Appendix 1

Lancet Psychiatry Commission on Youth Mental Health – Policy Brief

Background

Mental ill-health represents the principal threat to the health, well-being and productivity of young people who are in transition from childhood to mature adulthood. Emerging adulthood, from puberty through to the mid to late twenties, is a vulnerable period for the onset of mental illnesses: up to 75% of mental illnesses have their onset prior to the age of 25.[1,2] Yet the majority of young people are unable to access good quality evidence-based care[3,4] and the policy focus and funding for prevention are grossly inadequate. Mental illnesses are a major cause of premature death from physical illness and from suicide and are the largest and most rapidly growing cause of disability and lost human potential and productivity across the lifespan.

There is now substantial evidence showing that youth mental health has deteriorated since the early 2010s, with a rising tide of anxiety, depression, psychological distress, self-harm and suicide.[5-9] Since COVID-19, young people have further experienced disproportionately poorer mental health outcomes.[10,11]

Megatrends over the past two decades have undermined young people's personal and economic security and hope for the future. The lack of action on climate change, unregulated social media, social exclusion and declining social cohesiveness and socio-economic precarity, as reflected in insecure employment, reduced access to affordable housing, rapidly growing intergenerational inequality and polarisation of political views, have combined to create a bleak present and future for young people. It is no exaggeration to characterise young people as the "miners' canaries" of society, in that they are manifesting the warning signs and symptoms of a society and world that is in serious trouble.

The Lancet Psychiatry Commission on Youth Mental Health is a call to action for policy makers, health professionals and society at large to address the global youth mental health crisis and ensure that the design, structure and capacity of youth mental health care is fit for purpose.

Policy inertia

Despite compelling evidence of mental health need among young people, political will for a response, in proportion to the scale and urgency of the crisis, is yet to materialise. This stems partly from insufficient public pressure for change and the stigma-based neglect of mental health worldwide. For young people, the decline in their mental health may have been overshadowed by the improvements over the past seven decades in their physical health, creating the impression that their health overall is in good shape, fuelled by the inequitable bias towards physical health and older people. Mental health systems worldwide are typically underfunded, inequitable and inefficient.[12,13] Only 2% of health budgets globally are devoted to mental health care and even in the highest resourced countries less than half of the need is addressed.[14] Furthermore, and paradoxically, even within this neglected aspect of health care, youth mental health care is the weakest link.[15] This is despite evidence of both effective and cost-effective interventions and service delivery paradigms,[16-19] and the fact that early intervention and youth mental health care is one of the best buys in health care[20] and much more likely to deliver a major return on investment than equivalent investments to treat other non-communicable diseases in older adults.

Solutions

An urgent transformative movement, a genuine paradigm shift, is needed to adequately address the youth mental health crisis. This will involve two synergistic policy dimensions.

First, government policies must be forensically analysed to diagnose which policy settings are contributing to the youth mental health crisis. This will extend well beyond the usual suspects among the social determinants of mental health to encompass new megatrends which have surfaced over the past two decades. These include climate change, the rise of smartphones, social media and the increased time spent on digital devices, the impacts of new technologies (most notably in the new arena of AI), geopolitical insecurity, and the serious socio-economic consequences of unrestrained neoliberal economic policies, which have worsened inequality, especially intergenerational inequality, in so many nations. It will be important to ensure that this analysis is genuine since there is a risk that softer targets such as reduced individual "resilience" and social media will distract from more fundamental economic forces and be therefore preferred as culprits by political leaders, vested interests and even the mental health field, who may feel political economy is outside their comfort zone. The field will have been encouraged by the stance taken recently by Vikram Patel in a recent Lancet editorial.[21] The urgency to adopt a much more assertive stance in relation to these harmful megatrends derives not only from the manifest public health crisis, but also from socio-economic and human rights considerations.

Second, to respond effectively to the rising tide of youth mental ill-health, youth mental health (with a strong emphasis on indicated prevention and high-quality early intervention) must become the top priority in mental health for reform and investment rather than patching up a residual and reactive system yoked and constrained to palliating chronic mental illness, which has been the dominant focus for over a century and a consequence of funding neglect. Naturally, such a pre-emptive focus must be complemented by ensuring that the substantial cohort of people who do need longer term care can be guaranteed sustained optimal care to build on and maintain the gains of early intervention and to support those who take longer to recover or may not do so. A new proactive and stigma free system of youth mental health care is needed that is developmentally, culturally and epidemiologically appropriate. Its content and expertise must be holistic, designed so that it is proportional to stage and complexity

of illness, and socio-cultural context. Integrated models of enhanced primary youth mental health care, which maximise access, acceptability and outcomes and are already shown to be cost-effective for mild to moderate levels of need for which they were designed,[16] lie at the heart of this reform front, covering puberty to the attainment of mature adulthood, approximately the age period of 12-25 years.[22] However, these portals and focal points of care must be complemented by other elements, notably upstream by preventive efforts and detection strategies, and downstream by a specialised back-up system for more persistent and complex conditions and comorbid health and social issues, by digital mental health platforms that empower young people as partners in their health care journey while genuinely promoting responsive, measurement-based care, and sophisticated mental health programs in educational settings and workplaces.

