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A Global Framework for Youth Mental Health: Investing in Future Mental Capital for Individuals, Communities and Economies

May 2020

A Global Framework for Youth Mental Health: Investing in Future Mental Capital for Individuals, Communities and Economies

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ISBN-13: 978-2-940631-02-5
The Report is available at www.weforum.org.

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Foreword

Mental ill-health represents a major threat to the health, survival and the future potential of young people around the world. The evidence for this is to be found within the pages of this landmark resource: *A Global Framework for Youth Mental Health*, the central pillar of a novel joint venture between the World Economic Forum and Orygen, Australia's globally unique translational youth mental health research and care organization. This threat has been magnified through the lens of the COVID-19 disaster, which has cast a pall over the lives and vocational and economic futures of young people all over the world. The massive efforts of the global community to save as many lives as possible during the pandemic has paradoxically resulted in an immediate and serious decline in mental health and well-being for many of us, while the economic recession that is likely to follow will impact more severely on the lives, security and futures of young people, who already bear the main burden of mental ill-health.

> Mental disorders are the chronic diseases of the young.
>
> Insel and Fenton[1]

This World Economic Forum/Orygen framework is unashamedly solution-focused, and now, more than ever, it represents a genuine blueprint for societies to respond to a public health challenge that has been overlooked and neglected for too long. The post-COVID world offers us all another chance to seize the opportunity to end this neglect. The foundations of this framework lie in real-world advances in early intervention and innovative youth-friendly cultures of mental healthcare that began in Australia and have spread to a number of countries across the globe through a process of collaborative leadership and dynamic partnerships with young people.[2,3] It has been a struggle even in high-resource settings to induce societies and their governments to invest in a new approach to the mental healthcare of young people, but genuine momentum has been achieved in recent years.[4] The voice of young people has been crucial in advocacy and design. Indeed, the catalyst for this partnership between Orygen and the World Economic Forum was a Forum global shaper, Carlo Guaia, also a member of Orygen's Youth Advisory Council, who identified the opportunity for our organizations to work together and facilitated the connection.

The framework is a distillate of the perspectives and experiences of young people from an incredibly diverse range of backgrounds and cultures, the best available scientific evidence and the hard-won experience of pioneers and innovators in youth mental healthcare worldwide. It can be seen as a blueprint and a launch pad for a wave of further innovation and reform that will teach us much about how to maximize the potential of the emerging generations around the world.

The Lancet Commission on Global Mental Health and Sustainable Development[5] highlights the neglect of mental health in all countries, and refers to "the near absence of access to quality care globally". Indeed, a co-author of this monograph, former WHO director of mental health Shekar Saxena, once famously stated: "When it comes to mental health, all countries are developing countries."[6]

Yet the Global Mental Health Movement has, for many years, continued to divide the world into high-, middle- or low-income countries. This subdivision is now increasingly misleading and obsolete, especially for mental health. Emerging concepts include the categorization of countries as WEIRD (Western, Educated, Industrialized, Rich and Democratic), or non-WEIRD, and the related concept of the "Global South". This latter term was first introduced as a more open and value-free alternative to "third world" and is used by the World Bank. Countries of the Global South have been described as newly industrialized or in the process of industrializing, are largely considered by freedom indices to have lower-quality democracies and frequently have a history of colonization by Northern, often European states.[7] These concepts highlight the dynamic shifts that are occurring and may also be affected by COVID-19. Until recently, rising wealth across the world in recent decades has resulted in a shift such that only 9% of countries now fall into the original low-income category as defined by Hans Rosling, the celebrated author of *Factfulness*, who has mapped this progress.[8] A better concept for service planning is low-, middle- and high-resource settings. Countries traditionally designated as high-income countries, such as the US, actually contain low-, middle- and high-resource settings, and so-called middle-income countries also have a mix of these settings. The high-, middle- and low-income and even the WEIRD vs. non-WEIRD countries now differ only on the relative proportion of these resource settings that lie within their borders.

Furthermore, green shoots of progress are sprouting in mental health. There has been a shift in many WEIRD countries to develop new models of care for youth mental health.[9,10] These have generally comprised enhanced versions of primary care that offer "soft entry" to care, often with a stigma-free or layperson first point of contact, yet with mental health and other needs-based expertise also embedded.[11] This approach is highly consistent with the WHO policy of expanding mental healthcare through primary-care platforms in preference to hospital-based and tertiary settings. It is also one that is much more achievable in settings where investment in mental healthcare is at least modest. In high-resource settings within some WEIRD countries, it is now possible to design and aspire to increasingly comprehensive models of care that extend from the community through primary care to secondary and tertiary levels of sophisticated quality care. Yet in most other parts of these societies, and all non-WEIRD countries, these complete systems of care remain merely aspirational.

> The neglect of youth mental health is a form of self-harm that society has inflicted on itself.
>
> John Gunn[12]

This is also a dynamic situation, with the momentum – at least until the COVID-19 crisis – moving in a positive direction. Yet it must be acknowledged that mental health remains at a low base compared to other health conditions in WEIRD and non-WEIRD countries alike. So, while the Global Mental Health Movement,

> Government investment and development assistance for mental health remain pitifully small. Collective failure to respond to this global health crisis results in monumental loss of human capabilities and avoidable suffering… The burden of mental disorders can only be reduced through the combined actions of the prevention of mental disorders and the effective clinical and social care of people with mental disorders.
>
> The Lancet Commission on Global Mental Health and Sustainable Development[13]

appropriately dismayed by the gross neglect and enormous treatment gap present in low-resource settings, especially in non-WEIRD countries, has been impressed by the ingenuity of efforts to address mental ill-health through creative approaches such as the Friendship Bench,[14] these must be seen merely as an inspiring starting point for a better deal for people with mental ill-health. Not only are these invaluable in low-resource settings, but they can be inspiring and helpful imports into middle- and high-resource settings in WEIRD countries.

Nonetheless, we cannot be satisfied with accepting the status quo, however pragmatic and creative, as being "as good as it gets" for people in low-resource settings, and we must seek to progressively share, learn and adapt youth mental health models based upon a holistic primary-care model, reflecting the universal blueprint that this project has sought to formulate. This is an issue of equity and human rights as well as pure logic and economics. Ultimately, we want to see all young people the world over being able to access culturally safe and adapted, evidence-based integrated care for their dominant health and social needs in their local communities so that they have the best chance of leading long and fulfilling lives.

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Executive summary

Mental illness is the number one threat to the health, well-being and productivity of young people, with 75% of mental disorders having an onset before the age of 25. More than 50% of young people will have experienced at least one period of mental ill-health by the age of 25. This has substantial consequences for individuals, their families and communities, as well as local, national and global economies.

The onset of mental illness during adolescence and (young) adulthood often disrupts the normal developmental processes occurring during these stages of life, as people move from dependent childhood to independent adulthood. These processes include developing an identity separate from one's family of origin, transitioning from education to employment, developing adult friendships and intimate relationships and potentially creating a family of one's own. Disruption of these processes during the period of greatest "mental capital" can lead to economic costs that far exceed treatment expenditure, particularly if mental illness derails the ability of individuals to reach the full potential of their social and economic contribution to society over time. Given the scale of mental illness, this in turn affects the economic development and growth of civil society.

In 2019, the World Economic Forum prioritized the need for action on mental health and identified youth mental health and early intervention as key areas for impactful change.

The Forum partnered with Orygen, the world-leading youth mental health research and clinical translation centre, to develop a Global Youth Mental Health Framework to assist low-, middle- and high-resource settings or countries to build systems of care. The aim was to promote the mental health of young people and to respond to their needs using evidence-informed approaches. Given the paucity of such systems of care in most countries and resource settings, the rationale for investing in, and advocating for, youth mental health systems was also a vital element in supporting the framework.

This framework was developed using a combination of evidence review and extensive consultations with youth mental health stakeholders – namely, young people and their families, as well as the service providers and planners, clinicians, non-government organizations (NGOs), government and researchers who are dedicated to system development and reform to better meet the mental health needs of young people. The resultant Global Youth Mental Health framework consists of eight principles, underpinned by a series of practices, to guide local implementation of youth mental healthcare in any resource setting or country. These eight principles are:

1. Rapid, easy and affordable access
2. Youth-specific care
3. Awareness, engagement and integration
4. Early intervention
5. Youth partnership
6. Family engagement and support
7. Continuous improvement
8. Prevention

The universal messages from the consultation process, which spanned the geographic and income spectrum, were the importance of a local voice in developing and interpreting the framework's principles and the centrality of young people to this process. Consequently, the local context is not subsumed under the principles of the framework but is an element co-equal with the principles. It is intended that implementation of the framework principles will be led by local stakeholders with appropriate consultation from others with experience or expertise to assist local implementation.

The framework is also grounded in the ambition and optimism expressed by stakeholders across all resource contexts, with a view to the framework being implemented to provide the best possible level of care. The aim is to draw on all available evidence to provide holistic, optimistic, recovery-focused care for young people that assists them to achieve their aims of full participation in, and connection with, their communities.

A significant issue that has arisen post-consultations and will undoubtedly have a significant impact on the mental health of young people now and into the future is the health and economic consequences of COVID-19. In the short term, there is likely to be a rise in anxiety and depression. This is likely across the population but, with their particular vulnerability, young people will be more exposed to this. Young people have always suffered more in economic downturns.[15,16,17] They are not yet established in work and possibly have fewer transferable skills than others. This economic marginalization and the inability to realize career ambitions can also predispose them to mental ill-health. The response of government, civil society and communities to COVID-19 must include a focus on the mental health of all, but particularly young people.

