integrating mental health into **physical health services**
- **Child, adolescent and family-friendly services** that are inclusive
- **Community-based and mobile services** for hard-to-reach children and adolescents
- Residential **rehabilitation** services
- Ongoing **participation in education** for those with mental health problems

- **Guidance and support for schools** on effective interventions following crisis (such as suicide in community)
- Supporting **teacher well-being**
- Raising **awareness on nurturing care, positive parenting and non-violent discipline**
- Designing and implementing **parenting programs** focused on building skills to support nurturing care, positive parenting practices and non-violent discipline
- Identifying and addressing the **mental health needs of parents/guardians/carers**
- Addressing **peer victimization, including through digital media** (universal)

- Adopting a **national mental health strategy/policy that details the multi-tiered and multi-sectoral vision and plan for mental health,** and adopt a **multisectoral implementation plan** (including coordination)
- Integrating mental health into **the education sector policy and plan**
- Integrating mental health **into early childhood development, child protection/ ending violence against children, social welfare and social protection policies, strategies and plans**

FIGURE 15. ACTIONS FOR LONG-TERM IMPLEMENTATION

Actions given priority for implementation in the next five years:

- **Education and support for parents** of children and adolescents with mental health needs

- Implementing a **whole-school approach to mental health and well-being**
- Implementing a **'whole-school/education' approach to tackling violence and bullying**
- Designing and implementing **school substance use policies**
- Promoting **teacher-parent communication** on the safety and well-being of children and adolescents
- Providing **training and resources for teachers** to provide environments that meet the learning, well-being and safety needs of children and adolescents
- Implementing **universal psychosocial interventions in schools and out-of-school settings** that focus on building social and emotional skills, positive behaviours, school connectedness, effective problem-solving, help-seeking behaviours and address risk factors

- Adopting **legislation and actions required for effective mental health services** for children and adolescents
- Implementing **laws that protect children and adolescents** within the mental health system
- Implementing **policies/programmes and strategies that protect** children and adolescents **from harm and discrimination**

Recommended sectoral roles and responsibilities

Table 4 provides an overview of the key roles of the health, education, social welfare and justice sectors in implementing the priority package of MHPSS actions. The health sector was identified as having an overarching leadership role with respect to setting national policy, planning and oversight of MHPSS. However, stakeholders across sectors described a critical role for the education, social welfare and justice sectors in terms of prevention and promotion, as well as supporting a strong referral system.

Table 4. Sectoral roles in implementing MHPSS actions: Accessible and responsive care for mental health conditions

*Actions in **bold** indicate where a sector is recommended to have a leading role or primary responsibility for implementation*

Accessible and responsive care for mental health conditions			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Screening for those at risk, including parents/caregivers with mental health conditions	Early identification of those with mental health conditions or risks	Screening for children and adolescents with high-risk exposures (and parents/ caregivers) with high-risk exposures	Screening for high-risk behaviours and exposures
Referral systems and mechanisms (referral criteria and protocols both within the health system and from other sectors/ settings (schools, social welfare/child protection, justice)) Self-referral hotlines	Referral linkages and mechanisms (particularly protocols for referral of children identified through schools for health or social welfare services)	Referral linkages and mechanisms Self-referral hotlines	Referral linkages and mechanisms
Multidisciplinary case management and support Targeted education and support for parents of children with mental health conditions and complex behaviours	Ongoing education participation for those with mental health conditions	Multidisciplinary case management Targeted education and support for parents of children with mental health conditions and complex behaviours	Specialized services and supports, including mental health services in detention settings
Community-based and outreach services		Community-based and outreach services	
Establishing specialized and clinical services		**Establishing specialized services and case management for families**	
Establishing residential services		Supporting residential mental health services	

Responsive care: Health sector

For the provision of accessible and responsive care for mental health conditions, the health sector plays the most prominent role among all the key sectors. Most stakeholders recommended that the health sector take the lead role in responsive care, with support from the other sectors in different subdomains such as the provision of technical support and coordination of community-level programmes.

Screening for at-risk populations (for example, children and adolescents impacted by substance use and family violence, marginalized children and children orphaned by the COVID-19 pandemic) was identified as the primary responsibility of healthcare providers. Stakeholders emphasized that screening must be supported by a strong referral system with mechanisms that facilitate self-referral or inter-agency referral from the education, social welfare or justice sectors. The health sector was identified as having overarching responsibility for developing guidelines, procedures and protocols for referral within the health sector and between health and other sectors (including a public-private linkage in view of the two-tier healthcare system in Malaysia).

Stakeholders also described an urgent need for the health sector to expand specialized clinical services for children and adolescents, including residential care. The majority of specialized psychiatrists (with sub-specialization qualifications) are based in the private healthcare sector, which receives a lower percentage of patients compared with the public health sector. This group of specialized mental health experts was identified as being important for improving the accessibility of mental healthcare, as well as providing training and support to other health providers. While the health sector has primary responsibility for technical guidance and policy related to MHPSS in addition to implementation of health services, stakeholders also identified a critical coordinating role for the sector in terms of improving linkages and collaboration with the education, social welfare and justice sectors and NGOs to support multidisciplinary care.

Responsive care: Education sector

The education sector was identified as playing an important role in implementing early identification and screening, particularly given that teachers and school counsellors are often the first to respond to behavioural problems and mental health concerns. To support this, stakeholders recommended that school-based counsellors and other staff involved in social services in the education sector have access to training and supervision (for example, from psychiatrists and psychologists) specifically in relation to mental health and the use of screening tools. The education sector was also seen to be a critical part of a strong referral system – this is particularly important as school-based screening in the absence of accessible services and support can be harmful and stigmatizing. Additionally, the education sector was recommended to have responsibility for ensuring the inclusion of children and adolescents with mental health conditions in the formal education system.

Responsive care: Social welfare sector

The social welfare sector was identified as having a key role in the provision of responsive care at the community level. Stakeholders described community-level care as being equally as important as institutional-level, health-facility care due to the possibility of long-standing or recurrent mental health conditions. The social welfare sector can be the primary source of social support and peer support to deliver person-centred care for adolescents and children in need. This sector is also the best placed to work with NGOs to ensure that access to education and continuous support can be provided to children, parents and families via community-based and mobile services.

The DSW, through the Children's Division, has established a strategic partnership with communities throughout the country that includes a programme as follows:

a. Child Protection Teams (PPKK) – 140
b. Child Welfare Teams (PKKK) – 133
c. Assistant Protector – 299

THE DSW also provides protection and rehabilitation services in 39 children's institutions with a capacity for 3,955 children as follows:

a. Rehabilitation institutions – 22
b. Protection institutions – 17

On a similar note, the social welfare sector was furthermore recommended to take a lead role in the establishment of residential rehabilitation services as a medium- to long-term priority action. At the moment, the majority of such services are provided by NGOs. With many organizations facing limited funding and other restrictions, it is timely for the social welfare sector to assume a bigger role in this area.

Responsive care: Justice sector

The justice sector currently plays a minimal role in responsive care, except for children and adolescents who are engaged in the justice system (for example, victims of family violence). Psychologists within the justice system provide psychological assessment, screening, management and referral for children and adolescents who come into contact with the justice system. Although they do not widely advertise their services to the public, they do encourage the public to utilize the services that they provide. For example, parents and/or students do visit the psychologists at the police station after their engagement at schools during MHPSS awareness campaigns.

Table 5. Sectoral roles in implementing MHPSS actions: Prevention of mental health conditions in the immediate social context

*Actions in **bold** indicate where a sector is recommended to have a leading role or primary responsibility for implementation*

Prevention of mental health conditions in the immediate social context			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Support to mental health approaches in education, including teacher well-being	**School and education-based programmes and approaches:** • Whole-of-education mental health promotion, including a focus on creating safe, respectful and inclusive learning environments, supporting social and emotional learning, and supporting positive peer and peer-teacher relationships • Teacher-parent communication • Teacher and staff well-being	Support to mental health approaches in education	

Prevention of mental health conditions in the immediate social context			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
	Establishing youth and peer support groups	Establishing youth and peer support groups	
Digital literacy, **online networks for mental health**	**Digital literacy and civility education**	Digital literacy, online networks for mental health	
Intensive interventions to address risk factors Support to schools following crisis (e.g., suicide in community)	**Intensive interventions to address risk factors** **School-based interventions following crisis in the community (e.g., suicide)**	Intensive interventions to address risk factors	Supporting intensive interventions to address risk factors (including substance use)
Identify and address mental health needs of parents/carers	Raise awareness about positive parenting	**Parenting programmes** to build skills in nurturing and responsive care, and non-violent discipline	

Prevention: Education sector

The education sector was recommended to have a major role in the implementation of actions to prevent poor mental health. This includes a leading role in coordination and implementation of actions to optimize learning environments, build individual assets and support healthy peer relationships. Schools in particular were identified as a key platform for delivery of many MHPSS actions. As such, the education sector should have a greater role in developing and implementing whole-of-school or education mental health promotion approaches through the development of policies, implementation guidance and delivery of training for teachers, school counsellors and other education staff in mental health. This sector also has lead responsibility for developing curricula to support social and emotional learning; addressing bullying, harassment and substance use; and implementing programmes to foster healthy peer relationships and build interpersonal skills. Schools were also noted to be an important source of programmes to support digital literacy and civility and to potentially play a role in establishing both online and in-person peer groups and networks in relation to mental health. Given the linkages between schools and parents, the education sector was also recommended to support implementation of parenting programmes in collaboration with social welfare.

Prevention: Health sector

The health sector was recommended to play a supporting role to the education sector in mental health preventive approaches. These include the training of educators in mental health and providing school-based interventions following a crisis in the community (e.g., suicide).

Prevention: Social welfare sector

Most stakeholders agreed that social welfare should play a major role alongside the education sector in preventive services, particularly in the development and implementation of large-scale parenting programmes. This sector was also seen to have primary responsibility for targeted interventions

to address children and adolescents at risk of poor mental health (for example, children who have experienced violence, abuse or neglect).

Prevention: Justice sector

Although the justice sector was identified as playing a minor role in prevention, the sector is needed to support intensive interventions to address risk factors. The sector could also be engaged in programmes to promote anti-violence and bullying in school.

Table 6. Sectoral roles in implementing MHPSS actions: Mental health promotion – Ensuring an enabling and safe environment

*Actions in **bold** indicate where a sector is recommended to have a leading role or primary responsibility for implementation*

Mental health promotion: Ensuring an enabling and safe environment			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
National, multisectoral mental health plans and strategies, including suicide prevention	**Integrating mental health into education policies**	**Integrating mental health into early childhood development, child protection/ending violence, social welfare and social protection policies and plans**	**Integrating mental health of children and adolescents into juvenile justice and justice health policy and plans**
Integration of mental health into maternal and child health, adolescent health, nutrition, and HIV policies and strategies			
Policy and standards for high quality mental healthcare		Identifying barriers in access to mental health services for marginalized groups	**Protections for children and adolescents in the mental health system**
			Legislation mandating access to mental healthcare, including removing mandatory parental consent requirements **Legislation mandating access to mental healthcare for children and adolescents deprived of liberty and in out-of-home placements**

Mental health promotion: Ensuring an enabling and safe environment			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
		Support to legislation and policies to protect children and adolescents from violence and harm	**Legislation and policies to prohibit violence, harm, discrimination** • Decriminalize suicide • End all forms of violence • Child marriage • Discrimination • Control of substance use • Restrict access to lethal means • Child labour • Recruitment to armed forces • Minimum age of criminal responsibility
		Social protection programmes for families	
Training and community-based programmes to address stigma and discrimination		Training and community-based programmes to address stigma and discrimination	
Capacity building in adolescents to support participation, including those with lived experience of mental health needs or risks, in the planning and design of MHPSS	Capacity building in adolescents to support participation, including those with lived experience of mental health needs or risks, in the planning and design of MHPSS	Capacity building in adolescents to support participation, including those with lived experience of mental health needs or risks, in the planning and design of MHPSS	

Promotion: Justice sector

The justice sector was identified as having a lead role in developing and enforcing legislation to protect children and adolescents from harm and discrimination. This includes amending legislation to decriminalize suicide and increase the minimum age of criminal responsibility.