In low and middle resource settings, and quite different cultural settings, where most of the young people in the world are now growing up, youth mental health reform may need to adopt a variety of strategies fit for their specific cultures and circumstances (Table 1). The Global Framework for Youth Mental Health,[23] developed in partnership with stakeholders from various countries and settings, outlines areas where investment can be directed depending on the cultural, resourcing and workforce contexts of different countries and regions. In a fully-fledged model of youth mental care, which will require higher levels of resources, vertical integration of services – across the broad spectrum from self-care through various primary care options and onto secondary and tertiary levels – is essential to eliminate fragmentation and effectively meet the needs of young people experiencing severe, complex and persistent mental illness in a proactive and proportional way (Figure 1).

Policy actions

1. Whole of government analysis of all policies to reduce harms to mental health and to improve mental health and well-being.

2. Accelerate research and analysis to understand and reduce the impacts of new drivers and megatrends causing psychological harm for young people.
3. Substantially increase investment and funding in mental health care towards parity with physical health within health budgets, with new investments prioritised to youth mental health, early intervention and prevention.
4. Affirmative action in health care systems for the universal development of, and ensuring equitable access to, integrated youth mental health care at the community, primary and secondary care levels, with a clear focus on the crucial transition age range of 12-25 years.
5. Complementary investment in longer term community based mental health care to sustain and build upon the gains that preventively oriented youth mental health care delivers.
6. Implement strategies for promotion and prevention in youth mental health.
7. Support the digital and telecommunications infrastructure required to deliver, and track the outcomes from, the provision of high quality and measurement-based care in the most equitable ways.
8. Focus on providing equitable access to the range of employment, education and training opportunities for young people experiencing mental ill-health during this critical developmental period.
9. Ensuring reasonable access to financial, secure housing and welfare supports for young people experiencing persistent mental health disorders during this critical developmental period.

Table 1: Implementation of integrated youth mental health care according to level of resource[234]