One opportunity arising from the pandemic is the chance to bolster or reshape societal systems towards better incentives for community-based care, similar to the sort of care advocated in this framework. Because social determinants of health, such as level of education and employment and access to clean food and secure housing, are linked to mental health outcomes, policy-makers interested in better mental health outcomes will also be wise to craft and implement holistic, inclusive policy focused on correcting systemic social inequities. The principles and practices outlined in this framework can be integrated with such policies, paving the way for healthier lives and more secure livelihoods for young people in the long term.

Why is youth mental health a concern?

The primary purpose of any society is to create environments in which children can safely develop into healthy, fulfilled and contributing adults. Previously the biggest obstacle to this was childhood mortality, which, 200 years ago, accounted for nearly half of all deaths. Over the past 80 years, childhood mortality has fallen from 23.9% to 3.9%[18] through the concerted efforts of government, industry, medical research and civil society. Now, nearly all people born will reach adulthood. A significant obstacle to successfully transitioning into adulthood is the onset of mental illness. Combating this will require the same vision, persistence, broad collaboration and dedication to the task that was applied to childhood mortality

Mental illness is the leading cause of disability and poor life outcomes for young people,[19] contributing 45% of the overall burden of disease in those aged 10–24 years. The onset of mental illness peaks in adolescence and early adulthood (*Figure 1*), with 50% of all mental disorders developing before the age of 15 years and 75% by the age of 25.[20]

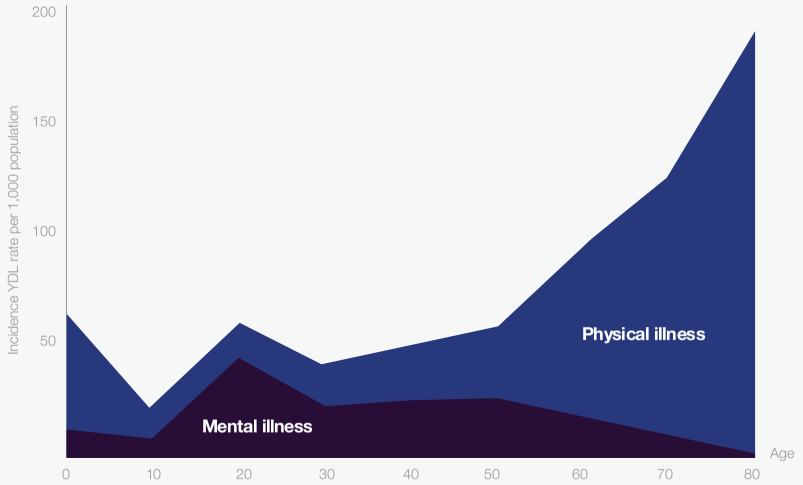
The experience and impact of mental ill-health during this life stage can interfere with a range of developmental skills necessary to successfully navigate social and economic milestones, including social engagement, educational attainment, employment prospects, romantic and intimate relationships, housing security, family connectedness, and self-confidence and self-efficacy.

From an economic perspective, youth is a crucial period when "mental capital" is formed. Mental capital broadly refers to a person's cognitive and emotional resources, including their flexibility and efficiency of learning, the ability to transfer skills from one area to another, and "emotional intelligence", such as social skills and resilience in the face of adversity.[21] Disruptions to acquiring mental capital can adversely affect future life opportunities, including success in education, skills acquisition and the transition to employment.[22] The chances of building long-term relationships or living independently may also be compromised and increase the risks of vulnerability to poverty,[23] homelessness[24] and crime.[25] Poor mental health also increases the risks and costs of physical illness.[26]

Mental illness not only affects daily functioning but can affect mortality. Suicide is the second most common cause of death globally for young people aged 15–29 (*Figure 2*) and of the estimated 800,000 people who die by suicide annually, the majority are young (*Figure 3*). **Targeting preventive measures and effective early intervention at young people presents the best opportunity to reduce the social and economic costs of mental illness**, including un/under employment, health and

FIGURE 1

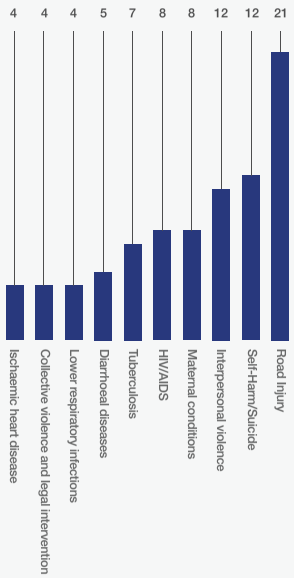
Incidence of mental and physical illness across the lifespan



Source: Vos T, Begg S. Victorian Burden of Disease Study: Morbidity. Public Health Division, Department of Human Services, 2003.

FIGURE 2

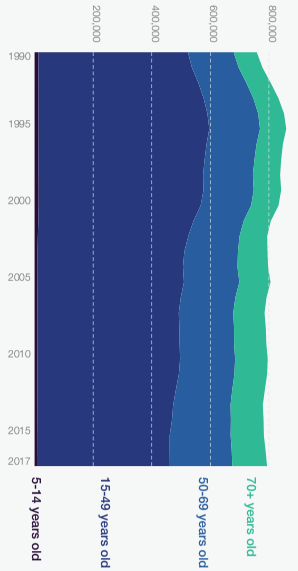
Top 10 global causes of death for people aged 10-19



Source: WHO: http://apps.who.int/adolescent/second-decade/section3/page2/mortality.html

FIGURE 3

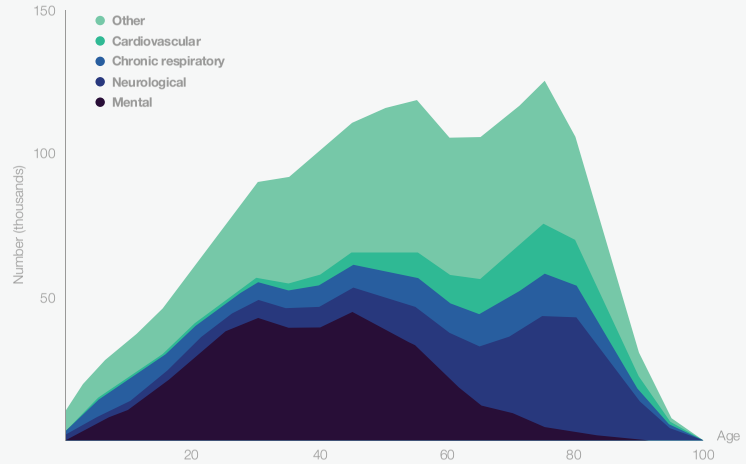
Suicide deaths by age, world



Source: Our World in Data: https://ourworldindata.org/grapher/suicide-deaths-by-age

FIGURE 4

Disability caused by mental illness persists across lifespan



Source: Vos T, Begg S. Victorian Burden of Disease Study: Morbidity. Public Health Division, Department of Human Services, 2003.

TABLE 1

Global cost of mental health conditions in 2010 and 2030. Costs shown in billions of 2010 US$

	Low- and middle-income countries			High-income countries			World		
	Direct costs	Indirect costs	Total cost of illness	Direct costs	Indirect costs	Total cost of illness	Direct costs	Indirect costs	Total cost of illness
2010	287	583	870	536	1,088	1,624	823	1,671	2,493
2030	697	1,416	2,113	1,298	2,635	3,933	1,995	4,051	6,046

Source: Bloom, DE, et al. The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum, 2011.

welfare spending and premature death, over the lifespan.[27]

Mental illness in young people is costly

In addition to the human costs associated with mental illness, there are significant economic costs to public and private enterprises and economies. **Mental illness places the most serious burden on gross domestic product (GDP) of all non-communicable diseases (NCDs) due to the time of its onset in the life cycle**. At a time when society usually expects to see a "return on the investment" of child-rearing, education and training – the peak of "mental capital" – this may be derailed by mental illness.

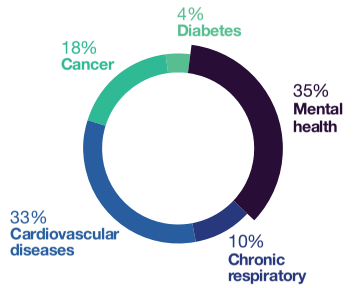
The *duration of disability* associated with mental illness, caused by the common lack of an early response, is also a major contributing factor to economic burden (see *Figure 4*). Society pays a price for the lack of an early, sustained and recovery-focused response to the onset of mental illness (see *Table 1*). The cost of late care is almost always more burdensome than early intervention, along with associated costs that often accompany more chronic forms of illness, including hospitalization, social welfare benefits, taxes foregone and, in a minority of cases, imprisonment or detention.

The World Economic Forum reported in 2011 that mental ill-health accounted for 35% of the global economic burden of non-communicable diseases, more than cardiovascular disease, cancer or diabetes (see Figure 5). It estimated that, between 2011 and 2030, this will cost $16 trillion in lost economic output worldwide.[28]

Young people also face a "new work order"[29] in terms of economic participation, with the World Economic Forum identifying that most of today's available and in-demand jobs did not exist as recently as 10–15 years ago.[30] School completion and further education will be critical to gain the translatable skills needed to adapt to, and compete in, the future job market. Since young people with mental illness are almost twice as likely not to be in education, employment or training (NEET) than those in the general population,[31] this will ultimately reduce the available workforce and tax base. A shrinking tax base will be compounded by "population ageing" (particularly in medium- and high-resource countries). These trends have the potential to increase both dependence ratios (more people claiming welfare benefits and fewer people paying taxes) and spending on long-term care.[32]

FIGURE 5

The global economic burden of non-communicable diseases



Source: Bloom, DE, et al. The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum, 2011.

