

The Lancet Psychiatry Commission on youth mental health



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Executive Summary

Mental ill health, which has been the leading health and social issue impacting the lives and futures of young people for decades, has entered a dangerous phase. Accumulating research evidence indicates that in many countries, the mental health of emerging adults has been declining steadily over the past two decades, with a major surge of mental ill health driven by the COVID-19 pandemic, the measures taken to contain it, and its aftermath. This alarming trend signals a warning that global megatrends (major, long-lasting societal changes such as environmental, social, economic, political, or technological changes) and changes in many societies around the world in the past two decades have harmed the mental health of young people and increased mental ill health among them.

Mental illnesses have a peak age of onset of 15 years, with 63–75% of onsets occurring by age 25 years, which represents the epidemiological inverse of physical illnesses. Unless treated effectively, mental illnesses are a major cause of premature death from physical illness and suicide. Even when these illnesses do not cause death, they are the largest and most rapidly growing cause of disability and lost human potential and productivity across the lifespan. In 2011, the World Economic Forum reported that among the non-communicable diseases, mental illness was the largest source of loss of gross domestic product (GDP) globally. These human impacts and economic losses largely stem from the timing of their onset in life, combined with worldwide neglect of mental illness due to stigma and discrimination within health care and medical research. Mental illness has been described as a scandal and a form of self-harm inflicted by society upon itself.

Encouraging signs suggest that the danger is being sensed and some responses are emerging. The US Surgeon General has labelled the deteriorating situation a youth mental health crisis and is formulating strategies to combat it in the USA. However, the crisis is global and demands forensic analysis of the megatrends and the malleable risk and protective factors that are influencing it, and a global strategy that can catalyse national and local action plans to counter it. The cohesion and prosperity of societies around the world are at risk and not limited to health outcomes alone. The concept of mental wealth has been formulated to capture the enormous potential benefits that could flow from better promotion of mental

health and wellbeing, combined with early intervention and high-quality treatment of young people with emerging mental illness that is extended for as long as necessary. With the recognition that the cost of modern health care is becoming unsustainable, logic, rather than emotion, will need to determine how finite resources are allocated. Health care is already rationed in a covert fashion and, worldwide, mental illness is affected most by this rationing. The widespread delivery of low-value health care of many kinds should be reconsidered in relation to the value proposition of saving the lives and productive futures of young people. The rising incidence of mental ill health in young people makes continuing neglect of their needs intolerable.

Part 1: The changing landscape of youth mental health

A new field of youth mental health is being created with a focus on individuals aged 12–25 years. This Commission examines the changing landscape and the underlying megatrends influencing this change. The damage that some of these megatrends, such as rising inter-generational inequality, unregulated social media, wage theft, insecurity of employment, and climate change, is inflicting is deep and widespread within societies. The highly correlated domains of distress, diagnosable episodes of mental ill health with a need for care, and more severe, sustained, or recurrent forms of mental illness are at an all-time high. Young people are showing the most serious warning signs and symptoms of a society and a world that is in serious trouble.

Part 2: Conceptual frameworks and trajectories

To inform a new field of youth mental health, youth-appropriate conceptual building blocks and perspectives are needed, including new developmental thinking and clinical staging. Mental health care for young people (age 12–25 years) must be sensitive to this age group's specific biological, cognitive, social, and cultural changes. The physical, cognitive, and behavioural differences between young people and adults are likely to influence the way mental health problems present, and they indicate the need for different intervention approaches.

Part 3: Models of care

The principles, core features, and strategies seen as necessary for designing, testing, and scaling up new

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models of youth mental health care are widely agreed on. Integrated youth primary mental health care lies at the heart of the needed reform, and many countries have laid the foundations for this new approach to health care. However, considerable barriers and gaps remain across all resource settings, and particularly in low-resource settings, which must be addressed.

Parts 4 and 5: The economic and political imperative

This Commission also discusses perspectives on the economic dimension of youth mental health and the politics of reform. Youth mental health care, as well as prevention and promotion provided in a timely and proportional way, can be highly cost-effective. Implementation strategies have been created but require great force and sophistication. To achieve transformational reform, a combination of approaches, including strong economic arguments, emotionally engaging storytelling, real-world solutions, high-profile societal champions, media support, and targeted campaigns are needed.

We have attempted to adopt an inclusive approach to this global problem and recognise that much of the data and practical reform has been limited to high-resource and

middle-resource settings, specifically in terms of health and health workforce resources and appetite and vision for reform. This Commission includes authors from low-resource settings to formulate a staged approach to building systems of care across settings. Strategies for enhancing youth mental health systems will need to differ between low-resource settings, where most of the world's young people live, and the highest-resource settings, where nascent reforms remain insufficient. Improving youth mental health is of the utmost importance given the state of the world and how dependent societies are on the capacities and contributions of their young people. As long as adolescents and emerging adults are undervalued, languishing in precarity, and denied respect and nurture, society itself will become more precarious. The youth mental health crisis is more than a warning; it might be our last chance to take action.

Part 1: The changing landscape of youth mental health

Introduction

Mental ill health is an umbrella term that includes time-limited episodes of ill health with a need for care as well as more sustained, recurrent, and variably more disabling forms of ill health that the term mental illness tends to capture. Mental ill health is a major threat to the lives and futures of young people, and alarming evidence suggests that its prevalence and impact are steadily increasing in many high-resource settings where hard data are available (panel 1).¹⁻⁴ The US Surgeon General has labelled the deteriorating situation a "youth mental health crisis"⁴ and is formulating strategies to combat it in the USA. Distress, alienation, and loneliness have also increased steadily, and although these concerns might not necessarily warrant a health service response, they are a broader reflection of societal dysfunction that the public health crisis of youth mental health represents. Nearly three decades ago, with the retreat of the main physical illnesses that had affected young people throughout history until the second half of the 20th century, Michael Rutter⁵ highlighted that mental ill health, or "psychosocial disorders"⁵ as he put it, were now by far the principal cause of burden of disease in many parts of the world.⁶ He noted that young people had become physically more healthy than at any time in history, largely due to the retreat of infectious disease, but their mental health was worse than ever. Although some environmental, economic, and lifestyle threats to physical health are growing, the trend of deteriorating mental health is more striking and has continued and even accelerated over the past two decades.³ The epidemiology of mental illness is unique, with the peak onset of most mental illnesses occurring during the transitional period from childhood to mature adulthood.⁷ This onset period is inextricably linked to the momentum of complex and dramatic biopsychosocial change that permeates and surrounds this transition.

Panel 1: Methods and approach

The initial consultation meeting for this Commission occurred in July, 2019. The meeting brought together experts and researchers with expertise in youth mental health across a range of specialties, including clinical psychology, psychiatry, neuroscience, epidemiology, social science, economics, and service reform, as well as young people from a range of low-income, middle-income, and high-income countries. Attendees were identified through international networks such as the International Association for Youth Mental Health, which links people from more than 60 different nations, and through literature searches. The attendees participated in a range of discussions focused on the overarching themes and outcomes of the Commission, the inclusion of young people, and key information that should be included or considered in each section of the Commission. Attendees were from Australia, Europe, North America, and Asia. The need to include a range of perspectives during the development of the Commission was acknowledged, and this is reflected in the authorship, which includes young people with lived experience as youth Commissioners and youth authors, as well as experts working in or originally from low-resource settings.

The Commission provides a synthesis of evidence across five key topics that are considered important by the authors in formulating a blueprint to transform prevention and care for young people at risk of or with mental illness. We have used evidence from systematic reviews and meta-analyses where available and appropriate and have cited publications that we deemed relevant in capturing the current state of knowledge across the five topics.

Emerging adulthood

The term emerging adulthood captures the scope and direction of the developmental momentum during the whole of this sensitive period from puberty through to the mid-to-late twenties.^{8,9} This transition has expanded in recent decades and can be argued to now incorporate and transcend the constraints of the older term adolescence. Emerging adulthood involves dramatic and visible changes in biological maturity that are mirrored by less outwardly visible changes in brain structure and function, psychological development, and social and vocational spheres. Developmental tasks include the evolution of a stable sense of self, individuating from the family of origin, establishing independence, and often establishing a family of one's own. This development is daunting, even for the mentally well; stress, adversity, risk, uncertainty, and loss are constant and necessary companions within the ecosystem of growth. Such developmental challenges are increasingly complex and protracted, and concern is growing that a series of megatrends that have arisen over the past two decades are harming the mental health of children and young people in transition to adulthood. A number of such trends have been observed, including changes in the social construction of the transition to adulthood; the extension of education and the lifespan; the later average age of marriage and childbirth; a new raft of destabilising social, technological, and economic changes in society including globalisation, neoliberalism, and consequent rising inequality; the rise of the smartphone and unregulated social media;^{10,11} pressure to achieve academically;¹² challenges of artificial intelligence to future educational and occupational expectations; serious erosion of the rights of younger workers; and climate change.^{13–16} These trends differ in extent across the globe but have been validated by the voices of young people and examined recently by Twenge,¹⁷ Duffy,¹⁸ and Pennington,¹⁴ among others. Evidence suggests delayed onset of sexual activity, delayed and reduced use of alcohol and illicit drugs except in marginalised groups, and a trend to slower maturation, including if and when economic independence is attained.^{15,19,20} Although commonalities are preserved across generations, being a young person navigating the transition to mature adulthood today is very different than it was even 20 years ago.^{15,21,22} These trends have been defined, and much of the data indicating a serious decline in the mental health of young people has been collected in western, educated, industrialised, rich, and democratic (WEIRD) nations or high-income countries (HICs), although globalisation means that such trends might be or become equally relevant in the rest of the world, including in low-income and middle-income countries (LMICs) where the majority of children and young people are growing up.³

Mental ill health emerging during youth typically disrupts development and maturation, undermining the attainment of key milestones including identity and

relationship formation, educational and vocational attainment, financial independence, and culturally appropriate personal autonomy.^{23,24} Key demographic and socioeconomic changes have amplified this threat, transforming it into what has been termed a perfect storm.²⁵ Childhood mortality has fallen dramatically over the past century, the birth rate has decreased, and life expectancy has increased globally. These trends contribute to increasing the dependence of society on the health and productivity of young people. In non-WEIRD low-resource and middle-resource countries the mean age of the population is usually much younger than in WEIRD high-resource countries; for instance, the UN estimated the mean age of the population of sub-Saharan Africa to be 18·7 years in 2020 and that the birth rate and life expectancy will have fallen as a result of the COVID-19 pandemic,²⁶ albeit temporarily. In comparison, the mean age in Italy was 45·7 years in 2020.²⁷ Although the age dependency ratio is decreasing in non-WEIRD countries, the reverse is occurring in WEIRD nations.²⁸

More than ever, premature death and disability need to be prevented or reduced in young people to enable them to shoulder the financial and social burden of the dependent older population. Particularly in WEIRD nations with ageing populations, the loss of productivity wrought by preventable, untreated, or poorly treated mental ill health in young people cannot be afforded. In non-WEIRD low-resource and middle-resource countries, young people represent a much larger proportion of the population and are an abundant, vibrant resource upon whose contributions and development the prospects of entire nations are dependent. Furthermore, as pointed out by Moffit and Caspi in 2019,²⁵ mental ill health in young people is a potent yet largely ignored risk factor for age-related medical illnesses later in life. Hence, effective prevention and treatment of mental ill health in youth will ultimately help to reduce the total burden of disease over the life course, making it one of the best investments in health and social policy reform, as the potential return on investment is enormous.²⁹

The threat of mental ill health to young people

Mental ill health is the primary threat to the health, wellbeing, and productivity of young people who are in transition from childhood to mature adulthood. Improvements in global childhood mortality have shifted the main period of health risk from before puberty to the mid-twenties; mental ill health now accounts for at least 45% of the overall burden of disease in those aged 10–24 years.⁶ Globally, mental disorders are among the leading causes of disability among this age group.^{30–32} Suicide is the leading cause of death among people aged 15–44 years in Australia,³³ people aged 15–19 years in New Zealand,³⁴ and people aged 15–39 years in India.³⁵ Suicide is also the second leading cause of death among people

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aged 15–34 years in Canada³⁶ and people aged 10–14 years and 25–34 years in the USA.³⁷ Worldwide, trends are variable. Although suicide rates are higher and are continuing to increase modestly for men and boys than for women and girls, in many countries rates are increasing more rapidly in young women than in young men.^{38,39} Suicide remains the fourth most common cause of death for those aged 15–29 years globally.⁴⁰ Suicide rates in adolescent males increased in Brazil between 2001 and 2015;⁴¹ however, the Global School-based Student Health Survey showed that rates of self-harm and suicide attempts might have been decreasing in children aged 12–15 years in 12 LMICs until 2017.⁴² Indigenous young people in many countries (eg, Australia, Canada, the USA, and India) have substantially higher rates of suicide than the general population.⁴³ Furthermore, mental disorders and self-harm are increasingly common during this transition, with onset peaking at age 15 years⁴⁴ and at least 50% of emerging adults developing a threshold disorder with a need for care by age 25 years.^{23,45} A recent systematic review and meta-analysis studied the proportions from 192 epidemiological studies of 708 561 individuals who had onset of any mental disorder.⁷ By ages 14, 18, and 25 years, the proportions were 34·6%, 48·4%, 62·5% of the total, respectively, emphasising the burden of mental ill health in young people.⁷

Despite this compelling evidence of need, only a small minority of young people can access adequate care even in high-resource settings,^{46–48} and primary forms of prevention are daunting, elusive, and typically a very low priority. In low-resource and middle-resource settings, availability and access to mental health services for young people are grossly inadequate.⁴⁹ These settings often have low rates of recognition and treatment of mental disorders⁵⁰ and a paucity of data on the prevalence of mental disorders.⁵¹ Poverty, armed conflict, violence, displacement, and environmental stressors and disasters tend to be endemic in these settings and contribute to substantial psychiatric morbidity, particularly depression, anxiety, and conduct-related difficulties.⁵²

The neglect of youth mental health can be partly ascribed to the stigma-based neglect of mental health worldwide.⁵³ This neglect is amplified by the perverse and self-defeating ambivalence that society continues to display towards young people and their needs.^{18,54} Insufficient action on climate change, an unregulated and unsafe digital world and social media environment, and social exclusion as reflected by insecure employment, reduced access to affordable housing, and intergenerational inequality have combined to create a bleak present and future for young people in many countries.^{55–58} These harmful megatrends

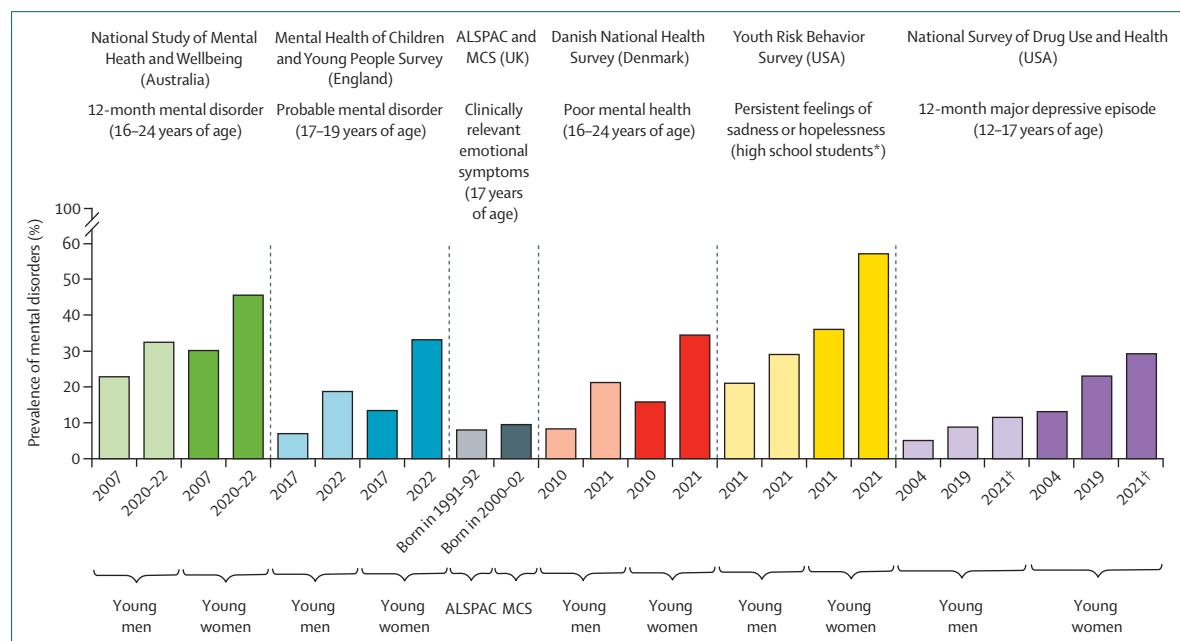


Figure 1: Youth mental health trends by country and sex

Measures used were the National Study of Mental Health and Wellbeing: WHO's Composite International Diagnostic Interview, version 3.0;⁵⁹ Mental Health of Children and Young People Survey: Strengths and Difficulties Questionnaire;⁶⁰ ALSPAC and MCS: Strengths and Difficulties Questionnaire (emotional subscale; trends by sex unavailable);⁶¹ the Danish National Health Survey: 12-item Short Form Health Survey, version 2;⁶² the Youth Risk Behavior Survey (survey item: "during the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?");⁶³ the National Survey on Drug Use and Health (which measures the nine symptoms associated with major depressive episode as defined in the DSM-5);⁶⁴ and survey questions adapted from the depression section of the National Comorbidity Survey Replication Adolescent Supplement.⁶⁵ ALSPAC=Avon Longitudinal Study of Parents and Children. MCS=Millennium Cohort Study. *Here, high school students are in grades 9–12, aged approximately 14–18 years. †2021 estimates are not comparable with estimates from 2019 and earlier, as 2021 estimates are based on multimode data collection and estimates from 2019 and earlier are based on in-person data collection alone.

that have emerged over the past two decades reflect little concern or support for young people, and have undermined their economic security and hope for the future. In many LMICs, these megatrends might be greatly overshadowed by more immediate threats to survival, such as war, conflict, severe poverty, and insufficient food security and shelter, which powerfully affect not only physical health, but also mental health.

