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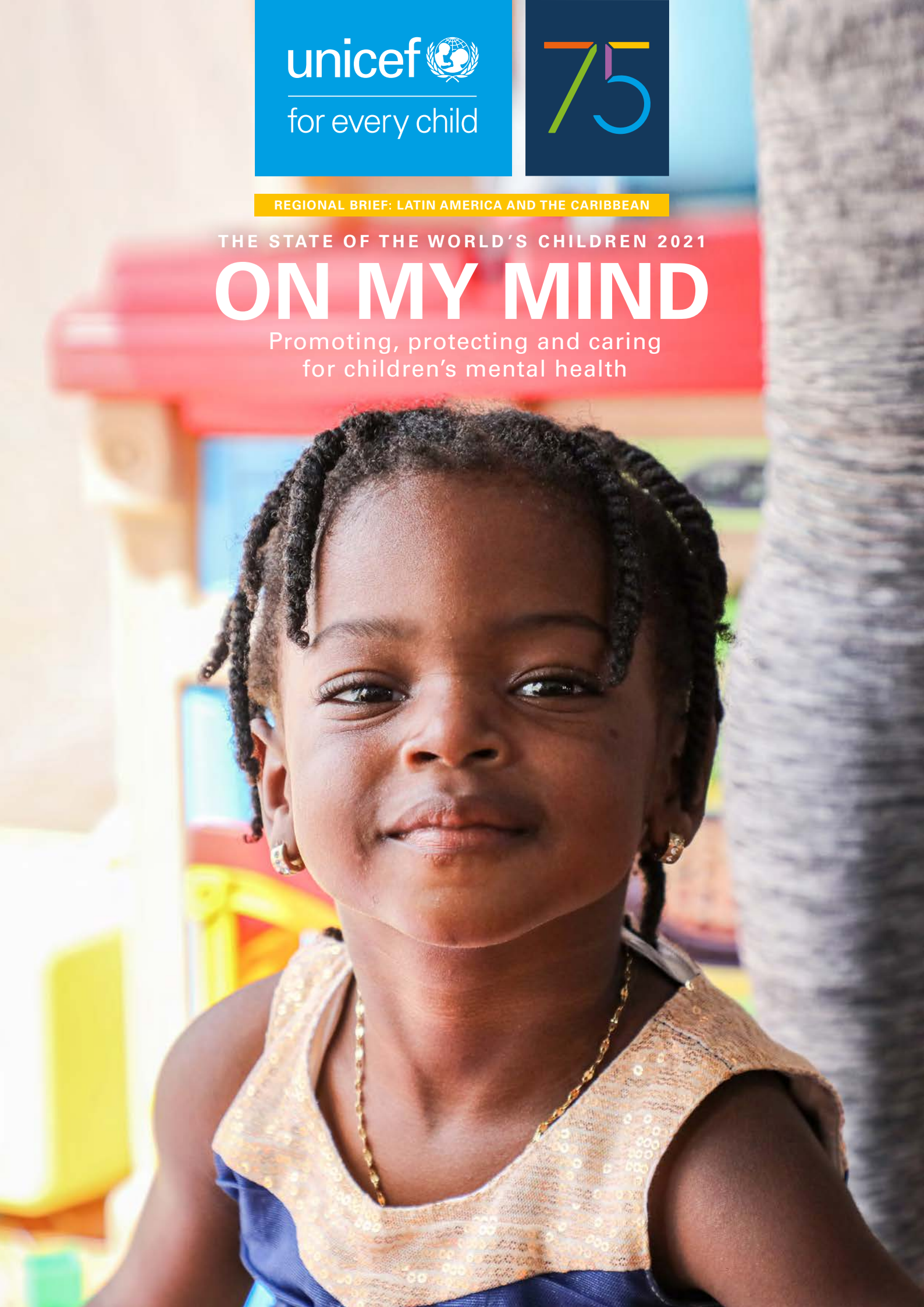
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REGIONAL BRIEF: LATIN AMERICA AND THE CARIBBEAN

THE STATE OF THE WORLD'S CHILDREN 2021

ON MY MIND

Promoting, protecting and caring
for children's mental health



A TIME FOR LEADERSHIP ON MENTAL HEALTH

Fear. Loneliness. Grief.

As the coronavirus pandemic descended on the world in 2020, these powerful emotions enveloped the lives of many millions of children, young people and families. In the early days especially, many experts feared they would persist, damaging the mental health of a generation.

In truth, it will be years before we can really assess the impact of COVID-19 on our mental health.

For even if the potency of the virus fades, the pandemic's economic and social impact will linger: over the fathers and mothers who thought they had left the worst of times behind them, but are once

again struggling to put food in a baby's bowl; over the boy falling behind in school after months of disrupted learning; and the girl dropping out to work on a farm or in a factory. It will hang over the aspirations and lifetime earnings of a generation whose education has been disrupted.

Indeed, the risk is that the aftershocks of this pandemic will chip away at the happiness and well-being of children, adolescents and caregivers for years to come – that they will pose a risk to the foundations of mental health.