The case for investing in youth mental health

A 2009 report by Access Economics in Australia indicated the substantial costs (AUS $10.6 billion in 2009) arising from mental illness in young people, predominantly related to lost productivity (~70%; including un/under employment, absenteeism and premature death), deadweight losses (~15%, from transfers including welfare payments and taxation foregone), direct health system expenditure (~14%) and other indirect costs such as for informal carers. The additional costs of lost well-being (disability and premature death) was estimated at AUS $20.5 billion.

Despite these economic impacts, investment in mental health (for all age groups) has been insufficient to address mental health needs in all contexts, but especially in low- and middle-income countries. Investment in mental health has historically been regarded as a luxury and something to be pursued only in those high-income economies less likely to be troubled by high rates of mortality from communicable disease, mass poverty, political instability or limited infrastructure for economic development. This is despite a growing body of evidence on

the impacts of poor mental health in low- and middle-resource settings.[33,34]

A greater focus on linking mental health (or mental capital) to innovation and economic development has started to transform this mindset, such as the World Bank's *World Development Report* in 2015 (*Mind, Society and Behaviour*), which emphasized the links between economic development and mental capital.[35] The World Bank, along with the World Health Organization, has called on governments and agencies to bring mental health "out of the shadows" and to view it as a global development priority.[36] At the time of this report's publication, the #timetoinvest movement spearheaded by United for Global Mental Health and other mental health organizations has been making the case for a great investment in mental health services globally.

The economics of mental health is not just about the need for funding, **but the costs of not taking action to promote and protect mental health.** Not taking action is rarely cost-free and may come with costs that could have been preventable.[37,38] These include a lifetime of lost earnings due to leaving education with fewer qualifications and skills as a result of mental ill-health during youth. The costs of inaction on mental health also fall across multiple sectors of government or economies and can be long-lasting, meaning that policy-makers should have a strong vested interest in seeing more investment in youth mental health.

The potential return on investment for youth mental health

Many of the benefits of preventing poor mental health are enjoyed outside of the health sector, such as increased participation in the workforce and higher levels of educational attainment. Return on investment (RoI) analysis enables decision-makers to compare investments in the youth mental health system with investments in other areas of the economy, such as industrial development, education or housing. These analyses are increasingly being conducted to present evidence on the value of investments in mental health in high- and low-resource settings.[39] Prevention and early intervention are critical in all contexts here, and include raising awareness of mental health issues and mental health literacy,[40,41,42] reducing stigma related to seeking help, appropriate signposting to services and supports, and the greater use of digital platforms.[43]

Proactive early intervention services for severe mental illness problems are more effective than the usual "reactive" care pathways,[44] and where evaluated (almost entirely in high-income settings) have been shown to be cost-effective,[45] especially when broader benefits beyond the healthcare system, such as impact on participation in work, are taken into account.[46,47] There is also an important role to be played by specialist education and employment services that can help young people to stay in education and/or obtain employment.[48] (See call out box for example).

For mental health overall, the earlier the intervention the greater the return on investment.[58] Even simple interventions, such as supporting young people during exams (periods of high stress), can have long-term benefits – for instance, influencing future higher education and career prospects. However, *integrated* systems of care that address all needs – mental, physical, educational/vocational and social – are the ideal.

ILLUSTRATIVE EXAMPLE

Self-harm and suicide prevention in South Korea

In South Korea, self-harm and suicide are the leading causes of death in young people,[49] accounting for 36% of all years of life lost for 10–24 year olds.[50] For the entire population, self-harm is the single greatest cost in the overall economic burden of the country at more than $8.3 billion (2015 prices) per annum.[51] Emerging research in other countries supports the effectiveness and cost-effectiveness of school-based programmes that are designed to raise mental health awareness and provide skills to help people cope with adverse life events, stress and suicidal behaviours.[52,53] Such programmes are being implemented in some locations in Korea, with economic modelling indicating their potential RoI of $7.50 for each $1 invested.

The modelling used the nationwide emergency department-based Injury In-depth Surveillance (EDIIS) registry to identify hospital-presenting cases of non-fatal and fatal deliberate self-harm by young people,[55] and a survey of more than 72,000 young people aged 12–18 to identify self-harm rates in the past year. Age-standardized suicide rates were taken from Statistics Korea's cause of death data, and included only deaths coded as intentional self-harm. The costs of treating self-harm were taken from a previously published analysis of poisoning by young people in Korea;[57] because this covers just the costs of poisoning, it is likely to be a conservative estimate of costs (as other means of self-harm tend to be more costly). The analysis assumed that individuals presenting to hospital for self-harm would subsequently receive psychological treatment for depression.

The model indicates that avoided costs to health services and the police (for investigating fatal and non-fatal suicidal events) cover actual programme costs within four years, and if productivity losses due to premature mortality – solely for ages 18–20 – are considered, then there is a **positive return on investment of $7.50 for every $1 spent**. This RoI would be many times greater if lifetime economic benefits from reduced premature mortality were included. The analysis is conservative in many other ways, not considering benefits seen within school (such as a better school climate and reduced pressure on teachers due to lower risk of pupil self-harm) or within families (such as a reduced need to take time off work to support someone experiencing self-harm).

Taken from a report prepared for the Global Framework Project by David McDaid and colleagues at LSE. For the full report, please see Orygen's website. https://www.orygen.org.au/

The recent *Return on the Individual* report, released by United for Global Mental Health in April 2020, provided an argument to extend our understanding of the benefits of investing in mental health beyond economic and monetary terms and into the perspective of what it means to an individual to experience good or improved mental health, and by extension what it means for their families and their communities.[59]

Developing 'fit for purpose' mental health systems for young people

Despite the well-established epidemiology of onset, the impact that mental illness has on the vulnerable developmental processes that occur in young people, and the high personal and economic costs, most mental health systems – where such systems even exist – are not "fit for purpose". Most mental health systems are structured on a child and adolescent system that provides care up to the age of 17, followed by an adult system that cares for people aged 18 and over. This break in continuity results in care being weakest where it needs to be strongest[60] and requires the young person and their family to navigate a new and often quite different system when they are least able to do so due to crisis or distress. **Barriers to accessing appropriate care, or reluctance to engage with developmentally inappropriate services, are strong contributors to a majority of young people not accessing or receiving mental healthcare when needed.**[61,62]

In response to the limitations and failures of the traditional mental health system, a "youth mental health" approach has emerged and is gaining traction in many high-resource settings. A specific youth focus is appropriate because the age group 10–25 is heterogeneous and requires developmentally and culturally appropriate methods that acknowledge the complex and evolving psychosocial issues, symptom patterns and morbidity seen in this age group. This includes services that are accessible (e.g. no or very low barriers to entry), community-based, non-judgemental and non-stigmatizing, where young people feel comfortable and have a sense of trust.

Key characteristics of youth mental health services

Integrated care mental health, physical health, and social care as well as vocational services provided ideally in a single location. This encourages coordinated holistic care that meets a young person's needs rather than a traditional "siloed" system and approach.

A base in primary care as it is the first point of contact for most people in the health system. It has a wide generalist scope and high levels of continuity of care.

Youth-centred philosophy works in partnership with young people to develop and deliver the services that are responsive to their multiple needs, taking into account developmental consideration in a seamless way.

Accessible by having low or no barriers to entry as well as a centralized and easy-to-reach location, flexible hours of operation (not confined to 9-5) and provide self-referral and drop-in services (e.g. barriers should not be based on diagnostic or severity thresholds or availability to pay for services).

Youth-friendly facilities that are welcoming and engaging, use highly visible, non-stigmatizing branding that's recognizable and acceptable to young people, and an informal, non-clinical environment and ambience.

Embedded in the community to build on local, contextual needs and **evidence-based care.**

The example of early intervention in psychosis has provided a template for broader early intervention in mental health, and youth mental health services in particular, given the epidemiology. The early psychosis model advocates for timely and comprehensive intervention during the first episode of psychosis, whereby the necessary "scaffolding" is put in place to support the young person through the onset phase of their illness. This model has demonstrated – consistent with physical health conditions – that early detection and early response is likely to lead to a better prognosis and less disability and disengagement.[63] From initial service development in 1995, there are now early psychosis intervention services established in many countries, including those within the National Health Service in the UK, the headspace Early Psychosis programme in Australia and a myriad of first-episode programmes across the US. While there are significant similarities between different national models of early psychosis, there are also local variations that reflect context-specific interpretations of the more general early psychosis framework.

The success of the early psychosis model and its "proof of concept" for early intervention has encouraged the wider application of early diagnosis and specialized treatment for the full range of emerging disorders in young people, notably mood and anxiety disorders and substance use disorders that affect a substantially higher proportion of the population (between 20 and 25% of young people at any one time).[64] A number of youth mental health services have been established in high-resource settings, initially in Australia with headspace (see call out box on the following page), followed by Ireland with Jigsaw, as well as Canada, Denmark, France, Israel, Iceland, the Netherlands, New Zealand, the UK and the US.

In addition to these characteristics, youth mental health services in high-resource settings also involve community education to increase youth mental health literacy in the community, reduce stigma[65] and create awareness of the service. Reducing stigma is essential since this contributes to the low rate of engagement with traditional mental health services in low-, middle- and high-resource countries.[66] There is little point in establishing a service if no one will use it for fear of the stigma that might attach to them in doing so. This can be countered by placing services in low-stigma environments (such as where young people may congregate anyway) and reducing the external emphasis that the service places on its mental health offering.