The global youth mental health crisis

Monitoring trends in mental ill health requires robust epidemiological strategies and evidence, which to date have mainly been available in HICs.^{30,32} Such trends are unlikely to show linearity or the same pattern for different age groups, countries, or forms of psychopathology; however, in many WEIRD nations where epidemiological trends are being accurately mapped, youth mental health has been deteriorating over the past decade or more³³ (figure 1). Long before the COVID-19 pandemic, substantial evidence indicated that young people were facing rising rates of mental ill health, including anxiety, depressive symptoms, psychological distress, self-harm, and suicide, with increases beginning in the early 2010s.^{4,59,66–69} In the UK, emotional problems are emerging earlier in the lifespan and showing a trend towards increasing prevalence as indicated in a study comparing two cohorts a decade apart.⁷⁰ More alarmingly, the recent national study of mental health and wellbeing in Australia (2020–22) showed a 50% increase in prevalence of diagnostic-level mental disorders in people aged 16–24 years since 2007, reaching an annual prevalence rate of 39% in 2020–22, which reached nearly 50% in young women.⁵⁹ On the basis of face-to-face interviews and classified according to the ICD-10, this large, nationally representative study showed that the 12-month prevalence rates of anxiety, affective, and substance use disorders in people aged 16–24 years were 32%, 14%, and 7·8%, respectively (other diagnoses, such as eating and psychotic disorders, were not assessed).⁵⁹ In 2007, the respective rates were 15%, 6%, and 13% (figure 1).⁷¹ US data on suicide and self-harm can be found in the appendix (p 14).

The adverse effect of the COVID-19 pandemic on youth mental health is a global trend, occurring across resource and income levels,⁷² and the treatment gap widens across that spectrum. Although some studies conducted early in the pandemic did not report this trend,^{73,74} young people as a cohort have had a marked increase in distress and disproportionately poorer mental health outcomes since the COVID-19 pandemic,^{75–80} especially those living with social and economic disadvantage.⁸¹ Although some surveys have noted an improvement in mental health among young people following a decline at the start of the pandemic, psychological distress remains more prevalent than it was before the pandemic.⁸²

In low-resource settings, the prevalence and time trends of mental illness and related dimensions such as loneliness vary, as shown in various recent studies.^{83–86} A

2021 systematic review of 51 studies of the prevalence of mental health problems in sub-Saharan adolescents showed high rates of mental health need, particularly in vulnerable populations such as those affected by HIV and those in post-conflict settings.⁸⁷ The prevalence of common mental disorders in children and young people in Blantyre, Malawi's finance and commercial centre, appears similar to the prevalence reported by studies from WEIRD settings with similar socioeconomic risk factors.⁸⁸ Malawi has developed public mental health policies, including ambitious and targeted unconditional cash transfers to ultra-poor households in order to improve youth mental health, an intervention that shows promise.⁸⁹ Epidemiological studies using rigorous methods have shown substantial need in disadvantaged populations in Lebanon,⁹⁰ in urban and peri-urban youth in Zimbabwe,⁹¹ and in children attending schools in Nepal.⁹² The consequences of this situation are enormous, impacting young people, their families and community, and the economy at local, national, and global levels. Outcomes for young people in low-resource and middle-resource settings might be worse than for previous generations; however, systematic monitoring of youth mental health trends in low-resource and middle-resource settings is relatively insufficient compared with high-resource settings.⁹³

Some people have questioned whether the widespread rise in the prevalence of mental disorders has been inflated through a widening of the boundaries of diagnostic criteria of mental ill health and by overzealous or ill-conceived mental health awareness programmes, including via unregulated social media platforms such as TikTok.^{94–96} These factors might have led to the inclusion of a cohort of young people who have transient or self-limiting distress and might not necessarily have a need for care. A related critique in support of this so-called prevalence inflation hypothesis suggests that some of the studies indicating high rates of need rely too heavily on self-report and screening instruments that are then used to determine caseness through crosswalks, which are intended to create valid estimates of disorder.⁹⁶ However, this crosswalk is an accepted research technique, and key studies using robust interview-based methods confirm that the major rise in prevalence is largely real and sustained.⁵⁹ Greater awareness of mental ill health might contribute to rising rates either by facilitating help seeking or by artificially inducing distress through a form of contagion that might not in fact need care.⁹⁴ Frances, in his polemic *Saving Normal*, something of a mea culpa for his role in the expansion of diagnostic criteria as Editor-in-Chief of the DSM-IV process, sought to set much narrower boundaries.⁹⁷ In Foulkes' 2021 book and other work, she posed the question of whether, in addition to leading to better detection and reporting of previously unrecognised symptoms and need for care, mental health awareness and universal mental health intervention in schools might have harmful impacts, including a form of

See Online for appendix

contagion effect, which can also occur via social media.^{94–96} Although a recent trial did not support mindfulness as a universal intervention in schools for the primary outcomes of risk for depression, social-emotional-behavioural functioning, and wellbeing,⁹⁸ other studies of school-based interventions have reported benefits in reducing the number of suicide attempts and severe suicidal ideation,⁹⁹ and promoting resilience in children exposed to adverse childhood experiences.¹⁰⁰ The evidence for universal interventions is generally weak, but conducting studies with a large enough sample size and consequently sufficient power to detect the very small effect sizes that are achievable if the interventions do work is challenging.¹⁰¹

Although more research might clarify whether there is a contagion effect elevating distress, well intentioned yet naive awareness raising can be viewed as irresponsible when it is linked with dilute universal wellbeing programmes in school settings and active screening, in the absence of accessible skilled mental health care for those young people who have already manifested clear mental ill health. Particularly in the light of evidence from methodologically sound, interview-based community surveys that the rise in prevalence and need for care is both real and substantial, a negligent, or worse, a denialist response would be unacceptable and harmful.^{4,59,66,67,78,102} The great modern paradox is that the risk of physical illnesses in young people is substantially reduced compared with past eras, and at the same time, young people show unprecedented rates of distress, mental ill health, and mental illness. The erosion of their mental health, alongside their shrinking social prospects and precarious economic prospects, is beginning to convince mainstream society of the urgent need to address this global mental health crisis.

The hero's journey

A key challenge is finding a way to respond to genuinely increasing rates of mental ill health that justifies and benefits from evidence-based care and does no harm through labelling or stigmatising young people who are transiently distressed, or through overtreatment. A second and related challenge is how to ensure that youth in need of mental health care can engage in this care in a way that protects and enhances their sense of agency. One well developed perspective that can be deployed is positive psychology.^{103–106}

A more fundamental and engaging version of this idea was formulated by the philosopher Joseph Campbell, who recognised the so-called hero's journey as a common theme across all cultures, with deep relevance to the human condition.¹⁰⁷ This theme is reflected in many novels, plays, and movies. Perhaps the best known recent examples are *Star Wars* and *Harry Potter*. The ubiquity of the hero's journey motif validates its relevance. The idea has been used therapeutically, as a metaphor in normalising our responses to the challenges and threats

that we all face during the struggle for maturity. Elements of the hero's journey concept, such as the call to adventure (transition to adulthood), the road of trials (struggles during this transition, often navigated with help of an experienced older adult), achieving the goal (actualised adult identity realisation of developmental milestones), the return (adopting new adult roles within one's community), and the application (making a positive social contribution), will make sense to most people. This concept creates the space for a positive psychology perspective, which is a strengths-based stance to distress and struggle during the transition to adulthood, but one with much greater popular resonance. The hero's journey also allows us to accept and see value in a soft border or flexible boundary between mental health and mental ill health during the struggle, enabling people with and without a need for professional help to reframe their experience. This perspective validates a role not only for the scaffolding of the family and the social network surrounding the young person, but also for mental health professionals and the treatment of mental injury and illness without these valid needs being perceived as indicative of weakness.

Mental distress in response to stressful events reflects a spectrum of underlying processes that current diagnostic systems loosely place in three pragmatic categories: first, a self-limited, non-pathological state (ie, acute stress reaction); second, a time-limited state in which excessive distress is reinforced by preoccupations (eg, adjustment disorder), with increased risks of progression into the third state, which is a pathological disorder that can persist beyond the presence of stressors (eg, major depressive disorder, post-traumatic stress disorder). Initial adaptive stress responses can trigger cascades of changes in networks of symptoms, brain circuits, or molecular pathways that can become entrenched and self-sustaining.

The conceptual blurring between pathological and subclinical states when external stressors are persistent might increase the use of the so-called disorder perspective. The attached stigma might inadvertently impede help seeking, which is often already compromised. Instead, when population events play a decisive causal role, the concept of psychological injury would be more fitting, when the source of the condition is rightly relocated from the individual to the environment.

Seeing things from this perspective can allow the transcendence of polarising and typically unproductive debates concerning labelling and overdiagnosis. The latter debates concerning overdiagnosis have not recognised the routine neglect of the need for care, the importance of context, and how a more permeable mindset enables the crucial strategy of early intervention. The hero's journey concept thus navigates the space between the concern about labelling common experiences as abnormal and valuing the crucial need for help and support, including expert medical and professional help, but it has not yet been mobilised for routine therapeutic use. Finally,

although this concept confronts and accepts the extent of the threats and challenges within the journey as well as the possibility of defeat, it maintains the hope of ultimate success even in the darkest times. In this way, it illustrates that resilience, defined by Masten as the “capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development”,¹⁰⁸ rather than being an *a priori* quality, actually emerges from facing inevitable adversity during the journey to adulthood. By highlighting the key role of cultural resources, supportive environments, and mentorship, including professional help, the traditional one-dimensional and individualistic nature of the popular concept of resilience, which often means young people tend to be blamed for failure and mental ill health, is enriched.¹⁰⁹ The hero's journey is also compatible with the concept of post-traumatic growth.¹¹⁰ The hope that this concept nurtures is a crucial element in any effective approach to the mental health care of young people. Haidt¹¹¹ has similarly argued that the related concept of antifragility¹¹¹ applies to the development of children and adolescents. He states that children need to be exposed to setbacks and failures in order to be able to develop strengths and resilience; however, the reality is substantially more complex, with both underlying vulnerabilities and the potency and duration of social and environmental stressors influencing whether or not such exposures are health-promoting and consistent with an antifragile effect, or whether (such as with persistent bullying) they can be toxic and even fatal.

Part 2: Conceptual frameworks and trajectories

Introduction

As highlighted in Part 1, adolescence and emerging adulthood can be defined as the period of life between puberty and adult independence, approximately corresponding to age 10–24 years.²² This is a period of profound biological (hormonal and neural), psychological, and social change. Sociocultural expectations of this age group differ widely between (and even within) cultures and countries; financial and social independence occurs much earlier in some settings than in others. Nevertheless, the development of behaviours typical of this phase, such as risk taking and sensation seeking, is similar across contexts.¹¹² Emerging adulthood is also a vulnerable period for the onset of mental illnesses: 63–75% of mental illnesses first appear before the age of 25,^{7,45,113} with onset during this period associated with greater duration of illness and diversity of comorbid disorders.⁴⁵ Furthermore, the physical, cognitive, and behavioural differences between young people and adults are likely to influence the way mental health problems present, and they therefore require different approaches for interventions. The shifting socioeconomic conditions of the past two decades have added another dimension to understanding risk and protective factors in the onset and persistence of mental ill health. Here, we consider the range of

perspectives relevant to understanding the genesis, complexity, pattern, and scale of mental ill health in young people.

Biological perspective

The start of traditional adolescence and emerging adulthood is puberty, which results in reproductive maturity. Evidence suggests that the increase in sex hormones at puberty plays a role in brain development,^{114–117} social outcomes,¹¹⁸ and mental health.^{119–121}

Extensive research using brain imaging has shown that the human brain undergoes substantial and protracted development across adolescence.¹²² Research studies using MRI have shown structural brain development that is marked by a decline in cortical grey matter volume from late childhood to the mid-twenties, and a gradual increase in cerebral white matter volume between childhood and mid-adulthood.^{123,124} These changes in the brain's macrostructure, as observed in MRI scans, are proposed to correspond to microstructural developmental processes, including the development of axons and the reorganisation of synapses. These processes are crucial for brain development, are mechanisms of neuroplasticity, and are dependent partly on genetics, the environment, and the interaction between the two.¹²⁵

Different brain regions develop at different rates (appendix p 10)^{124,126} and mature at different ages.^{127,128} For example, on average, subcortical regions involved in emotion and reward processing develop earlier than prefrontal regions involved in decision making and self-regulation, although this pattern differs between individuals.^{129,130}

Social and cognitive perspective

Substantial changes in social exposure and orientation take place during adolescence, as more time is spent with peers than with family,^{131–134} the influence of friends or peers increases, and the influence of parents or adults decreases (appendix p 11).^{135,136} Adolescents are particularly sensitive to peer rejection^{137–139} and social approval.¹⁴⁰ The heightened susceptibility to social influence in adolescence, combined with increased concern about social rejection, increases the likelihood that adolescents will conform to their peers in order to gain social acceptance and avoid the social risk of being excluded by their peer group.^{141–143}

At the same time, cognitive skills such as planning, future thinking, inhibiting inappropriate behaviour, emotion regulation, decision making, and particular forms of memory continue to improve during adolescence (figure 2).^{144–149} Mentalisation, the ability to understand other people's minds and emotions, and the ability to take another person's perspective are still developing.^{150,151} These cognitive advances, at a time when the body, brain, and social environment are changing, provide adolescents with the cognitive machinery to reflect on themselves, their place in the social hierarchy, and their futures.

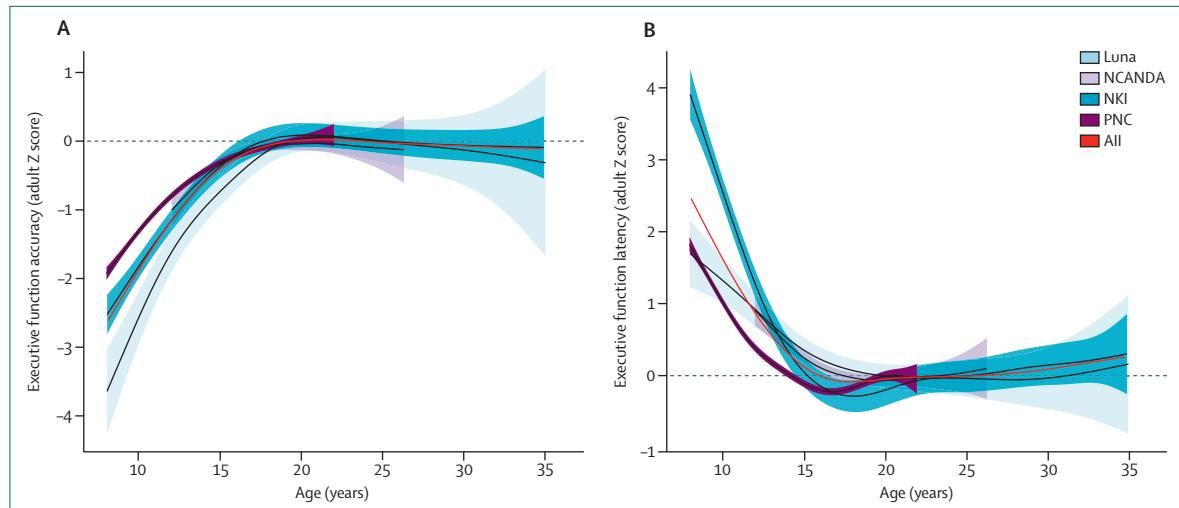


Figure 2: Developmental trajectory of executive function across datasets and tasks in adolescence

Accuracy (A) and latency (B) composite from four datasets: Luna (N=196; 666 total visits), NCANDA (N=831; 3412 total visits), NKI (N=588), and PNC (N=9151). Each measure within each dataset is Z scored to the performance of adults (participants aged 20–30 years). NCANDA=National Consortium on Alcohol and Neurodevelopment in Adolescence. NKI=Nathan Kline Institute—Rockland Sample. PNC=Philadelphia Neurodevelopmental Cohort. Figure reproduced from Tervo-Clemmons et al.¹⁴⁴

The boundaries between biological, cognitive, social, and cultural changes are not clearly defined. The biological changes at puberty lead to changes in appearance, and this results in young people being treated differently by society and those around them. As young people go through puberty, they are often given more autonomy and responsibility, and are put under increasing societal and social pressure to look and act particular ways. At the same time, environmental input affects the way the brain develops. For example, with changing social expectations comes exposure to new experiences, such as exposure to alcohol and other drugs, which might in turn influence brain development.¹⁵²

Entering into peer and intimate relationships is a key feature of emerging adulthood and marks a shift from an exclusive dependence on the family of origin. This shift results in changes in the quality and strength of the bonds with parents and siblings, and it can create tensions and stress for everyone in the family. The metaphorical scaffolding around the emerging adult is crucial for the safe and successful navigation of this developmental phase, but it constantly evolves.^{153,154} If this scaffolding is fragile or crumbles, a risk for mental ill health is posed. Conversely, mental ill health, and especially sustained mental illness, can severely damage this scaffolding, causing tensions within the family and causing the peer network to diminish or even collapse. Positive mentoring relationships beyond the family and surrogate peer relationships can mitigate these effects.⁵ The development of a sense of self and identity beyond that of a dependent child is a key developmental task.

One aspect of this developmental stage is sexual and gender identity. Although LGBTIQ+ sexual identity and

diversity is much more accepted in some countries than in others, much progress can still be made. The prevalence of mental ill health and suicidal risk is substantially higher in LGBTIQ+ and gender-diverse young people compared with their non-LGBTIQ+ and non-gender-diverse peers.^{155–157} The number of young people identifying as gender diverse has substantially increased in the past decade,¹⁵⁸ but controversy has arisen within the medical and psychiatric fields as to how to understand and respond to this trend, including the reasons for and source of the increase.¹⁵⁹ Regrettably, this issue risks becoming drawn into ideological culture wars, undermining a scientific and human rights approach to health care generally.