For if the pandemic has taught us anything, it is that our mental health is profoundly affected by the world around us. Far from being

simply a question of what is going on in a person's mind, the state of each child's or adolescent's mental health is profoundly affected by the circumstances of their lives – their experiences with parents and caregivers, the connections they form with friends and their chances to play, learn and grow. Mental health is also a reflection of the ways their lives are influenced by the poverty, conflict, disease and access to opportunities that exist in their worlds.

If these connections were not clear before the pandemic, they certainly are now.

This is the reality that is at the heart of *The State of the World's Children 2021*.

A challenge ignored

Indeed, what we have learned is that mental health is positive – an asset: It is about a little girl being able to thrive with the love and support of her family, sharing the ups and downs of daily life. It is about a teenage boy being able to talk and laugh with his friends, supporting them when they are down and being able to turn to them when he is down. It is about a young woman having a sense of purpose in her life and the self-confidence to take on and meet

challenges. It is about a mother or father being able to support their child's emotional health and well-being, bonding and attaching.

The links between mental and physical health and well-being, and the importance of mental health in shaping life outcomes, are increasingly being recognized. They are reflected in the connection between mental health and the foundations of a healthy and prosperous world acknowledged

in the Sustainable Development Goals. Indeed, that agreement among the nations of the world positioned the promotion and protection of mental health and well-being as key to the global development agenda.

Despite all this, governments and societies are investing far, far too little in **promoting, protecting and caring** for the mental health of children, young people and their caregivers.

A time for leadership

At the heart of our societies' failure to respond to the mental health needs of children, adolescents and caregivers is an absence of **leadership** and **commitment**. We need commitment, especially financial commitment, from global and national leaders and from a broad range of stakeholders that reflects the important role of social and other determinants in helping to shape mental health outcomes. The implications of such an approach are profound. They demand that we set our sights on a clear shared goal of supporting children

and adolescents at crucial moments in their development to minimize risk – and maximize protective – factors.

As well as commitment, we need **communication**: We need to end stigmas, to break the silence on mental health, and to ensure that young people are heard, especially those with lived experience of mental health conditions. Without their voices being heard and their active participation and engagement, the challenge of developing relevant mental health programmes and initiatives will not be met.

And we need **action**: We need to better support parents so that they can better support their children; we need schools that meet children's social and emotional needs; we need to lift mental health out of its 'silo' in the health system and address the needs of children, adolescents and caregivers across a range of systems, including parenting, education, primary health care, social protection and humanitarian response; and we need to improve data, research and evidence to better understand the prevalence of mental health conditions and to improve responses.

A time for action

The COVID-19 pandemic has upended our world, creating a global crisis unprecedented in our lifetime. It has created serious concerns about the mental health of children and their families during lockdowns, and it has illustrated in the starkest light how events in the wider world can affect the world inside our heads. It has also highlighted the fragility of support systems for mental health in many countries, and it has – once again – underlined how these hardships fall disproportionately on the most disadvantaged communities.

But the pandemic also offers an opportunity to build back better. As *The State of the World's Children's 2021* sets out, we know about the key role of parents and caregivers in shaping mental health in early childhood; we know too about children's and adolescents' need for connection; and we know about the dire impact that poverty, discrimination and marginalization can have on mental health. And while there is still much work to be done in developing responses, we already know the importance of key interventions, such as challenging stigmas, supporting

parents, creating caring schools, working across sectors, building robust mental health workforces, and establishing policies that encourage investment and lay a solid foundation for mental health and well-being.

We have a historic chance to commit, communicate and take action to promote, protect and care for the mental health of a generation. We can provide support for the foundation of a generation equipped to pursue their dreams, reach their potential and contribute to the world.