EXAMPLE OF AN INTEGRATED YOUTH MENTAL HEALTH SERVICE

headspace, Australia

headspace, Australia's National Youth Mental Health Foundation, commenced in 2007, in response to the inability or unwillingness of the majority of young people diagnosed with a mental illness to access existing mental services (child and adolescent, and adult services) or because they were "falling through the gap" in the transition to adult services at the age of 18.

The headspace model provides a youth-friendly service for young people (aged 12–25) to access a range of mental health programmes, including primary care, psychological support, vocational and educational support and drug and alcohol services. It also provides a national online support service (eheadspace) where young people can chat with a mental health professional online or by phone with access to therapeutic care (seven days a week, 9am–1am). The core tenet of headspace is the notion of a one-stop shop or a hub-and-spoke model (in non-metropolitan areas) that provides integrated, coordinated services. The programme operates on an enhanced primary-care model, providing a mixed-staff care structure with close links to local community supports such as schools, youth-facing organizations and specialist mental healthcare.

Each site is led by an independent consortium of like-minded organizations, which is overseen by local primary healthcare networks (commissioning agencies of the Australian government). Evidence-based psychological interventions are used as first-line treatments to intervene early and prevent the onset of significant clinical symptoms. Medication may be used when the initial intervention does not work for the young person or when more severe symptoms persist.

headspace is funded by the Australian government's Department of Health, which supports the centre and its infrastructure. In addition, *clinical* sessions are financed through Australia's Medical Benefits Scheme. Some headspace centres receive additional funding to deliver specific programmes from other sources outside health. The first 10 centres opened in 2007, and there are now 140 across Australia, with headspace having strong brand awareness among young people. Evaluations show that headspace has increased access to care, particularly among indigenous young Australians, as well as young males (traditionally a hard-to-engage population). Up to 15 other countries have now adopted a headspace-like model that is specific to the cultural and workforce context of the country, including Denmark, Israel, the Netherlands and Iceland.

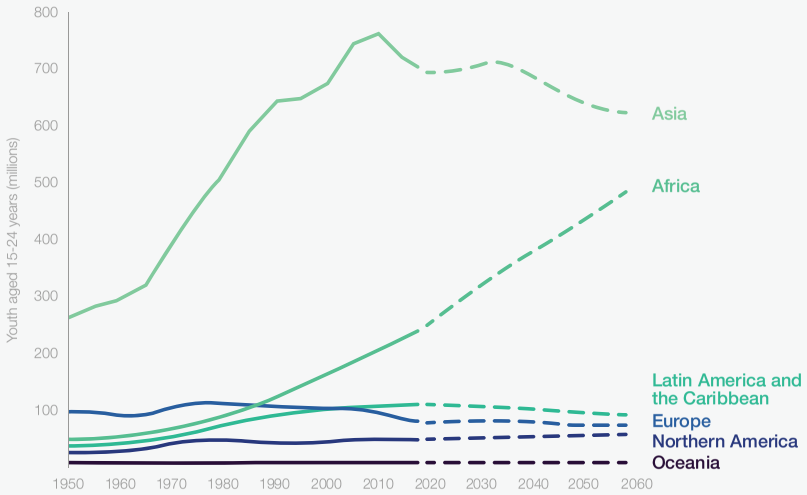
Why the need for a global framework for youth mental health?

The youth mental health services being implemented in a number of high-resource settings represent a blueprint for much-needed system reform. It is critical to learn from these systems, their development and application, but it is not possible to ignore the contexts in which they developed. While often facing opposition from advocates of the traditional mental health structure (or status quo) in their own contexts, these services have been developed in privileged settings with willing governments and available infrastructure, including the necessary workforce. The majority of the world's population, however, and the majority of young people, do not live in these circumstances.[67] Nearly nine out of 10 young people worldwide live in low- and middle-resource countries (see *Figure 6*).[68] **The principles for youth mental health that have been developed in high-income settings probably need to be reinterpreted and reoperationalized locally to succeed in low- and middle-income (LAMI) contexts**.

Furthermore, although relatively poorly funded compared to physical health everywhere, funding for mental health in LAMI contexts is also significantly lower per capita than in high-income countries. (see *Figure 7*).

FIGURE 6

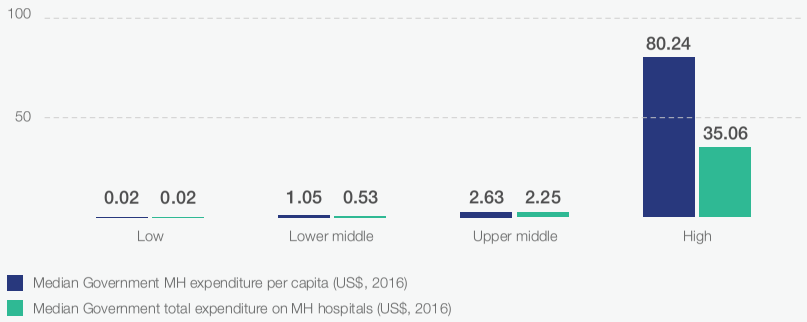
Global youth population by region from 1950, with projection to 2050



Source: United Nations, World Population Prospects: The 2012 Revision. 2013

FIGURE 7

Mental health expenditure per capita by World Bank income groups



WHO, *Mental Health Atlas 2017*. World Health Organisation, 2018.

What should a global youth mental health framework look like?

The evidence

In February 2019, a literature scan was conducted, canvassing peer-reviewed and other literature regarding the key principles that had been articulated in existing youth mental health services. The review indicated six key principles of youth mental healthcare. These were: early intervention; youth and family engagement; community awareness; continuous improvement, including professional and service development; youth-specific care; and rapid access to care.

This review helped inform a draft framework that was produced in March 2019, ahead of a meeting in April with international experts and young people to build consensus regarding the key principles underlying the framework.

The expertise

In London in April 2019, 35 people met to review the draft framework and contribute their perspectives and expertise. The attendees were an international group of academics, youth mental health service developers and providers and youth mental health clinicians. The meeting also included young people from England, Ireland, Brazil, Thailand, Jordan, Bosnia and Herzegovina and Nigeria. It was at this meeting that the eight principles were agreed, along with the identified practices. This information was then used as a basis to consult with young people, families and other experts globally.

The voice of young people (the consultations)

The revised draft then provided a basis for consultations that were held in Europe, Australia, New Zealand, Asia, Africa and North America from May to November 2019. These consultations included young people, family members, clinicians, academics, businesspeople, health administrators, insurance executives, public servants and politicians. Consultations were held as small-group, one-to-one or virtual meetings, and as short workshops.

In September 2019, an online survey was launched and promoted via social media. The purpose of the survey was to seek input from an even wider group of young people on their views of the principles and elements of the emerging framework, as well as to gauge the perceived access to mental healthcare in their own communities.

This allowed for the input of more than 300 young people from 50 countries from all six of the inhabited continents.

Young people were asked a range of questions about their experience of mental health services. In general, people felt that they could access mental health services if they needed to, especially those living in high-income countries. Except in high-income countries, there was uncertainty that mental health services would be of a good quality. In all countries, but particularly in middle-income countries, there was an anticipation of stigma if a young person were to seek help for their mental health.

Young people who participated in the survey were also asked their views on the framework principles and some of the enabling practices. Both the principles and practices were soundly endorsed by young people. A fuller report will be made available as a supplementary document.

As noted earlier, young people are the population group most at risk of developing mental ill- health. While there are undoubtedly biological factors such as the onset of puberty, brain development and genetic vulnerability, there are several pertinent environmental factors that increase the risk of stress and the development of mental ill-health. Some of these were mentioned to us frequently by the young people we met and with whom we consulted. In particular, three issues were raised in almost every setting:

1. **Academic success:** The first and most common issue raised was the pressure young people feel to succeed academically. Young people felt that the expectation to do well at school was significant and, in their opinion, greater than that faced by their parents and previous generations.

2. **The impact of technology and social media:** This was the second issue raised and it was perceived as both helpful and oppressive in terms of (respectively) the potential to connect young people and enable their views to be expressed, and the constant social comparison and the potential for bullying.

3. **Climate anxiety:** The third common issue raised was the uncertain impact of inaction on climate change. Many young people felt that their lives would be made much more difficult and they would face greater struggles because little was being done to address this issue. This was the cause, according to them, of a lot of anxiety.