Cultural factors

Cultural factors, and especially the sociocultural landscape that young people grow up in, influence the expression of youth mental health, and can include such diverse factors as religion, cultural traditions, technological change, economic inequality, and future uncertainty. The globalisation of cultural influences, mediated via the digital revolution, social media, and the advent of powerful influencers, might be diluting some more traditional cultural factors. Nevertheless, moving beyond a predominantly westernised approach to the discussion is crucial¹⁶⁰ because culture can provide a lens through which to better understand how young people think about mental health, whether they seek help for mental health problems, and how young people and mental health professionals interact with one another.¹⁶¹ Importantly, many of these cultural influences can rapidly change, as has been the case for digital communication and social media. Cultural factors, including religion, can have a large influence on

the emergence, recognition, and interpretation of mental ill health in young people. For example, evidence suggests that one's understanding of emotions is dependent on one's cultural background, that recognition of one's own and others' emotions is better between members of the same cultural group,¹⁶² and that perceiving and expressing emotions is determined by the prevailing cultural models.¹⁶³ Furthermore, the development of these social abilities is strongly influenced by culture via interactions between genes, environment, behaviour, and the brain.^{164,165} Immigration and acculturation modify and complicate the influence of cultural factors.¹⁶⁶

Particularly among immigrant, racialised, marginalised, and Indigenous youth,¹⁶⁷ cultural connectedness and strong or positive cultural identity help increase resilience,^{168,169} self-esteem, self-efficacy, self-clarity,^{170,171} life satisfaction, wellbeing, and mental health.^{167,170,171} Cultural identity can also protect against suicide risk, depression, problematic substance use, and other evidence of mental ill health. Using data from 200 Indigenous communities in British Columbia in Canada, Chandler and Lalonde¹⁷² showed that cultural continuity (eg, cultural facilities, language, and governance) was strongly associated with significantly lower suicide rates. Spiritual wellbeing has been found to be protective against depression, but negative religious coping (eg, feeling abandoned by God) can negatively affect mental health.¹⁷³

Culture also influences how risk factors interact with social support and help-seeking behaviour to determine youth mental health outcomes. Attitudes about mental health services, such as receptivity to care, anticipated and real negative consequences from others, self-consciousness, and stigma tolerance, have been linked to mental health help seeking and to the use of formal mental health services. Mental health stigma is often more intense in collectivistic communities compared with individualistic communities.¹⁷⁴ Non-White Americans often express greater public stigma or self-stigma (or both) than White American groups,¹⁷⁵ tend to emphasise non-biomedical interpretations of behavioural, emotional, and cognitive problems, and are often critical of mental health services.¹⁷⁵ Elsewhere, undergraduate students in Japan report greater reluctance to seek professional help than those in the USA.¹⁷⁶ These intercultural differences result in variation in the timing of help seeking and from whom that help is sought. Furthermore, factors such as inadequate health coverage in countries without universal, publicly funded health care, culturally insensitive views by mental health service providers, and the use of culturally inappropriate screening measures and treatment approaches might also serve as institutional barriers to care.¹⁷⁷

Cultural differences help shape beliefs and perceptions of mental health, and influence one's decision to seek help and one's choice of a formal mental health provider. Culture must be carefully considered in the identification, development, and adaptation of appropriate prevention and intervention strategies.¹⁷⁸

Global political, socioeconomic, and structural megatrends

The cultural, social, and cognitive perspectives discussed here might have been evolving over recent generations, but they are likely to be responding to other deeper and more potent forces driving the youth mental health crisis. A range of recent global megatrends can be identified as candidates and targets for prevention. Patel¹⁷⁹ made a powerful argument from a human rights perspective for the right to be protected from known harms to mental health. He contends that these harms are the result of policies that create and sustain a range of structural forces that undermine mental health. This argument echoes the work of Wilkinson and Pickett¹⁸⁰ on the impacts of inequality, including intergenerational inequality and wealth transfer, violence of all kinds, the marginalisation of many groups, displacement due to war, conflict, and climate. Young people are uniquely sensitive to prevailing social, political, and economic conditions and structural forces, and the effects of these factors influence mental health across the lifespan. Although these forces are not new, major shifts and megatrends have more severely impacted young people than before, as the US Surgeon General recognised.⁴ Both natural and man-made global crises and disasters (eg, earthquakes, wildfires, tsunamis, wars, conflict, and economic depressions) are well known to be associated with predictable harmful effects on the mental health of the population; however, the present mental health crisis appears to be heavily and selectively affecting young people. We need to understand why, and formulate policies to mitigate this impact. Patel's robust stance^{179,181} suggests that the appetite for such an approach might be growing: "It is not possible to act on the goal of mental health as a universal human right without squarely acknowledging how the policies that have contributed to these powerful structural forces are intentional and ideologically motivated. The colonial and neoliberal economic policies that led to the devastation of marginalised populations and environments, and to grotesque levels of inequality, must be called out and confronted. And, as with any human rights discourse, we must acknowledge that such policies are, fundamentally, an ideological and political choice."¹⁷⁹

Four decades of neoliberalism have resulted in what has been termed precarity, resulting in a growing section of society termed the precariat.¹⁸² In WEIRD countries at least, this political and economic megatrend that began in the 1980s has produced rising intergenerational inequality, a serious erosion of job security for young people entering the workforce, wealth transfer from the younger to the older generations, reduced prospects of home ownership with the added insult of a rental accommodation crisis, and rising student debt.^{14,183} Pennington,¹⁴ an Australian economist, describes the subjective effects of these changes immediately after finally securing a stable job: "I'd been deprived of the

ability to secure life's basics. I'd been anxious, defensive and sick for so long. That was all I knew. But with a stable job for the first time in my life, I could feel my brain being reconstituted... I gained agency over my life."¹⁴

Pennington also analysed the economic forces resulting from neoliberalism that are heavily implicated in the harm caused to the mental health and wellbeing of young people. Although conditions of work have sharply declined and caused chronic insecurity and distress, the proportion of young people not in employment, education, and training is also substantially higher in young people with mental ill health than in those without, reflecting a circular problem.¹⁸⁴ A related trend that young people themselves frequently report is academic pressure, which varies across and within cultures.^{12,185,186} Many young people are consigned to a life of precarity and marginalisation within the poverty trap of welfare benefits. A caveat here is that these dynamics and welfare systems are less evident in LMICs, where most of the young people in the world actually live. The data are not yet readily available to make a judgement.

Climate change is a substantial existential concern for young people. Young people will suffer most because they will have to live through the climate crisis, and there is an implicit pressure on young people to solve it, even though political power does not rest with them. Recent studies on ecoanxiety in young people show large individual differences, but generally substantial climate anxiety.^{187,188}

Social media use increases dramatically in adolescence, and this too might affect the way that the brain develops and could contribute to social pressures, mental ill health, and life satisfaction (figure 3).^{189,190} The evidence on social media use in adolescence is still emerging, and so far indicates a potentially potent role, but it also suggests the relationship between social media and mental health is complex and bidirectional.^{189,191} Although social media and the rise of smartphones, which now permeate the societies of young people in low-resource and middle-resource settings,¹⁹² offer new avenues for prevention and intervention, widespread and growing fears surround their public health effect on youth mental health.^{10,17,56,68,193} Although the temporal association is strong, data from longitudinal and well controlled experimental studies are scarce. Nevertheless, many argue that action is urgently needed to regulate this potential source of harm. Building upon the work of Twenge,^{10,17} Haidt has argued strongly for this issue to be taken much more seriously as a key megatrend undermining the mental health of children and young people.¹¹ Similarly, the unprecedented economic power of those who control this technical revolution, the so-called cloud capitalists who currently have no constraint, has been exposed in a recent work by Varoufakis, and the adverse effects of these technologies can be linked back to a deeper wave of economic and neoliberal forces.¹⁹⁴ Haidt and Twenge contend that smartphones are the only change that can account for the timing and pattern of the youth mental health crisis and that urgent action is required on many geographical and societal levels; however, despite the evidence they have assembled, and the consensus among many political leaders and the wider public, the makeup of causes is likely to be vastly more complex. The issue risks becoming unnecessarily polarised. Smartphones and social media are likely to be merely one element, even if potent, in a wider and more pervasive set of harmful megatrends that are yet to be fully understood or tamed.^{18,56}

Developmentally congruent clinical frameworks

Clinical frameworks in youth mental health, and their use, need to reflect the state of constant evolution and flux occurring within the biological, cognitive, and social landscape outlined so far. These frameworks also need to adopt a preventive and pre-emptive stance. The onset of mental ill health in emerging adults is complex. Young people commonly have a mixture of sleep disturbance, motivational changes, anxiety, and mood dysregulation, which influence each other in myriad ways, as emphasised

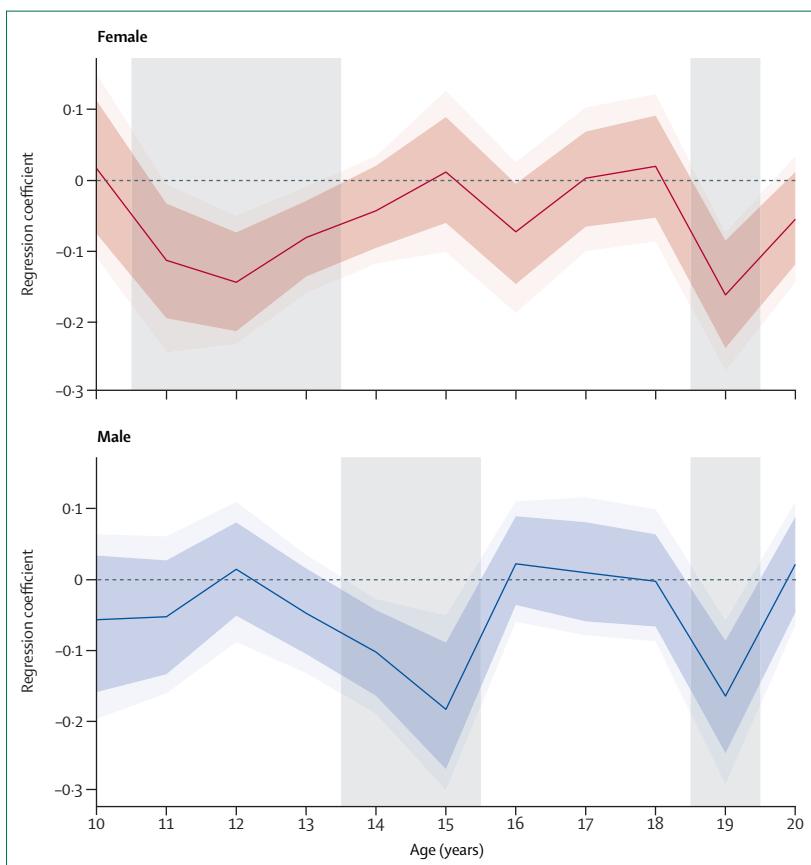


Figure 3: How social media use predicts life satisfaction in longitudinal data from 17 409 participants aged 10–21 years

Results from the cross-lagged path connecting estimated social media use to life satisfaction ratings 1 year later, estimated through a random intercept cross-lagged panel model. Grey boxes indicate ages when the path became significant ($p < 0.05$) and increases in estimated social media use from expected amounts predicted a decrease in life satisfaction ratings from expected amounts 1 year later. Figure reproduced from Orben et al.¹⁸⁹

by network theory.¹⁹⁵ These experiences and behaviours are influenced by individual differences in the development of the self and interpersonal functioning, along with social and cultural variation as to how they are understood and communicated. Symptoms emerge and subside as microphenotypes, which typically do not follow clear trajectories to discrete diagnoses such as schizophrenia or bipolar disorder; early-phase conditions have pluripotential (multiple end-stage) outcomes, and heterotypy (shifts across diagnostic categories) and syndromal comorbidity are the norm rather than the exception.⁴⁵ The need for care precedes the emergence of a traditional diagnostic picture or late macrophenotypes.¹⁹⁶ This approach contradicts longstanding assumptions that mental disorders constitute stable categorical entities whose form is retained from initial onset to later, more stable presentation, and it also highlights the limitation of current diagnostic systems, which are likely to reify artificial endpoints of developmental trajectories.

These patterns of emergence underline an urgent need for novel approaches to define disorders, caseness, and the need for care in young people. Transdiagnostic models^{197,198} recognise the fluid nature of mental illness in this age group and make a distinction between early clinical stages (which are assumed to have low rates of progression to severe, persistent, or recurrent disorders) and later stages (which are characterised by high rates of persistence, impairment, and disease extension).¹⁹⁹ Clinical staging^{197,200–203} is one such emerging heuristic framework, which allows the boundary between health and illness to be defined and managed such that interventions can be proportional to need and overdiagnosis, overtreatment, and undertreatment can be minimised.^{200,202–205} Clinical staging, with its longitudinal perspective, is congruent and synergistic with many developmental and related conceptual frameworks, and it allows the exploration of mechanisms that underpin the onset and course of mental ill health (figure 4). This framework places people along a multidimensional continuum of health to illness, capturing elements of risk, onset, course, and prognosis. Staging frameworks can also guide preventive or therapeutic interventions: less intensive approaches being appropriate at earlier stages and interventions with a higher risk to benefit ratio being reserved for later stages.

In addition to their differing symptom presentations and stages of illness, which are often moderated by their developmental stage, young people require very different approaches to care and cultures of care based on their developmental stage. For example, the needs of someone aged 19 years with recent onset of illness are radically different than those of someone aged 45 years with longstanding and disabling illness in terms of psychosocial support; approach to psychopharmacology; medical needs; educational, vocational and employment assistance; family support; and hope and optimism for recovery. Such patients should not be mixed in residential or community care. Clinical services (and the entire

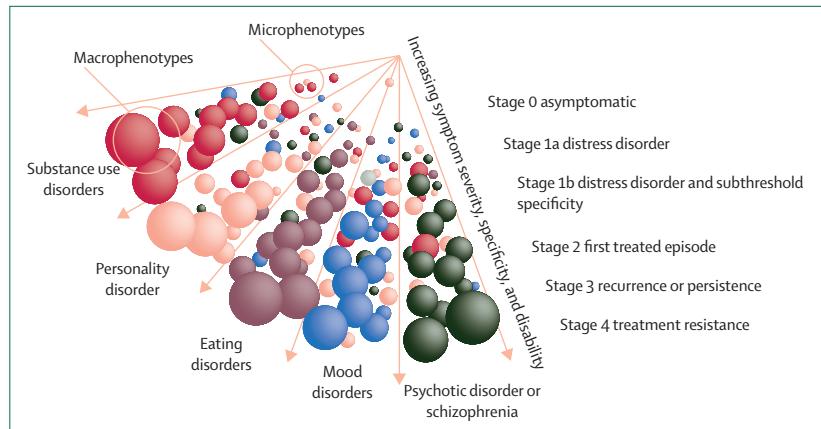


Figure 4: Heuristic clinical staging model for mental disorders

The model illustrates clusters of early symptoms (microphenotypes) and their potential progression into clear, and often comorbid, syndromes (macrophenotypes). Progression across stages is characterised by increasing symptom severity, specificity, and disability (represented by sphere size). Spheres and colours represent phenotypes. Adapted from McGorry and Mei²⁰⁶ with permission.

mental health system more broadly) therefore need to reflect not only differing sets of needs, and the crucial need for realistic optimism and hope, but also how services are delivered: available at times that suit a young person's lifestyle, and in a setting that is welcoming, holistic, and not narrowly clinical.^{29,207–209}

Together, these concepts and approaches can set the scene for the development of mental health care for young people that is fit for purpose through being sensitive to their specific needs and focused on providing a continuum of high-quality interventions that facilitate recovery and prevent persistent impairment.

Part 3: Models of care

The origins and status of contemporary mental health care

Mental health care around the world has been characterised by severe misunderstanding, prejudice, and neglect, which sadly continue to this day.²¹⁰ Only 2% of health budgets globally are devoted to mental health care²¹¹ and, even in the richest countries, less than half of the need is addressed. Quality of mental health care lags well behind that found in physical health care.²¹² People with a range of mental illnesses die 15–20 years earlier than the general population,²¹³ primarily from physical morbidity, and the seeds of this premature mortality are sown from the onset of illness and often even before that. Suicide is also much more prevalent in those with mental illness than in the general population,²¹⁴ representing a major source of preventable premature death that remains a low priority in all regions of the world. Many physical non-communicable diseases that have a smaller effect on the health and wealth of society than mental ill health due to their much later timing in life remain a substantially higher priority in health budgets, primarily for political and emotional reasons, notwithstanding diminishing returns.

The neglect of mental illness as a major source of preventable premature deaths has been described as a scandal.²¹⁵ Until recently, most societies only responded to severe forms of adult mental illness and did so through the 19th century asylum model, which was a humane improvement when it began.^{216,217} A global wave of deinstitutionalisation has removed this model from many, but not all, HICs with the goal of integrating mental health care with physical health care. Unfortunately, this reform has failed in many respects. A successful outcome of the dramatic reduction in residential hospital care, which was the hallmark of deinstitutionalisation, was wholly dependent upon the creation and growth of a well designed and well funded ecosystem model of community-based health care, stable and secure housing, and financial security to replace the old asylums.²¹⁸ This outcome did not occur systematically in any HIC, and cramped and poorly designed general hospital inpatient units and emergency rooms have generally been overwhelmed and unable to provide humane, evidence-based care.^{219,220} The new adult systems continue to be largely restricted to middle-aged and older adults with persistent and disabling illnesses, meaning that only younger people who display extreme problems or risk, or those who have a record of chronic disability, are able to secure even a time-limited tenure of care. We do not suggest that poor access to inpatient or residential care for young people is the biggest flaw of the post-institutional era; instead, we argue that the failure to assemble modern systems of community-based care that offer early intervention and evidence-based care has created the systemic dysfunction, unnecessary suffering, and widespread unmet need that now exists.