Promotion: Health sector

With respect to policy and legislation, the health sector was identified as having a lead role in developing mental health policy and technical guidance to support the delivery of responsive care. This includes a role in advocating for legislation that ensures the rights of children and adolescents to mental healthcare, removes mandatory requirements for parental consent, and protects children and adolescents within the mental health system from harm. This sector was also seen as having overall responsibility for developing national, multisectoral mental health policy and strategies. Additionally, the heath sector was identified as having a role in supporting efforts to improve mental health literacy and mental health promotion.

Promotion: Social welfare sector

Because of its existing close linkages with communities, the social welfare sector was identified as having a key role in developing and implementing programmes to promote mental health and address the broader social determinants of well-being (such as early childhood development). This sector was also recommended to have a leading role, along with the justice sector, in supporting the enforcement of legislation and policies to protect children from harm, including supporting mandatory reporting of child abuse.

Promotion: Education sector

Strengthening the integration of mental health into education policies and plans was identified as a key priority for the education sector. This sector was also noted to play an important role in addressing mental health stigma and discrimination through curriculum-based and other learning programmes related to mental health.

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

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

Non-governmental organizations

Not-for-profit NGOs were seen to play a potentially important role in the implementation of MHPSS. Many local and international organizations are engaged in areas that relate in some way to mental health and well-being (such as physical health, sexual and reproductive health, child welfare and child development), providing a platform to integrate more specific MHPSS actions. In particular, strong partnerships with communities and understanding of community needs would facilitate delivery of actions around mental health literacy, addressing stigma, community-based service delivery (identification, referral and first aid), and programmes to support parents and families. The NGO sector was also seen to have an important role in supporting mental health advocacy. Within this sector, youth organizations were also identified as crucial in promoting mental health literacy and participating in the implementation of preventive and care interventions in community and school settings.

Private sector

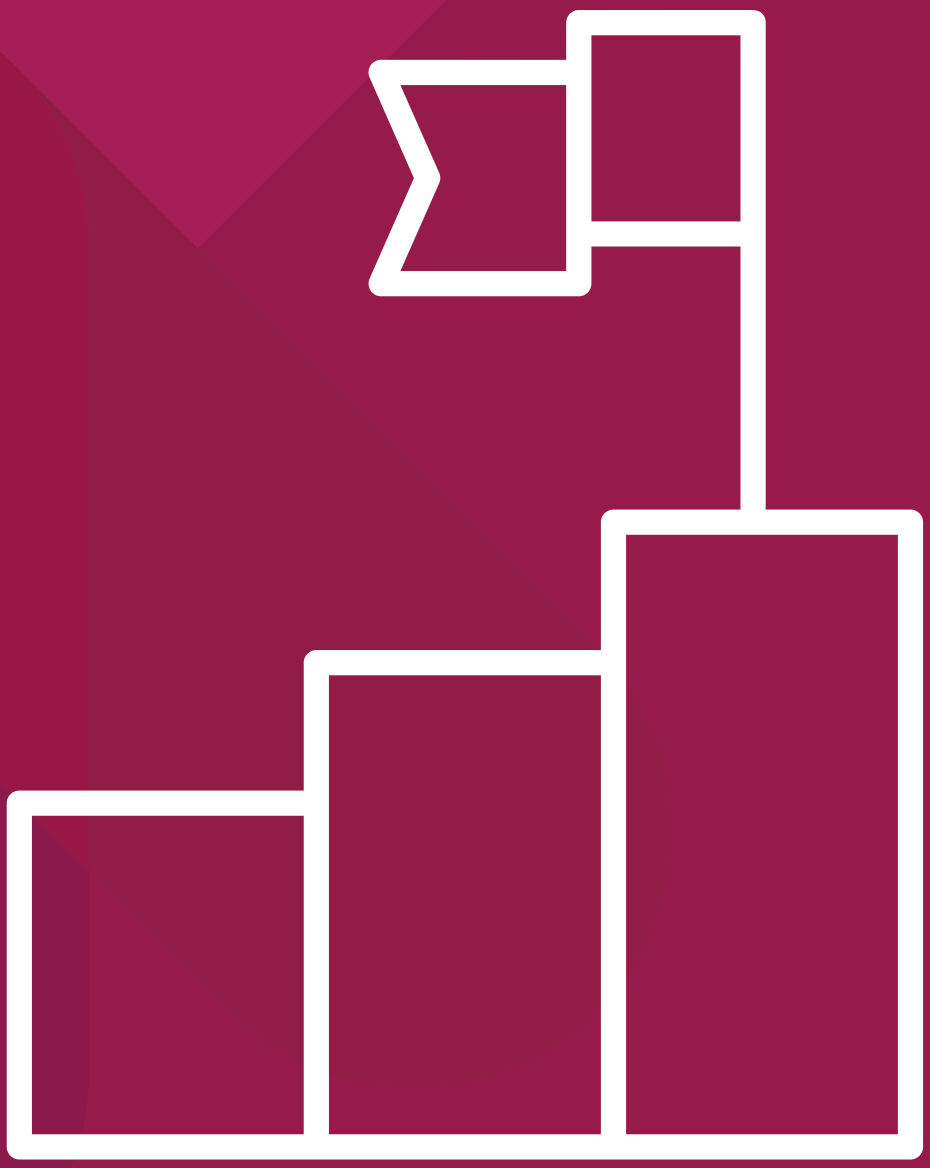
The private sector was identified as having a significant role to play in filling the service delivery gaps as this sector provides a large proportion of health services, including mental health services. In general, stakeholders recommended that further mapping was required to better understand the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

UNICEF

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

- Advancing the advocacy agenda in relation to children and adolescent mental health prevention and promotion;
- Playing a crucial convening role in facilitating linkages between sectors (such as health, social welfare, child protection and education) and supporting cross-sectoral dialogue, planning and resource allocation;
- Data synthesis and evidence generation through supporting research to draw attention to key mental health needs and advocating for evidence-based action;
- Supporting, through funding, new initiatives, pilot projects and other innovations to test new ways of delivering MHPSS for children and adolescents;
- Integrating MHPSS into existing UNICEF programmes and platforms (including primary healthcare, education, parenting programmes and child protection);
- Supporting and delivering programmes to address mental health-related stigma and improve mental health literacy through national-level advocacy and community-based programming; and
- Integrating MHPSS in emergency settings.

Challenges and recommendations for strengthening the multisectoral mental health system



Legislation, policy and strategy

Malaysia has a strong legislative and policy framework to support MHPSS and ensure the mental health and well-being of children and adolescents. The **National Strategic Plan for Mental Health 2020–2025** lays the foundation for multisectoral action to promote well-being, prevent poor mental health, provide responsive services and protect the rights of children and adolescents. The Strategic Plan includes some specific actions to address the unique needs of this age group (such as screening and early detection, mental health education and responsive care in schools). However, while the Strategic Plan recognizes the importance of engaging sectors in addition to health, it does not articulate a clear, multisectoral vision for mental health or describe the mechanisms needed to enable cross-sectoral collaboration and accountability. This includes a lack of performance indicators or other mechanisms to monitor collaboration or coordination.

The **Mental Health Act 2001** includes some general protections of rights of those within the mental health system in relation to physical restraint, deprivation of liberty, involuntary treatment, and appeal. However, there are no specific protections for children and adolescents. Such protections could include:

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

Other recommendations from stakeholders included merging the Child Act and Mental Health Act to develop an act that specifically caters to mental health in children; developing a national Mental Capacity Act to provide greater clarity on the rights of children and adolescents with respect to consent and assent to mental healthcare (particularly in cases of severe mental disorder) and the rights and responsibilities of parents; and amending Article 8(2) of the Federal Constitution to include protection from discrimination on the basis of disability, including children with a developmental disorder. An additional gap in legislation exists for undocumented migrants and asylum seekers, including children and adolescents. Due to their lack of legal status, these children may not be eligible for healthcare services, including for mental health.

Mental health has been integrated to some extent into the **sectoral policies and plans of education and social welfare**. The National Education Blueprint recognizes the importance of emotional development and the school curriculum and environment in supporting resilience, emotional skills and peer relationships, and there is currently a national programme to support screening in schools. However, there are gaps in relation to greater inclusion of mental health literacy and social and emotional learning within the national standard curriculum, a clear, whole-of-education policy to support mental health, and strategies to reach out-of-school children and adolescents with MHPSS.

Malaysia also has a suite of laws, policies and plans related to child welfare and protection that address some of the key determinants of mental health (such as violence, trafficking, education and participation), with inclusion of MHPSS (such as counselling and psychosocial support) and strong linkages with health services. Stakeholders identified a need for strengthened social protection policy, with a greater focus on children and families. The justice sector has also included the provision of psychiatric assessment and care in legislation and policy with respect to management of children in custody, as well as some protections for child victims and those in conflict with the law to prevent further psychological harm. Nevertheless, policies that more clearly articulate the roles and responsibilities of these sectors with respect to MHPSS would strengthen access to and the quality of MHPSS for those most at risk. The justice sector, in particular, noted that this process takes time and requires greater ministerial support across sectors.

"Amending the law will take a long time. You need a supporting ministry. And then you need the AG (Attorney General) chamber to table a bill in parliament. And usually, it takes political will. So, you need to have somebody within the cabinet to campaign for mental health and support services. I think currently the priority is the GDP and economy. I don't know how highly they rate mental health support services. So, you need to get people to go and talk to their members of parliament, so that they can raise this. You need to advocate, you need the mental health practitioners to raise it with their ministers and their relevant ministries, you need the MOE (Ministry of Education) to raise it, so that there is joint effort. Because this is not something that is politically slanted. ***It's apolitical. It's for the benefit of the country but only if they see it as a priority.*** *"* —A justice sector informant

Across sectors, stakeholders noted that in addition to addressing these gaps, there was a need for implementation strategies, plans and frameworks that more clearly defined the roles and responsibilities of agencies, particularly at local level units. While supportive policies are in place, the lack of clear guidance and accountability contributes to limited implementation.