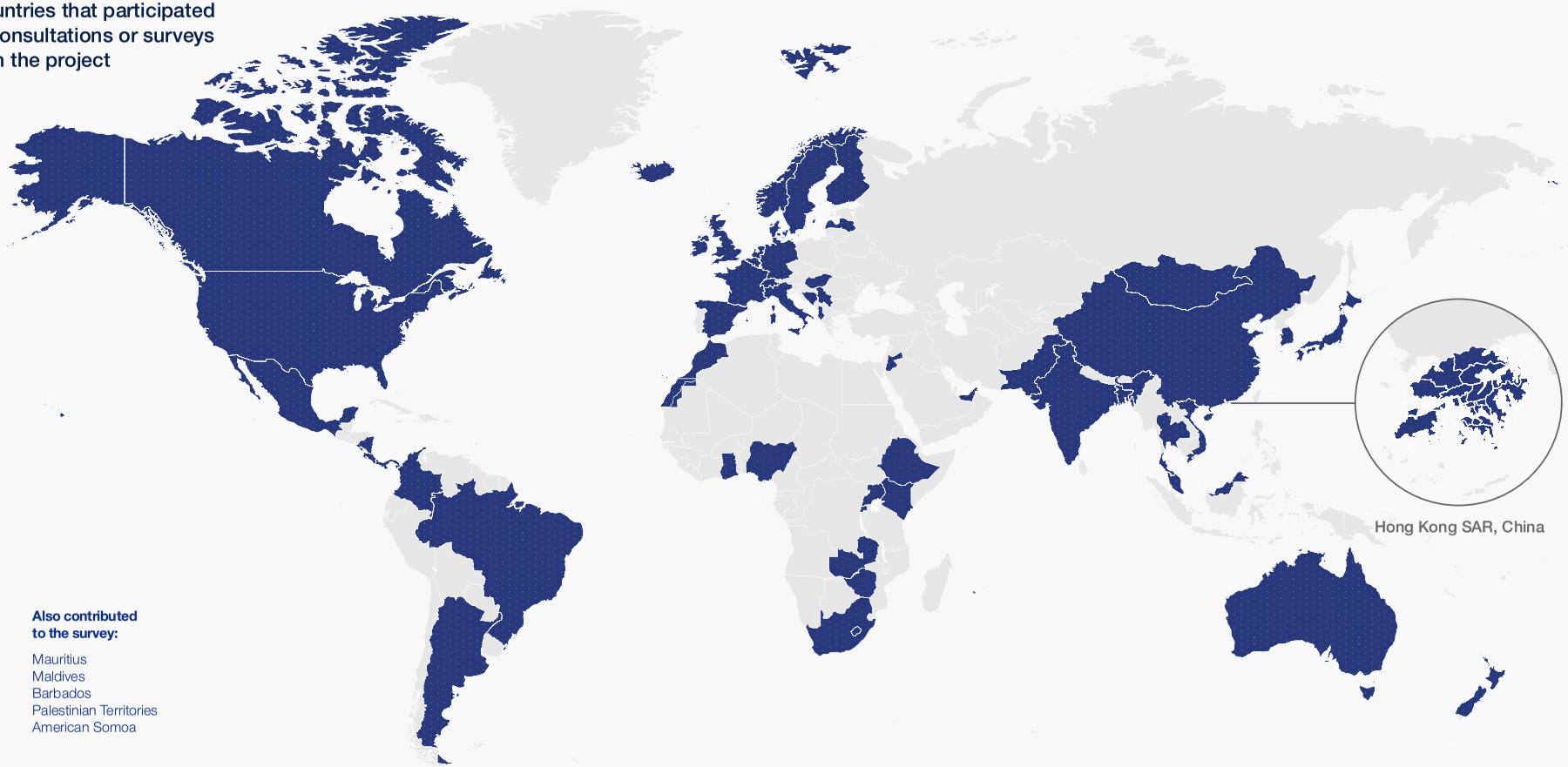
The project consulted with and heard from young people, families, clinicians, researchers and others from more than 30 countries (see *Figure 9*).

A consistent theme in all of the consultations was that there is a **strong need for local involvement in the implementation of any new approach to mental health for young people.** Young people from all income settings are resistant to having a prescribed model imposed upon them. Instead, they are eager for guidance but equally willing to contribute a local viewpoint on how the guidance should be interpreted and implemented.

The need to engage with local stakeholders is a well-known element of creating sustainable change. Conceptualizations around mental health vary from place to place, resulting in a need to follow local guidance on factors such as culturally relevant language. Similarly, while some settings have a small number of qualified mental health professionals, a local contribution to framework interpretation and operationalization may be able to suggest other, locally acceptable ways to provide services, such as detailed design and implementation plans for task shifting. Other local contributions may include ensuring that proposed

FIGURE 8

Countries that participated in consultations or surveys with the project



Also contributed to the survey:

Mauritius
Maldives
Barbados
Palestinian Territories
American Somoa

measures of success are appropriate to the context, identifying barriers and facilitators to implementation and describing and addressing the local level of stigma about mental ill-health.

Summary

The framework was repeatedly revised through evidence review and consultation with experts and youth. The project's steering committee, project team and external experts added new concepts and refined or challenged existing concepts. The one constant throughout this process – and the one concept never compromised through the consultations – was that young people and the local community should be involved in interpreting and implementing the framework.

EIGHT CORE PRINCIPLES AND THEIR SUPPORTING PRACTICES

A Global Framework for Youth Mental Health

The framework is based on the premise that healthcare, including mental healthcare, is a human right and that young people should be safe to seek care for their mental health.[69,70] There should be no economic, social, civic or political discrimination against those who seek care for their mental health. The framework acknowledges that individual settings or contexts may be further along the journey of reducing discrimination and stigma towards people with mental ill-health, and this variation is reflected in a number of principles and practices that are articulated in the sections below.

The framework is also based on the premise that optimism and hope are critical elements of any youth mental health system or response. In places where there is no early response to mental ill-health, behavioural manifestations of acute episodes of severe mental illness are the most common publicly seen form of the illness. This reinforces a stereotype of mental illness that is inaccurate as most behaviour exhibited by people with mental ill-health is not the type of conduct society would deem to be extremely abnormal. It also reinforces the pessimism associated with mental illness and the stigma and discrimination that affected individuals and their families face. Intervening in the early stages of illness changes the perception of mental illness and provides hope that recovery and management of illness are not only possible but to be expected.

In seeking to avoid a prescriptive model, which is not appropriate within a global context, we propose a *principle-based framework* that enables local interpretation of the principles when implemented. A principle is a "settled ground or basis of conduct or practice".[71] By articulating the principles of a youth mental health framework, we aim to provide a common set of values and actions to inform the local development and implementation of services.

In this framework, reference is made throughout to evidence-based care or interventions, which indicates that the practice has been evaluated in one of a number of recognized ways.[72] However, unique contextual factors make the application of available evidence in practice more of an "extrapolation" in some settings than others. **As local interpretations of this global framework are established, implementation research and routine evaluation should seek to validate that the local models and interventions are achieving their aims.**

Key principles of a Global Framework for Youth Mental Health	
Rapid, easy and affordable access	Youth partnership
Youth-specific	Family engagement and support
Awareness, engagement and integration	Continuous improvement
Early intervention	Prevention

Key principles of a Global Framework for Youth Mental Health

Rapid, easy and affordable access
No referral required
Low physical or geographic barriers
Low or no cost barriers
Low stigma setting
Create awareness of service
Mapping of referral pathways
Simple means of contact

1. Rapid, easy and affordable access

All youth mental health services should be based on an idea of primary care – that is, a young person should be able to access the service without a referral or other administrative barrier to cross. Ideally, when a young person contacts or is referred to a youth mental health service, there should be the capacity to provide a service in a reasonable and short period of time and at either no cost or a cost that does not discourage access. One of the disincentives for contacting services is the knowledge that it will be a long time before anything will happen and delay in access may even lead to refusal of treatment.[73] There are several reasons for minimizing the wait for a service response to a young person seeking help, led by evidence that better recovery comes from shorter periods of untreated illness,[74] and that this relationship appears to be true both in high-income[75] and low-income[76] settings. While much of the research on delay in accessing treatment has been conducted in populations of people with psychosis, it is reasonable to assume that the longer other mental health disorders are ignored, the more severe they are likely to be when treatment is commenced and the more disability and disconnectedness that may have occurred. Similarly, it is important that, to every degree possible, the cost of the service is not, nor is perceived to be, a disincentive to seek care as early as possible. Ideally, service would be provided with no out-of-pocket costs to the young person or their family.

Several practices facilitate rapid and easy access for young people and families. The underlying driver is to identify and remove barriers. For example:

- No requirement for a referral to the service removes the need to visit, convince and possibly pay a "gatekeeper", such as a GP, to allow access.

- Where there are other service systems such as child mental health, developing good relationships with those services allows for there to be little lag time if a young person is transitioning from one service to the other.

- Ease of access is facilitated through considerations such as locating the service close to public transport hubs, schools (dependent on stigma and feedback from

young people) or in an area that can be easily accessed should transport be limited or non-existent.

- Ensuring that the service is open when young people can access it (not necessarily traditional 9-to-5 working hours) is important. This may include offering services over an evening or a weekend.

- Arranging that, where possible, there is no direct cost to the young person and where this is not possible minimizing this cost will ensure that finance is not a barrier to seeking access to care and support.

- Providing a simple, free and direct means of contact will ease access. This may be via toll-free telephone numbers, internet or walking in.

Youth-specific care

- Holistic care, including functional recovery
- Guidelines for youth practice, with consideration of developmental stage
- Evidence-informed, individually tailored interventions
- Broad considerations of individual's context
- Youth-specific services
- Consultation with youth about service environment
- Developmentally appropriate transitions into and out of care
- Inclusive environment
- Shared decision-making
- Using technology

2. Youth-specific care

Part of the rationale for the early psychosis model was that existing services created a falsely pessimistic view of potential outcomes for new patients. This was exacerbated by burnt-out staff, and treatment settings that concentrated on accumulating the small percentage of the most unwell people with long-term chronic illness, as well as treatment environments that were neither youth-friendly nor spoke in any way of the possibility of recovery.

Youth-appropriate care seeks to address these deficits by changing the culture, environment, attitude of staff or volunteers and content of treatment provided. Young people, not surprisingly, are more likely to use services that are co-designed with them to take account of their needs. While there are several local factors that will contribute to making a service youth-friendly, research has shown that all young people want to be treated with respect and have their confidentiality respected.[78]

Youth-appropriate care also means care that acknowledges young people's developmental stage of life and the impact that mental ill-health can have on this development. As a consequence, elements such as employment, education, social involvement and relationships and independent living should be given equal weight as presenting symptoms. Concern with the specific developmental impact of mental ill-health on young people is one of the important features that differentiates youth mental health from adult or child approaches.

Practices designed to make the service and treatment as youth-specific and inclusive as possible aim to engage young people as active participants in their treatment from the first contact through to when they no longer need the service:

- Assessment measures for young people need to take a broad consideration of context and include culture and developmental issues,[79] and focus not only on impairments (termed the "deficit model") but also on the young person's strengths and recovery goals.