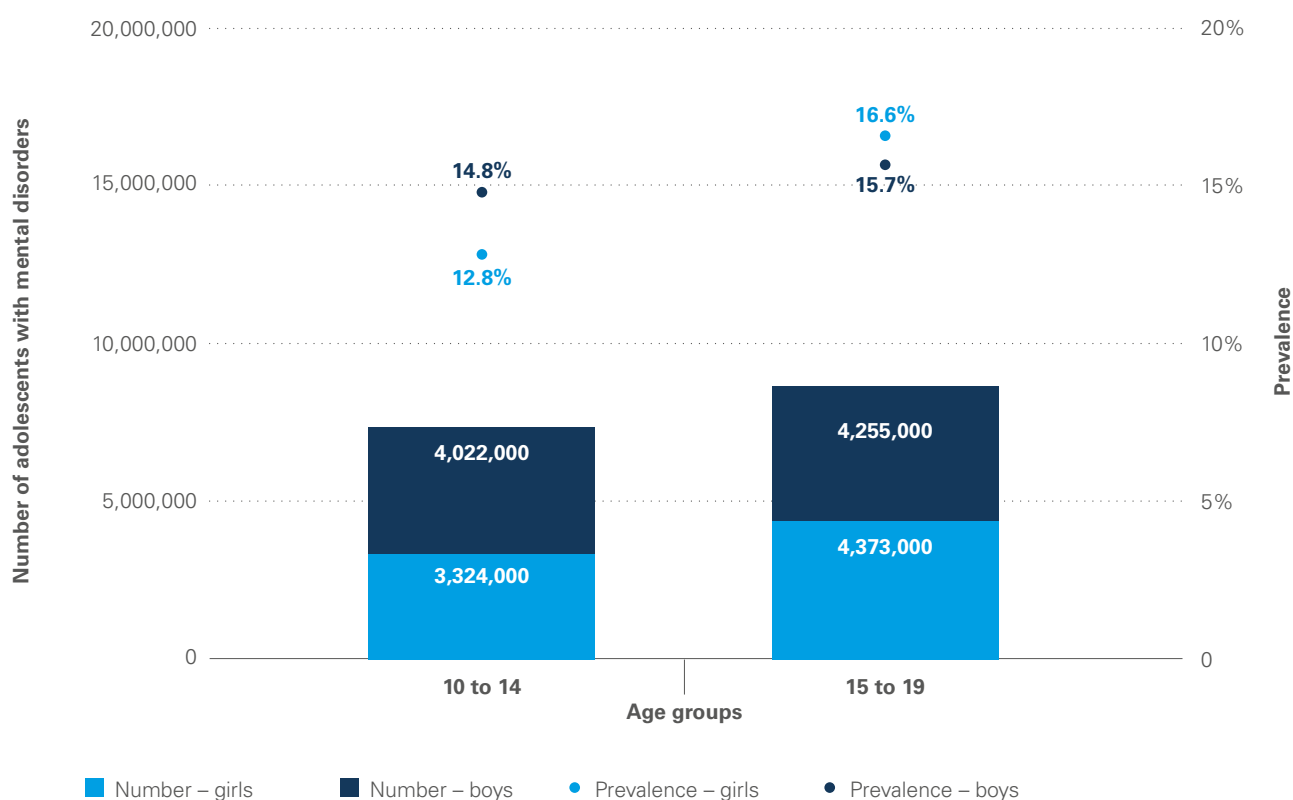
BY THE NUMBERS

Prevalence of mental disorders

Nearly 16 million adolescents aged 10–19 live with a mental disorder in Latin America and the Caribbean (LAC).



Estimated prevalence and number of adolescents aged 10–19 with mental disorders in LAC, 2019



Note: The number of adolescents with mental disorders is rounded to the nearest 1,000; calculations are based on these disorders: depression, anxiety, bipolar, eating, autism spectrum, conduct, schizophrenia, idiopathic intellectual disability, attention deficit/hyperactivity (ADHD) and a group of personality disorders.

Source: UNICEF analysis based on estimates from the Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Study, 2019.



Estimated prevalence of mental disorders among adolescents aged 10–19 in LAC, 2019

Country	Girls and boys aged 10–19		Girls aged 10–19		Boys aged 10–19	
	Prevalence %	Number	Prevalence %	Number	Prevalence %	Number
Antigua and Barbuda	16.4%	2,143	14.5%	930	18.2%	1,213
Argentina	15.1%	1,064,820	14.3%	499,278	15.8%	565,542
Bahamas	16.3%	10,157	14.4%	4,527	18.2%	5,630
Barbados	16.5%	6,338	14.6%	2,740	18.3%	3,598
Belize	16.6%	14,748	14.6%	6,514	18.5%	8,234
Bolivia (Plurinational State of)	15.6%	338,654	14.7%	158,197	16.4%	180,457
Brazil	17.1%	5,617,833	17.6%	2,843,045	16.7%	2,774,788
Chile	16.0%	391,622	16.6%	198,622	15.4%	193,000
Colombia	12.9%	993,977	12.6%	472,918	13.2%	521,059
Costa Rica	13.5%	97,396	13.0%	46,545	14.0%	50,851
Cuba	16.8%	214,213	14.8%	91,766	18.6%	122,447
Dominica	16.5%	1,852	14.5%	792	18.4%	1,060
Dominican Republic	16.8%	323,257	15.1%	143,624	18.5%	179,633
Ecuador	15.4%	508,706	14.6%	237,737	16.1%	270,969
El Salvador	13.9%	158,801	13.7%	76,516	14.2%	82,284
Grenada	16.6%	2,750	14.6%	1,152	18.5%	1,598
Guatemala	13.8%	522,652	13.4%	249,374	14.1%	273,279
Guyana	17.5%	24,775	15.9%	11,120	19.0%	13,655
Haiti	17.6%	450,458	15.8%	202,322	19.4%	248,136
Honduras	13.5%	287,849	12.9%	136,659	14.0%	151,190
Jamaica	16.4%	77,198	14.4%	33,214	18.3%	43,984
Mexico	12.1%	2,664,151	11.8%	1,281,841	12.5%	1,382,310
Nicaragua	14.0%	179,984	13.6%	85,595	14.3%	94,390
Panama	12.9%	92,399	12.2%	42,944	13.5%	49,455
Paraguay	16.5%	215,870	17.1%	109,570	15.8%	106,300
Peru	14.9%	864,837	13.9%	381,875	15.8%	482,962
Saint Kitts and Nevis	16.7%	1,451	14.9%	647	18.4%	804
Saint Lucia	16.7%	4,249	14.7%	1,842	18.6%	2,406
Saint Vincent and the Grenadines	16.7%	3,010	14.6%	1,286	18.6%	1,724
Suriname	17.2%	16,660	15.5%	7,268	18.7%	9,392
Trinidad and Tobago	16.5%	30,382	14.6%	13,212	18.3%	17,169
Uruguay	15.0%	73,105	14.8%	35,178	15.3%	37,927
Venezuela (Bolivarian Republic of)	15.4%	716,988	13.8%	317,221	16.9%	399,768