In parallel, child and adolescent psychiatry emerged as a stream of care in mostly HICs; however, this field is sparsely funded within already under-resourced mental health-care systems. In low-resource and middle-resource settings, child and adolescent mental health services scarcely exist, except perhaps to an extent in high-resource segments within these countries. Even in the highest-resourced countries, these services are overwhelmed, with only a small percentage of children and adolescents able to gain any access to care.²²¹ Studies have confirmed that even when care is accessed from child and adolescent mental health services, few patients make a successful transition to adult mental health services, because this transition is to traditional older adult models of care that are not personalised to the clinical and developmental needs of the young person.^{222,223} For example, the TRACK study in the UK highlighted the damaging gap in care between the upper boundary of child psychiatry at age 16–18 years and the lower boundary of adult psychiatry at age 18 years, defined by educational and legal parameters rather than health or developmental needs.^{223,224} The European MILESTONE study, recruiting from 39 services across eight countries, assembled a cohort of 763 young people in transition from child and adolescent mental health

services to adult mental health services.²²⁵ The MILESTONE study confirmed that only 19·6% of participants transitioned to adult services after reaching the upper age limit of child and adolescent mental health services (either at age 18 years or 16–19 years), and 26·8% remained in child and adolescent mental health services for a period after age 18 years.²²⁵ The mental health of people who left care completely did not deteriorate and they did not have a higher rate of use of other health services compared with people who were retained in care, but functional outcomes were less clear, as was future need for care.²²⁵ The representativeness of this sample is unclear, and possible selection bias limits the generalisability of the findings. Furthermore, the appropriateness and effectiveness of the care provided in the adult system of care for those who did transition was not examined. The approach within the MILESTONE study follows the status quo and studies how well it operates with an implied stance of incrementalism. In contrast, various alternative models of service provision have been developing over the past two decades to address the issue of optimal transition and the much more salient issue of need beyond the minority who are able to access child and adolescent mental health services or adult mental health services during the period of 12–25 years of age.²²⁶

A paediatric and adult model ignores the epidemiology of mental illness, with the peak incidence and prevalence occurring during the late adolescent and early adult phase of life.^{7,45} This model also does not account for the myriad of important neurobiological and psychosocial developmental processes that extend across and throughout this period, including well beyond age 18 years.²¹ The result of the limitations of this model is that the very group of patients with the greatest need for care and the best prospects of responding to early intervention and treatment (ie, emerging adults) have the worst access to care across the whole lifespan.^{223,227} Until recently in HICs, the system has been weakest where it needs to be strongest.²²⁷ In low-resource and middle-resource settings, any mental health-care system for children and young people is typically absent.

Status quo for young people

Notwithstanding the debate around the boundaries of the need for care, robust evidence shows that even in high-resource settings, a substantial proportion of young people with mental ill health do not seek treatment.^{228,229} When young people seek treatment, they face long waiting times due to high demand and few resources.²³⁰ Waiting for care is associated with substantial adverse consequences, with a 2022 UK survey finding that 58% of young people had a deterioration of their mental health and as many as 24% tried to take their own life while they were waiting for care.²³¹ As in most health care, treatment is less likely to be effective if the illness becomes entrenched.²³² For those who do access services, quality of

care is patchy at best, and attrition rates are high, with a large study reporting a 42% drop out of treatment by one's third therapy session.²³³ Young people who do successfully complete treatment rarely receive ongoing relapse support, yet up to 80% of young people with complex mental health conditions have repeated relapses.^{234,235} Reviews have shown that the mental health system worldwide is difficult to navigate and young people face major barriers to transitioning between services, leading to poor continuity of care and disengagement from treatment.²³⁶ Finally, even when young people receive established mental health interventions, their effectiveness is poor, with between a third and two-thirds of those receiving interventions not having symptom reductions.²³⁷ Key limitations on effectiveness include slow progress in discovery of new treatments, poor fidelity to existing evidence-based care, and insufficient treatment continuity, intensity, and personalisation. Yet these are all flaws that can be effectively addressed.

In low-resource and middle-resource settings, numerous barriers exist for the supply and demand of mental health care.²³⁸ In terms of resources, these settings tend to have constraints such as inadequate funding or spending (or both) on mental health, a paucity of mental health care workers, and poorly integrated health systems that contribute to inaccessible mental health care, especially for adolescents. Zhou and colleagues,⁴⁹ in a review of child and adolescent mental health policies in LMICs, identified various challenges related to policy development and implementation in these countries, including poor public awareness, little political willingness, stigma against mental health, cultural biases against children and adolescents, a paucity of child and adolescent mental health data, a shortage of resources and international support, resulting in decreased local responsibility and unsustainable programmes. As a result of these challenges, fewer people seek professional help in LMICs than in HICs, and when they do, they face long delays with few and variable pathways to accessing care. LMICs are culturally, socioeconomically, and linguistically diverse regions, making it very challenging to identify strategies that are culturally sensitive and contextually relevant. Nevertheless, such efforts are underway and benefit from the work of the wider global mental health movement, but different strategies that can be augmented over time will be needed.

A global challenge

To address the needs of young people in terms of mental health care, a consciously global perspective must be taken, as nearly 90% of the people in the world aged between 10 years and 24 years live in what are classified as LMICs.²³⁹ The UN and the World Bank have for many years divided the world into high-income, middle-income, or low-income countries. It is our view that with economic

growth and increasing wealth, poorly distributed within countries due to rising inequality, this model of categorisation is being increasingly regarded as obsolete, especially for mental health. Alternative concepts, touched on earlier, include the categorisation of countries as WEIRD or non-WEIRD, and the concept of the Global South. Countries of the Global South have been described as being in the process of industrialising, are largely considered to have lower-quality democracies than countries in the Global North, and frequently have a history of colonisation by northern, often European states. Increasing wealth across the world in 6 decades, at least before the COVID-19 pandemic, has resulted in a shift such that only 9% of countries fall into the original low-income category as defined by the late Hans Rosling.²⁴⁰ The concept for service planning that we prefer is low-resource, middle-resource, and high-resource settings.²⁴¹ The high-income, middle-income, and low-income countries, and even the WEIRD and non-WEIRD countries, would then differ only by the relative proportion of these resource settings which lie within their borders. When it comes to the global population, the Pew Research Centre estimated that, in 2020, most people were either low-income (51%) or poor (10%), 17% were middle-income, 15% were upper-middle-income, and 7% were high-income.²⁴² These proportions will differ by country and are subject to change over time. In summary, although there is great inequality and variation in amounts of health resources, much of this is now within countries, not only across countries, and it is harder to categorise countries as high-income, middle-income, or low-income. Each country, particularly with rising inequality, has within its borders low-resource, middle-resource, and high-resource settings.

Reform and maturation

Several factors have combined to create change and provide an avenue for genuine progress in youth mental health over the past 30 years. First, the consistent evidence that early intervention for psychosis provided an optimistic, evidence-informed model that bridged child and adult mental health services and produced better outcomes built confidence.^{232,243,244} A series of landmark studies showed that reductions in treatment delay improved long-term outcomes,²⁴⁵ that early intervention in psychosis services achieved improved symptomatic and functional outcomes and lower suicide rates during the first 2–5 years after diagnosis, and that transition to psychosis from the clinical high-risk or ultra-high-risk stage of illness to first-episode psychosis could be delayed and ameliorated.^{246–248} Evidence from a 2023 study highlighted that this stage-linked model is by itself insufficient and must be complemented by ongoing high-quality care in order to sustain and build on these gains.²⁴⁹ Second, the epidemiology and changing landscape of the developmental transition to adulthood has become much more obvious.^{21,113} Finally, the

For more on the International Association for Youth Mental Health see www.iaymh.org

accumulating evidence of a deterioration in the mental health and wellbeing of young people, with rising incidence and prevalence rates, has become impossible to ignore.

Slowly, a broad-spectrum youth mental health approach has emerged and is gaining momentum in many high-resource settings in an increasing number of WEIRD countries.^{209,250} This approach has generally comprised enhanced versions of primary care that offer

Panel 2: Key elements of youth mental health care

- Increase community awareness, education, and advocacy, especially for prevention and the social and economic determinants of mental ill health
- Ensure youth engagement and participation (including peer workers) in all service elements to ensure that services are youth-friendly and stigma-free
- Implement a soft entry to care that is rapid, easy, and affordable (eg, self-referral and drop-in services that are free or low-cost, in accessible locations with non-stigmatising branding and non-clinical ambience), and use mobile outreach and detection strategies combined with community education programmes to reach a range of groups, including engaging diagnostic subgroups, notably within psychosis and eating disorders
- Use a holistic and optimistic approach to prevention and early intervention that offers evidence-informed care proportionate to the stage of illness and guided by shared decision making
- Create an integrated practice unit or one-stop shop that is organised around the needs of young people and provides the full cycle of care via a multidisciplinary team of clinical and non-clinical staff, ideally in a single location
- Integrate mental and physical health services, substance use services, and educational and vocational support
- Build strong connections with schools and tertiary educational organisations
- Integrate digital support across all stages of care (entry, blended models of care, and post-discharge) as well as before entry to face-to-face care
- Prioritise youth-specific care that is inclusive and culturally and developmentally appropriate, reflecting the epidemiology of mental illness and the specific needs associated with the life stage of emerging adulthood—this involves careful attention to issues of privacy and confidentiality and ensuring that the support systems around young people, notably family, educational and employment structures, are engaged and supported
- Draw on family engagement and support, including family peer workers
- Create seamless transitions into and out of services (eg, when transitioning from services for younger children or into services for older adults)
- Enable continuous learning and improvement through auditing, evaluation, and workforce development

stigma-free or soft entry to care, often with a lay young person or clinician as a first contact point, with mental health and other needs-based expertise embedded. This model has been supported by the International Association for Youth Mental Health, a network of academics, health professionals, educators, young people, families, and other leadership and constituencies. Integrated youth primary mental health care lies at the heart of this reform front, with a focus on the age group of 12–25 years, challenging the disruptive transition point at age 18 years.^{209,227,251} Primary care has been central to WHO strategy for global mental health care,²⁵² although primary care might mean different things in different cultures. In youth mental health, enhanced primary care offers great advantages as an affordable, low-stigma foundation on which to build many other features, adapting to local resources, financial models, and cultural dimensions.²⁰⁹ A primary care model using lay community human resources, clinicians, and digital support where possible is more achievable in settings where investment in mental health care is modest at best. However, primary care is only the first step, as many young people require intensive and expert care to recover from persistent, complex, or severe forms of illness.²⁵³ In high-resource settings within some WEIRD countries, it is becoming possible to design and implement comprehensive models of care for people aged 12–25 years that extend from the community through primary care to secondary and tertiary levels of sophisticated quality care, integrating both face-to-face and digital support.^{227,236,254,255} However, such specialised and sustained expert community mental health care to support the entry-level primary care models has not yet materialised.

In order to span the adolescent and emerging adult years, a new system of care is required that is developmentally and culturally appropriate and that recognises youth-specific biopsychosocial issues and the patterns of mental health symptom emergence and comorbidity.^{227,251} The World Economic Forum has recognised the need to prioritise and build momentum in developing a youth-specific system of care and, together with Oxygen, which is based in Australia, has produced a blueprint for addressing this global challenge based on review of the evidence and extensive consultation with young people and other key stakeholders across the world.²⁹ The resultant framework specifies key elements of youth mental health care (panel 2), highlighting that services must be codesigned and highly accessible in the community, with barriers to care minimised (including a de-emphasis on formal diagnosis) and with all young people and their families feeling welcomed in an inclusive, positive, and non-stigmatising environment.²⁰⁸ Consistent with clinical staging, holistic, safe, stage-specific, and evidence-based care should be provided at the earliest opportunity.²⁰²

Layers and stages of care

The collaborative global effort to create a framework for youth mental health has identified key areas that have universal relevance across all resource settings. These areas include mental health promotion and community awareness; prevention programmes; integrated primary youth mental health care; secondary and tertiary care; school and university settings; integrated digital mental health platforms; and multidisciplinary workforce, volunteers, and peer workers. The implementation of components within these areas will vary according to the level of resources available (table 1). A fully developed model, which will require more resources and vertical integration of services and settings from the community through primary care to secondary and tertiary levels of care, is essential to eliminate fragmentation for all young people accessing mental health care, and their families, and to effectively meet the needs of those young people experiencing severe, complex, and persistent mental illness in a proactive, pre-emptive and proportional way (figure 5).

Mental health promotion and community awareness

Population health initiatives that educate the public to recognise and appropriately respond to the early signs of mental ill health in young people are an essential first step in alleviating the burden of mental ill health and improving help-seeking behaviours.^{209,251} Strategies can include mental health promotion interventions,²⁵⁶ self-help strategies,²⁵⁷ community awareness campaigns,²⁵⁸ and anti-stigma programmes.⁵³ In many parts of the world, stigma and insufficient knowledge of the concepts and causes of mental ill health are widespread, and respecting and working with religious and other traditional perspectives is needed to make progress.

Adolescent and youth versions of mental health first aid have been developed and evaluated in the USA and Australia, with reviews indicating benefits for participants who received mental health first aid training.²⁵⁹ Improvements in the mental health of the young people receiving aid, however, have not been found.²⁶⁰ As referred to previously, raising awareness, particularly with universal strategies within schools, has been hypothesised to increase anxiety and lead to a contagion effect that might be inflating rates of distress and mental ill health.⁹⁴ Despite universal strategies having a place in suicide prevention,²⁶¹ this hypothesis requires testing, as evidence indicates that it is unable to account for the extent of the rise in prevalence of mental ill health,^{68,262–265} and the optimal approach might be to combine evidence-based universal strategies with other effective strategies (especially targeted interventions). Universal approaches, however, have been shown to have a diluting effect on the capacity to respond to the substantial subset of young people with more severe and persistent mental health conditions.²⁶⁶

The engagement of young people with lived experience of mental ill health is crucial and powerful for promoting

	High-resource settings	Medium-resource settings	Low-resource settings
Community			
Programmes to address the social, economic, and commercial determinants of health, including mental health: environment and climate, housing security, intergenerational inequality, and other aspects of socioeconomic inequality	Yes	Yes	Yes
Community education and development	Yes	Yes	Yes
Digital mental health platforms	Yes	Yes	Yes
Early detection and, in certain scenarios, screening programmes	Yes
Prevention programmes (eg, anti-suicide, antibullying, anti-maltreatment, and harm reduction for substance use)	Yes
Mental health promotion programmes (eg, wellbeing, stress management, social connection, physical health, and nutrition)	Yes
School, university, and workplace awareness; mental health promotion; and prevention and early detection programmes	Yes
Prevention and school-based programmes, including those delivered via social media	..	Yes	Yes
Primary care			
Horizontally integrated youth (aged 12–25 years) health and social care platforms as one-stop shops	Yes
Integrated youth health and social care platforms as one-stop shops	..	Yes	..
Peer support and lay volunteers (eg, friendship bridge)	Yes	Yes	..
School and university mental health services	Yes	Yes	..
Digital interventions and telehealth integrated with primary care	Yes	Yes	..
Volunteer, peer, or lay worker programmes (eg, friendship bench or bridge concept)	Yes
Digital interventions, telehealth platforms, and social media	Yes
Secondary care			
Multidisciplinary youth mental health systems providing face-to-face and online care, closely linked to primary care and community platforms	Yes
Complementary, synergistic, and integrated digital platforms, including those targeting comorbidities that are not the primary focus of care	Yes
Multidisciplinary community mental health teams (face-to-face or online)	..	Yes	..
Complementary, synergistic, and integrated digital platforms	..	Yes	..
Primary care health professionals, including general practitioners and volunteers, who are trained in youth-friendly practice and mental health skills and provide care within mainstream community primary care settings with face-to-face, telehealth, and digital options	Yes
Tertiary care			
A suite of specialised, codesigned youth inpatient and residential services linked to acuity and stage of illness	Yes
Home-based acute care and assertive community treatment, including aftercare following self-harm or a suicide attempt	Yes
Diagnostic stream expertise (eg, psychotic, mood, personality, substance use, and eating disorders)	Yes
Integrated, blended, digital and face-to-face support when feasible	Yes	Yes	..
Inpatient services that are distinct from adult facilities, and home-based acute care if distinct inpatient services are not feasible	..	Yes	..
Home-based acute care with telehealth backup systems	Yes

Potential interventions according to the authors are shown. Adapted from McGorry et al²⁰⁹ with permission.

Table 1: Implementation of integrated youth mental health care according to level of resource²⁴¹

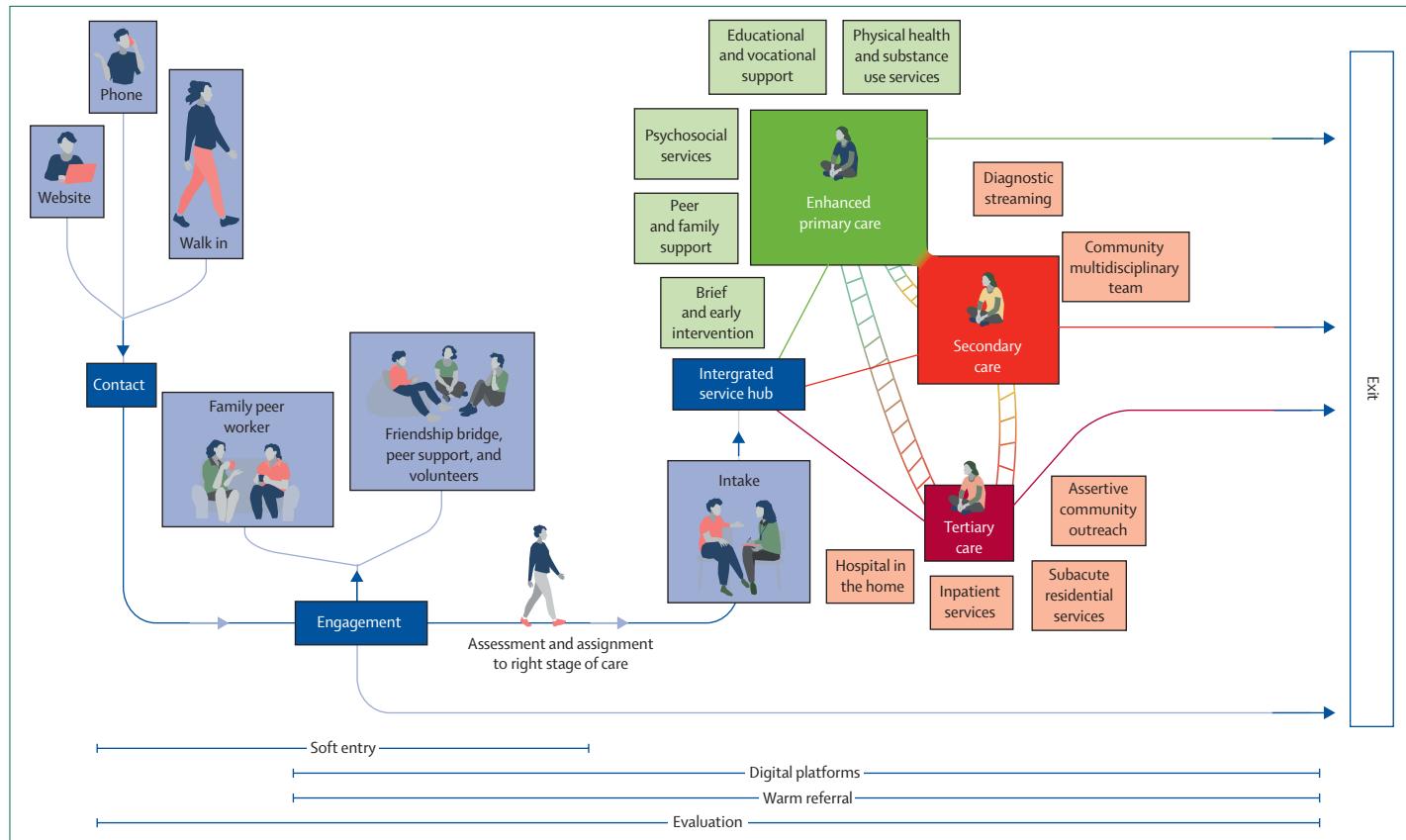


Figure 5: Integrated youth mental health care model

Service entry should be welcoming and stigma-free, with eliminated or reduced barriers to care (soft entry). For some young people, having a conversation with a peer worker or volunteer (friendship bridge) might sufficiently meet their current needs. Others are assigned to the right level of care (primary, secondary, or tertiary) based on their presenting needs, following assessment by the intake team. As their needs change, young people can move between these levels of care with supported transitions and seamless referrals.