"So far, there are policies like, for example, National Adolescents Guidelines policies where it says...it looks into the needs...it addresses the needs for adolescents, all in all. But ***policies are remaining as policies.*** *"* —A health sector informant

"I was saying that ***something to move the needle is having policy****. Then, it makes things happen. Having a policy, and getting the stakeholder to buy into that policy and implementing and following up to make things happen. You will see changes."* —A social welfare sector *informant*

"You can come up with all the action plans, we always say you have a strategic plan, action plan, ***but where's the action?*** *So, that part is lacking."* —A social welfare sector informant

KEY RECOMMENDATIONS – LEGISLATION AND POLICY:

- Ensure 'mental health in all policies' with more explicit recognition and actions to address mental health in non-health sector policies, and as part of the COVID-19 response.
- Expand existing national mental health policy, or develop specific child and adolescent mental health policy, to provide clearer and more comprehensive guidance on actions to promote, prevent and respond to the mental health needs of this age group.
- Strengthen mental health legislation to include specific protections and considerations for children and adolescents, including clearer rights with respect to consent to mental healthcare and removal of mandatory requirements for parental consent.
- Amend Article 8(2) of the Federal Constitution to include protection from discrimination on the basis of disability, including protection for children with developmental disorder(s).
- Develop multisectoral implementation plans and guidance with clear roles, responsibilities and accountability at all levels (including key performance indicators related to multisectoral coordination).
- Review legislative and regulatory barriers to access (e.g., undocumented migrants, mandatory requirement for parental consent).
- Develop policies and strategies to reach out-of-school children and adolescents, and other marginalized groups.
- Improve dissemination of MHPSS-related policies and plans across sectors and to administrative and implementation agencies.
- Develop multisectoral mental health plans at subnational level to support coordination and implementation.
- Strengthen legal protections against all forms of harm and discrimination, including decriminalization of suicide and prohibition of all forms of corporal punishment.
- Strengthen social protection policy, with a focus on children and families.

Leadership and governance

While there are examples of programmes and approaches that have engaged multiple sectors, such as coordination between the social welfare and health sectors in child protection cases, limited multisectoral collaboration and lack of coordinated leadership across sectors was identified as one of the major challenges to implementation of MHPSS.

National level

Limited high-level, multisectoral coordination of policy and planning remains a challenge in Malaysia. Stakeholders across sectors noted that each sector has a different policy focus, planning cycle and budget priorities and that these are not currently aligned around a common vision or goal for child and adolescent mental health. Stakeholders recommended that the health sector, specifically the Ministry of Health, have overall leadership and accountability for MHPSS, including responsibility for mental health policy, technical guidance, oversight of training, and monitoring and evaluation. However, key roles were also identified for other sectors in providing leadership for MHPSS – most notably the social welfare sector (for marginalized children and those at risk) and the education sector (for developing and implementing school-based actions and MHPSS in learning environments), with roles also for the justice sector in supporting MHPSS for children and families at high risk. UNICEF, WHO and NGOs were also identified as having key leadership roles – particularly in relation to supporting evidence-based policy through technical guidance, and linkages with communities. The private sector was additionally identified as an important national stakeholder that should be engaged in policy and planning to improve coverage of services.

Stakeholders across sectors emphasized the need for collaborative, high-level support for mental health with a clear, multisectoral vision, acknowledging that many of the determinants and necessary actions for mental health lay outside the traditional scope of the health sector. To facilitate better collaboration and coordination, it was recommended that a national steering committee be established, led by the Ministry of Health, with membership of all key sectors (including UN agencies and NGOs) and the authority and resources to drive action. The National Strategic Plan lays the foundation for this, by including the establishment of a national coordinating body with representation from health, education, labour, social welfare and local government units to support greater coordination and integration of mental health into all policies.

Subnational implementation levels

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

To overcome these challenges, stakeholders recommended that greater support be provided to District Offices to: increase awareness of mental health and relevant policies and plans; support planning and resource allocation; and establish district-level, multisectoral committees to guide implementation and collaboration.

> *"So, I agree **we all tend to work in silos.** There's no real platform for sharing and I think that is also one of the problems that we have is that sometimes, nobody knows."* —A social welfare sector informant

> *"So, if you ask me, all of them have their role and all of them are doing their best when it comes to MHPSS. **But they're all not connected to each other.**"*—A health sector informant

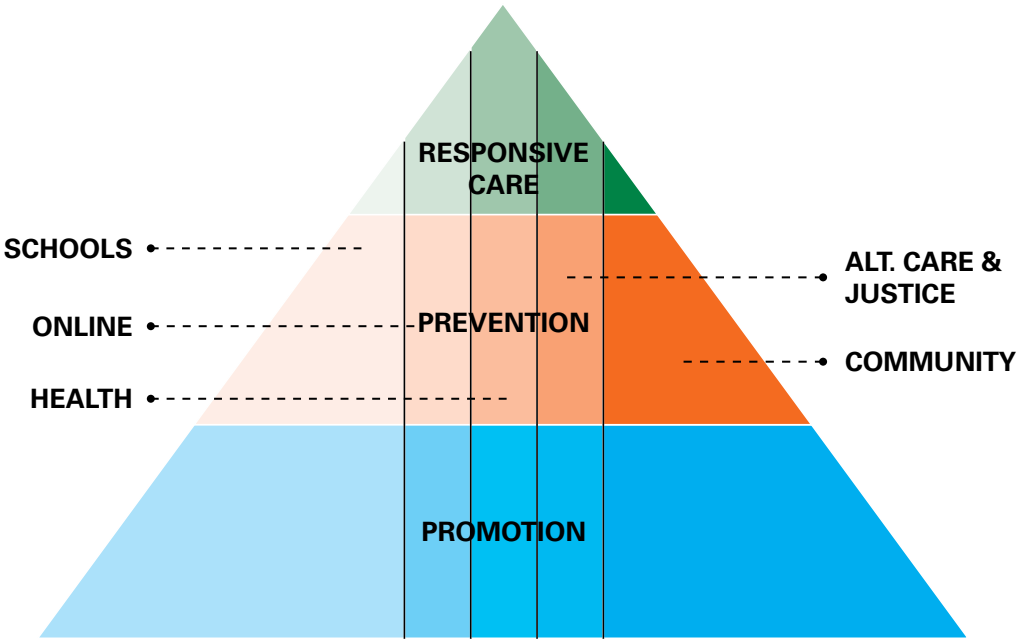
KEY RECOMMENDATIONS – LEADERSHIP AND GOVERNANCE:

- Establish a high-level, multisectoral national steering committee led by the Ministry of Health, with representation from all key sectors (including UN agencies, NGOs and the private sector), and with the authority and resources to drive action.
- Build the capacity of District Offices in MHPSS to support local planning, coordination and resource allocation.
- Establish local, multisectoral committees to support coordination and implementation of the priority MHPSS package.
- Develop subnational implementation plans for MHPSS that clearly articulate sectoral roles and responsibilities and are aligned with national goals and strategies for mental health.

Service delivery

Multiple platforms exist to support the delivery of MHPSS actions (see Figure 16). Within responsive care, **health facilities** (primary, secondary and tertiary level) remain an important setting to deliver screening through to specialized care. The National Strategic Plan and Operational Framework emphasize the need to strengthen primary-level and community-based mental health services and avoid admission of children into adult institutional care settings. Greater investment is needed in developing child/adolescent-centred and friendly care models; strengthening entry points for children, adolescents and their families through maternal and child health services, nutrition programmes, adolescent health and other physical health services; and establishing child-focused, multidisciplinary teams. The National Strategic Plan as well as stakeholders also recommended expanding models of service delivery outside traditional clinical settings, in particular transitioning to community-based and mobile services to improve access to screening, referral and care, and home-based services to provide more person-centred care (particularly for subclinical or continuing care) and to reduce the burden on health facilities.

Figure 16. Platforms for delivery of MHPSS across the three tiers of MPHSS actions



In addition to the delivery of responsive care actions, **community-based delivery** was also identified as an important platform for implementing actions to address mental health literacy, shift community norms and stigma, and deliver preventive actions (including parenting programmes, family violence programmes and targeted interventions for children, adolescents and families at risk). To address gaps in service delivery and the workforce, community-based organizations and NGOs were identified as important partners, with opportunities to work with existing NGOs to integrate MHPSS actions into their programming. Stakeholders also recommended considering the establishment of community-based centres providing safe spaces for children and adolescents that include provision of information and services for mental health. There was also a recommendation for young people to lead MHPSS programmes designed for children and adolescents, particularly in preventive care. Additionally, to ensure that MHPSS is more accessible to people with disabilities and marginalized populations, stakeholders recommended fortifying on-the-ground outreach and peer-to-peer support systems led by young people and NGOs.

Schools and other learning environments are a critical platform for reaching large numbers of children and adolescents with MHPSS. All sectors nominated school-based delivery as essential to the effective implementation of MHPSS, with a focus on improving early identification and screening, contributing to multidisciplinary and continuing care and, most significantly, actions to build individual assets, promote positive peer relationships and create safe learning environments. There have already been important efforts to integrate screening into secondary school settings. However, much greater attention to the training and supportive supervision needs of teachers and school counsellors is needed to support these programmes and referral linkages with other sectors and service providers, as well as consideration of the additional demands on teachers' time to support MHPSS. Opportunities to strengthen curriculum-based approaches to support social and emotional learning and teachers in behavioural management should be further explored. Schools are not only a platform for delivering interventions. Learning environments in and of themselves have a profound influence on mental health and well-being from early childhood through to adolescence. Addressing the school/learning culture, academic pressures, respect and inclusiveness through the development of whole-of-education approaches to mental health promotion are also important to support mental health and well-being.

The potential of **online and digital platforms** has received increasing recognition, particularly in the context of COVID-19. Malaysia has several hotlines, helplines and online applications that provide information, mental health literacy and referral linkages. However, these platforms are currently underutilized, with potential to make better use of online technology to support counselling, telehealth for mental healthcare, interactive parenting programmes and integrating mental health into academic online education for students.

Justice settings are also important for the delivery of screening, referral, targeted interventions to address risk factors and continuing care for children who are victims or witnesses of crime, as well as juvenile offenders. Several existing models of collaborative care were noted in Malaysia, with the justice, health and social sectors collaborating to provide mental health assessment and referral. However, stakeholders noted that these approaches could be strengthened through clearer policies and protocols in relation to MHPSS for children in conflict with the law and child victims/witnesses, and stronger linkages with other sectors and agencies.

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

KEY RECOMMENDATIONS – SERVICE DELIVERY:

- Develop models and standards of child and adolescent-centred health services for mental health
- Strengthen two-way referral mechanisms between primary and tertiary care.
- Transition to integrated community-based services that span the three tiers of MHPSS.
- Integrate MHPSS into other health services at community level, including maternal and child health, nutrition, adolescent health and general medical/physical health.
- Establish more community centres that provide safe spaces for children and adolescents and provide MHPSS information and services.
- Build on existing school-based models to strengthen responsive care as well as key preventive actions.
- Strengthen and evaluate online and digital service delivery models that link mental health promotion, positive peer relationships, parenting programmes and responsive care (self-referral and counselling).
- Strengthen protocols within justice settings to support the delivery of MHPSS and protect children and adolescents from psychological harm, and strengthen linkages with health and social welfare agencies.
- Identify barriers and service-delivery preferences for marginalized and underserved communities, particularly strategies needed to reach out-of-school children and adolescents, and those living with disability.

Standards and oversight

Several recommendations were made to strengthen the quality of MHPSS and improve oversight. At a national level, the Ministry of Health was identified as having primary responsibility for quality assurance through setting technical standards and guidance, establishing indicators and monitoring performance. While this role is more clearly defined with respect to responsive care and clinical health services, oversight in relation to actions against the other tiers (prevention and promotion) is less clearly articulated. To support oversight, it was recommended that a harmonized set of indicators for MHPSS be developed that could be used to monitor performance and quality across multiple sectors. Stakeholders also recommended establishing an independent monitoring body (or technical advisory committee) made up of representatives from key sectors, reporting to the Ministry of Health, with responsibility for monitoring quality and compliance and evaluating MHPSS programmes provided across all sectors.