Note: Figures are based on these disorders: depression, anxiety, bipolar, eating, autism spectrum, conduct, schizophrenia, idiopathic intellectual disability, attention deficit/hyperactivity (ADHD) and a group of personality disorders.

Source: UNICEF analysis based on data from the IHME, Global Burden of Disease Study, 2019.

Suicide estimates

Suicide is the third most common cause of death among adolescents aged 15–19 in LAC.



Top five causes of death among adolescents aged 15–19 in LAC

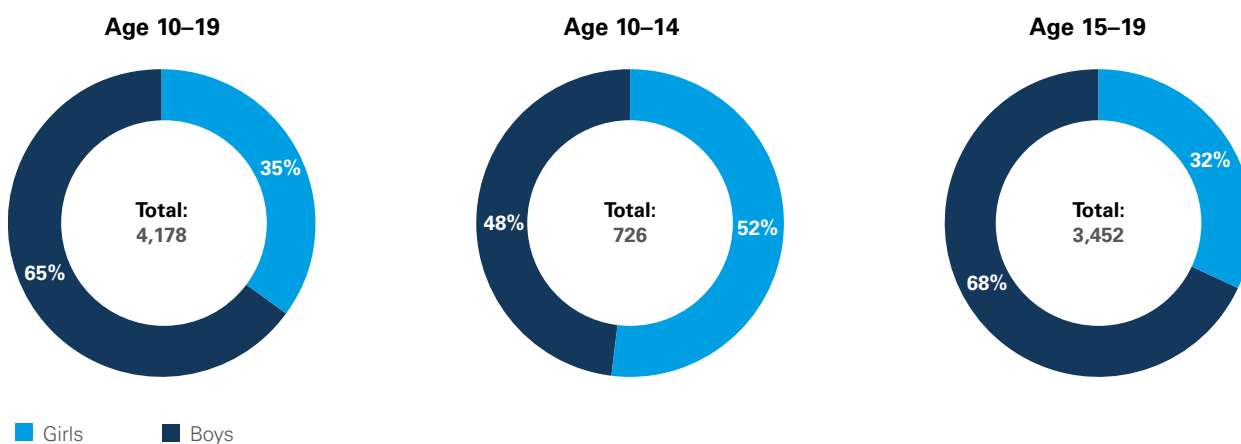
Rank	Cause	Deaths per 100,000
1	Interpersonal violence	36
2	Road injury	15
3	Suicide	6
4	Drowning	3
5	Leukaemia	2

Source: UNICEF analysis based on WHO Global Health Estimates; global estimates were calculated using population data from the United Nations Population Division World Population Prospects, 2019.

More than 10 adolescents lose their lives every day due to suicide in LAC.



Estimates of suicide as a cause of death in LAC



Note: Confidence intervals for estimated number of deaths for adolescents at different age groups are 10–19, 3,166–5,405; 10–14, 521–979; 15–19, 2,645–4,426.

Source: UNICEF analysis based on WHO Global Health Estimates, 2019; global estimates were calculated using population data from the United Nations Population Division World Population Prospects, 2019.

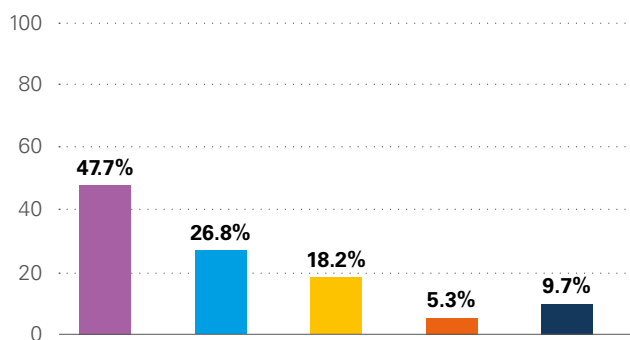
Anxiety and depression

Anxiety and depression account for almost 50 per cent of mental disorders among adolescents aged 10–19 in LAC.