- Young people repeatedly report that they want holistic care that not only focuses on the remediation of their mental health symptoms but also takes into account the functional impacts of mental illness on their educational and employment development, their social relationships, housing and physical health.[80,81]

- Guidelines for many disorders are directed at the treatment of adults and not necessarily at younger people and this can lead to treatment gaps[82] or poor outcomes in terms of symptom response.[83]

- Often there is less well-developed evidence for treatment recommendations for young people. Therefore, interventions need to be "evidence-informed" where there is no specific evidence base to guide practice. "Evidence-informed" means borrowing from evidence developed in the closest population and adapting this so that it is age, developmentally and culturally appropriate. Alongside the introduction of youth mental health services, research needs to be conducted to create a better evidence base in a range of resource settings for youth mental health.

- When young people are treated in services that are specific to their age group, they have better outcomes.[84]

- Some practices can facilitate the development of a youth-specific care culture. These might include consultation or partnership with young people in developing, evaluating and evolving the service environment and offerings as research indicates that young people have different preferences from older people in this regard.[85]

- Cultural context is another important factor in thinking about appropriate care for young people. While services are generally established for a broad population group, young people are not a homogeneous group and a young person's cultural background and context can significantly affect their willingness to access care if it's not culturally appropriate, thus impacting on care outcomes.

- Inclusive environments will best promote youth-specific care, making gender and diversity issues paramount considerations.

Awareness, engagement and integration

- Stakeholder mapping and engagement
- Develop relationships with stakeholders
- Education of community
- Education of referrers
- Integration across services and systems
- Anti-stigma measures
- Advocacy
- Cross-sector partnerships

3. Awareness, engagement and integration

The reasons behind awareness, engagement and integration include: informing community members of the youth mental health service and referral pathways; educating about the reality of positive benefits from early and good treatment; creating optimism about the potential outcomes for young people and their families; destigmatizing illness; creating relationships with potential referrers; and increasing the level of skill in others who interact with young people to accurately detect the early stages of mental illness.

"Engagement" means that the community is involved with all elements of the design and delivery services. "Awareness" means the community understands the need for care, the availability of services, the importance of efforts to reduce barriers of stigma and ignorance to facilitate young people accessing the help they need. In areas where there are volunteers or lay health workers involved in the provision of services, awareness and engagement with the community may be even more important.

"Integration" builds on awareness and engagement by incorporating the expertise of other groups and organizations engaged in youth mental health activities. It includes concepts such as ensuring that the services established for young people are integrated into the broader health and social care system so that there can be smooth transitions between levels of care or services for the young person. This would also extend to consideration of how elements such as medical records and other information are shared across organizations.

There is also a need to build partnerships with other agencies such as government, researchers and civil society.

Engaging the community and building awareness of the service being developed is fundamental to ensuring its acceptability, relevance and sustainability. It is hard to conceive of any communities that do not want their young people to succeed. Additionally, it is vitally important to conduct community awareness and education activities because this enables the service to become known in the community that it serves, reduces the period of time that illness goes untreated and informs the public and community about the range of treatments and the positive outcomes that can result from early intervention.[86] Several practices are necessary to do this, including:

- Developing a sound knowledge of, and strong relationships with, the range of stakeholders and allies concerned for the mental health of young people in the community.

- Understanding the main sources of referral and educating those referrers in identifying possible signs or symptoms of a mental illness and how and when to refer. This includes not only teachers and doctors but also sports coaches; peers; religious, spiritual or community leaders; police; and others who regularly interact with young people. Good examples include the TIPS project in Norway and the mindmap programme in the US.

- Integrating youth mental health services with other elements of a health service. For example, in many places outpatient and inpatient care are run by different organizations and there is a need for agreements about record-sharing and "no wrong door" policies to be developed with these stakeholders.

- Building close relationships for potential integration with other relevant agencies, which may include health, welfare and community providers.

- Developing partnerships with academia in order to document implementation and help grow the youth mental health evidence base.

- Reducing stigma, via community education and awareness.

Other work arising from the enactment of this principle is to campaign for appropriate resources and to encourage the community to actively advocate for the health and well-being needs of their young people.

Early intervention

- Development and use of screening tools
- Active community partnerships
- High-risk group awareness
- Community outreach
- Training
- Community setting
- Community education
- Crisis intervention for suicide risk

4. Early intervention

When mental health is considered from the perspective of the staging model, intervention can occur at any point from the time a person is at risk of developing a problem to when they have developed the problem or when the problem has become chronic. A central tenet of youth mental health is that intervention provided at the earliest opportunity yields the best symptomatic, functional and social outcomes for the young person. The point in the development of a person's mental ill-health at which they receive help will influence the type of help that they might need (supportive counselling or medication, for example). As well as having processes to enable early identification of mental health problems in the general population of young people, measures should be developed to focus on known high-risk groups. These will vary by culture and context but might include LGBTQIA+ young people, refugees, minority ethnic or religious groups and young people with other chronic health conditions, among others. Again, working with local champions in the interpretation of the principles will help identify early intervention opportunities and priority groups with whom to engage.

Early identification of problems and early treatment are associated with the best prognostic picture.[87] Despite this, there is often a gap of years between the onset of the first symptoms of illness and the diagnosis and treatment of the illness.[88] Early identification involves a number of practices that increase the likelihood that mental illness will be identified as soon as possible after it has begun. In the best cases, it may be identified before it has begun, when the individual is at an elevated risk of onset. For example:

- The CAARMS[89] is a tool used to identify young people at high risk of developing psychosis. There are some well-evaluated screening tools for other disorders such as that for case finding by community health workers[90,91,92] or for mental health problems in general,[93,94,95] but there is a need for the development of others for other disorders, populations and language/cultural contexts.

- Early identification requires active partnership with, and outreach into, the community. Several different approaches have been taken to achieve this, including collaborating with schools and teachers and providing mental health literacy training to important groups such as teachers, youth workers and primary-care providers. The pros and cons of each strategy should be considered.[96]

- There is a wealth of evidence that certain groups are at particularly high risk of mental health problems. These groups can vary by setting (e.g. immigrants in some contexts) and there are other groups at elevated risk in many settings (e.g. LGBTQIA+ young people). In local contexts, high-risk groups should be identified and proactively engaged by the youth mental health service.

- Situating early intervention services in community settings such as a leisure centre, youth facility, primary care or other setting appropriate to young people locally is important.

- Training other professionals such as pharmacists, community workers, teachers, lay health workers and others to recognize symptoms of mental illness is critical to promoting an early intervention approach.

In countries with limited or no professional mental health support, there may be a need to equip key community leaders or family members with some simple mental health skills and strategies that facilitate the young person opening up about their mental health concerns. A similar approach may enable members of the community to be trained in skills to provide crisis intervention for suicide risk.

Youth partnership and engagement

- Youth empowerment
- Youth advisory group
- Shared decision-making
- Workforce training
- Co-design
- Peer workers

5. Youth partnership

The World Health Organization and the United Nations have indicated that young people must be involved in the systems that care for them.[97] The benefits of this are that the young people can identify service deficits that are not always apparent to older people; that the service offering becomes more valid for young people; and that the involvement of young people in the service is a measure to ensure that all young people who use the service are treated with respect. Ensuring that young people have a meaningful voice in relation to services is also a means to youth empowerment. Youth partnership is a feature of existing youth mental health services and provides a means of ensuring that services are youth-friendly. Further developments in youth partnership can help ensure that evaluation includes domains important to the recovery of young people. This also applies to youth mental health research. Throughout the consultations with young people, the need for co-designed principles to be used throughout service implementation, evaluation and evolution was strongly articulated.

An important part of the philosophy of youth mental health is that young people are not just the recipients of the service provided but are *partners* in all elements of that service. Services should adhere to the idea of "nothing about us, without us". While there is currently insufficient research on youth participation in mental health services, this can be facilitated in at least five ways:

- Establishing youth advisory groups. Young people on these groups can provide input on matters from the youth-friendliness of the service's physical environment to its governance.

- Providing peer workers to work alongside professional workers provides a different skill set and another avenue for young people's engagement with the service.

- Young people can be partners in their own treatment through the use of shared decision-making (SDM) principles. SDM is a process in which a young person is informed of the evidence for, and the pros and cons of, particular treatment choices and arrives at a shared treatment choice in collaboration with their clinicians, and potentially family and other important people.[99] Studies have shown that the use of shared decision-making and the presence of peer workers can increase satisfaction with youth mental health services for young people attending them.[100]

- Young people should be included in the co-design of the physical space of youth mental health services; this concept can be broadened to include youth co-researching, co-producing and co-delivering services. A good example is the recovery college movement in the UK, more commonly applied to adult mental health, but with clear application to youth mental health.[101]

- Research and evaluation initiatives equally need to partner with young people to determine what is important to them to gauge recovery and the design and development of tools and methods to measure such recovery.

Family engagement and support

- Psychoeducation
- Family therapy
- Family support
- Self-care
- Family peer workers

6. Family engagement and support

In the context of youth mental health services, "family" is defined broadly to include people who are important and close to the young person, whether they are related or not. The onset of illness for families of young people is often a difficult time and their need for support must be recognized and responded to. Additionally, "family" members are often a strong ally in the recovery process and will ultimately be more physically present for the young person than the youth mental health service. Therefore, ensuring that the family is cared for and engaged maximizes treatment response.[102]

Most young people are connected to family or, if not family, a significant adult (e.g. a coach, teacher or community elder). The impact of the onset of illness in the young person can be significant for the family, and several practices arise from the principle of family engagement. While many of these focus on providing support to the family, some extend to the concept of

having family peer workers. Important elements of family engagement include:

- Having a family peer worker who provides support and information for families who are in the initial phases of having a child receiving help for mental illness. People in this role can make use of their own experience as a carer to assist other families to feel more able to support their young person who is living with a mental illness. They can also help family members to identify their own needs for support and provide suggestions about how they might find that support.