For more on Baatcheet see
www.sangath.in/baatcheet

For more on It's Ok To Talk see
www.itsoktotalk.in

for more on Mann Mela see
www.mannmela.in

community awareness and reducing stigma.⁵³ The Baty programme in Australia, for example, was created by young people for young people to reduce stigma and promote help seeking within school and university settings.²⁶⁷ This engagement requires capacity building and training to ensure that young people with lived experience of mental ill health are well supported and feel safe in leadership and advocacy roles.²⁶⁸ Orygen has recognised this need and, in 2022, launched the Orygen Global Youth Mental Health Advocacy Fellowship and the Association of Southeast Asian Nations–Australian Youth Mental Health Fellowship, which provide individuals aged 18–30 years with advocacy education and training, including expert mentoring, peer mentoring, and contact with leaders in global mental health. Interventions have been launched in low-resource settings as well. The It's Ok To Talk initiative by Sangath in India advocates sharing personal mental health narratives of young people to address stigma and promote wellbeing through a digital storytelling website. The programme has included young people in various capacities as youth advisors, as storytellers through a virtual mental health museum, Mann Mela, and as evaluators analysing key messages

derived from narratives received by the platform.²⁶⁹ Recent developments to the programme include the involvement of youth in the codesign, development, delivery, and evaluation of a peer-delivered storytelling intervention called Baatcheet that targets depression, anxiety, and social disability among people aged 16–24 years.

Prevention

An urgent and global response is clearly needed to reduce the burden and rising incidence of youth mental ill health.^{4,270} A crucial distinction needs to be made between universal interventions targeting the harmful megatrends identified earlier and those targeting more traditional social determinants of and risk factors for mental ill health. Although some advances have been made in defining risk factors and social and economic determinants of mental disorders (eg, ethnicity, poverty and social adversity, housing insecurity, trauma, war, forced migration, neighbourhood deprivation, social support, education, physical health, and parental mental illness),^{52,271} much more needs to be understood. Candidate risk factors that might have contributed to rising rates of mental ill health involve recent social,

technological, and economic megatrends. Many potential universal strategies are beyond the scope of the health portfolio. Childhood, adolescence, and early adulthood are all sensitive periods when risk factors (eg, childhood maltreatment, peer victimisation and bullying, and substance misuse) can increase vulnerability to mental illness with long-term consequences.²⁷¹ Thus, prevention targeted towards risk factors within these developmental stages might be more effective in the short term and long term than universal strategies.

Missing elements to the implementation of large-scale and long-term prevention strategies are political will²⁷² and adequate and effective financing and economic evaluation frameworks.²⁷³ Preventive strategies must span universal, selective, and indicated prevention, and they must extend across all stages of illness, as is the case for other non-communicable diseases.²⁷⁴ Although indicated prevention is currently the most promising avenue for preventive efforts,^{198,275} universal and selective interventions also have value.^{276,277} For adolescents and young adults, strategies that are focused on promoting resilience and exercise and preventing maltreatment and bullying, substance use, self-harm, and suicide might be useful and contribute to improved mental health.^{210,271,276} Universal and selective interventions are effective in young people for alcohol use, psychological distress, anxiety features, affective symptoms, and other emotional and behavioural problems, but not for eating-related problems.²⁷⁷ Selective programmes that are based on lifestyle modification and dissonance, however, might reduce the onset of eating disorders.²⁷⁸ Other specific preventive interventions that have been found to be effective include psychoeducation for affective symptoms and psychotherapy for anxiety features.²⁷⁷ Regarding indicated prevention of psychosis, pairwise meta-analyses support the efficacy of cognitive behavioural interventions in reducing the likelihood of transition to psychosis in individuals at ultra-high risk for psychosis.^{279,280} Although network meta-analyses suggest a paucity of evidence for the superiority of any one type of intervention,^{279,281} the included trials indicate that transition rates are reduced at a group level.²⁸² Interventions that result in improvement do not appear to be syndrome-specific, and so far fall short of achieving full symptomatic and functional recovery, as shown in a large adaptive trial involving support and problem solving, cognitive behavioural case management, and fluoxetine.²⁸³ Although group-level improvements in functional and symptomatic measures were found, remission rates were low and relapse rates were high, indicating the need for treatment innovation for patients at ultra-high risk for psychosis, and the identification of treatment-relevant subtypes.²⁸³

Integrated primary youth mental health care

As WHO has highlighted for many years, primary care is key to global mental health,²⁵² and this is where youth mental health reform has made the most progress to

date.²⁰⁹ Integrated primary mental health care has been proposed as a solution to reduce service fragmentation and maximise outcomes due to its focus on patient-centred care delivered by a coordinated multidisciplinary team of clinical and non-clinical staff, preferably in a single location.²⁰⁷ Young people and service providers have endorsed an integrated service model for youth mental health.^{284,285}

Panel 3: headspace

headspace, Australia's National Youth Mental Health Foundation, was created in 2006 for people aged 12–25 years, in response to young people's poor access to and quality of mental health care. The foundations of headspace lie in the successful early psychosis paradigm that emerged in the early 1990s. headspace is funded by the Australian government and has been progressively scaled up to 164 centres across Australia. Each headspace centre is operated by a lead agency that works in collaboration with an independent consortium of local organisations to provide governance.

headspace operates as an enhanced primary care model, or one-stop shop, with a stigma-free soft entry to care. Through a multidisciplinary team of clinical and non-clinical staff, headspace provides a range of youth-friendly services across four core streams of care: mental health, drug and alcohol use, physical and sexual health, and vocational services. Although headspace is designed for young people with mild-to-moderate mental health problems, because it is a primary care model, all help-seeking young people are welcomed and can access at least some services and support (referred to as the no-wrong-door approach), including those with more severe and persistent illness, even if they do not identify as experiencing mental ill health. headspace offers a nationwide online and phone service, eheadspace, that provides services via web chat, email, and telephone. headspace also delivers a school support programme that provides suicide postvention support, and a range of community awareness campaigns focused on reducing stigma and promoting help seeking, early identification, and referral pathways. In several Australian states, the standard headspace digital platform is enhanced with more comprehensive and fully integrated digital support, provided alongside face-to-face support across different stages of treatment via the government-funded, evidence-based Moderated Online Social Therapy platform.^{254,255,287}

At headspace, stepped care is provided to young people within a clinical staging framework. Benign interventions (eg, psychoeducation and support) are offered in the earlier stages of illness, and medications are offered when first-line psychosocial interventions are ineffective alone or when symptoms are more severe. headspace has undergone three independent evaluations, with findings indicating that the model has had a positive impact on access to care and outcomes, especially for those with mild-to-moderate mental health needs.²⁸⁸

Within the past two decades, a range of integrated youth mental health care services have emerged internationally, although reform has largely occurred in high-resource settings.^{209,250,286} The Australian headspace model (panel 3), created in 2006, has been a prototype for global reform. headspace is a national network of youth-friendly, one-stop shops that provide young people with a range of health and social services, including mental health services, drug and alcohol education, physical and sexual health services, educational and vocational support, and integrated digital support.^{208,255} Other jurisdictions—notably, Ireland,²⁸⁹ Canada^{290–292} the UK,^{293,294} Denmark, Singapore,²⁹⁵ the USA, the Netherlands,²⁹⁶ Japan,²⁹⁷ South Korea,²⁹⁸ Israel,²⁹⁹ Hong Kong,³⁰⁰ Iceland, France,³⁰¹ and New Zealand³⁰²—have implemented variations of similar models, which have been adapted to meet local need as well as cultural, workforce, and financial factors (panel 4). Common across these services are the goals to reduce barriers to care by delivering mental health services that are youth-friendly with youth and family involvement, to be easily

accessible in the community (eg, the mindset that there is no wrong door), and low-stigma, and to provide seamless and holistic care during the transition from adolescence to early adulthood.^{209,286,304} Codesign (by which the model of care benefits from the ideas and views of young people with lived experience of mental ill health) and youth partnership (in which young people have an ongoing role in the operation of the service) are underlying principles and are essential elements for building a trusted brand (table 2).^{208,209,286}

Evaluation is an essential component to ensure that services are achieving their intended aims.²⁹ Independent and in-house evaluations have found that integrated youth mental health-care services are associated with high satisfaction rates among young people,^{288,296,306,310,313} are cost-effective,²⁸⁸ and offer a range of benefits: increased help-seeking behaviours and enhanced access to care; inclusion of marginalised and at-risk populations such as Indigenous people and LGBTIQA+ people^{292,306,313} (although effectively meeting the needs of these populations requires strengthening);²⁸⁸ reductions in distress, symptoms,^{288,306,311,313} suicidal ideation, and self-harm;³⁰⁶ and improvements in social, educational, and occupational functioning.^{288,306,313} A 2017 review of integrated youth mental health services confirmed that young people are highly satisfied with these services and have benefitted from improvements in service accessibility as well as symptomatic and functional recovery.²⁵⁰ Evaluations should also seek to identify any iatrogenic effects of models of care and interventions, such as stigma and barriers to engagement and continuity of care.

As with any paradigm shift, these reforms have attracted critics as well as early adopters.^{319,320} Critiques can be seen as a sign that real change is underway and, by pointing out weaknesses and gaps, can suggest ways of improving new models of care. The main criticisms of integrated youth mental health care have been that focusing on early-stage illness can detract from or divert focus from the care of later stages of illness, that the models have insufficient clinical expertise, and that the evidence for the benefits provided is insufficient. Reformers have typically engaged with and responded to such critiques,^{321–323} emphasising that integrated youth mental health care is a primary care that is designed for early stages of illness and the degree of severity that can be managed in primary care. These responses are by no means the complete answer, but they are often judged as if they were. Rather than draw funds away from seriously ill patients, integrated youth mental health primary care centres have been created with new funding, acting as a portal for those patients who are seriously ill to better access the next tier of care where this exists, publicly exposing the need for this access, and increasing the pressure on governments to ensure that the needs of this large cohort of patients with persistent and potentially disabling illnesses will be addressed. The evidence for the

Panel 4: Integrated youth services in Canada

Throughout the past decade, integrated youth service models for mental health and substance use have been increasingly adopted across Canada, with most provinces and territories having developed or committed to an integrated youth services network. The most established networks are ACCESS Open Minds (pan-Canadian), Aire ouverte in Quebec, Foundry (British Columbia), and Youth Wellness Hubs Ontario (Ontario). Other networks include Huddle (Manitoba), Newfoundland and Labrador Integrated Youth Services, Integrated Youth Services Nova Scotia, Saskatchewan Integrated Youth Services, Integrated Youth Services New Brunswick and Kickstand (Alberta). Approximately 77 youth hubs are in operation and an additional 44 are in development. In 2022, the Integrated Youth Services Network of Networks initiative was launched to link existing and emerging provincial and territorial networks and to develop a pan-Canadian network of learning health systems to improve service delivery.

To guide the development of integrated youth services networks across Canada, ten principles have been developed: engagement with young people and family; collaborative partnerships; accessible services; youth-centred care; responsiveness to the needs of young people; cultural safety; social justice; holistic care; early intervention and health promotion; and continuous learning and improvement.³⁰³ Consensus guidelines have been developed to operationalise these principles. Services delivered through Canada's integrated youth services model include primary care, mental health care, substance use services, peer and family support, Indigenous programming, work and employment support, housing, and other social services. This approach has been codesigned and delivered in partnership with young people and families.

Year established	Location	Service description	Number of centres	Target age, years	Number of young people accessing service	Key outcomes
Youth One Stop Shops ³⁰²	1994 New Zealand	Holistic health and social care	14	10–25	11 430 occasions of service (mean, per centre per year)	94% of young people and 89% of stakeholders report that the service is effective in improving health and wellbeing
Maisons des Adolescents ^{301,305}	1999 France	Integrated youth health care service	104	11–25	700–1000 (per centre per year)	Young people report that the service contributes to their wellbeing, and professionals report that the service responds to individual situations and helps to prevent deterioration
headspace ^{288,306–308}	2006 Australia	Enhanced primary health-care service offering integrated care across four core streams of support: mental health, drug and alcohol use, physical and sexual health, and vocational	164 (plus 9 upcoming)	12–25	106 574 (2020–21)	Increased access to services; cost-effective; 74% of young people have high or very high severity of psychological distress at entry; post-treatment, young people had decreased psychological distress (47%), improved wellbeing (82%), significant symptomatic or functional improvement (60%), statistically significant reductions in suicidal ideation and self-harm, a statistically significant increase in the number of days working or studying, and a reduced impact of mental health issues on work and study (83%); 88% of young people who used the service were satisfied
Jigsaw ^{309–311}	2008 Ireland	Youth mental health service focused on prevention and early intervention	14 (plus 1 upcoming)	12–25	>44 000 (since 2008)	52% of young people have moderate-to-severe or severe distress at entry; psychological distress post-treatment: 62% aged 17–25 years showed reliable and clinically significant improvement and 68% aged 12–16 years showed reliable improvement; >90% of all users were satisfied with the support received
CHAT ^{295,312}	2009 Singapore	National youth mental health check and outreach programme	1	16–30	3343 (2009–19)	>90% of young people report that the CHAT assessment service is accessible, acceptable, and appropriate; of those receiving CHAT supportive interventions, 47% showed a >25% change in distress reduction and 20% showed a 6–25% change in distress reduction; >90% of young people were satisfied with CHAT supportive interventions
headspace*	2013 Denmark	Counselling and support service	28 (plus 4 upcoming)	12–25	NA	Since 2020, the number of young people who require support and report suicidal thoughts has increased; young people's satisfaction with both life and their wellbeing increased during service engagement
ACCESS Open Minds ^{301,313}	2014 Canada	Integrated youth service offering mental health care and access to physical health and sexual health services, traditional Indigenous programmes and support, and other social services	14	11–25	8043 referrals and 5280 youth evaluated (2016–20)	64% of young people have moderate to severe mental health problems at entry; as hypothesised, significant increases occurred over time in referred or help-seeking youth and reductions in delays to evaluation and services received; post-treatment: significant reductions occurred in distress and the severity of mental health problems, and improvements occurred in mental health and school, work, and social functioning; the service had high satisfaction rates: 88% of young people were satisfied with service received and 86% satisfied with services overall; \$9.70 savings for every \$1 invested
headspace ^{299,314}	2014 Israel	Integrated youth mental health service with three major components: prevention and early intervention, community awareness, and training and education for professionals	2	12–25	652 (Bat Yam centre)	66% present with high or very high severity of distress; the service has increased the accessibility and familiarity of mental health services available to young people and has high satisfaction
Foundry ²⁹²	2015 British Columbia, Canada	Integrated health and social service centres offering access to physical health, mental health, substance use, peer support, and social support care	17 (plus 18 upcoming)	12–24	4783 (2015–18)	81% of young people have high or very high severity of distress at entry; young people strongly agree that having multiple services in one location makes it easier to get help; excellent access for Indigenous and LGBTIQ+ groups; 70% of users report that services meet their needs; 75% of users are satisfied overall (unpublished)

(Table 2 continues on next page)

Year established	Location	Service description	Number of centres	Target age, years	Number of young people accessing service	Key outcomes	
(Continued from previous page)							
Mindlink ²⁹⁸	2016	South Korea	Accessible, youth-friendly, stigma-free, community-based early intervention centres providing intensive case management and group programmes	16	15–30	206 (2019)	Diagnoses: schizophrenia spectrum disorder (53·4%), depression (24·8%), ultra-high risk for psychosis (9·7%), and bipolar disorder (9·2%)
Youth Wellness Hubs Ontario ²⁹⁹	2017	Ontario, Canada	Integrated service hubs offering services related to mental health, substance use, primary care, education, employment, training, housing and other community and social services. Hubs also include peer services, outreach, and system navigation services	25 (plus 5 upcoming)	12–25	9585 (2020–23)	91% of young people have moderate-to-severe psychological distress at entry; 46% of young people report suicidal ideation in the past 2 weeks; post-treatment, statistically significant reductions in distress and severity of mental health problems, and improvements in mental health occurred; >90% of young people report positive service experience across multiple service domains
@ease ^{226,296}	2018	Netherlands	Youth-friendly, easily accessible support for mental health and wellbeing	12 (plus 4 upcoming)	12–25	>750 face-to-face sessions and >3000 online chats	High diversity and complexity of need at entry; statistically significant improvement in symptoms and functioning post-treatment; 33·3% of users improved clinically and 39·6% reliably improved (SOFAS); 43·2% improved to a better clinical category and 28·4% improved reliably (CORE-10); on average, young people were satisfied or very satisfied with wait times and their conversations
Aire Ouverte ³¹⁵	2019	Quebec, Canada	Integrated youth services providing a variety of health and social services, including mental health, sexual health, vocational support, and other related services	28 (plus 14 satellite sites)	12–25	19 056 (2024 [24 sites])	The majority of young people present for mental health and psychosocial needs; high numbers of vulnerable youth at entry (eg, looked-after youth and LGBTQIA+); young people report being satisfied and appreciating the flexibility of the model and access pathways
headspace*	2019	Iceland	Counselling and support service	2 (plus 22 satellite services)	12–25	390	Characteristics of service users: average age 19 years, 69% female, 26% live independently, 56% live in Reykjavík, 66% became aware of the service via friends or family; young people have benefitted from a counselling model: few service users have required more intensive treatment (~10%) and the service has helped young people remain in work or education; four sessions attended on average; collaboration has increased with headspace Denmark and headspace Norway, termed Nordic headspace; a conference has been planned for 2024
Piki ³¹⁶	2019	New Zealand	Integrated youth mental health care service	NA	18–25	5307 (2019–20)	Diversity of need exists at entry; however, likelihood of severe distress presentations is greater; 75% would recommend Piki to others
SODA ²⁹⁷	2019	Japan	Integrated youth mental health service providing clinical case management	1	12–35	105 (March to September 2020)	80% of users required short-term support; 20% received clinical case management for 6 months, with improvements in Global Assessment of Functioning scores at the end of treatment
Levelmind, with Headwind (online service) ^{300,317}	2019	Hong Kong	Integrated youth mental health platform offering multidisciplinary care in community youth centres, with service stratified in 3 tiers based on distress and clinical assessment	8	12–25	>18 000	Initial outcomes suggest a reduction of distress in young people with moderate distress and prevention of deterioration in distress in young people with low distress
Allcove ³¹⁸	2021	USA	Early mental health services, primary medical care, substance use services, peer and family support, and supported education and employment services	2 (plus 9 upcoming)	12–25	5000 (2021–23)	NA

Services were identified via author knowledge and the International Association for Youth Mental Health. ACCESS=adolescent/young adult connections to community-driven, early, strengths-based and stigma-free services. CHAT=Centre of Excellence for Youth Mental Health. CORE-10=Clinical Outcomes in Routine Evaluation 10. NA=not available. SODA=Support with One-Stop Care on Demand for Adolescents and Young Adults in Adachi. SOFAS=Social and Occupational Functioning Assessment Scale. *Unpublished data.

