

Closing the global gap in adolescent mental health



Effective and sustainable interventions to address the global burden of mental disorders in children and adolescents require evidence-based research that fully acknowledges the social, cultural and economic challenges.

People experience substantial physical, social and psychological transformations during adolescence that are linked to susceptibility to both positive influences and negative influences. Adolescents in low- to middle-income countries (LMICs) are particularly vulnerable to adverse and traumatic experiences, as they often must deal with negative socioeconomic, cultural, political and environmental circumstances.

At the end of 2023, the World Health Organization (WHO) and UNICEF published their first psychological intervention, called Early Adolescent Skills for Emotions (EASE)¹, for young adolescents affected by distress. The WHO–UNICEF EASE intervention addresses a major unmet need for new approaches to the prevention or treatment of mental health conditions in the global adolescent population. Although considerable research already exists on the effectiveness of psychological interventions for young people, these data are almost entirely from high-resource settings and high-intensity interventions delivered by mental health professionals². Given that 90% of the world's 1.2 billion adolescents live in LMICs³, more evidence is needed to show how these interventions can be implemented in these settings, in which healthy development is often threatened by rapid social and economic change, exposure to conflict, increased urbanization, the widening gap between rich and poor, and gender disparities.

Major challenges limit the capacity to effectively deliver mental health interventions in LMICs. Governments and donors in these regions have not made the psychosocial well-being and development of children and adolescents a priority, and investment has often been inadequate and misplaced.

This has resulted in a lack of specialists, with the average number of psychiatrists who specialize in treating children and adolescents being less than 0.1 per 100,000 in LMICs³, which is 100 times less than the median in the United States⁴. The lack of investment also limits the capacity of frontline workers, such as community-based workers, who are not equipped to address the toll of mental health across multiple sectors, including primary healthcare, education, social protection and child protection. Even when interventions are available, stigma and discrimination against children and adolescents with mental health conditions and their families act as a barrier to accessing treatment options⁵. Children and adolescents with mental health conditions also face the risk of human rights violations, including unequal access to education and health services, unnecessary separation from caregivers, institutionalization, exposure to violence and neglect⁵. Finally, comprehensive age- and sex-disaggregated data on child and adolescent mental health and development are lacking in most LMICs, where only 2% of the mental health data available is on children and adolescents³. Without data, it is difficult to know which interventions should be scaled up to give more young people access to the support they need.

Priorities must focus on closing the research gaps in epidemiology, intervention and implementation approaches to improve child and adolescent mental health in low-resource settings. Epidemiological studies using standardized methods and International Classification of Diseases criteria need to be done to determine the extent or severity of untreated mental disorders in adolescents living in LMICs, as has been done for adults⁶. Interventions must be designed to be delivered at low cost by non-specialists, and at scale, such as lay-counselor-delivered interventions for adolescent mental health problems in schools in low-income areas in India⁷. Collaborations with local stakeholders, community leaders and people with lived experiences are needed in order to design interventions that are culturally acceptable and address the challenges of the community. Finally, a

bigger focus on implementation research is needed to better understand the feasibility, acceptance and cost of an intervention within the setting before implementation. For example, a recent implementation trial demonstrated the feasibility and acceptance of a newly developed internet-based application in helping to close communication gaps for Farsi- or Arabic-speaking refugees receiving inpatient treatment for depression, anxiety disorder or post-traumatic stress disorder in Germany⁸. These implementation studies should also look at the effectiveness of interventions across Sustainable Development Goal outcomes beyond health, such as school achievement, employment and gender equity.

Studies indicate that local data have a decisive role in modifying professional practice in health care. A large survey found that health-care providers in LMICs believe that research done and published in their own country is more likely to change their clinical practice than is research generated in high-income countries⁹. Despite that, only about 10% of randomized controlled clinical trials of mental health in children and adolescents are in LMICs, with the vast majority focusing on psychopharmacological interventions¹⁰. The lack of high-quality studies assessing psychosocial or combined treatments for childhood mental health conditions, particularly in LMICs, is particularly relevant, as these interventions require culture-specific evidence.

The switch to delivering mental health services or interventions through digital platforms has the potential to make health, education and social service systems more effective, efficient and equitable, and expand access to children and adolescents who have typically not been reached by conventional means. Reports show that an increasing number of people in low-resourced settings are finding ways to access the internet, particularly through mobile devices. Pilot studies have highlighted the feasibility and acceptance of video-conferencing-based platforms used by psychiatrists for diagnosis or follow-up care for people with depression and other mental disorders in Somaliland, South Africa and India¹¹. A guided,

internet-delivered cognitive behavioral treatment for anxiety and depression yielded high remission rates in resource-constrained settings in two Latin American countries¹², and online-video-game-based interventions are promising strategies for supporting depression treatment in young female adolescents¹³. These technologies may be able to address some of the major challenges in LMICs, including a lack of frontline workers and/or specialists, and the reluctance of some to seek services because of stigma, long travel distances or out-of-pocket expenses.

Failure to adequately meet and protect the mental health and psychosocial well-being needs of children and adolescents in LMICs now could put an entire generation at risk, with profound social and economic consequences over the long term.

Published online: 20 February 2024

References

1. World Health Organization and the United Nations Children's Fund (UNICEF). <https://go.nature.com/4byGq6U> (20 December 2023).
2. Patel, V. et al. *Lancet* **392**, 1553–1598 (2018).
3. United Nations Children's Fund and World Health Organization. <https://go.nature.com/3w7uBEC> (2022).
4. The American Academy of Child and Adolescent Psychiatry. <https://go.nature.com/42ANnAA> (12 April 2018).
5. United Nations Children's Fund. <https://go.nature.com/3Szw7qr> (October 2021).
6. The WHO World Mental Health Survey Consortium. *J. Am. Med. Assoc.* **291**, 2581–2590 (2004).
7. Michelson, D. et al. *Lancet Child Adolesc. Health* **4**, 571–582 (2020).
8. Reinhardt, I. et al. *BMC Health Serv. Res.* **23**, 1409 (2023).
9. Guindon, G. E. et al. *CMAJ* **182**, E362–E372 (2010).
10. Kieling, C. et al. *Lancet* **378**, 1515–1525 (2011).
11. Naslund, J. A. et al. *Lancet Psychiatry* **4**, 486–500 (2017).
12. Benjet, C. et al. *JAMA Psychiatry* **80**, 768–777 (2023).
13. Carrasco, A. E. *Res. Psychother.* <https://doi.org/10.4081/ripppo.2016.182> (2016).