- Psychoeducation refers to the process of providing education and information to those seeking or receiving mental health services, including both the young person and their family members.

- Family therapy, while a relatively specialized skill set, is a great resource to support families in which there are complex family dynamics that affect the young person's mental health.

- Self-care is an important aspect of taking an active role in protecting the young person's own well-being, particularly during periods of high stress.

- Consideration should be given to elements of the family-centred care approach, such as: taking into account the broader family needs and strengths in management plans; treating family members as experts; enabling families to take part/contribute to decision-making so that they can be partners in care and recovery.

- In many communities and contexts, family support is critical in being able to support the family while a young person is in distress or their illness particularly heightened. Family support can include that of friends, neighbours or relatives who provide a critical support base for the family.

Continuous improvement

- Workforce development and training
- Supervision
- Needs-based programmes
- Auditing systems
- Young person and family feedback
- Clinical governance
- Change management
- Evaluation informing improvement
- Using technology
- Map needs before developing programme

7. Continuous improvement

Since youth mental health, as a field, is still in an early stage of its own development, there must be a commitment to improvement and learning. This improvement lies in the service design, provider skills, youth and family participation and partnership as well as the quest to ensure that all young people receive the best, evidence-based care and interventions.

In common with all health services, there is a need in youth mental healthcare to seek to continuously improve and offer a high-quality and context-appropriate service that young people will want to access and use. This can be achieved through:

- Ensuring that staff and volunteers have access to supervision and professional development. This may be delivered using technology to overcome geographic barriers.

- Mapping the technical and conceptual needs of staff (their "skills and knowledge") before developing professional programmes.

- Providing methods to audit and evaluate the desired outcomes and performance of the service (access, clinical improvement, youth friendliness, family engagement etc). These should be developed in collaboration with young people.

- Feeding the results of evaluation and audit processes back into the service. A mechanism for ensuring this happens should be developed.

- Developing a governance framework: In an integrated youth mental health service, it is likely that there will be a range of providers; to ensure this works, a governance framework will need to be devised and implemented to which all organizations adhere. It will also need to be evaluated on a regular basis.

- Valuing a multidisciplinary, collaborative approach. Success in implementing new models, practices and interventions depends upon the ability of partners, service providers, youth and families to understand, see value in and apply such an approach to integrated youth services. To help achieve this, a change management approach could be adopted.

- Seeking and responding to the opinions of young people and families in a meaningful way.

Prevention

- Health promotion
- Anti-stigma measures
- Suicide prevention
- High-risk group focus
- Addressing social determinants

8. Prevention

While the focus of youth mental health service provision is often on providing assessment, intervention and support to young people presenting with mental ill-health and their families, youth mental health services also seek to promote prevention of mental illness. This may be in collaboration with broader public health initiatives, or in the absence of such, it may involve generating their own prevention programme. The role of community in developing prevention strategies is critical in many contexts and cultures.

As well as providing interventions and support to young people with mental illness and their families, youth mental health services also seek to be involved with, or indeed lead, efforts to prevent mental illness and suicide. Services may be developed and implemented in collaboration with broader public health initiatives, for example. Similarly, communities can play an active role in promoting better mental health and this can often be undertaken in collaboration with a youth mental health service or those responsible for young people's mental health locally. Practices enabling the principle of prevention may include:

- Health-promotion activities, such as providing information to parents about healthy parenting for adolescents and

FIGURE 10

Importance of local contextual factors in a youth mental health approach

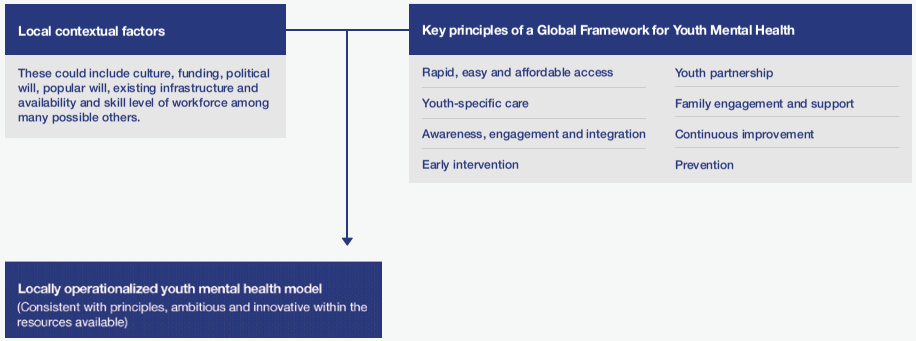
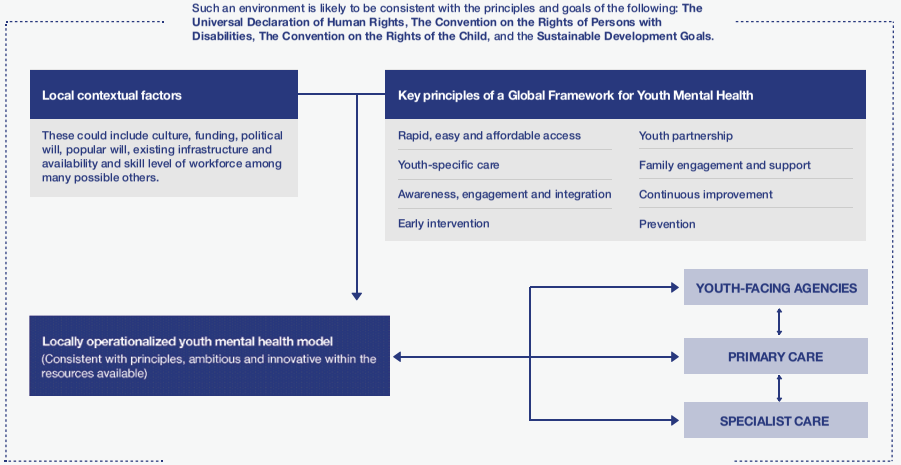


FIGURE 11

All elements of the global youth mental health framework



young adults, initiatives to reduce bullying such as the KiVa anti-bullying intervention scheme,[103,104] advising planners about mental healthy planning, educating school staff on mental health-positive activities for their school.

- Community members being educated about the signs and symptoms of mental health and being able to signpost the young person to appropriate support options, be it clinical services or community supports.

- Promoting or creating anti-stigma measures. These might be directed at young people, parents, schools, religious leaders, employers and the broader community.

- Suicide prevention, which may include publicizing suicide helplines, promoting evidence-based material such as the #chatsafe guidelines,[105] establishing postvention responses or education.

- Identifying high-risk groups in the local community who are at greater risk of developing mental illness and working with those groups to bring forward proactive strategies to engage and welcome them into the service when they need it.

- Identifying key local social determinants of health and working with other advocates and local community leaders to address these. Note that systemically addressing social determinants is likely to increase mental health outcomes,[106] so in this sense "prevention" of mental ill-health is intrinsically linked to "integration" of youth mental health efforts, with efforts on issues such as housing security, financial security, access to clean and healthy food and water, and other determinants.

Translating principles to action

Local contextual factors are important to the successful implementation and sustainability of a youth mental health approach. The key principles of the framework need to be interpreted and operationalized through this lens.

Cross-cutting considerations

There are two particular considerations that cut across all of the principles listed above. The first is that these principles are **operationalized locally** and consider the range of cultural contexts that are unique to any situation or setting. As far as possible, these local contexts should be used to refine and enhance the youth mental health service developed or provided.

Secondly, **consideration should be given to the use of technology** and how it might assist the implementation of the local operationalization of these principles. There is currently significant research on interventions using online and other technological approaches. The acceptability and feasibility of these should be explored with young people and families in local contexts. Feasibility may address issues such as the affordability of data for young people or the capacity of telephone or data services to provide access to the interventions.

Beyond interventions, technology may feature in service and workforce development, supervision, auditing, evaluation and research.

Bringing the framework together

The global framework for youth mental health specifies that any new youth mental health service needs to integrate with other youth-serving agencies. These might include other primary and secondary health services, but will also include additional youth-involved services and community resources such as schools, sports clubs, youth centres, religious groups, etc.

While resources will vary across settings, **some aspects of the framework are universal.** These include a **primary-care service – that is a service accessible to young people in which there are no referral, cost or administrative barriers.** The service may physically range from a bench or beach to an SMS engagement to an online social media portal to a purpose-built environment. However it is configured, the service should be open to all young people and **should proactively identify and reach out to young people who**

are members of groups at particularly high risk of mental ill-health. The service offering **should be organized on evidence-based (or evidence-informed) principles and tailored to the local context.** In settings in which there is little or no direct evidence to guide practice, evidence-based interventions should be adapted and tailored to the local contexts. Further to this, the service should, if possible, through its own evaluation and perhaps in partnership with researchers, contribute to the development of evidence. In conducting evaluation and evolution of the service, **young people should be partners in the process.** Young people should also be partners in the design, running and management of the service. The service should support and provide information to families, and should be integrated in its community, and be known by young people and those who work with or have contact with young people.

Action and investment can't be blind: A plan for implementing the global youth mental healthcare framework

The framework emphasizes the necessity of involving local voices in the interpretation of the principles for the local context. These local voices may include young people, families of young people living with mental ill-health, representatives of government, health funders, community members who manage youth-facing agencies such as schools, sports clubs, religious groups, civil society organizations and youth mental health champions such as Global Shapers, among others.