Table 2: Characteristics and outcomes of youth mental health services

effectiveness of the enhanced primary care models has accumulated over time from independent evaluations,^{288,306} and areas for improvement have been identified. Many critiques have been helpful, and although some seem to have been poorly motivated and misleading, critiques overall are an inevitable companion to real progress when the status quo is being challenged.

Secondary and tertiary services

Although primary care services are predominantly designed for young people with mild-to-moderate needs, individuals with higher or more complex needs are increasingly accessing these services.^{250,286,288} This group of young people who require more specialised, sustained, and multidisciplinary care than those with mild-to-moderate needs have been termed the missing middle.³²⁴ A substantial proportion of these young people do not respond to simple primary care models,³²⁵ which function as a stigma-free entry portal to the next tier of care for this group. Access to this next tier is currently only feasible in a minority of high-resource settings. In Victoria, Australia, the Royal Commission into mental health care²³⁶ catalysed a major restructure of public sector specialist or secondary mental health care, which will now see the child and youth system boundary with adult mental health shift to 25 years of age. There will now be two zones or cultures of care within this system—one for younger children aged 0–11 years, and one for young people and emerging adults aged 12–25 years. The zone or stream of care for those aged 12–25 years is youth-friendly and codesigned with multimodal and holistic components of care, from residential services through to multidisciplinary community care, and it is vertically integrated with the enhanced primary care system of headspace centres, which have focused on individuals in this age group for 17 years. Implementation will include substantial challenges related to training, workforce, sufficient financial resources, and appetite for workplace culture reform. Such reform needs to address access to services for groups of young people whose needs have historically been seen as reasons to discriminate against them and to deny them services, such as those living with personality disorders or substance use disorders, and young people involved with the justice system.

At a tertiary level, options available to young people, particularly in high-resource settings, should include inpatient or intensive home-based care, subacute programmes, and short-term or long-term residential care that is strengths-based and recovery-focused. These facilities must be adequately funded, codesigned with young people and families, and distinct from younger childhood and adult facilities (ie, they should be developmentally and culturally acceptable to young people). In low-resource settings, home-based acute care should be available if youth-specific inpatient services are not feasible or affordable. In India, Support, Advocacy

and Mental Health Interventions for Children in Vulnerable Circumstances and Distress (SAMVAD) is a national initiative located in a tertiary mental health care facility.³²⁶ SAMVAD aims to address the challenges in delivering child and adolescent mental health care in low-resource settings and enhance access to child and adolescent mental health services. SAMVAD incorporates the integration of these services into child protection, judicial and education systems, and delivers culturally specific training and capacity building, mentoring, and public awareness initiatives. Between 2020 and 2023, it provided training to 24 599 mental health professionals across India.³²⁷

School and university settings

Educational settings are a prime platform for the mental health care of young people due to the large volume of time young people spend at school, although this is not applicable to some low-resource settings, and access to education varies across and within countries.³²⁸ Educational settings have a central role in promoting mental health,^{329,330} recognising the warning signs of mental ill health,³³¹ and delivering prevention and intervention programmes.^{271,332} Meta-analyses of school-based preventive interventions have found weak or modest evidence for the prevention of anxiety and depression,^{333,334} with indications that targeted prevention might be more effective than universal prevention for depression.³³³ Evidence from both high-resource and low-resource settings suggests that low-cost interventions that target the whole school environment are effective in lowering rates of bullying victimisation, improving wellbeing,³³⁵ and reducing the severity of depressive symptoms, particularly when delivered by lay counsellors.³³⁶ Findings from a large cluster randomised controlled trial of a universal school-based mindfulness programme, however, indicate that more research is needed to codesign interventions with young people and to determine what works for whom and under what circumstances.⁹⁸ That study found no evidence for the superior effectiveness of mindfulness compared with teaching as usual in reducing the risk of mental health problems and promoting wellbeing, although engagement was low and acceptability was mixed.⁹⁸ Where there was evidence of a difference between treatment groups, outcomes were marginally worse for the mindfulness group (ie, across the domains of hyperactivity and inattention, panic disorder, obsessive-compulsive disorder, emotional symptoms, and mindfulness skills).

Within non-WEIRD countries, Premium for Adolescents (PRIDE) is the largest ever adolescent mental health research programme, implemented from 2016–22 in low-income schools across Goa and New Delhi, India. The aims were to develop and test a suite of psychosocial interventions arranged around a transdiagnostic stepped-care architecture for common adolescent mental health problems. A fully powered randomised controlled trial showed that step one (a lay

counsellor-delivered, brief problem-solving intervention reduced youth-reported psychosocial problem severity and that these effects were sustained over a year.^{337,338} Classroom information sessions, compared with school-wide publicity materials, greatly enhanced demand for step one in a stepped-wedge cluster randomised trial.³³⁹ An alternative digital format of problem solving proved to be feasible and acceptable with in-person guidance, but remote delivery was less viable.^{340,341} Evidence was also found for the incremental benefit of a tailored, second-step intervention for non-responders to step one.³⁴² A randomised trial of two different e-learning formats found that periodic coaching can improve learning outcomes and engagement among novice counsellors.³⁴³

Regarding higher education, a 2022 systematic review on mental health interventions in university and college settings found evidence for the effectiveness of mindfulness-based interventions, cognitive behavioural therapy (CBT), and interventions delivered via technology, whereas psychoeducation appeared to be less effective.³⁴⁴ CBT-related interventions were also found to deliver sustained effects over time;³⁴⁴ however, research has identified that integrated models of university-based mental health care that can meet a spectrum of student wellbeing and mental health support needs across prevention, early intervention, and treatment, rather than stand-alone interventions, are needed.^{345,346} These models include supported transitions to community services when clinically indicated and the integration of effective digital mental health interventions.³⁴⁷ A comprehensive approach is needed beyond wellbeing strategies and outdated student health models, which have not addressed the scale and severity of the mental ill health that exists in tertiary educational settings.

Digital technologies to drive service innovation and reform in youth mental health

Young people are the highest users of the internet and digital technology. Being raised entirely within a connected and digital world, young people (termed digital natives)³⁴⁸ are the first to adopt new digital technologies as they arise and engage extensively with existing technologies and all features of the internet.³⁴⁹ For example, a 2022 report from the Pew Research Centre found that, in the USA, 95% of adolescents (aged 13–17 years) had access to a smartphone (and 98% of adolescents aged 15–17 years), 97% used the internet daily, and 35% used one of the top online social media platforms “almost constantly”.³⁵⁰ Notably, the percentage of adolescents who reported being almost constantly online doubled over the previous 7 years (46% in 2022 vs 24% in 2017).³⁵⁰ Much attention has been focused on the potential for harm and risks to mental health posed by this dramatic change. Conversely, the use of smartphones might offer opportunities to extend and enhance models of care globally and to bridge the digital divide previously present in LMICs,^{351,352} although access varies across

countries; for example, only 56% of adolescents aged 10–15 years in Tanzania have access to their own or someone else’s mobile phone, compared with 95% in Sudan.³⁵³ This mobile phone usage means that digital and virtual technologies and interventions can not only deliver accessible support in settings where mental health professionals are non-existent or in short supply, but they can also augment the reach, impact of, and even transition between existing mental health services. Digital interventions have the scope to address some of the key shortcomings of youth mental health services and interventions, particularly making it difficult to seek treatment, creating poor access to treatment, long waiting lists, poor continuity of care, and insufficient personalisation and fidelity to evidence. Integrated digital interventions and blended models of care have the potential to address most of these issues and thus improve overall effectiveness.

The role of digital and mobile technology and smartphones is therefore crucial in the redesign of mental health services. These technologies now include a wide range of highly personalised (passive and active) mobile sensors and apps that can capture subjective data on repeated occasions, without the need for physical attendance at a clinic. Therapeutic platforms of care are now becoming available and can be integrated within face-to-face care systems.^{254,255} These platforms can also be used to reduce the risk of suicide and self-harm,^{354,355} depression, and alcohol misuse.³⁵⁶ Improving the scalability of such approaches is the next challenge.

More than 100 efficacy trials have shown that online interventions improve accessibility and produce engagement and effectiveness outcomes that are equivalent to traditional face-to-face services and interventions.^{357,358} Rates of engagement in these first-generation, standalone digital interventions appear to be lower in young people compared with adults.^{359,360} A plausible contributing factor to this finding is that young people have consistently endorsed integrated digital interventions that blend face-to-face services and digital support, as opposed to standalone digital interventions.^{361,362} Similarly, experts and consumers alike have called for a contemporary youth mental health system enabled by digital technology, where digital interventions are blended into service delivery to improve accessibility and continuity of care and are shaped by interdisciplinary translational research that informs service delivery and policy.^{236,363} Yet, despite evidence from 15 years of research for the effectiveness of digital mental health interventions, a historical and global research translation gap has hindered clinical implementation, and very few digital interventions have been successfully integrated into mental services.³⁶⁴ This failure is twofold. First, nearly every digital mental health intervention has been designed in academic or commercial settings, in isolation from clinical services, thereby not considering service constraints and needs.^{364–366} Second, the science of digital mental health

implementation is often based on trial and error, with little systematic research on implementing digital technologies.³⁶⁷

Promisingly, developments have been made in integrating digital technologies into youth mental health services. A key example is the Moderated Online Social Therapy (MOST) platform, which is a purpose-built digital intervention designed to provide an integrated solution to youth mental health service limitations.²⁸⁷ To achieve this aim, MOST was designed in partnership with young people, clinicians, mental health services, and industry partners. This platform merges evidence-based, trans-diagnostic, interactive psychological treatment with professional psychological, vocational, and peer support that is integrated with a social network of peers and peer workers. MOST was designed to work in tandem with services and address their limitations across the care pathway or phases of care (ie, entry and waitlists blended with face-to-face care and post-discharge). Results from several pilot studies and a clinical trial showed that MOST was engaging over prolonged periods of time; safe; non-stigmatising; endorsed and valued by young people, clinicians, and services; effective in improving vocational recovery and reducing use of hospital services in youth psychosis; cost-saving; and cost-effective, with four clinical trials underway.^{254,368-372} After being adapted and tested across Australia, the USA, Canada, and Europe, MOST has now been implemented in headspace centres and specialist youth mental health services, including in more than 200 clinics across eastern Australia.³⁷³⁻³⁷⁵ Comprehensive, multifaceted digital tools such as MOST have great potential in low-resource and middle-resource settings where the content must be adapted through codesign and translation within local cultural and language conditions. Social media platforms have similar potential to deliver mental health interventions in low-resource and middle-resource settings,³⁷⁶ and have been safely used in high-resource settings with appropriate risk management strategies among young people experiencing active suicidal ideation.³⁷⁷

Although the aforementioned examples are promising in terms of the potential of digital technology to drive the development of new models of care in youth mental health, the rapid development and adoption of breakthrough technologies including artificial intelligence, natural language processing, virtual and augmented reality, and virtual worlds provides an unprecedented opportunity to use new innovations to address historical problems in youth mental health.^{237,378,379} To fulfil this opportunity, there is a need to adopt robust scientific designs, develop new models of translational research that expedite the development–evaluation–implementation cycle and enhance the external validity of our interventions, and embrace best practice in implementation science, psychological interventions, behavioural science, and user-centred design.

Multidisciplinary workforce, peer workers, and volunteers

The successful implementation of youth mental health reform requires a multidisciplinary and appropriately skilled workforce that includes clinical and non-clinical staff (eg, psychologists, psychiatrists, social workers, youth workers, nurses, general practitioners, alcohol and other drug workers, vocational workers, and peer workers). The demand for youth mental health care has increased,^{230,380-382} and workforce and skills shortages are a major challenge globally, particularly in low-resource settings.³⁸³⁻³⁸⁵ Even in high-resource settings, youth mental health services have faced difficulties in attracting and retaining a multidisciplinary workforce, leading to excessive wait times.^{230,288}

Strategies to meet workforce and skills challenges include the creation of new subspecialty training in youth psychiatry³⁸⁶ (or, in Europe, transitional psychiatry), leveraging digital technologies,³⁸⁷ and increased government investment to support training and incentivise workforce growth and retention in the youth mental health sector. Neither adult nor child and adolescent training programmes are currently fit for purpose, as another dimension of skills and evidence is needed to effectively respond to emerging adults. Additionally, an abundance of human resources, including in low-resource and middle-resource settings, can be drawn upon to innovatively build systems of mental health care that are context-appropriate.^{388,389} The Friendship Bench concept³⁹⁰ is the best known example of this strategy; however, the use of volunteers and peer workers in new youth primary care services has been a creative response to the difficulty in assembling professional clinical workforces and structures that occurs even in high-resource settings.²⁹⁶ Peer or lay workers are a core component of the youth mental health workforce across all resource settings,^{29,286,343} complementing traditional clinical roles rather than merely filling staff shortages. The incorporation of peer workers assists in providing care that is holistic, strengths-based, patient-centred, and recovery-oriented both in face-to-face and digital settings. Peer workers' roles are diverse and might include enhancing service engagement, providing emotional support, assisting in navigating the mental health system, and prioritising and planning treatment.^{391,392} When combined with shared decision making, peer support can strengthen young people's involvement in treatment decisions.³⁹³ This strategy also enhances and catalyses engagement capacity for culturally diverse communities. Peer work is an emerging and demanding role. For it to be safe and sustainable, quality training, supervision, support, and appropriate remuneration are essential. Scope of practice should be clearly defined to avoid stress and burnout.