A high priority is strengthening a national protocol for early identification, screening and referral for children and adolescents with mental health conditions and those at increased risk. This includes expanding locally validated and age-appropriate screening tools (including for children) and detailed protocols for administering these within different settings (health, education, child welfare and justice). A national, standard protocol and procedures for referral of children and adolescents with mental health needs are also critical – not only for efficient referral within the health system but to support inter-agency referral between sectors (for example from schools or child protection settings to health services). Stakeholders also emphasized that these protocols needed to be two-way in order to improve communication between specialist services and primary providers (health, education and social welfare) and strengthen follow-up and continuing care and support.

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

Stakeholders also recommended developing a standardized system for NGOs to engage with the Government in MHPSS. This included a standardized process for applying for funding, aligned with MHPSS delivery priorities.

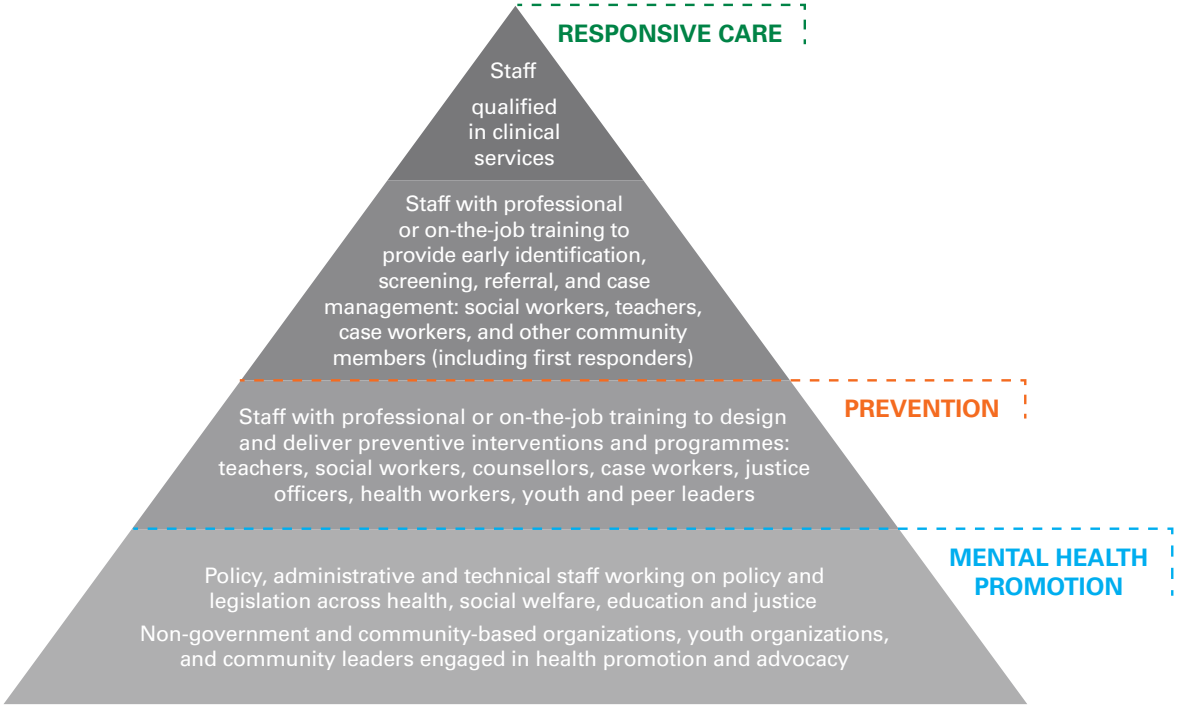
KEY RECOMMENDATIONS – STANDARDS AND OVERSIGHT:

- Define clear multisectoral indicators to monitor MHPSS performance.
- Establish a national, independent monitoring body (or technical advisory committee) with cross-sectoral representation, reporting to the Ministry of Health, to monitor quality, compliance and performance of MHPSS programmes.
- Strengthen guidance, protocols and procedures with respect to delivery of child- and adolescent-friendly mental health services, including parental consent and trauma-informed approaches.
- Develop clear guidance and protocols for early identification, screening and referral (within sectors and between), with clearly defined roles and accountability of key actors.
- Establish standard operating procedures across agencies to support coordinated care of children and adolescents engaged in child protection or justice settings.
- Strengthen justice-related protocols to minimize harm to children and adolescents who come into contact with the justice sector.
- Develop a national, standard referral protocol across health, education, social welfare, justice and other settings (including for NGOs) that also supports communication back to primary providers to support follow-up and continuing care.
- Develop a national, standard mental health education curriculum for all levels of education.
- Standardize a system to support NGO engagement in MHPSS.
- Strengthen continuous evaluation of the accreditation of the mental health workforce.

Multisectoral mental health and psychosocial support workforce

The multisectoral MHPSS workforce is challenging to define as it is diverse and dynamic. It ranges from specialist providers whose primary roles relate to mental health to providers and volunteers who may be required to deliver some aspect of MHPSS but for whom this is not a primary responsibility and who have fragmented access to training, accreditation and support. The three tiers of MHPSS actions (responsive care, prevention and promotion) can be coarsely mapped against the corresponding multisectoral mental health workforce as shown in Figure 17.

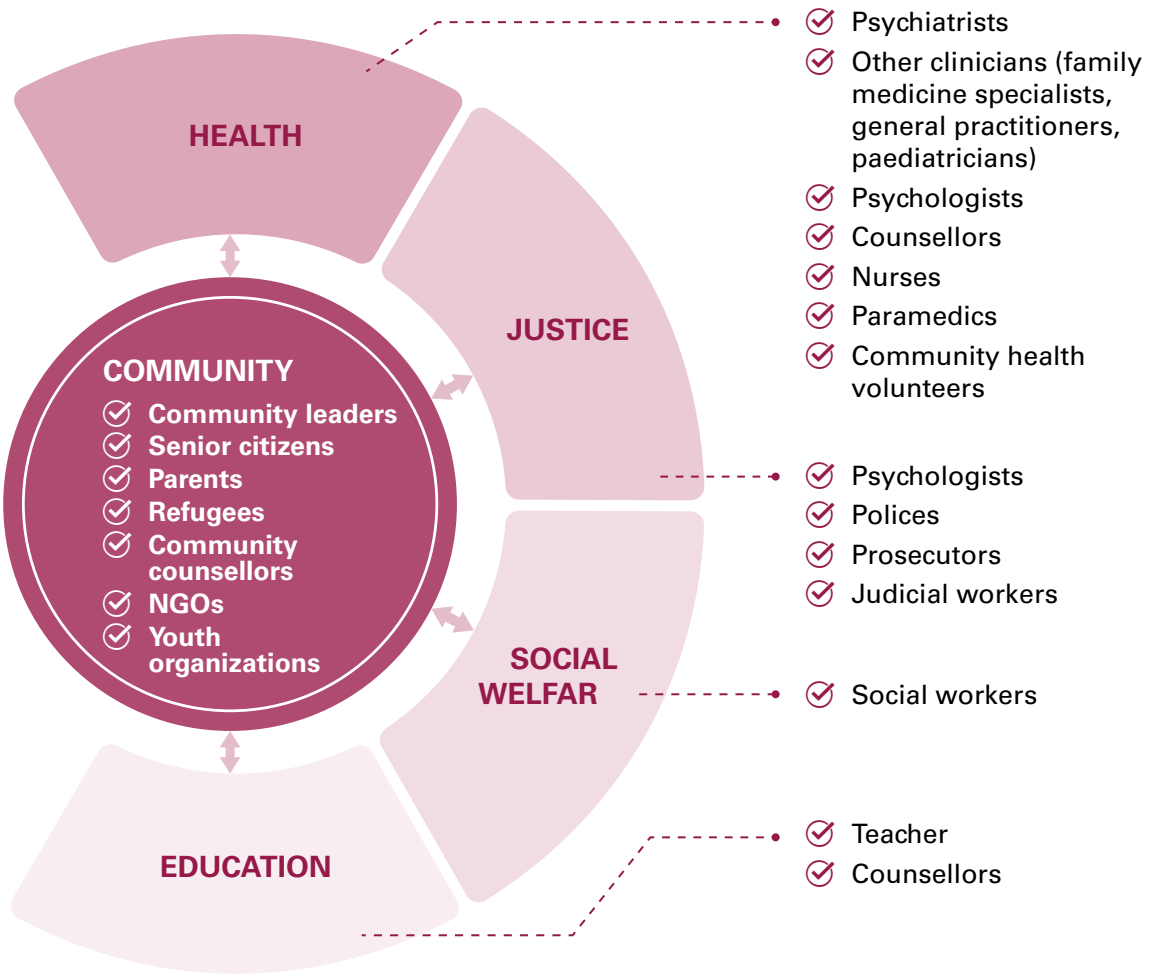
Figure 17. Key tiers of the workforce required to ensure MHPSS



The current MHPSS workforce

In Malaysia, the MHPSS workforce includes public, private and non-government actors across the health, education, social welfare/child protection, justice and community sectors (see Figure 18). All sectors identified workforce shortages as a major challenge impacting on implementation of MHPSS policies and programmes. Limited numbers of professionals trained to deliver components of MHPSS (such as health professionals, teachers, school counsellors, social workers and psychologists) contribute to constraints on service delivery, very high caseloads and over-reliance on tertiary services leading to referral bottlenecks and delayed access to care. To address inequity in access to MHPSS, there is also a need to consider the skills mix and distribution of the workforce as well as the need for collaborative and multidisciplinary teams. In addition to increasing the number of skilled providers in rural areas, stakeholders also emphasized the need for providers with diverse gender, disability, ethnic and cultural backgrounds so that communities have access to an appropriate and trusted provider.

FIGURE 18. MULTISECTORAL MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT WORKFORCE



Recommended roles for the MHPSS workforce

Many priority MHPSS actions are already integrated into existing workforce roles, although providers' capacity to carry out these roles is hampered by the challenges noted above. Table 7 outlines key recommended roles by sector.

Within the **health sector**, specialist clinicians have primary responsibility for delivery of responsive care (screening, referral and clinical care). Malaysia currently has 1.27 psychiatrists per 100,000 population,[23] compared to the upper-middle-income country average of 2.03.[15,17] The number of psychologists is 1.03 per 100,000, compared to the upper-middle-income country average of 1.47. There are only 0.07 child psychiatrists per 100,000 and 6.84 mental health nurses per 100,000 in Malaysia.[15] Aside from these specialist clinicians, paediatricians, family medicine specialists and general practitioners also provide MHPSS responsive care to children and adolescents. Furthermore, nurses and assistant medical officers are also a part of the clinical team providing MHPSS. To address constraints in specialist provider availability, stakeholders recommended improving training and support to non-specialist providers (including mental health volunteers) to provide MHPSS, noting that most children and adolescents do not require highly specialized care, but could be better managed at primary level by trained providers supported by specialists as needed.