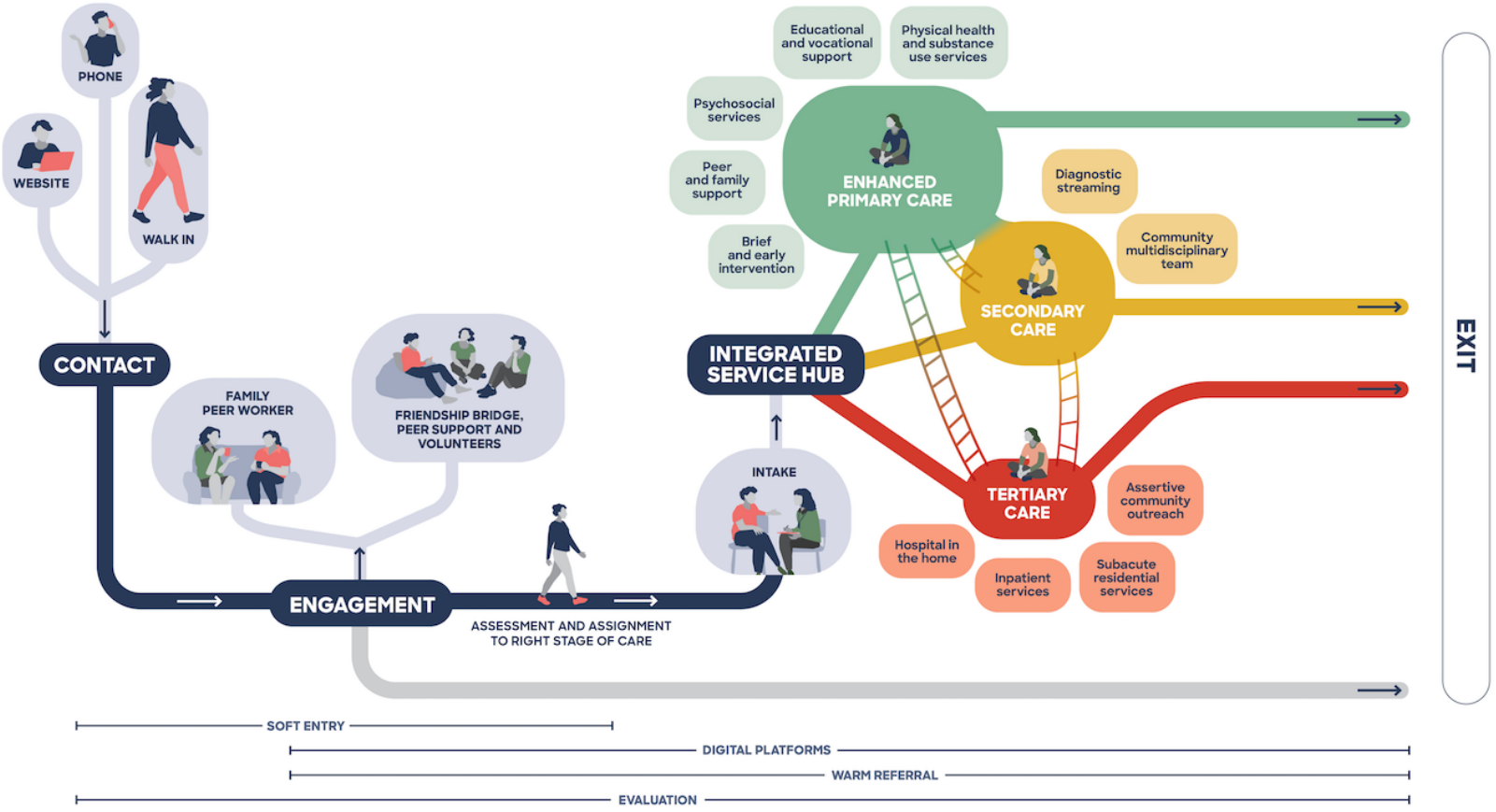
<table>
<tr><th></th><th>HIGH-RESOURCE SETTINGS</th><th>MEDIUM-RESOURCE SETTINGS</th><th>LOW-RESOURCE SETTINGS</th></tr>
<tr><td rowspan="3">COMMUNITY</td><td colspan="3">● Programs to address the social and economic/commercial determinants of health, which include mental health: environment and climate; housing security; intergenerational inequality and other aspects of socioeconomic inequality.
● Community education and development</td></tr>
<tr><td>● Early detection and, in certain scenarios, screening programs
● Prevention programs (e.g., anti-suicide, anti-bullying, anti-maltreatment, harm reduction for substance use)
● Mental health promotion programs (e.g., wellbeing, stress management, social connection, physical health, nutrition)
● School, university and workplace awareness, mental health promotion, prevention, and early detection programs</td><td colspan="2">● Prevention and school-based programs (including those delivered via social media)</td></tr>
<tr><td colspan="3">● Digital mental health platforms</td></tr>
</table>

PRIMARY CARE	● Horizontally integrated youth (12–25 years) health and social care platforms as "one-stop shops"	● Integrated youth health and social care platforms as "one-stop shops"	
	● Peer support and lay volunteers: "Friendship Bridge" ● School and university mental health services		● Volunteer, peer or lay worker programs (Friendship Bench/Bridge concept)
	● Digital interventions and telehealth integrated with primary care		● Digital interventions, telehealth platforms, and social media
SECONDARY CARE	● Multidisciplinary youth mental health systems providing face-to-face and online care closely linked to primary care and community platforms ● Complementary, synergistic and integrated digital platforms, including those targeting comorbidities that are not the primary focus of care	● Multidisciplinary community mental health teams (face-to-face or online) ● Complementary, synergistic and integrated digital platforms	● Primary care health professionals, including general practitioners and volunteers, trained in youth-friendly practice and mental health skills, providing care within mainstream community primary care settings with face-to-face, telehealth and digital options

TERTIARY CARE	● A suite of specialised, co-designed youth inpatient and residential services linked to acuity and stage of illness ● Home-based acute care and assertive community treatment, including 'after care' following self-harm or a suicide attempt ● Diagnostic stream expertise (e.g., psychotic, mood, personality, substance use, and eating disorders) ● Integrated, blended, digital and face-to-face support when feasible	● Inpatient services distinct from adult facilities and home-based acute care if this is not feasible ● Integrated, blended, digital and face-to-face support when feasible	● Home-based acute care with telehealth backup systems

Adapted from McGorry et al (2022)[202] with permission.

Figure 1: Integrated youth mental health care model. Young people and their families can access care via a range of methods, including website contact, phone contact and walk in. Service entry should be welcoming and stigma-free, with barriers to care eliminated or reduced ("soft entry"). For some young people, having a conversation with a peer worker or volunteer (friendship bridge) may sufficiently meet their needs. For others, they 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 are able to move between these levels of care with supported transitions and seamless referrals.



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Appendix 2

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