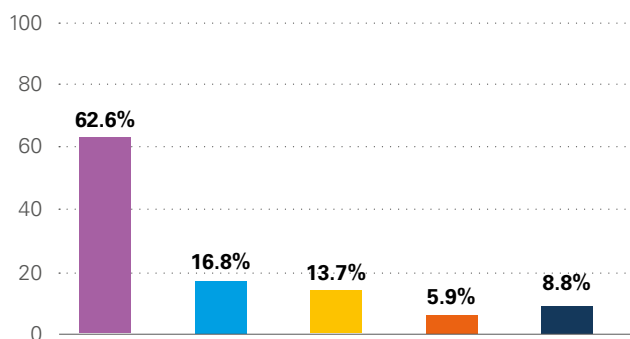


Estimates of key mental disorders among adolescents in LAC, 2019

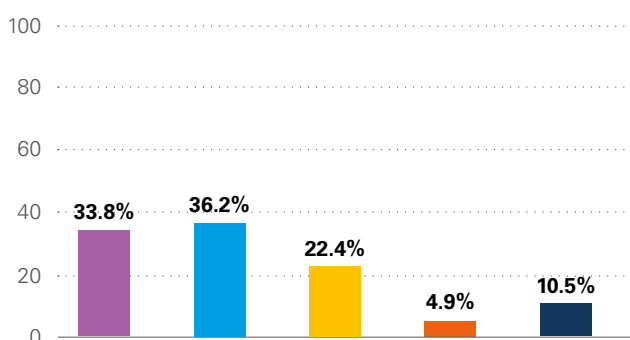
Boys and girls aged 10–19



Girls aged 10–19



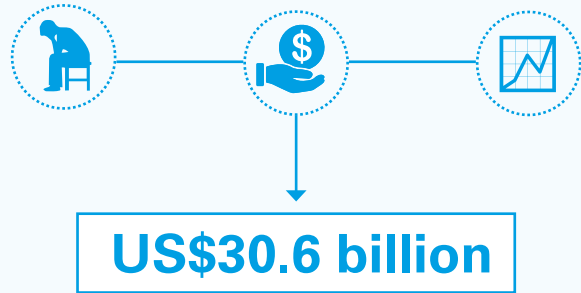
Boys aged 10–19



■ Anxiety and depression disorders
 ■ ADHD
 ■ Conduct disorder
 ■ Bipolar disorder
 ■ Remaining mental disorders

Note: The sum of the prevalence of individual disorders exceeds 100 per cent due to the co-morbidity between the disorders; calculations are based on the disorders noted above.
Source: UNICEF analysis based on IHME Global Burden of Disease Study, 2019.

The cost of mental disorders in LAC



This figure is the annual loss of human capital from mental disorders based on country-specific values for disability-adjusted life years (DALYs). The estimate is based on the value of lost mental capital – or cognitive and emotional resources – that children and young people would contribute to economies if they were not thwarted by mental health conditions. David McDaid and Sara Evans-Lacko of the Department of Health Policy of the London School of Economics and Political Science started with estimates of the burden of disease attributable to mental health expressed in DALYs. One DALY represents the loss of a year of healthy living caused by disability or premature death. The researchers then assigned a monetary value to each disability-free year based on the average output each person contributes in an economy. One DALY is therefore equivalent to a country’s gross domestic product (GDP) per capita, expressed in purchasing power parity (PPP) terms. This formulation allows comparisons to be made globally. (see *The State of the World’s Children 2021 for a full account of the costs of mental disorders.*)

The analysis in these pages includes data from the Institute for Health Metrics and Evaluation (IHME), World Health Organization (WHO) and World Population Prospects (WPP). IHME data were not available for Anguilla, the British Virgin Islands, Montserrat or Turks and Caicos Islands, therefore, these countries are not included in the analyses that relied on those data. WHO and WPP data were not available for Anguilla, British Virgin Islands, Dominica, Montserrat, Saint Kitts and Nevis or Turks and Caicos Islands.

CASE STUDY

Peru

Community-based Mental Health Care

Two years ago, when Andre* was 12 years old, his mother, Roxana, received a distressed phone call from his school.

“He was under a desk, crying, and saying that he didn’t want to keep living,” she said.

Roxana knew Andre needed help. But they lived in the northern outskirts of Lima, and hospitals and private clinics were either too far away or too expensive. However, a visit to a local health centre provided them with public health insurance and a referral to the Community Mental Health Centre in Carabayllo, a 10-minute bus ride away.

The centre is housed in a repurposed municipal stadium and staffed by a multidisciplinary

team that includes psychiatrists, psychologists, nurses, a social worker and pharmacy staff.

Andre was diagnosed with anxiety and depression linked, in part, to his parents’ separation. He was prescribed an antidepressant and referred to a psychologist, psychiatrist and social worker for therapy.

“We made an integrated plan to help him understand and manage what he’s going through,” psychologist Yesica Chambilla said. “We provided him with tools to make his own changes.”

The centre also provided guidance to Roxana, who plays an active role in her son’s care.



Doing better: A community health centre has helped Andre with his mental health: “I feel much better,” he says, “and I don’t want to give up.”
© UNICEF/UN0476518/Mandros

The integrated plan is part of Peru’s community-based mental health-care model, which offers services at the primary health-care level, close to where people live and where they can access their communities’ network of support.