Within the **education sector**, teachers and counsellors currently perform screening for common mental health conditions. Through screening for learning difficulties (the Literation and Numeration Screening – LINUS programme), teachers can opportunistically detect underlying mental health conditions. School-based counsellors have also been trained to use age-validated screening tools. Counsellors provide counselling or refer to psychologists or psychiatrists for more complex clinical cases. Teachers are also the primary providers of education related to mental health, although the need for standardized curricula and teaching aids to support this was noted as a key challenge. To better support teachers and counsellors, stakeholders recommended establishing a collaborative programme whereby a psychiatrist and/or psychologist is assigned to be in charge of the schools under a particular district so that the schools have direct access to them for consultation or referral regarding children with potential mental health conditions. However, to achieve this, the number of mental health experts dealing with adolescents and children needs to be increased, especially in the public health sector.

Within the **social welfare sector**, social workers and psychologists encompass a broad workforce in Malaysia, providing case management of children and adolescents within the social welfare system. Social workers are primarily employed by the Ministry of Women, Family and Community Development (national level) and by the Department of Social Welfare at subnational levels. However, they also work within health (e.g., hospitals) and justice settings and are employed through NGOs. Accurate data regarding the total size of the social welfare workforce are lacking. However, in 2018 it was estimated that there were around 3,352 social workers employed across child protection, justice and anti-trafficking programmes. An estimated 236 were directly engaged in child protection and 183 in managing children within the justice system.[67] Social workers supervise children and adolescents in their daily activities to promote life skills, independence and resilience. Psychologists are responsible for the screening of mental health problems and providing initial treatments such as psychological first aid and counselling. Non-government volunteers also play a crucial role in tele-counselling by operating helplines and they also participate in community programmes to reach vulnerable populations to deliver MHPSS. One stakeholder highlighted a challenge noted for social workers at social welfare homes that also applies to the MHPSS workforce at large. It regards work-life balance and the general well-being of the MHPSS workforce while caring for the mental health of their clients.

> *"**…we find that our staff working at social welfare homes themselves are experiencing distress**...because they have two shifts, but their shift starts as early as 6.00 a.m., so their own welfare they cannot manage well."*—A social welfare sector informant

Within the **justice sector**, there are psychologists from Section D11 (Sexual, Women and Children Investigation) of the Royal Malaysia Police that provide responsive care and prevention for children and adolescents. Although their main focus is on victims, suspects and witnesses of crimes within the justice system, their services are also open to the public. They provide screening and counselling, while referring to clinical psychologists or psychiatrists for more complex cases. They also actively engage with schools to deliver MHPSS education and information. A challenge identified by stakeholders is that the public is not aware that they can access MHPSS services at the police station. This is because of the stigma associated with seeing a psychologist at a police station, with connotations of criminality. Nonetheless, through their outreach programmes at schools, these psychologists continue to encourage parents and students to use the MHPSS services that they offer.

Table 7. Overview of key MHPSS roles, by sector

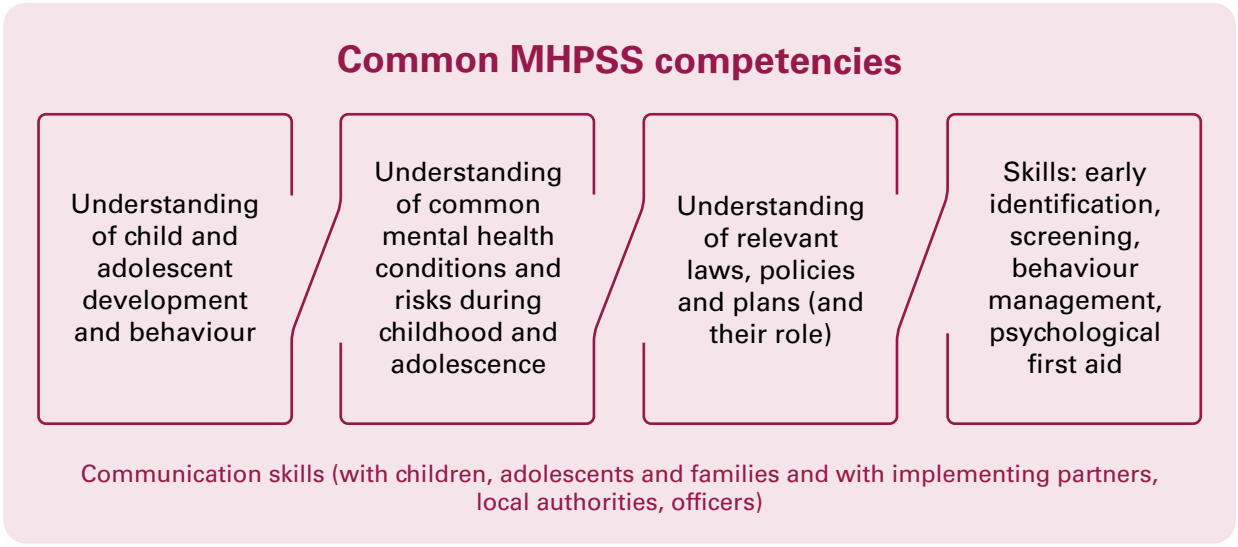
Sector	Provider	Responsive care	Prevention	Promotion
Health	Specialist mental health clinicians	Screening, diagnosis and management as part of a multidisciplinary team	Targeted interventions to address risks (e.g., harmful substance use) Supporting school-based approaches	
	Other clinicians	Screening,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

Sector	Provider	Responsive care	Prevention	Promotion
Social welfare and child protection	Social workers/ community development officers	Early identification, screening and referral of children and adolescents at increased risk Management as part of a multidisciplinary team (facility, residential and community-based)	Parenting programmes (universal) and support to families in need (targeted) Other targeted interventions to address risks	Mental health literacy and programmes to address stigma and discrimination Social protection programmes for children and families
Justice	Police, court psychologists and other frontline justice workers	Early identification and referral for screening, diagnosis and management	Targeted interventions and follow-up of children, adolescents and families at risk (including meaningful skills training for young offenders)	
Community	Youth leaders, community leaders, community-based organizations	Early identification and mental health first aid	Promoting positive peer relationships, positive parenting, and support to community-based interventions	Mental health literacy and programmes to address stigma and discrimination

Competencies, training and support

Stakeholders identified the common competencies required of the multisectoral MHPSS workforce (see Figure 19). Particular emphasis was placed on improving understanding of child and adolescent mental health and related behaviours, as well as specific skills in relation to screening, managing difficult behaviour and dealing with crisis (including psychological first aid).

FIGURE 19. COMMON CROSS-SECTORAL MHPSS COMPETENCIES



Specialist training programmes for **health sector** clinicians is relatively well established in Malaysia. Postgraduate psychiatry training is monitored by the Ministry of Health and a Conjoint Board.[71] Two parallel pathways exist for postgraduate training – a postgraduate Masters programme in psychiatry and the Member of the Royal College of Psychiatrists (MRCPsych) qualification.[71] To be able to practice, psychiatrists are required to register with the Malaysia Medical Council and National Specialist Register. Another cadre of the MHPSS workforce in the health sector consists of clinical psychologists. They are trained in specialized postgraduate courses to obtain a qualification in clinical psychology[72] and are regulated by the Allied Health Professions Act (Act 774).

For the **education sector**, limited teacher training in mental health and well-being has contributed to low awareness of mental health, lack of recognition of mental health conditions and behavioural problems, and limited skills in positive behavioural management. Additionally, stakeholders noted that there are no specific guidelines for school counsellors for continuous professional development. Stakeholders recommended that all teachers receive training in mental health skills to support children with developmental disorders, learning difficulties and other needs; and improved skills in early identification of mental health conditions (including training in the use of screening tools). To facilitate this, it was recommended that a specific mental health committee be established within the Ministry of Education with responsibility for training, support and supervision of teachers and counsellors. Another recommendation was establishing a policy to support the professionalization, quality and oversight of counsellors within the Malaysian Counselling Board. It was further recommended that the education sector work in collaboration with the Ministry of Health to support continuous training for counsellors and teachers.

Training and education of the **social service workforce** is fragmented, with no national requirement for a specific education or qualification. Some social workers have degrees in social work (offered by seven universities) or other social sciences, while others have non-related degrees or qualifications. Assistant social welfare officers have diploma-level training, which may or may not be in relevant fields or disciplines. There is currently no systematic programme to integrate child protection or mental health into training of the social welfare workforce. The Malaysian Association of Social Work has developed a definition of social work and a code of ethics; however, there is no specific legislation supporting the professionalization of this workforce. Like the **justice sector**, psychologists within social welfare and justice settings primarily receive in-service training, although this is not standardized. Stakeholders recommended incorporating mental health into the pre- and in-service training of teachers, social workers, police and other justice sector workers, as well as greater collaboration with the Ministry of Health to support continuous development and access to mental health training for those with specific MHPSS roles.

There were also recommendations to improve support for and supervision of the mental health workforce. These included establishing cross-sectoral, multidisciplinary teams at implementation level, particularly to improve support for and supervision of non-specialist providers (such as linking teachers and social workers to psychologists and psychiatrists), incentives to work in MHPSS (such as free training); and increasing the salary and remuneration of social workers, psychologists and others engaged in mental health and child protection to attract skilled and dedicated workers and improve retention and motivation. Establishing workforce networks, such as school counsellor networks, was also recommended to encourage the sharing of knowledge, experience and support. Attention to the mental health needs of providers is also needed, reflecting the often stressful and sometimes distressing roles required. Stakeholders further recommended providing mental health training to communities (including community leaders, religious leaders, parents and refugees) to support implementation of community-based actions, such as improving awareness, addressing stigma and providing psychological first aid, to improve accessibility.

Overall, greater coordination across sectors to map the mental health workforce, roles and competencies is needed to support workforce planning – including training, supportive supervision, distribution and collaboration through multidisciplinary teams at a local level.

KEY RECOMMENDATIONS – MENTAL HEALTH WORKFORCE:

- Improve collaboration across sectors at national level to facilitate development, planning and support of the mental health workforce. This could include establishing committees within sectors (e.g., Ministry of Education) to oversee mental health workforce training and support, in collaboration with the Ministry of Health.
- Undertake further detailed mapping of the multisectoral mental health workforce and existing mental health competencies to identify gaps (numbers, skills, distribution).
- Integrate and strengthen pre-service mental health training for health, education, social welfare and justice sector providers – including for non-specialist providers.
- Provide updated in-service training for non-specialist health providers, teachers, counsellors, psychologists, social workers and police aligned with clearly defined MHPSS roles and ensure that this training in ongoing to support continuous development (including establishing ongoing training as a requirement for accreditation).
- Provide opportunities for mental health training for community members to support mental health awareness.
- Establish steps to support professionalization of the social service workforce (this could also include school counsellors).
- Strengthen job aids, tools and protocols to support key MHPSS roles (screening, referral, behaviour management and mental health first aid).
- More explicitly integrate MHPSS actions into the defined roles and performance indicators of key cadres (teachers, counsellors, social workers and justice officers).
- Improve remuneration and job security/career pathways for social workers, psychologists and other mental health professionals.
- Establish mechanisms for support supervision of the mental health workforce through multidisciplinary teams, support networks and services and supports to address the mental health of providers.