The models of youth mental health care that are emerging represent a prescient response to what has now been revealed as a global crisis in youth mental health, but they are merely a foundation for a much greater mission. The youth mental health crisis and

rising prevalence have placed these first-generation models under increasing demand pressures. The challenge is now to tackle the sources and structural forces underpinning this crisis and to build several tiers of evidence-based care to respond such that the full ecosystem of care is accessible. This endeavour will involve global collaboration and a mission-based approach with a series of phases powered by innovation.³⁹⁴

Part 4: The economic imperative

Introduction

The 2019 Global Burden of Disease study confirmed that mental disorders accounted for the highest disease burden (as measured by disability-adjusted life-years) for the age 10–24 years group across all income groupings: high-income, upper-middle-income, lower-middle-income, and low-income countries.³⁹⁵ Suicide is also a major contributor to the disease burden globally in this age group, being the leading cause of years of life lost in the WHO southeast Asian region, and in the top three causes of years of life lost in all other WHO regions except Africa, where it is 10th.⁶⁹

Poor mental health in young people is also associated with substantive personal and economic effects. Most of

these costs are incurred outside of health-care systems and involve the costs of social welfare programmes, lost taxation receipts, loss of productivity or mental wealth, costs of violence, crime and incarceration, costs of suicide, and premature mortality.³⁹⁶ The global cost of all mental disorders for all age groups was estimated to range from US\$2·5–8·5 trillion in 2010, depending on the method of assessment used, with the cost projected to double by 2030.³⁹⁷ A key cost driver is that mental disorders typically emerge by age 25 years.^{7,113} Mental health problems emerging early in life adversely affect crucial developmental transitions, potentially with profound consequences for life trajectories. For example, 30–70% of adolescents with depressive symptoms or major depressive disorders are likely to experience fully fledged and persistent major depressive disorder in adulthood.³⁹⁸ As indicated previously, the risk of mental disorders is also influenced by social determinants such as socioeconomic status, immigrant status, and exposure to traumatic life events.⁵²

Young people with depression are more likely to smoke³⁹⁹ or vape,⁴⁰⁰ and poor mental health has been associated with a substantially increased risk of lifetime adverse physical health outcomes such as coronary heart disease or stroke^{401–403} and disparities of decades in life expectancy, even in affluent countries with strong social

Panel 5: Recommendations for economic strategies to reduce the impact of mental ill health in young people

- Invest in proven, cost-effective programmes for mental health promotion, prevention, and early intervention at several life stages
- Invest in cost-effective models of youth mental health care in high-resource settings, specifically early intervention for psychosis and integrated, enhanced primary care platforms such as headspace (Australia), Jigsaw (Ireland), and Integrated Youth Services (Canada; eg, Youth Wellness Hubs Ontario and Foundry in British Columbia), with careful consideration given to fidelity of implementation of these multidisciplinary models of care; these programmes, especially when well implemented and supported by longer term continuity of care via multidisciplinary teams, will provide good value for money with probable savings across many government portfolios, as supported by a range of economic studies
- Explore new cost-effective methods of providing care in low-resource and middle-resource settings where health professionals are in short supply; modified primary care models enhanced through task sharing and task shifting and by telehealth and digital health care are likely to be the best value for money
- Invest in programmes that improve the physical health of young people with mental health problems and prevent the onset of comorbid non-communicable medical illnesses such as cancer and cardiovascular disease, which result in premature mortality and additional health costs in this high-risk group
- Address challenges related to securing substantial additional public investment in youth mental health and expanding the scope, range, and quality of economic research in mental health
- Identify, reverse, and mitigate harmful political, economic, and social policies that are undermining mental health and wellbeing and contributing to the increase of the incidence and prevalence of mental illness in young people, including:
 - Reversing intergenerational inequality and wealth transfer, which has increased the socioeconomic precarity of young people in many countries
 - Improving housing and rental affordability as a proportion of annual income, which has worsened steadily over recent decades in many societies
 - Reversing the trend to commodification and privatisation of education, including the improving equality of opportunity
 - Improving working conditions and the rights of younger workers and reversing the casualisation of the younger workforce
 - Supporting policies to genuinely respond to the climate emergency and climate anxiety
 - Developing policies to limit the harm caused to the mental health of young people by unregulated social media platforms and smartphones

safety nets and universal health-care systems.⁴⁰⁴ Poor mental health in adolescence increases the risk of poor educational attainment,²⁴ and non-participation in post-secondary education, unemployment, low income when working, and being a recipient of welfare payments.^{405,406}

These substantial personal, community, and economic burdens demand better policy responses. In this section, we provide an overview of current economic evidence for action and identify areas in which action can be strengthened (panel 5). As the generalisability of economic evidence can be open to questions and depends on multiple factors, including similarity of resource contexts, we discuss this evidence according to resource level. Key terms used throughout this section are defined in the appendix (pp 15–16).

Evidence of cost-effective interventions and approaches from high-resource settings

Prevention

Evidence is reasonably good for several cost-effective interventions for mental disorder prevention and mental health promotion specifically targeting young people in high-resource settings. Economic evidence of psychological interventions targeting high-risk populations for the prevention of anxiety disorders has consistently shown that youth-focused CBT, parent-focused CBT, or parent-focused psychoeducational interventions provide good value for money.^{407,408} With respect to the prevention of depression in young people, the evidence is mixed; for example, recent Australian modelled studies have shown that school-based psychological interventions were cost-effective regardless of whether they were universal or indicated interventions.⁴⁰⁹ In contrast, trial-based economic evaluations found that school-based CBT was more costly and less effective than usual care for indicated prevention of major depressive disorder over a 1-year period.^{410,411} Similarly, a universal school-based mindfulness programme was neither more effective nor more cost-effective than standard teaching based on the coprimary outcomes (risk for depression, social-emotional-behavioural functioning, and wellbeing), although evidence suggested some cost-effectiveness when quality-adjusted life-years were used as the measure of benefit.⁹⁸ The cost-effectiveness of many public health and health-promotion interventions depends not only on their availability and affordability, but also on their initial uptake and sustained engagement by their intended target population. For example, in 2017 Le and colleagues found that a cognitive dissonance intervention for the prevention of anorexia nervosa and bulimia nervosa would become cost-effective if more young people (aged 15–18 years) agreed to participate.⁴¹² Interventions need to be acceptable to young people and delivered in a way that minimises their risk of stigmatisation and exclusion. Cost-effectiveness can also be affected by how interventions are implemented (eg, whether secure multiannual funding is made available to attract and retain required staff) and the

context of the health systems in which interventions are delivered (eg, whether the availability and capability of third-party services facilitate adequate, appropriate, and timely referrals to and from an intervention service). No unintended or unaccounted for consequences of implementation (such as increased waiting times) should occur.

The economic case for investing in mental health prevention and promotion when different interventions are completed within the same study context has been examined in the UK⁴¹³ and Australia.⁴¹⁴ Results for interventions targeting young people, using conservative modelling assumptions, have shown that for every Australian dollar invested in the prevention of depression or anxiety at school or university, there is an approximate AU\$1·1 to \$3·1 return from that investment in terms of health-care service savings and increased productivity.⁴¹⁴

Service models and treatments

One concept focusing on young people that has been robustly evaluated from an economic perspective is early intervention in psychosis. Evidence consistently shows cost-effectiveness of early interventions in psychosis across different health systems.^{415–420} A Hong Kong-based study associated early intervention with 35% savings in health-care costs for every point of improvement on general psychopathology measured by the Positive and Negative Syndrome Scale.⁴²¹ In the UK, models and individual patient data analyses have reported cost savings and increased benefits (such as improvements on clinical outcome scales) associated with early intervention in psychosis services.^{422–425}

Easy-access, youth-friendly, and integrated community-based primary care services that provide evidence-based interventions for people aged 12–25 years have been established in several countries.²⁵⁰ These services have been shown to increase access to mental health services and improve symptomatic and functional recovery post-service.²⁵⁰ Given that these services are fairly new and are also complex, multifaceted, intersectoral, community-based, and organic, economic evidence is still emerging.⁴²⁶ An independent evaluation commissioned by the Australian Government concluded that headspace's primary youth mental health services were effective and cost-effective, especially for those for whom they were designed.²⁸⁸ Although the cost-effectiveness of digital mental health services remains unclear,⁴²⁷ some studies in Australia have found that an online intervention with the sole aim of increasing access to care for young people resulted in improvements to quality of life and was cost-saving compared with usual care.⁴²⁸ A collaborative care model has also been found to be very cost-effective in reducing depressive symptoms in adolescents when implemented in an integrated health-care environment.⁴²⁹ Other evidence for specific interventions targeting

disorders that occur mainly in young people (such as depressive or eating disorders) have also been found to be highly cost-effective.^{430–432}

Evidence of cost-effective interventions and approaches from low-resource and middle-resource settings

Most of the literature on this matter has focused on the classification of countries as low-income and middle-income, as previously discussed. The World Bank has emphasised the links between economic development, cognitive capacity, and mental capital (ie, cognitive and emotional resources)⁴³³ in LMICs.⁴³⁴ These issues, however, pertain not only to particular countries and parts of the world where such low resourcing is most prominent, but also to substantial sections of what are termed high-income and middle-income countries, where disadvantage and poor access to care are also widespread. Already, economic modelling studies are helping to “debunk the overgeneralized claim that treatment of mental disorders is not a cost-effective use of scarce health care resources”.⁴³⁵ There is scope to adapt some actions implemented in high-resource settings for delivery in low-resource and middle-resource settings wherever they are located, and a requirement to develop novel solutions that address the specific challenges of low-resource settings. The optimal way to determine cost-effectiveness in LMICs is unclear. The most common approach is to apply a criterion that the incremental cost of an intervention should be no more than 1–3 times the per capita GDP for each disability-adjusted life-year (DALY) averted, but this approach remains controversial.⁴³⁶

Prevention

Few economic assessments of the value of promotion and prevention within a low-resource context exist. Given the association between poverty and poor mental health, the use of fiscal measures such as cash transfer programmes and other poverty reduction measures to promote and improve the mental health of young people have come to prominence.⁴³⁷ Although formal cost-benefit analyses of most of these programmes are still needed, some evidence suggests they protect mental health.⁴³⁸ In Malawi, a cluster randomised trial of an unconditional cash transfer programme targeted to very poor households statistically significantly reduced depressive symptoms in young people, especially young women.⁸⁹ A trial of a similar programme in Kenya reported statistically significantly lower rates of depression in young men compared with young women.⁴³⁹ In Uganda, a trial of two financial incentives encouraging young orphans to save more money reported statistically significant reductions in depression at 2-year follow up, with the most generous financial scheme being more cost-effective.⁴⁴⁰ At 4-year follow up, these improvements in depression were no longer statistically significant, although other benefits, such as

reduced hopelessness, persisted.⁴⁴⁰ In Brazil, lower suicide rates have been observed following receipt of a cash transfer programme conditional on attendance at school, although the cost-effectiveness of the intervention was not examined.⁴⁴¹

Legislative measures that reduce harmful behaviours such as excess alcohol consumption have been modelled as cost-effective in all WHO regions.⁴⁴² Measures to reduce suicide risk, such as legislation to restrict access to hazardous pesticides, have been associated with a substantial decrease in suicide rates in some Asian countries, including in Sri Lanka, at a very cost-effective US\$1·23 per DALY averted.⁴⁴³

Treatment

Economic modelling work for the general population in all WHO regions indicates that investment in both pharmacological and psychological therapies can be cost-effective even in the most resource-constrained regions of the world.^{444,445} Examples of country-level modelling of mental health care also exist. In Ethiopia, at a willingness-to-pay amount of US\$500 (approximately GDP per capita in Ethiopia) per DALY averted, investment in antidepressant therapy and psychotherapy would be considered cost-effective; if the threshold were \$1500, then some psychosocial treatments and lithium for bipolar disorder would also be cost-effective.⁴⁴⁶

Some effectiveness evaluations in low-resource settings target specific vulnerable groups that are not common in high-resource settings, such as young people living with communicable disease or who are exposed to conflict-related trauma. For example, psychological therapy for young people in Sierra Leone who had experienced war-related psychological distress has a cost per quality-adjusted life-year gained equivalent to 2·6 times GDP per capita.⁴⁴⁷ This ratio would be more favourable if non-health-related benefits, such as long-term benefits of increased education participation, were included.

Task-shifting and task-sharing

The challenges in resource-constrained settings have also led to innovation in intervention delivery. To address workforce constraints, it is possible to shift responsibility for mental health care delivery from mental health specialists to primary care or lay health workers, or to share this responsibility, and still provide care that is effective at reducing the burden of common mental disorders.³⁸⁹ Task-shifting and task-sharing are strategies that have been explored in generic adult services in low-resource and middle-resource settings.^{448,449} Even in high-resource settings, these strategies are an example of entry-level, youth-integrated primary care models, which can optimise the role of more specialised professionals who are in short supply. In India, brief psychological therapy delivered by lay health workers to young people living with severe depression was found to be cost-effective at both 3-month and 12-month follow-up from a

health system perspective, and was found to be cost-saving when considering impacts on subsistence activity and employment.^{450,451} Lay-delivered therapy to improve adolescents' self-reported psychosocial problems and mental health symptoms has been found to be effective and could be scaled up in India at a cost of US\$4 per student.³³⁷ Brief lay-delivered therapy for treatment of depression in young people living with HIV in Uganda is also highly cost-effective at \$13 per DALY averted.⁴⁵²

Broader economic considerations

Despite evidence of effective and cost-effective interventions and service delivery models, mental health systems worldwide, even in high-resource settings, are typically underfunded, unfair, and inefficient.^{453,454} These systems fall short of delivering the health gains theoretically attainable with current technologies.^{444,455,456} Although a major priority for system improvement initiatives is to provide better and more timely support to young people, achieving this goal requires addressing challenges related to securing substantial additional public investment and expanding the scope of the type of economic research conducted in mental health.⁴⁵⁷

The economic evidence for mental health prevention and treatment is already substantial, with more than 4000 reports published on this topic,²¹¹ but this evidence principally examines questions of cost-effectiveness, with budget effect questions underexplored. As a result, more is known about the value for money of programmes than about their affordability. This distinction is important because many, perhaps most, cost-effective youth mental health programmes are not cost-saving, and a number are likely to be expensive to scale up, particularly in cases where unmet need is high. Even where programmes might potentially be cost-saving, many of these benefits are not accrued to health systems, but other sectors of the economy such as social welfare systems. Measurement of these cross-sectoral impacts could be improved through methodological innovations such as broadening the cost perspectives of economic evaluations and adopting cost-benefit and return of investment analyses that provide actionable insights for government decision makers in portfolios beyond health. Methods such as Multiple Criteria Decision Analysis can provide a formal means of integrating these effects with other concerns of relevance to decision makers.⁴⁵⁸

The need for economic evaluations to better account for demand and supply constraints is particularly important in low-resource settings.⁴⁵⁹ Health systems and contexts across the world are inherently different, and generalisability is a challenge for economics research. Arguably, this challenge is particularly important in mental health, where both the epidemiology and service response of often complex interventions are highly contextual. Research into how context shapes resource use and outcomes, however, is underdeveloped.^{460,461} Continuity of support is also an issue to consider in

economic analyses; fragmentation of youth mental health support between child and adult service structures can hinder effective implementation.²⁹¹ As with health care more broadly, aspects of the conduct and reporting of economic evaluations in low-resource settings create additional barriers to generalisability⁴⁶⁰ that can in part be addressed by funding more high-quality economic research in these contexts.

Major injections of public funding to provide cost-effective, but initially expensive, youth mental health service systems will require difficult choices about how such funding is sourced (eg, reducing other areas of public expenditure or levying additional taxes). If effective, however, youth mental health care is much more likely to deliver a major return on investment than equivalent investments to treat other non-communicable diseases in older adults, simply due to the timing of mental illness compared with other non-communicable diseases in the lifespan. Innovative financing arrangements have been recommended as enablers of achieving these gains, including pooled cross-sectoral funding, social impact bonds, and systematic linking of health technology assessment to funding decisions.⁴⁵⁷ Choices involve normative judgements about the societal value of young people's mental health, and it has therefore been argued that advocacy for additional resources should be more explicitly grounded in moral values rather than economics.⁴⁶² Such a values-based framing aligns with the major role that politics has on youth mental health-care resource allocation decisions,⁴⁶³ even if how this relationship works is perhaps inadequately understood.⁴⁶⁴ As David Haslam, former Chair of the National Institute for Health and Care Excellence in the UK, pointed out in his 2022 book, the value proposition of investing in mental health, which has a lifelong impact due to its emergence in young people, might represent a better value proposition than very expensive late-stage cancer treatments, for example, which at best prolong life by a few months.⁴⁶⁵ Haslam contends that even if all cancers were cured, only a few years would be added to the already high life expectancy. The greatest gains in life expectancy overall might now come from better mental health care. This argument gives a clear example of the difficult choices that are faced as health-care costs spiral out of control. Such choices are being made covertly already, which we would argue is driven by stigma and prejudice in relation to the mentally ill, and these choices have resulted in severe neglect of the mentally ill and particularly young people. Low-value health care abounds throughout health-care systems, including in areas of mental health care, and it must be defined and deprioritised.⁴⁶⁶ Although some people might find such debates and choices confronting, the case made by Haslam for a more rational allocation of resources and prioritising primary, community, and mental health care, is timely. Gawande's classic work, *Being Mortal: medicine and what matters in the end*, makes similar points

regarding a compassionate yet rational approach to end-of-life care, in a moving and powerful way.⁴⁶⁷ Equity and public health risks associated with defunding programmes can be mitigated by ensuring that such decisions are informed by robust and up-to-date health technology assessment processes.

Policies to meaningfully reshape entire mental health service systems should be grounded in appropriately validated theories of how those systems behave and how they are expected to respond to alternative policy settings, such as changes to clinician incentives, budget constraints, workforce supply, skills and scope of practice, increased emphasis on prevention and early intervention, and promoting greater use of digital mental health services. Such whole system theories are currently fairly rare in economic and epidemiological simulation models of mental health,⁴⁶⁸ which have historically performed poorly in predicting the population health effect of scaling up investment in mental health.⁴⁶⁹ Economic research in mental health over 3 decades has increased clarity about the cost-effectiveness of individual prevention and treatment strategies,²¹¹ yet modelling the behaviour of a complex system is a very different and much longer-term undertaking than looking at single strategies. Such complex modelling calls for a field-building endeavour of multidisciplinary researchers worldwide. Initial steps that can be taken towards this technically challenging goal include establishing collaborative networks of mental health modellers and service planners,⁷⁰ greater understanding of the ethical risks associated with inappropriate model implementation,⁴⁷¹ and the development of enabling technologies such as software frameworks to facilitate transferable, open, and modular model implementations.⁴⁷² The scope of economic research in mental health needs to expand into neglected areas such as preferences, incentives, and behaviours; pricing implementation risk; and developing novel financing instruments, including value-based pricing or paying for outcomes.

Crucially, a radical rethink is needed in terms of what is meant by the mental health system. Mental health services cannot operate in isolation, and they require improved integration and coordination with general health services and buy-in and political support of many different sectors of the economy.⁴⁷³ Political arguments for investment in mental health will need to be made across sectors, especially as some of the key actions to protect mental health must be implemented in other sectors, including secure housing, equity in education, and social welfare safety nets that guarantee a minimum income for families and help young people remain in school, thus contributing to the development of their mental capital. Specialist education and employment services that support young people to enter and stay in higher education or employment are another important factor. These services have been shown to be effective in supporting recovery in many different health systems and welfare contexts,⁷⁴ to be

cost-effective for adult populations,⁴⁷⁵ and to have growing evidence of efficacy in youth populations.⁴⁷⁶ International development agencies could also be a part of a mental health system. Good mental health for young people is already recognised as an important objective within the UN's Sustainable Development Goals, but translating words into action can be helped by making moral and economic arguments to major international development agencies on the importance and value of investing in youth mental health and reducing the harms that undermine it.¹⁷⁹

We have highlighted a broad evidence base of effective and cost-effective interventions that can be rolled out in high-resource settings as well as growing evidence on interventions in low-resource and middle-resource settings. Unfortunately, such interventions and services are still not routinely available to most young people that need them, even in high-resource settings. Achieving an appropriately financed and organised mental health system that improves the mental health of young people is a challenge that is partly political and values-based and partly about ensuring that solutions are adapted to local needs and contexts. This challenge also requires addressing some important knowledge gaps. Implementation will vary in pace and scope depending upon the resources of the setting (eg, in low-resource settings, access to all types of specialist care is low, and primary and community health care workers are relied on even more than in high-resource settings). More can also be done to explore how to expand the appropriate use of digital technologies, and much can be learnt in complex systems from examples of effective delivery of mental health services in low-resource settings.⁴⁷⁷ Meanwhile, in all contexts, services will need to be developed in ways that appeal to young people and that will lead to uptake and sustained use by those who would most benefit.