To address the gap between the need for and the availability of mental health services, the Peruvian Government instituted a series of reforms to expand community-based care, including adding mental health-care coverage to the national health insurance scheme and establishing a mental health results-based budget programme that boosted public spending. A new national mental health law was passed in 2019. The network of community-based mental

health care centres increased from 22 in 2015 to 203 in 2021.

For Andre, the lockdown due to the COVID-19 pandemic was stressful, but he was able to speak regularly with his psychologist by phone. Now, more than a year after his first visit to the centre, Andre is coming off his medication and experiencing positive changes.

*“Before coming, things were really bad,” Andre said.
“Now I feel much better, and I don’t want to give up.”*

* Andre and Roxana are pseudonyms used to protect their identities. They were interviewed in Lima in June 2021.

CASE STUDY

Mexico

Making Sense of Sadness: Protecting the mental health of unaccompanied migrant children

In November 2020, Hurricane Eta ripped through Honduras, orphaning María,* 16, who decided to leave home in search of family in the United States.

María's hopes were dashed when she was detained by immigration officials near the border of Guatemala and Mexico. She was transferred to the Albergue Temporal para Niñas y Adolescentes Migrantes Separados o No Acompañados, a 29-bed temporary shelter in Tapachula for unaccompanied migrant girls. The shelter provides them with food, a bed and psychosocial support for up to 45 days while officials assess the possibility of uniting them with family. It is funded by the Mexican Government and managed by the local

municipality. UNICEF provides support to strengthen the shelter's programme to provide holistic care and child-centred attention, resilience building and life skills development, and psychosocial activities through recreation and sports.

"Research has shown that children experience stress when they are limited to one space," said Adriana Arce, UNICEF Field Office Manager in Tapachula. "They've also experienced stress in transit when migrating from one country to another."

Many of the girls have also fled dangers at home, including abuse, gang violence, human trafficking and natural disasters.



Mask making: Materials for a psychosocial support activity at a shelter for unaccompanied migrant girls in Mexico.
© UNICEF/UN0436866/Guerrero VII Photo

Many arrive with experiences that, without the support of a caring adult, can lead to toxic stress – a significant risk to their development and mental health.

“Their rights, resilience, self-esteem and the power to lead their lives travel with them,” said Ana Cecilia Carvajal, who monitors psychosocial support carried out by UNICEF partners in the field. “We want to provide them with support and to remind them of their worth and to help them think positively.”

In March 2021, when María was there, 18 other girls and 4 babies lived in the shelter. During her stay, María made it a priority to attend the classes and has

learned how to manage her stress and regulate her emotions. She has gained an appreciation of her rights. Though she has struggled with sadness, her faith also helps her to remain hopeful and focused on her future.

“Sometimes you can learn a lot even if you don’t know why God brought you to a place,” she said.

* María is a pseudonym used for her protection. She was interviewed in March 2021 at the Albergue Temporal para Niñas y Adolescentes Migrantes Separados o No Acompañados.

WHAT YOUNG PEOPLE SAY

Background: For this edition of *The State of the World's Children* report, UNICEF teamed up with researchers from the Global Early Adolescent Study at Johns Hopkins Bloomberg School of Public Health (JHU) to host focus group discussions on mental health and well-being. From February to June 2021, local partners facilitated focus group discussions for adolescents aged 10–14 and 15–19 in 13 countries worldwide. In LAC, the focus groups were implemented in Chile and Jamaica. This brief includes quotes from some of the adolescents who participated in the focus groups. A fuller companion report on the discussions will be released in 2022.

The **COVID-19 pandemic** has dramatically shifted the lives of young people all over the world. When schools closed, adolescents, who increasingly rely on connections with peers as they mature, were cut off from those social networks. During the focus group discussions, adolescents described significant impacts on mental health. **Social isolation** and challenges with **remote learning** are two examples of issues raised:

"I feel that... because of the pandemic we've all felt a little sadder, because you don't usually meet with friends or go out anymore, and I feel that it has affected us a lot." (Older boy, Chile)

"Not being able to see your friends causes depression because talking on a screen is not the same – you don't have the same connection as seeing them in person." (Younger girl, Jamaica)

During the focus group discussions, adolescents shared different **levels of distress** that they may experience throughout life:

"I get very sad and then I start to shiver, I start to run out of air and then I start to cry, like without being able to hold it... I look like a zombie and I have nothing else to do or I try to get my spirits up but until I sleep it will not happen." (Younger girl, Chile)

"I personally believe that growing up, everyone goes through a phase where they start to develop a low level of depression... so I personally think that everyone really and truly experiences sadness, but when it becomes depression is when... those feelings are ignored or they're boosted or fuelled." (Older girl, Jamaica)

Adolescents also pointed out a potential **generation gap** when talking to parents about mental health issues and remarked on some of the challenges of parent-child relationships.