Budget and financing

Malaysia's public health system is financed mainly through general revenue and taxation collected by the federal Government, while the private sector is funded through private health insurance and out-of-pocket payments from consumers. Spending on health (at 4.3 per cent of GDP in 2019) remains below the average for upper-middle-income countries (at 5.85 per cent of GDP in 2019).[73,74] Public sources of financing account for 52 per cent of total health expenditure. The main sources of total health expenditure in 2019 were the Ministry of Health (45 per cent), followed by household out-of-pocket expenditure at 35 per cent.[73]

The WHO has estimated global average spending on mental health at 2.1 per cent of a country's national health budget,[75] which may be viewed as a sufficient national budget allocation for mental health. Meanwhile, government expenditure on mental health in Malaysia in 2017 was estimated to be 1.3 per cent of total health expenditure.[76] For the 2022 budget, the Malaysian Government has allocated a total of RM319 million (out of RM32.4 billion, or 0.98 per cent) on estimated operational expenditure which covers emoluments, services and supplies for mental health services under the Ministry of Health.[77,78] An additional RM70 million was also allocated to address mental health issues by strengthening support, counselling and psychosocial services, and to increase advocacy programmes and strengthen the role of NGOs as drivers of mental health programmes.[77] The total budget of RM389 million (1.2 per cent) for mental health in 2022 is markedly less than the WHO global benchmark.[75,77,78] There must also be greater expenditure on the psychosocial aspects (non-healthcare determinants) of mental health such as mental health literacy, living and working conditions, adequate income and wages, food security and physical activity. This can be achieved through investment in public health services and engagement with various stakeholders such as other ministries and community leaders to form a 'whole of society' approach.

Apart from government sources, funding is also provided through NGOs (financed by international or local donors), private foundations, corporate social responsibility programmes and through user out-of-pocket fees. Additionally, NGOs may be financed through state government funding. There are limited data on other sectors' spending on MHPSS-related services and programmes. However, stakeholders across sectors emphasized that current budgets were insufficient to support implementation, particularly with increasing demand for MHPSS as a result of COVID-19. Furthermore, stakeholders noted that budget processes are complex and cross-sectoral coordination limited, leading to a lack of cross-sectoral planning and budgeting, although some stakeholders indicated that there is some flexibility within sectors to reallocate non-MHPSS funding to support MHPSS programmes. In the absence of a detailed, costed, multisectoral mental health plan that clearly defines the roles and responsibilities of each sector, accurately apportioning the human and other resources required to implement MHPSS is a challenge. This is particularly so for programmes, services and supports provided outside the health sector.

KEY RECOMMENDATIONS – BUDGET AND FINANCIAL RESOURCES:

- Aim for MHPSS budget allocation of 2.1 per cent of the national health budget.
- Include mental health services (including outpatient services) within national insurance schemes.
- Include a national mental health goal in social and economic plans and/or as a primary programme within the Ministry of Health.
- Define a detailed minimum-services package for child and adolescent mental health (based on the tiered framework of actions) addressing responsive care, prevention and promotion that can be costed, with budget responsibility across key sectors clearly defined.
- Establish a national, cross-sectoral planning body and cross-sectoral budgeting committees for MHPSS to support efficient and coordinated budget requests and processes.
- Increase support for subnational and local government units to improve resource allocation for implementation of MHPSS.
- Consider establishing a public fund to provide additional funding for prevention, promotion, research and innovation with respect to mental health.

Participation

Mental health-related stigma, discrimination and lack of mental health literacy are major barriers to seeking support and services. Stigma and misconceptions were described as contributing to a lack of care-seeking by parents, who preferred to keep mental health conditions to themselves and address them privately. Misunderstandings and misconceptions about mental health and behaviour are also common, with teachers and parents dismissing signs of poor mental health as attention-seeking or misbehaviour. Limited mental health literacy among children, adolescents and their parents/carers also contributes to delays in care-seeking and the underutilization of available supports and services.

Engaging communities and strengthening the participation of children, adolescents and families is central to ensuring that policies, programmes and services respond to their needs and address barriers. According to stakeholders, further research and consultation are needed with children, adolescents and families (including marginalized and underserved groups) to understand the specific barriers and needs in relation to MHPSS to directly inform policies, programmes and services. Stakeholders particularly emphasized the need to improve mechanisms to engage migrants, refugees, out-of-school children and adolescents and those with disabilities, in policy and programme design. Youth participation (including young people with lived experience) was also seen as essential to developing policies and programmes that effectively respond to needs.

To support greater participation and engagement, stakeholders made a number of recommendations. At a national level, it was suggested that young people should have a formal role in the recently established NCMW. The NCMW came into being "to provide sustainable solutions to the possible long term mental health impact of COVID-19".[79] The coalition was initiated by Rotary Malaysia and its members include organizations such as the Malaysia Mental Health Association, Malaysian Psychiatric Association, Ministry of Health, WHO and UNICEF, among others. In addition to supporting planning, monitoring, evaluation and feedback on a national plan of action for mental health, the NCMW also provides a platform to discuss mental health issues beyond COVID-19. It was also recommended that key sectors more proactively seek the input and feedback of communities and young people by holding community meetings or 'roadshows' to explore mental health and MHPSS priorities.

At local level, stakeholders also recommended establishing community-based centres for children and adolescents that offer a safe space, opportunities to provide MHPSS information and services, and capacity building for young people (including in social and emotional skills), and are places where youth leadership could be supported and engaged in programme design. In addition to parenting programmes to improve parent/caregiver skills and mental health literacy, it was also recommended that parents be engaged in the design and delivery of MHPSS programmes. Parent-teacher associations were identified by multiple sectors as an underutilized platform for supporting parent engagement – to obtain input and feedback, support delivery of MHPSS programmes (such as mental health awareness) and build more effective linkages between communities, families and schools for MHPSS.

Strengthening mechanisms for community feedback and monitoring both at service-delivery level (e.g., health facilities) through to subnational and national government bodies responsible for mental health is also important. An accessible and responsive system to support feedback and complaints in relation to mental health services is needed. There is a national independent body to assess mental health facilities with respect to compliance with mental health legislation. Currently, a Public Complaint Management System exists to receive feedback regarding the healthcare services provided by the Ministry of Health. However, there is no such mechanism to cover the entire country (to include both public and private health systems) and that is specific to MHPSS.

KEY RECOMMENDATIONS – PARTICIPATION:

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

Data, health information and research

All stakeholders identified an urgent need to improve data and information systems related to MHPSS among children and adolescents. At a national level, timely and reliable statistics (disaggregated by location, age and sex) related to the prevalence of common mental health conditions and risks is needed to inform policies and support prioritization and implementation plans, and budgeting. These include estimates of common mental disorders (depression, anxiety, developmental disorders, psychosis), suicide rates, psychological distress and behavioural problems, key risk factors (substance use, bullying, violence, adolescent pregnancy), and population and service delivery data (such as the number of families requiring social welfare). Ensuring that data include marginalized populations was also identified as a key need, with capacity to identify those with the greatest needs or most underserved, and to monitor equity. Additionally, data on the impacts of COVID-19 were identified as a key short-term priority. Some data are collected through existing household surveys (such as the NHMS) and it was noted that mental health indicators also need to be integrated into routine information systems – for example, by re-establishing a national suicide surveillance system.

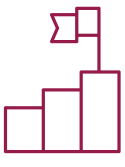
Stakeholders also highlighted the need to include mental health indicators in the routine data collection of sectors outside health and to improve the sharing of data within and between sectors to support planning and implementation. For example, enabling the timely sharing of data collected through the education, social welfare and justice sectors with multidisciplinary teams, for instance through data linkage, would improve the identification, planning and follow-up of children and families at risk. Currently, there are no mechanisms to collate, manage or share data efficiently between sectors. Establishing a multisectoral mental health information system that includes relevant government, private sector and NGO providers was a high priority, as was building a user-friendly platform to enable access to timely and relevant data. Stakeholders recommended the development of a common system that could function as a one-stop centre for data collection and sharing as well as for case management. The information provided should also be in a simplified version so that it can be easily understood by all key agencies, with a standardized approach to data collection (indicators, format, disaggregation) across agencies. Many stakeholders also recommended that additional and dedicated resources (financial and human resources) be provided to support information systems, rather than relying on frontline providers (such as doctors, nurses, teachers and social workers) to maintain systems and enter data.

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

Research priorities include: further studies to understand the needs, barriers and service-delivery preferences of children and adolescents; studies to determine the effectiveness of specific MHPSS interventions; and implementation research to understand effective models of service delivery. Building local research capacity was identified as key to supporting impactful research.

KEY RECOMMENDATIONS – DATA, INFORMATION AND RESEARCH:

- Establish a national suicide and self-harm surveillance system.
- Establish a child protection information management system that is accessible within and across sectors.
- Include mental health indicators in routine health information systems and provide age and sex-disaggregated data.
- Integrate child and adolescent mental health indicators into the routine information systems of the education, social welfare and justice sectors.
- Improve mechanisms for timely analysis, reporting and sharing of data within and across sectors to support implementation of MHPSS and continuity of care for those at risk.
- Establish a user-friendly platform 'one-stop shop' across sectors, to enable harmonized collection, use and sharing of data.
- Invest in further research and support local research capacity to understand demand-side needs, barriers and service-delivery preferences and build the evidence for specific actions and effective implementation models



Key recommendations and conclusions

Children and adolescents aged 0–18 years in Malaysia experience a high burden of poor mental health. Around 1 in 8 adolescents aged 10–19 and 1 in 20 children aged 5–9 are estimated to have a mental disorder (including developmental disorder). Suicide is the second leading cause of death for adolescents aged 15–19. Risk factors for poor mental health, including exposure to violence, peer victimization and bullying, loneliness and social isolation, particularly in the context of COVID-19, are also prevalent.

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

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

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

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

1. At national level, the Mental Health Act should be strengthened to more clearly articulate the specific considerations and protections for children and adolescents, including those within the mental health system. Consideration should also be given to developing a specific multisectoral child and adolescent mental health strategy that more clearly articulates the MHPSS actions across the three tiers of responsive care, prevention and promotion, and details a multisectoral plan (and coordination structure) for implementation, including cross-sectoral performance indicators and the clear roles, responsibilities and accountabilities of key sectors.