Those experts who have previously developed, researched and evaluated youth mental health services in other contexts are also a valued voice in the implementation process. While the contexts may differ, their experience in overcoming barriers to implementation is likely to provide helpful lessons and insights for those beginning this journey.

An implementation proposal

The existing global youth mental health community is small but highly supportive. While the initiatives that have developed across a range of high-income countries have developed separately, they have often done so with awareness of each other and in a spirit that advice is available if requested.

It is our intention that this informal arrangement be facilitated to be more systematic and available to those who wish to explore implementing youth mental health services in their own locations.

We suggest that this is done using the expertise of the various groups mentioned above. A potential way that this might work is as follows:

1. In a location there is a desire to provide youth mental health services for young people. This desire may arise from a community that recognizes that their young people are struggling with mental health issues. It may occur after a series of young people have died by suicide. The recognition of this need may arise from government seeing that the potential of a significant number of young people is not being realized because of their struggles with mental health. The recognition of this may also come from international organizations, civil society organizations or others in the location. Whatever the means, the desire for youth mental health approaches must arise in the location.

2. As part of the ongoing work of this project, Orygen is assembling the means to assist local groups to advocate for youth mental health resources. These resources will be of use to grassroots advocates as well as to advocates within government or other funders.

3. After a decision has been made to explore the feasibility of a youth mental health service, Orygen will look to provide expertise, advice and connections to other youth mental health services to help local leaders think about how the framework might be locally interpreted in their context.

4. After the development of the local implementation plan, the implementation itself would commence. This would include evaluation and feedback to monitor progress and success against access, uptake, engagement and outcome goals.

5. Where success is seen to occur in a pilot location, scaling up could be considered. Again, this would involve consideration of the local obstacles to be overcome and identifying other obstacles and solutions that were not present at the first site. For example, as sites become located in less urban areas, a different range of challenges might present,[107] or in some parts of a country the ethnic composition or language may be different from the place where things were first trialled.

6. Through the scaling-up process, efforts would again be made to ensure that various groups with a range of expertise would be included.

In summary, no place needs to develop its youth mental health approach in isolation.

What is possible

The table on the next page was developed from consultations conducted with service providers and by reviewing programmes appropriate for different settings and contexts that target young people. It is similar in construct to that developed for The Lancet Commission on Global Mental Health and Sustainable Development,[108] with the focus on youth mental health service provision across different resource settings and the different levels within those settings, from community to tertiary. It is important to note that the table reflects different resource contexts rather than countries, recognizing the disparities that exist within and between different countries.

One of the main approaches with the youth model is the preference to anchor services or programmes in the first two settings as these are most acceptable to young people. It is worth noting, however, that not all programmes are linear; some that are indicated as appropriate for high-resource settings, such as the headspace model, when in fact a similar model could be established within middle-resource settings, depending on the available workforce and resourcing. This can equally apply to some of the community programmes in middle-resource settings that could be applied in lower-resource contexts.

In an ideal scenario, young people from any resource setting should reasonably expect to access the best available evidence-based care. For too long, governments in many countries have not adequately funded mental health in general and certainly not to the level required for young people to access optimal care. This framework aims to elevate what different countries should be aiming to provide for their young people.

RELEVANT TO VARIOUS RESOURCE SETTINGS

Models and approaches to youth mental health

- (A) YOUTH AND COMMUNITY
- (B) PRIMARY HEALTHCARE
- (C) SECONDARY HEALTHCARE
- (D) TERTIARY HEALTHCARE

A Provided across a broad range of community and youth settings	B Provided by a general primary care workforce	C Provided in community clinics or hospital settings	D Provided by mental health specialists	
Community education and upskilling initiatives that increase people's understanding and awareness of mental health e.g. Mental Health First Aid Evidence-based programmes that work in a variety of settings such as schools, universities and workplaces Targeted suicide prevention initiatives that are location-specific e.g. Zero Suicide model	Primary-care youth mental health programmes "one stop shops" such as headspace, Jigsaw, Foundry etc. Service features include: - Volunteer counsellors - Mental health clinicians - GPs - Drug and alcohol support - Vocational supports - Telehealth capacity Youth-friendly primary care clinics, particularly in rural and remote locations with GPs trained in youth-friendly mental healthcare	A cadre of mental health professionals skilled in delivering youth-friendly evidence-based interventions that are accessible in person and online	A dedicated youth mental health inpatient facility that is equipped to manage young people experiencing mood, personality and anxiety disorders Specialist youth-oriented inpatient services for young people experiencing a first-episode psychosis	HIGH-RESOURCE SETTINGS
Targeted programmes that promote young people's mental health and well-being Therapeutic programmes that seek to engage young people outside of traditional clinical settings e.g. Waves for Change – surf therapy	Youth-friendly satellite clinics that operate from primary health facilities. e.g. similar to adolescent sexual health clinics Youth mental health training for primary care providers Primary-care providers providing in-reach services in settings such as schools or community/youth centres	Multidisciplinary community mental health teams with capacity to provide outreach to young people with serious mental ill-health conditions Integration of mental healthcare with other healthcare such as maternal and child health and sexual health	Youth-responsive inpatient care in psychiatric hospital settings	MEDIUM-RESOURCE SETTINGS
Programmes targeting children and young people's mental health and well-being. School-based programmes such as Helping Adolescents Thrive (HAT) Programmes targeting stigma reduction and promoting help-seeking among young people Suicide prevention initiatives that target both local and online communities, e.g. #chatsafe	Mental health and psychosocial support programmes e.g. WHO programme Volunteer or lay worker programmes providing low-intensity support e.g. Friendship Bench model Simple digital mental health interventions	Training and support provided to staff and volunteers working in community or primary-care settings Clinical interventions that can be provided either face to face or online (where resourcing allows) Capacity for group work Access to GPs	Mental health facility (inpatient and outpatient) within the general hospital located in the community	LOW-RESOURCE SETTINGS

Conclusion

Prior to the establishment of headspace in Australia in 2006, only 30% of young women and 13% of young men with mental health needs accessed care.[109] Over the past 13 years, headspace has grown to 110 centres around Australia and sees approximately 100,000 young people per year. In addition, another 33,000 young people use headspace's online eheadspace service. Priority populations such as young Aboriginal or Torres Strait Islander people, LGBTQIA+ young people and culturally and linguistically diverse young people are disproportionately over-represented among headspace clients. Youth mental health programmes meet a significant unmet need that is currently not provided in many settings. The importance of engaging young people in the design and delivery of local service models cannot be overstated.

A review of studies of youth mental health services found that across 43 evaluations of different services, young people noted a greater willingness to engage with youth mental health services.[110] They did so for the following reasons: it was at a convenient location, preferably close to public transport; staff and the environment were youth-friendly and welcoming; there were young people working in the service (as peers, admin or clinical staff); there were few cost or administrative barriers preventing access; there was a range of services (e.g. not just mental health, but in other important areas such as employment, education, housing and physical and sexual health); and there was a supportive and positive set of interventions provided.[111]

These benefits need not be offered only in high-income settings; they should be available anywhere where a desire to improve the lives of young people exists. Flexibility is vital, and while a number of existing programmes and services have been established as a result of a national or state policy, local adaptation, community readiness and incorporation of relevant cultural factors play a significant role in ensuring the programme's success locally.

In thinking about youth mental health programmes of the future, consideration must be given to the need for a diverse and expanded workforce that is nimble and agile enough to adapt to the changing needs of young people. This includes the use of volunteers as an initial point of contact for young people who want to talk to someone – not necessarily a professional – about their concerns or issues. Ideally, should this require escalation, clinical staff are part of the overall staff mix to provide youth-specific and evidence-informed care.

Similarly, thought must be given to how technology can enhance service engagement and access for young people where there are simply no options locally, or as an adjunct to existing service provision.

This framework should be seen as a blueprint for mental health service provision for young people across the globe. There are fundamental elements that lend themselves to translation across different settings and cultural contexts that are not necessarily dependant on high levels of resourcing. However, we should never lose sight of the desire for the best possible mental health supports for young people irrespective of what it costs.

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We would like to thank:

Carlo Guaia, a former member of Orygen's Youth Research Council and one of the World Economic Forum's Global Shapers, and Liam Foran, Community Lead, Australia and New Zealand. Carlo introduced Orygen to Liam and the Forum and, via a series of discussions in 2017 and 2018, the two organizations embarked on this collaborative project.

The many young people, families, clinicians, service managers, academics, policy-makers and staff working in international organizations who were consulted with or otherwise provided their feedback and input into the project. Their time, wisdom and optimism and belief in this project were an ongoing stimulus for this work.

Participants of a London, UK, workshop in April 2019 to draft the initial principles and practices in this framework and those who contributed their input remotely. The workshop was facilitated by The Talk Collective.

Kate Gwyther for her work supporting the evidence review that underpinned the first discussion paper of this project.

Corinne Rugolo for her excellent administrative support throughout this project.

The London School of Economics team led by David McDaid.

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The project funders, including:
- Australian Government
- The Victorian State Government
- The Hearts and Mind Foundation
- The Graham Boeckh Foundation

Suggested citation: Killackey E, Hodges C, Browne V, Gow E, Varnum P, McGorry P and Purcell R. A Global Framework for Youth Mental Health: Investing in Future Mental Capital for Individuals, Communities and Economies. Geneva: World Economic Forum, 2020

Supplementary materials: In addition to this report, a number of supplementary materials provide additional detail on the evidence and information used to inform the framework, as well as more detailed information on youth mental health programmes and the individuals and organizations consulted. These can be accessed at https://orygen.org.au/Policy/World-Economic-Forum-partnership

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