"[Parents invalidating our experiences] happens a lot. For example... a person tells [their] parents [about] their problems, and parents can say, "...You don't have [a] debt or anything for you to be sad," and things like that." (Younger boy, Chile)

"When I was younger, I did express my feelings much more, but they were not validated when I was 13, 14 years old. I could say, "I have depression, or I feel sad," and they would say, "No, you don't know what you feel because you are 12 years old." (Older girl, Chile)

Issues regarding **mental health stigma** were echoed during the focus group discussions, in which adolescents discussed the ways in which such stigma can impede help-seeking behaviours:

"In Jamaica, we don't talk about mental health like a normal thing. It's not a normal thing that we all talk about." (Younger girl, Jamaica)

Adolescents recognized prominent risk factors for mental health at the peer level. **Bullying** was the most widely discussed during the focus groups, as this girl from Chile remarked:

"[I was bullied a lot in] other schools... and I'm so marked by it, I feel that if I make new friends they will start to criticize [me]."
(Younger girl, Chile)

It was clear from focus group discussions around the world that **gender norms** matter for mental health for boys and girls alike. Adolescents generally agreed that girls are less constrained than boys by norms around help-seeking and could more easily reach out to friends and family members for support:

"In women [self-injury] is more likely to happen because we are exposed [to] a greater pressure in society... because we are judged more than [men] are... We have a lot of pressure because of our body [image]." (Older girl, Chile)

"It's okay for girls to express their feeling more than boys. [To be a man is] to be tough, to keep our feelings inside, and girls have the opportunity to speak to their peers and their parents and express how they feel inside, and boys have to hold it in." (Older boy, Jamaica)

Adolescents also discussed the ways in which mental health conditions can increase vulnerabilities and lead to **self-harm**:

"I think the reason why people do self-harm... I think it is because they are feeling so much emotional and mental pain that they think the physical pain is going to help block [it]."
(Younger girl, Jamaica)

"I feel that there are many problems such as self-injury... a lot of self-harming, even causing death... there is a lot of that in our age group, especially due to low self-esteem, family problems, harassment, and that kind of thing." (Older girl, Chile)

A FRAMEWORK FOR ACTION

The State of the World's Children 2021 has set out the mental health challenges facing children and adolescents and their families. It has shown that these challenges are global – from the poorest village to the wealthiest city, children and their families are suffering pain and distress. At an age and stage of life when children and young people should be laying strong foundations for lifelong mental health, they are instead facing challenges and experiences that can only

undermine those foundations. The cost for us all is incalculable.

It does not have to be this way. And it should not be this way.

Our priorities are – or should be – clear. We may not have all the answers, but we know enough to be able to act now to **promote** good mental health for every child, **protect** vulnerable children and **care** for children facing the greatest challenges.

This report sets out a framework to help the international community, governments, schools and other stakeholders do just that, grounded in three core principles: **Commitment** from leaders, backed by investment; **Communication** to break down stigmas and open conversations on mental health; and **Action** to strengthen the capacity of health, education, social protection and other workforces, better support families, schools and communities, and greatly improve data and research.

Commitment, Communication, and Action for Mental Health

► **TO COMMIT** means strengthening leadership to set the sights of a diverse range of partners and stakeholders on clear goals and ensuring investment in solutions and people across a range of sectors.

Provide regional and national leadership. Building on existing efforts, stronger regional and national leadership is needed to align stakeholders around clear goals and set priorities; to develop financing models that can help bridge the investment gap; to develop partnerships to share knowledge and experience – globally, regionally and nationally – on delivering services, building capacity, gathering data and evidence, and providing mental

health and psychosocial support (MHPSS) in crisis and emergency settings; and crucially, to monitor and evaluate progress.

Invest in supporting mental health. Mental health is woefully underfunded. Many governments spend only a few cents per capita directly on mental health, and allocations from international development assistance are meagre. Most spending goes into psychiatric services, meaning that almost nothing is spent on mental health prevention or promotion. In recent years, there has been considerable focus on, as well as support for, setting specific targets for mental health in health budgets – typically at least 5 per cent in low- and middle-

income countries (LMICs) and at least 10 per cent in high-income countries.

Investment is needed across sectors, not just in health, to support a strong focus on workforce development in health, education and social protection systems. Clear targets need to be set, and new and innovative sources of funding and investment need to be identified to meet those targets. And a guiding principle for all investment – regional and national – is that it must be in line with rights-based approaches that take account of the needs of people with lived experiences and comply with international human rights instruments.

► **TO COMMUNICATE** means tackling stigmas around mental health, opening conversations and improving mental health literacy. It means amplifying the global conversation on mental health to raise awareness and mobilize all stakeholders to take action and facilitate learning. It also means ensuring children, young people and people with lived experience are part of the conversation, that they have a voice and can meaningfully engage in the development of mental health responses.

Break the silence, end stigma.

Governments and other stakeholders, including the media, should work to break down stigmas around mental health and promote a message of inclusiveness. When adequate support and opportunities are available, living with a mental health condition or psychosocial disability need not be an obstacle to living a happy and healthy life. Tackling stigma also means promoting mental health literacy – supporting children, adolescents and caregivers to better understand how to promote positive mental health, how to recognize signs of distress in themselves and in others, and how to seek help when they most need it.