2. The Government should strengthen legislative protections for children and adolescents (including prohibiting corporal punishment, decriminalizing suicide, addressing discrimination, increasing protections within justice and institutional settings), and address legislative barriers to accessing MHPSS (such as mandatory parental consent and barriers for undocumented migrants).
3. Under the leadership of the Ministry of Health, a national, multisectoral steering committee for child and adolescent mental health should be established, with responsibility for coordinating policy, implementation and accountability.
4. Under the Ministry of Health, a cross-sectoral, independent monitoring body should be established to assess quality, compliance and performance of MHPSS programmes and services.
5. At district level, the state government should support district offices to develop local, multisectoral implementation plans, resource allocation and coordination for MHPSS. To support this, consider establishing district-level multisectoral subcommittees for mental health and provide capacity building for district-level decision-makers in mental health.
6. The Ministry of Health, in consultation with other sectors and technical partners, should strengthen national, standardized protocols for child and adolescent health across agencies, including:
    a. Early identification protocols and validated screening tools for this age group and detailed guidance on their use in different settings (including consideration of the potential harms of screening);
    b. Referral procedures across sectors;
    c. Non-specialist management;
    d. Case management of children and adolescents engaged in the child protection and justice sectors;
    e. Greater protections for children in conflict with the law and child victims within the justice system; and
    f. National quality service standards for child and adolescent mental health services across sectors.
7. The Government should include mental health services (including outpatient services) within the national health insurance programme and increase public resource allocation for mental health across the tiers of care, prevention and promotion. To support this, consideration should be given to including mental health as a primary programme, and a minimum-services package (based on the regional framework) should be defined and costed, with budget allocation and responsibility clearly defined across key sectors. The Government could also consider establishing a national, cross-sectoral body or budget committee on MHPSS to support coordinated and comprehensive budget requests that align with national MHPSS goals.
8. The Government, with support from professional associations, training institutions and development partners, should strengthen the multisectoral MHPSS workforce through:
    a. Further in-depth mapping to identify key roles across sectors against the MHPSS priority actions and the required competencies and inter-sectoral training needs to support these roles;
    b. Development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for key providers across sectors;
    c. Integration of child and adolescent development and mental health into the pre-service training of health professionals, the social service workforce, justice sector workers, teachers and other school-based staff, in alignment with the roles and responsibilities with respect to MHPSS;
    d. Strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers), social service workers, justice sector workers, teachers and education staff that is competency-based and aligned with expected MHPSS roles;

e. Training provided to relevant ministry-level staff from the health, education, social welfare and justice sectors to support planning and development of the workforce as well as broader MHPSS programmes;

f. Expansion of the number of posts at national and subnational levels; and

g. Improved supervision and support for MHPSS providers across sectors, including establishing provider support networks and multidisciplinary teams, improved remuneration, job security and career pathways, and attention to the mental health needs of providers themselves

9. The Ministry of Health, in consultation with other key sectors and academic and development partners, should improve the collection, use and accessibility of data at national and subnational levels – including data to identify mental health needs, support planning and implementation, and track progress. This should include the development of a minimum set of MHPSS-related indicators harmonized across sectors, including performance indicators related to multisectoral collaboration and development of user-friendly platforms (such as a data dashboard) to improve the access of service providers and communities to mental health data.
10. The Government, development partners and NGOs should increase opportunities for children and adolescents to participate in MHPSS policy and programming, including establishing more formal roles for young people (such as representation on the National Coalition for Mental Well-being, or national steering committee). The Ministry of Health should also improve child- and adolescent-friendly mechanisms for providing feedback on MHPSS programmes and mental health services.
11. The Government, development partners and NGOs should expedite the process of systematic decentralization of mental healthcare to community-based MHPSS by expanding national and community-based programmes to address mental health- related stigma and discrimination and improve mental health literacy (particularly aimed at children, adolescents and parents/caregivers).
12. The Government, development partners and NGOs should focus on expanding inter-agency collaboration as well as the monitoring and evaluation of implementation, outcomes and the impact of mental health programmes, including improved data and information sharing through digital platforms.

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Appendix A:
Workshop agenda, prioritization tool and interview guide

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

Programme outline

Day one

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

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

Day two

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

Example of the online prioritization tool

MHPSS Prioritisation Tool

Thank you for participating in this online consultation.

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

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

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

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

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

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

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Demographics

Which country do you work in?
* must provide value

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

reset

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

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

reset

What organisation do you represent?
* must provide value

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

reset

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

Specific action required

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

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

- (●) High
- ( ) Medium
- ( ) Low

reset

Who should be the lead sector?

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

reset

What other sectors should play a role in this action?

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

Is this action already being implemented?

- ( ) Yes
- ( ) No

reset

What is your suggested timeline for implementation?

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

reset

Any challenges or considerations in implementing this action?

Expand

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Translational workshopimplementing mental health and psychosocial support services (mhpss) for children and adolescents in east asia and the pacific region 14 december 2021

Programme outline

objectives:

1. To present key findings of the MHPSS project
2. Co-develop final recommendations for implementation of MHPSS

Proposed participants:

- Country TAG members
- UNICEF
- Youth representatives
- Additional government and non-government stakeholders from sectors under-represented in the country TAG

Time	Activity	Facilitator	Notes
Session A: Introduction			
8.55–9.00 a.m.	Hotel safety briefing	Dorsett Hotel staff	
9:00 – 9:15 a.m.	Welcome remarks and introductions	UNICEF / Country TAG co-chairs	
9.15–9.25 a.m.	Welcome remarks from the Director of ICR	Dr. Kalaiarasu M. Peariasamy	
9:25 – 9:40 a.m.	Overview of the project (aims, approach) and objectives of this workshop	Burnet	Recap the project aims, methods, and purpose of the workshop – emphasizing that this is a participatory workshop to develop and refine recommendations
Session B: Matching actions to needs			
9:40 – 10:30 a.m.	Presentation of key findings: • Research chronology • Mental health needs • Current response • Overview of priority actions: – Accessible and responsive services for mental health problems – Prevention of mental health problems – Mental health promotion	Country research lead	20-minute presentation of key findings, followed by 20 minutes for general questions/ feedback (noting there will be time to explore areas in more detail during the rest of the workshop)

Time	Activity	Facilitator	Notes
	• Overview of key findings on challenges and considerations for systems strengthening *Questions and reflections*		
10.30 – 10.45 a.m.	**BREAK**		
Session C: Deep dive on priority actions and implementation			
10:45 a.m. – 12.30 p.m.	**Group activity:** 1. **Group A:** Accessible and responsive services for mental health problems: screening, referral pathways, multidisciplinary care AND systems strengthening 2. **Group B:** Prevention of mental health problems: building skills (early childhood, schools, online), addressing risk factors AND system strengthening 3. **Group C:** Mental health promotion: community engagement and participation; and policy and legislation AND system strengthening	Country research team/ Stakeholders	
12.30 – 1.00 p.m.	**Sharing of experience (NGOs, youth, justice)**		
1.00 – 2.30 p.m.	**LUNCH BREAK**		
SESSION D: Group presentation			
2:30 – 3:15 p.m.	Group A presentation	Country research team/ Stakeholders	
3:15 – 4:00 p.m.	Group B presentation	Country research team/ Stakeholders	
4.00 – 4.15 p.m.	**Tea Break**		
4.15 – 5.00 p.m.	Group C presentation	Country research team/ Stakeholders	
Session E: Wrap up and next steps			
5:00 – 5:15 p.m.	Questions, reflections, feedback Next steps	Country research lead	
5:15 – 5:30 p.m.	Close workshop	UNICEF/TAG co-chairs	

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

Key informant interview

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

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

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

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

The session today will take approximately 60 to 90 minutes.

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

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

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

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

Question guide:

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

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

Theme	Questions

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

Barriers and enablers to providing current MHPSS	**I would like to ask now about what has been working well, and what some of the challenges have been in delivering MHPSS for children and adolescents** • What do you think is currently being done well to address the mental health of children and adolescents by your sector/organization? • What could be improved or strengthened? • What are the gaps (what specific areas of mental health and well-being aren't being addressed)?

Theme	Questions
	• What are the main challenges currently impacting on the delivery of MHPSS through your sector/organization? For example: – Lack of understanding or prioritization of mental health – Community/parent attitudes and norms/social taboos – Funding and other resources for MHPSS – Existence of nationally mandated programmes that include MHPSS – Mental health worker training and education – Linkages and coordination with other sectors (social welfare, education, health services, NGOs, etc) – Information sharing within your sector/organization and across sectors/organizations
What role *should* the social welfare sector have in implementing MHPSS and minimum-services package	**I would like to ask you now about what roles and responsibilities your sector/organization *should* have in MHPSS for children and adolescents** • Broadly speaking, what do you think the role of your sector/organization should be in implementing MHPSS? How is this different to the current roles we have already discussed? • Reflecting on the different 'tiers' of MHPSS, what role should your sector/organization have in: – Responsive care for children and adolescents with mental health problems – Prevention of mental health problems – Creating an enabling environment to promote good mental health *You can refer to figure A1 and table A1 in the conceptual framework* **I would like to ask you now about the specific MHPSS actions or services that your sector/organization should have responsibility for. This minimum-services package for MHPSS has been proposed by stakeholders across different sectors in [YOUR COUNTRY]** • Are there any actions that you think are missing? • What actions do you think your sector/organization should have primary responsibility for, and why? • Which of these would be feasible for your sector/organization to deliver, and why? • How could they be delivered? – What mechanisms currently exist to support implementation of these MHPSS actions? (what existing programmes or services could MHPSS be integrated with, what existing workforce could deliver MHPSS actions) – Do new delivery mechanisms or systems need to be developed? • What actions do you think your sector/organization could contribute to (if not primary responsibility), and how (linkages with other sectors etc)?

Theme	Questions
Challenges and considerations for implementation of a minimum-services package and strengthening a multisectoral mental health system	**I would like to ask you about how the MHPSS actions proposed in the minimum-services package could be effectively implemented. In particular I would like to ask about what frameworks, structures, resources or supports your sector/organization would need to strengthen implementation** **Legislation and policy** • What additional policies are needed to support the delivery of MHPSS? • What legislation or regulation changes are needed? • *[consider: sector-specific policies to enable delivery of MHPSS, multisectoral mental health policies that clearly define sectoral roles]* **Governance and leadership** • What government or non-government agency(ies) should have primary responsibility for implementation of MHPSS? – Planning – Implementation – Monitoring • What role in leadership or governance do you think your sector/organization should have, and why? • How could coordination be improved within your sector/organization (planning, implementation, monitoring)? • How could coordination with other sectors (health, education, justice, social welfare) and with NGOs and the private sector be improved? • What role should other sectors have in implementation of MHPSS? • What role should UNICEF have in supporting MHPSS? • What role should the private sector have in supporting or delivering MHPSS? • What role should NGOs have in supporting or delivering MHPSS? **Services** • How could MHPSS be integrated with existing services or programmes for children and adolescents? • What new services or programmes might be needed? • Are there systems or structure changes needed within this sector/organization to take on these roles and implementation of MHPSS? • What tools, resources or supports would be needed? • Is there an opportunity for online or digital delivery of MHPSS? • What actions are needed to ensure that children, adolescents and parents/carers have access to these services/supports? What actions are needed to reach the most underserved children and adolescents?

Theme	Questions
	Standards and oversight • What national standards, guidelines or other tools currently exist to support the delivery of MHPSS? How could these be improved? What additional guidance is needed? [Consider: new procedures, SOPs, programmes, referral mechanisms, etc] • What further actions are needed with respect to accreditation or certification of workers who are engaged in delivering MHPSS? • How should the quality of MHPSS be monitored and assessed? By who? **Resources** *Financial* • How are current (or planned) MHPSS delivered by your sector/ organization currently funded? – If government organization: » Are national policies or programmes that relate to MHPSS costed? » What is the source of the budget (through a specific programme, specific budget line, etc)? » To what extent does the budget include contributions from user fees, sponsor contributions, in-kind contributions, private sector/local business support? » Are MHPSS funded through national or district/local government? » How are the staff who deliver MHPSS funded? » How is infrastructure for MHPSS funded? – If non-gov/private/UN » Are MHPSS plans or programmes costed? » What is the source of budget for these? » To what extent does it include user fees, private sector support, government funding, other? • What additional financial resources would be required to support MHPSS? Where should these come from? *Workforce* • What additional human resources are required for MHPSS? • What 'types' of MHPSS providers are needed in your sector/ organization? With what competencies? • Can MHPSS be integrated into existing roles and/or are new roles needed? • What additional training is needed? For who? Who should provide this? • What supportive supervision is needed? • What job aids or other resources are needed? • What requirement or role might there be for professional associations for MHPSS workers in your sector/organization? • How could linkages with other MHPSS providers (health workers, teachers, social workers) be improved to support delivery of MHPSS?