Rising to the challenge requires a firm resolve to ensure that what is currently known to be effective and cost-effective is routinely implemented and delivered. Additionally, this process involves setting an ambitious research agenda by which new solutions, including broader mental health-care system organisation and financing innovations, are rigorously evaluated and adopted if they are found to be effective, cost-effective, and acceptable to young people. If we are to contain the damaging economic consequences that mental ill health in young people have on society, the harmful megatrends identified herein must be addressed. A broader call to action is urgently required to address the political, social, cultural, and economic determinants of young people's mental health. Although progress on mental health reform for young people is impossible in countries or regions where survival is threatened, where human action is leading to famine, or where basic human rights are disregarded, powerful forces are at play even in superficially intact societies. This knowledge requires not only an economic perspective, but a political one as well.

Part 5: The political imperative

Introduction

Throughout the past decade, considerable progress has occurred in the international recognition of the social and economic importance of youth mental health by governments, civil society, and the private sector.^{29,478} The alarming statistics and personal stories of rising psychological distress among young people before and during the COVID-19 pandemic have elevated the need for action across the global community.⁴⁷⁹ In contrast to the way governments around the world were galvanised by the COVID-19 pandemic to respond to a health crisis, the political momentum needed to drive policy makers to act in a manner commensurate to the scale and urgency of the problem has so far not materialised. The major structural reforms needed to support young people's mental health across health care, education, employment, and ongoing welfare support remain largely unrealised. This structural reform has two targets. The first is prevention, which now assumes even greater priority and requires governmental and community action across the broad range of social, economic, and commercial determinants of health and mental health. The second target is for youth mental health care to be made a top priority in all systems of health care around the world.

If the youth mental health crisis being amplified during the global COVID-19 pandemic did not create the imperative for sustained and systemic action, then one might ask, what will? Translating words, media events, international fora, celebrity endorsements, or government promises into sustained societal and political actions is never easy. As outlined in this section and panel 6, emotionally engaging storytelling based on a variety of lived experience, strong economic arguments, clearly defined packaging of real-world solutions, a key emphasis on prevention and early intervention, high-profile societal champions, media support, targeted campaigns, highly connected and relational political persuasion and advocacy, and much more aggressive grass-roots activism than we have seen hitherto, perhaps following in the footsteps of young climate activists, are all required to achieve transformational reform. An accompanying policy brief is available in the appendix (pp 1–13).

Strong economic arguments

Although the value proposition in human terms for youth mental health care should be sufficient, the economic argument for a return on investment in youth mental health, delivered through enhanced participation in education, training, and employment, is a strong additional selling point.^{29,480} Yet buyers remain oddly reluctant. The economic case for prioritising youth mental health care should help policy makers to see that investment in mental health is not poor or low-value spending, and it should highlight how good youth mental

Panel 6: Requirements and options to achieve transformational reform

Strong economic arguments

- Optimal way to achieve fast and sustainable growth in national productivity and long-term mental wealth

Tractable (retail) solutions

- Dynamic model of regional care
- Model of care (such as those described in part 3)
- Delineation of care elements
- Digital technology support and tracking

Key emphasis on prevention and early intervention

- Investment in early intervention and secondary prevention services
- Promotion of wider universal prevention strategies

Storytelling

- Lived experience advocates

Societal and political operatives that drive media attention and political connections

- Broad range of public figures with high credibility
- Effective use of social media platforms
- Active relationships with key decision makers, not just in health, but more importantly in finance and budget controls

Grassroots activism and global organising

- Support for the coalition of young people, families, and carers
- A relentless standing campaign
- Global networks of early adopters and pioneers

Real-world exemplars

- Local examples of service innovation that exemplify better care models

health and wellbeing can be considered a national resource to support productivity.⁴⁸³ In some countries, political leaders, policy makers, and researchers have described this concept as national mental wealth,⁴⁸¹ and New Zealand and Australia have even formulated wellbeing budgets. Investing in youth mental health is also advantageous because a return on investment can be achieved within relatively short time frames compared with longer-term but potentially valuable investments in early child development, and it has fiscal benefits across a wide range of portfolios (including health, justice, and social welfare) and many subsequent years of influence and reward, in contrast with investments in health care during later stages of life, the benefits of which are limited by the number of future productive years of life.

Real-world, locally relevant, and locally endorsed solutions

Advocates can spend substantial energy on articulating the challenge of youth mental ill health, but without

presenting practical and realistic solutions, it becomes just one of a myriad of problems being presented to governments and decision makers. For real-world solutions, visible and scalable platforms for care in communities are often best. Implementing proof-of-concept in the real world, underpinned by a model of care such as those described in part 3 but embedded within the setting's relevant social, cultural, geographical, and workforce context, is a valuable step to scalable solutions and their wider implementation.

Where a local solution carries the endorsement and investment of researchers and different workforces, professional groups, and young people and families with lived experience, the case for decision makers to endorse and scale up becomes even stronger. Although workforce compositions will vary by country and even community, interdisciplinary cooperation is important everywhere in the world. Political imperatives are diminished where there is fragmentation and siloing across key stakeholders and by policy makers and commissioners of services.

Translating local solutions into national and regional infrastructure can be achieved through dynamic modelling that can then be used to show the scale, timing, and sequencing of programme initiatives that are required to achieve the specific outcomes,⁴⁸² such as reduced psychological distress, reduced suicidal behaviour, or increased participation in education or employment. These programmes can also be combined with the development of long-term governance, implementation, and evaluation infrastructure to ensure their sustainability. Establishing real-world examples of clinical or technology-based service innovation is essential. The extent to which solutions are also scalable and relevant to the local context needs to be clearly demonstrated to political leaders and decision makers.

Prevention and early intervention

The emphasis in youth mental health on prevention and early intervention, as outlined in part 3, has remained central to the political discourse in many countries.⁴⁴⁸³ The opportunity to change the life course of young people by intervening as early in the onset of mental illness and as effectively as possible has wide political and public appeal. Mental health promotion for young people has been increasingly embedded within education systems,³³⁰ with an emphasis on sleep hygiene, physical activity, little alcohol and drug use, social connection, and cognitive-behavioural skills. Addressing the social determinants of poor mental health and suicide risk is also gaining traction, particularly among governments simultaneously seeking to address broader societal imperatives that affect young people's mental health, such as unemployment, housing insecurity, and financial distress. Approaches informed by ecological systems theory^{484,485} could also help to mobilise the public and politicians on youth mental health by focusing on interventions that support young people directly, the

social determinants of mental health, and strengthening the wider systems in which young people are embedded.⁴⁸⁶

The power of storytelling

Stories are essential to educate people and influence decisions throughout society. The emotional engagement and authenticity that flow from sharing lived experiences of many varieties are essential to creating momentum for reform, but this momentum dissipates when it is limited to awareness raising alone and is disconnected from other elements of strategy and calls to action. Awareness without purpose is counterproductive when it produces compassion fatigue and creates the false impression that something is being done to address the neglect and the crisis. Anti-stigma campaigns also run these risks and are ineffective in isolation. One of the best solutions to disease-related stigma, as previously seen in epilepsy, tuberculosis, and leprosy, is the advent of visibly effective treatment, which extends to welcoming, compassionate, and effective models of care, as witnessed with the scaling up of early intervention services and youth primary care platforms.

High-profile societal champions and political influencers

Linked to storytelling is sustained and high-quality media attention, which is crucial to any political campaign. Here, societal (eg, sport, entertainment, creative, fashion, and lifestyle) and high-profile (past and current political) champions, alongside the unified voice of genuine health and research experts, play a key role in ensuring that a message is received by a wider audience and appeals to the public in order to gain support from policy makers. This strategy should emphasise positive stories of effective care and innovation, combined with credible first-person accounts from service users and their families and carers. In the age of social media and highly segmented audiences, the effective real-time use of new technologies and platforms is increasingly crucial.

Furthermore, widespread national change typically relies on major decisions by the political leadership that controls financial and budgetary decisions. Health is often perceived by these groups as necessary but a poor spend, yet health expenditure has been growing inexorably worldwide to the point that it is becoming unsustainable.⁴⁶⁵ In our view, spending seems to be based less on logic and more on public sentiment and emotion.⁴⁶⁵ Large sums are spent on high-tech hospitals, very expensive cancer drugs, and a tranche of low-value health care. Investments in primary and community care, and particularly in mental health research and care, have great potential value. These investments, however, are neglected for a variety of reasons, including the needs of politicians and vested professional and commercial interests. Engagement and persuasion at the highest levels of government, and through their advisors and influencers, appear to be important but their productivity

is limited. Only when the community as a whole is educated, persuaded, and expertly mobilised through the strategies outlined here can transformation occur. This transformation is achievable but requires a new approach, as has been seen with climate change and the tobacco and fast-food industries, where powerful vested interests are involved. A value-based society and health system is the context for such a transformation, and we argue that activism is the missing strategy to attain it.

Grassroots activism and global organising

A common critique of modern governments is that although they fail to lead, they are very responsive to grassroots movements that threaten their political future. Former UK prime minister Tony Blair's official spokesperson, Alastair Campbell, illustrates this concept in his 2023 book, *But What Can I Do?*, and he offers guidance as to how to become involved.⁴⁸⁷ *New Power*, by Heimans and Timms,⁴⁸⁸ takes this concept further and provides a radical guide to creating reform and real change. To succeed, Heimans and Timms argue solid advice and careful planning need to be underpinned by aggressive, confident, and well organised grassroots activism based on the real-life experiences of young people who have lived with mental ill health, as well as experiences of their families and carers. Although not all young people will have lived experience of a mental health condition,⁴⁸⁹ a large proportion of the population is affected directly or indirectly by youth mental health difficulties through their work, families, friends, or community networks. The engagement of older age groups, who are typically much more connected to active decision makers in government, finance, and business, should not be underestimated.

Sensitive promotion of the lived experiences of young people and new solutions could also help to persuade the public to advocate for better access to evidence-based support, although careful consideration should be given to whose lived experience is being promoted. In many contexts, the voices of young people and those with mental health conditions have historically been marginalised. Many young people cannot participate in elections or do not have the financial or network-driven power to compete for attention or influence.⁴⁹⁰ Where mental ill health intersects with its known drivers (such as poverty and poor living standards, gender-based violence, discrimination based on sexuality, gender identity, and ethnicity), and where there is trauma from colonisation, displacement, and violations of human rights,^{491–496} opportunities for power are even more diminished. Therefore, campaigns to raise the political imperative must be as inclusive as possible of people whose voices have been excluded, and must also be careful not to place the onus on these young people to fight the cause alone.⁴⁸⁸

Finally, all reforms are powered by a collective set of principles and a shared mindset. The progress achieved

in building the youth mental health field to date has flowed from the establishment of scientifically and humanistically oriented global networks of pioneers, leaders, and supporters who have come together through a series of international forums over the past 25 years. This movement began with the International Early Psychosis Association in 1998, known since 2016 as IEPA (the International Early Intervention and Prevention in Mental Health Association), as well as, since 2010, the International Association for Youth Mental Health. Although these organisations are committed to science and evidence, they are nevertheless operating in a sociopolitical manner within professional and wider fields, and are partnering with individuals with lived experience and the public, to secure progress and build a new field and culture of early intervention and youth mental health.

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Conclusion and call to action

A new field of youth mental health is being created, and this endeavour must be accelerated, strengthened, and prioritised. In this Commission, we have aimed to capture the current state of this global endeavour, examine the changing landscape of youth mental health, acknowledge the threats and the opportunities within this landscape, and begin to identify the underlying megatrends influencing this change. The damage that some combination of these megatrends is inflicting is deep and widespread within societies and across the globe. Arguably, young people communicate the warning signs of our modern world, and are indicating that our society and world are in serious trouble. This underlines the central importance of taking a sophisticated, sociopolitical perspective and developing a clear objective supported by the most effective strategies and tactics. Such a plan must also be soundly and scientifically based. Conceptual building blocks and some of the perspectives needed to build a new field of youth mental health are innovations that have emerged. The principles, core features, and strategies necessary for designing, testing, and scaling up new models of youth mental health care are becoming more widely accepted, and substantial progress has been made in many jurisdictions. Although the barriers and remaining gaps to progress are considerable, definable solutions are available. The economic dimension of youth mental health and the politics of reform are where much energy needs to be devoted, with activism based on the best science and the safest policy to avoid mistakes and wrong turns. New approaches to creating reform and real change⁴⁸⁸ must be drawn upon, if youth mental health is to be transformed.

We have attempted to adopt as inclusive an approach as possible to this global problem while recognising that much of the data and practical reform has been limited to high-resource and middle-resource settings. The authorship and the model of producing this Commission were formulated and agreed to try to maximise inclusivity,

but greatly enhanced efforts are needed to address and strengthen youth mental health care in low-resource settings. Even in the highest-resource settings, youth mental health reform and care is still insufficient. In low-resource settings, where most of the young people in the world are growing up, youth mental health reform is only beginning and will need to adopt a modified strategy. The youth mental health crisis is of the utmost importance globally, given how dependent societies are on the capacities and contributions of young people. As long as so many emerging adults die prematurely, are consigned to a life of welfare dependency, are denied sufficient respect and nurture, and languish in precarity, society itself will become more precarious. The youth mental health crisis is more than a warning sign, and now might be our last chance to act.

Contributors

PDM conceived this Commission. The Commission report was led by the Commission editor (PDM), co-editors (EK, SNI, and CMe) and a youth co-editor (ND), who wrote, edited, and integrated the manuscript in collaboration with all section Commissioners and coauthors. The Commission consisted of five parts, to which authors were assigned as section Commissioners (lead authors), youth Commissioners, or co-authors (appendix pp 17–18). Part 1 was led by BD and PBJ with input from JF, IQN, MC, AD, TF, AJ, JT, JW, and AY. Part 2 was led by S-JB and SW with input from KP, MRB, AMC, IBH, CK, and JLS. Part 3 was led by PDM, EK, SNI, and M-AJ with input from ND, EG, EP, SH, SA, AMC, MD, PPG, JH, FK-L, AMa, DHN, DR, JR, SS, IS, KT, LV, TvA, SV, and JW. Part 4 was led by CMi and DM with input from FAEA, JTa, MPH, and LK-DL. Part 5 was led by VB and IBH with input from AMo, AH, EYHC, NMD, and PDM. All authors contributed to the writing of their respective sections and reviewed, commented on, and approved the final version of the Commission.

Declaration of interests

PDM is a founding director, patron, and former founding board member of headspace. He is the executive director of Orygen, Australia's National Centre of Excellence in Youth Mental Health and lead agency for five headspace centres across northwest Melbourne. He is a past President of the International Association for Youth Mental Health, and a past President of the IEPA; Early Intervention in Mental Health and of the Schizophrenia International Research Society. S-JB has provided paid expert witness work for UK charities and legal organisations. She is the author of two books related to the brain, education, and learning, for which she receives royalties. She gives talks in schools in the state and private sector, at education conferences, for education organisations, and for other public, private, and third sector organisations (some talks are remunerated). She is a member of the Rethinking Assessment group, the Steering Committee of the Cambridge Centre of Science Policy, the Technical Advisory Group for the UK Government Department of Education's Education and Outcomes Panel-C Study, the Singapore Government National Research Foundation Scientific Advisory Board, and the Singapore Government Human Potential Scientific Advisory Board. She was a member of the Times Education Commission (2021–22). IBH has received honoraria for consultancy and educational activities from Janssen Cilag. He was a member of the Clinical Advisory Group for the evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative, and is a member of Mental Health Reform Advisory Committee (Department of Health). He is the Chief Scientific Advisor to and a 3.2% equity shareholder in InnoWell, which aims to transform mental health services through the use of innovative technologies. FAEA has received honoraria for consultancy from Grand Challenges Canada and is a past member of the World Economic Forum's Global Future Council on Mental Health. AMC is a director of headspace, Australia's National Youth Mental Health Foundation, and the National Education Alliance for Borderline Personality Disorder. AD is the

Academic Secretary for the Royal College of Psychiatrists' Faculty of Child and Adolescent Psychiatry, a research advisory group member of the UK National Society for the Prevention of Cruelty to Children, a member of the UK Trauma Council, and an evidence panel member of the Early Intervention Foundation. TF's research group receives funding for consultancy to Place2Be, a third sector organisation that provides mental health training, support, and interventions to schools across the UK. JH is executive director of Youth Wellness Hubs Ontario and receives funding from Graham Boeckh Foundation and other donors through the Centre for Addiction and Mental Health Foundation. AJ is a trustee of the Samaritans and MQ. She has received fees for lecturing from the Scottish Association of Mental Health. She is an advisory board member of Our Future Health, UK. FK-L's work is the subject of publishing contracts with multiple companies in the EU, Magellan, Cobalt Therapeutics in the USA, and the National Health Service in the UK. Although she has received no remuneration to date, she might receive royalties in the future. She is a non-executive director of Orygen. CK is the founder of Wida, a digital mental health platform. He has received consulting fees from the UN Children's Fund. He has received grants from MQ: Transforming Mental Health in the UK, the Royal Academy of Engineering in the UK, the National Institutes of Health in the USA, the Medical Research Council in the UK, and Fundação do Amparo à Pesquisa do Estado do Rio Grande do Sul in Brazil. DR is a Chief Scientific Advisor to headspace, Australia's National Youth Mental Health Foundation. JT receives book royalties from Simon and Schuster, legal consulting fees from Bergman and Little and the Attorney General's office of the State of Tennessee, and honoraria for speaking engagements. EK is the immediate past President of the IEPA: Early Intervention in Mental Health, and during the period of the Commission was the President elect and President. All other authors declare no competing interests.

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