Ensure young people have a say.

Continued support is needed to provide all young people, especially those with lived experience of mental health conditions, with the means for active and meaningful engagement. This can be done through, for example, investment in community youth groups, co-creation of peer-to-peer initiatives and training programmes.

► **TO ACT** means working to minimize the risk factors and maximize

the protective factors for mental health in key areas of children's and adolescents' lives, especially the family and school. More broadly, it also means investment and workforce development across some key sectors and systems, including mental health services and social protection, and the development of strong data collection and research.

Support families, parents and caregivers.

Supporting parents and caregivers is essential to building child and adolescent well-being and to reducing and preventing violence against children. Stable relations at home can help protect children against toxic stress and promote resilience and overall well-being.

- **Promote responsive caregiving and nurturing connections.**

Parenting programmes need to be scaled up, with a focus on social and emotional learning to support families and children to develop positive attachments and to create a positive home environment.

- **Help parents support their children's health and well-being.**

Parents and caregivers need support to engage with their children throughout the child's and adolescent's life to foster their social, emotional, physical and cognitive development. Training programmes and counselling should share knowledge on health, nutrition and child development, and stimulate learning within the home.

- **Care for caregivers' mental health.**

Mental health programmes must prioritize caregivers, providing support to manage chronic stress and conflict, and to enhance coping strategies.

- **Give parents training to respond to children's mental health challenges.** Skills training for parents can improve the developmental, behavioural and familial outcomes for children and adolescents facing mental health challenges. Investments must be made to scale up family-centred approaches, including those designed to be delivered by non-specialists.

Ensure schools support mental health.

Schools play a unique and vital role in the lives of children and adolescents. Violence and bullying – both by teachers and other students – as well as excessive pressure to succeed can undermine children's mental health; on the other hand, a warm school environment and positive relationships between students and between students and teachers can bolster it.

- **Invest in a whole-of-school approach to mental health.**

A holistic approach means considering all the ways in which schools affect children's development and well-being. It should seek to encourage a positive and warm school climate that makes children feel safe and connected. It should provide regular mental health and psychosocial well-being training for teachers and other personnel and for children, adolescents and families.

- **Strengthen teachers' knowledge and socioemotional competencies.**

Teachers and other school personnel need support to build their capacity so that they, in turn, can help children and adolescents learn about mental health and develop healthy

habits, and so that they can recognize students in need of additional support.

- **Prevent suicide.** Specialized training for teachers and peers (as well as parents, school counsellors, social and health workers) can help ensure that at-risk children are identified and provided with support. National suicide prevention programmes can play an important role in restricting access to the means of suicide, encouraging responsible media reporting, and identifying and removing harmful content on social media.

Strengthen and equip multiple systems and workforces to meet complex challenges.

The focus for mental health programming and services needs to broaden to take advantage of opportunities to promote, protect and care for mental health not just in health services, but in areas like social protection and community care. But, for this to happen effectively and sustainably, child- and family-focused workforces and relevant systems need to be strengthened both to deliver services across systems and settings, and to ensure that the needs and human rights of every child are upheld.

- **Integrate mental health services into social protection and community care systems.** Services need to be provided across sectors and delivery

platforms, including health, education, social protection and community care. Community-based interventions are particularly positioned to identify and support at-risk children who require specialized care. Invest in training for community workers and ongoing support and supervision to build their knowledge and skills.

- **Provide MHPSS interventions in humanitarian and fragile settings.** Responses in those settings must be context specific and multi-layered, providing children the necessary means and resources to cope with anxiety and severe forms of distress. Specialized care for the most vulnerable populations should be offered.
- **Respect child rights in mental health services.** Child rights must be respected in the design and provision of mental health services, with service users treated not as patients but as individuals with rights. Care should be person-centred, free of coercion, recovery-oriented and supportive of decision-making.
- **Address gender inequalities in mental health programming.** Mental health programmes must actively seek to redress gender inequalities by assessing and addressing the needs of women, girls, boys, men and non-binary individuals through data collection, wide

consultation and participation, and monitoring.

Improve data, research and evidence.

Data on the mental health of children, adolescents and caregivers are sadly lacking, especially in LMICs, where most of the world's adolescents live. A lack of data and evidence renders children with mental health conditions invisible and is a major obstacle to policy development and planning. Progress on mental health is also hampered by a lack of research and inadequate investment in implementation research.

- **Strengthen research.** Greater investment is needed in research on children and adolescents, which should be cross-culturally applicable, adaptable to local realities and capable of capturing diverse experiences and realities.
- **Routinely monitor mental health.** A determined effort is needed to develop a consensus-based set of core indicators covering the prevalence of mental health conditions, the provision of mental health care, and the extent of efforts to promote mental health.
- **Support implementation research and science.** Increase investment in implementation science, which investigates how a range of factors can impede or accelerate the implementation of policies and interventions.