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

Appendix B:
Development of the conceptual framework

The approach to development of the project conceptual framework was consultative and iterative, as explained below.

Synthesis of the available evidence

An important foundation to this work was the framing of mental health and well-being in UNICEF's *The State of the World's Children 2021* report.[2] One of the core messages in the report is to consider the 'spheres of influence' that shape mental health and well-being from an early age. The key spheres are 'the world of the child' (focusing on home and caregiving settings), 'the world around the child' (involving healthy attachments in schools and communities) and 'the world at large' (including large-scale social determinants such as poverty and conflict). In a related commentary co-authored by UNICEF, opportunities to intervene were broadly mapped against these spheres of influence:[10] mental health promotion is largely aimed at the social determinants of health which impact on the world of the child, with preventive and treatment services more targeted towards the world of and around the child. The following additional documents and resources were reviewed in drafting the conceptual framework: UNICEF reports focusing on MHPSS; [11–14] WHO guidelines related to mental health;[15–19] the Lancet Commissions on Global Mental Health and Sustainable Development, and on Adolescent Health and Well-being;[20,21] UN guidance on social and emotional learning;[22,23] and available country-level operational guidance on implementation of MHPSS from both high-income settings[24–26] and available guidance from focal countries for this project (Thailand and the Philippines).[27–31] The draft framework considered the context of the region and in particular the experience and capacity of key sectors to implement MHPSS.

Review by the Regional Technical Advisory Group

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

Additional review by content experts

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

Finally, extensive feedback was sought from country-level stakeholders during an online, two-day workshop in each focal country.

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

Appendix C:
National-level data on mental health outcomes and risks

Mental health outcomes

Indicator	Sex	Age group	Residence	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of depressive disorders	Female	5 to 9		0.11	0.11	0.11	GBD	2019
	Male	5 to 9		0.06	0.06	0.06		2019
	Both	5 to 9		0.08	0.08	0.08		2019
	Female	10 to 14		2.60	2.60	2.60		2019
	Male	10 to 14		1.77	1.77	1.77		2019
	Both	10 to 14		2.19	2.19	2.19		2019
	Female	15 to 19		5.20	5.20	5.20		2019
	Male	15 to 19		4.02	4.02	4.02		2019
	Both	15 to 19		4.61	4.61	4.61		2019
Prevalence of bipolar disorder	Female	10 to 14		0.10	0.10	0.10	GBD	2019
	Male	10 to 14		0.11	0.11	0.11		2019
	Both	10 to 14		0.10	0.10	0.10		2019
	Female	15 to 19		0.36	0.36	0.36		2019
	Male	15 to 19		0.36	0.36	0.36		2019
	Both	15 to 19		0.36	0.36	0.36		2019
Prevalence of inability to sleep due to worry so much most of the time or always in the past 12 months	Female	13 to 17		7.70	8.76	6.85	NHMS – Adolescent Health	2017
	Male	13 to 17		6.40	7.21	5.75		2017
	Both	13 to 17		7.10	7.73	6.52		2017
Prevalence of anxiety disorders	Female	1 to 4		0.19	0.19	0.19	GBD	2019
	Male	1 to 4		0.12	0.12	0.12		2019
	Both	1 to 4		0.15	0.15	0.15		2019
	Female	5 to 9		2.27	2.27	2.27		2019
	Male	5 to 9		1.39	1.39	1.39		2019
	Both	5 to 9		1.83	1.83	1.83		2019
	Female	10 to 14		5.45	5.45	5.45		2019

Indicator	Sex	Age group	Residence	Estimate	Upper CI	Lower CI	Data source	Year
	Male	10 to 14		3.45	3.45	3.45		2019
	Both	10 to 14		4.46	4.46	4.46		2019
	Female	15 to 19		6.70	6.70	6.70		2019
	Male	15 to 19		4.10	4.10	4.10		2019
	Both	15 to 19		5.41	5.41	5.41		2019
Prevalence of conduct problems	Female	5 to 15		14.90	17.49	12.67	NHMS	2019
	Male	5 to 15		16.90	19.72	14.43		2019
	Both	5 to 9		15.20	18.03	12.79		2019
	Both	5 to 15		15.90	17.87	14.14		2019
	Both	5 to 15	Urban	15.70	18.14	13.57		2019
	Both	5 to 15	Rural	16.50	19.76	13.61		2019
	Both	10 to 15		16.50	19.23	14.06		2019
Prevalence of idiopathic developmental intellectual disability	Female	1 to 4		0.69	0.69	0.69	GBD	2019
	Male	1 to 4		0.40	0.40	0.40		2019
	Both	1 to 4		0.54	0.54	0.54		2019
	Female	5 to 9		0.81	0.81	0.81		2019
	Male	5 to 9		0.51	0.51	0.51		2019
	Both	5 to 9		0.66	0.66	0.66		2019
	Female	10 to 14		0.74	0.74	0.74		2019
	Male	10 to 14		0.48	0.48	0.48		2019
	Both	10 to 14		0.61	0.61	0.61		2019
	Female	15 to 19		0.66	0.66	0.66		2019
	Male	15 to 19		0.43	0.43	0.43		2019
	Both	15 to 19		0.55	0.55	0.55		2019
Prevalence of schizophrenia	Female	10 to 14		0.01	0.01	0.01	GBD	2019
	Male	10 to 14		0.01	0.01	0.01		2019
	Both	10 to 14		0.01	0.01	0.01		2019
	Female	15 to 19		0.08	0.08	0.08		2019
	Male	15 to 19		0.10	0.10	0.10		2019
	Both	15 to 19		0.09	0.09	0.09		2019
Prevalence of autism spectrum disorders	Female	1 to 4		0.20	0.20	0.20	GBD	2019
	Male	1 to 4		0.69	0.69	0.69		2019
	Both	1 to 4		0.45	0.45	0.45		2019
	Female	5 to 9		0.20	0.20	0.20		2019
	Male	5 to 9		0.68	0.68	0.68		2019

Indicator	Sex	Age group	Residence	Estimate	Upper CI	Lower CI	Data source	Year
	Both	5 to 9		0.44	0.44	0.44		2019
	Female	10 to 14		0.18	0.18	0.18		2019
	Male	10 to 14		0.65	0.65	0.65		2019
	Both	10 to 14		0.41	0.41	0.41		2019
	Female	15 to 19		0.17	0.17	0.17		2019
	Male	15 to 19		0.58	0.58	0.58		2019
	Both	15 to 19		0.38	0.38	0.38		2019
Prevalence of hyperactivity problems	Female	5 to 15		1.70	2.65	1.10	NHMS	2019
	Male	5 to 15		2.90	4.33	1.92		2019
	Both	5 to 9		2.10	3.07	1.43		2019
	Both	5 to 15		2.30	3.12	1.69		2019
	Both	5 to 15	Urban	2.20	3.21	1.44		2019
	Both	5 to 15	Rural	2.70	4.12	1.77		2019
	Both	10 to 15		2.50	3.79	1.60		2019
Prevalence of emotional health problems	Female	5 to 15		9.10	11.15	7.46	NHMS	2019
	Male	5 to 15		7.50	9.64	5.78		2019
	Both	5 to 9		6.40	8.08	5.02		2019
	Both	5 to 15		8.30	9.78	7.04		2019
	Both	5 to 15	Urban	7.90	9.72	6.36		2019
	Both	5 to 15	Rural	9.50	12.00	7.46		2019
	Both	10 to 15		9.90	12.19	7.99		2019
Prevalence of suicidal attempt one or more times in the past 12 months	Female	13 to 17		6.90	7.66	6.18	NHMS – Adolescent Health	2017
	Male	13 to 17		7.00	8.04	6.08		2017
	Both	13 to 17		6.90	7.71	6.24		2017
Mortality rate due to self-harm (deaths per 100,000 population)	Female	15 to 19		1.18	1.92	0.66	GBD	2019
	Male	10 to 14		0.23	0.61	0.10		2019
	Male	15 to 19		4.98	10.38	2.71		2019
	Both	15 to 19		3.13	5.91	1.89		2019
	Female	10 to 14		0.08	0.14	0.04		2019
	Both	10 to 14		0.16	0.35	0.08		2019

Mental health risks

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of lifetime marijuana use	Female	13 to 17	1.10	1.61	0.81	NHMS – Adolescent Health	2017
	Male	13 to 17	4.40	5.33	3.67		
	Both	13 to 17	2.80	3.40	2.30		
Prevalence of lifetime amphetamines or methamphetamines use	Female	13 to 17	1.30	1.72	0.98	NHMS – Adolescent Health	2017
	Male	13 to 17	3.60	4.45	2.93		
	Both	13 to 17	2.40	3.02	1.98		
Prevalence of lifetime drugs use	Female	13 to 17	2.00	2.63	1.57	NHMS – Adolescent Health	2017
	Male	13 to 17	6.60	7.80	5.60		
	Both	13 to 17	4.30	5.08	3.64		
Prevalence of having been bullied on at least one day in the past month	Female	13 to 17	13.70	14.81	12.70	NHMS – Adolescent Health	2017
	Male	13 to 17	18.70	19.99	17.48		
	Both	13 to 17	16.20	17.14	15.28		
Prevalence of physical abuse at home at least once in the past month	Female	13 to 17	11.00	12.23	9.91	NHMS – Adolescent Health	2017
	Male	13 to 17	12.70	14.07	11.37		
	Both	13 to 17	11.80	12.83	10.90		
Prevalence of verbal abuse at home at least once in the past month	Female	13 to 17	49.20	51.11	47.29	NHMS – Adolescent Health	2017
	Male	13 to 17	37.20	38.53	35.79		
	Both	13 to 17	43.20	44.60	41.85		
Prevalence of being physically attacked one or more times in the past 12 months	Female	13 to 17	19.30	21.00	17.78	NHMS – Adolescent Health	2017
	Male	13 to 17	31.40	32.78	30.01		
	Both	13 to 17	25.30	26.50	24.10		
Prevalence of loneliness most of the time or always in the past 12 months	Female	13 to 17	10.80	11.57	10.04	NHMS – Adolescent Health	2017
	Male	13 to 17	7.80	8.58	7.12		
	Both	13 to 17	9.30	9.91	8.75		
Prevalence of suicidal ideation in the past 12 months	Female	13 to 17	10.80	12.00	9.76	NHMS – Adolescent Health	2017
	Male	13 to 17	9.10	10.07	8.27		
	Both	13 to 17	10.00	10.79	9.24		
Prevalence of suicidal plan in the past 12 months	Female	13 to 17	7.80	8.68	7.06	NHMS – Adolescent Health	2017
	Male	13 to 17	6.80	7.87	5.90		
	Both	13 to 17	7.30	8.05	6.67		

unicef

for every child

UNICEF East Asia and Pacific Regional Office (EAPRO)
19 Phra Athit Road
Pranakorn, Bangkok 10200

Tel: +66 2 356 9499
Fax: +66 2 280 3563
Email: eapro@unicef.org

Facebook: www.facebook.com/unicefeap/
Twitter: @UNICEF_EAPRO
Website: www.unicef.org/eap/