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World Youth Report

Youth Mental Health and Well-being

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United Nations

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Technical notes: In this publication, unless otherwise indicated, the term "youth" refers to all those between the ages of 15 and 24, as reflected in the World Program of Action for Youth. The term "young people" may be used interchangeably with the word "youth".

Disclaimers: The views expressed in the contributions to this publication are those of the individual authors and do not imply the expression of any opinion on the part of the United Nations or of the organizations with which the authors are affiliated. The survey carried out for the present Report was created and conducted by an entity outside the United Nations system. The contents of the survey and survey results have been substantively preserved, though minor adjustments may have been made in language for the sake of clarity.

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Department of Economic and Social Affairs

The Department of Economic and Social Affairs of the United Nations Secretariat is a vital interface between global policies in the economic, social and environmental spheres and national action. The Department works in three main interlinked areas: it compiles, generates and analyses a wide range of economic, social and environmental data and information on which Member States of the United Nations draw to review common problems and to take stock of policy options; it facilitates the negotiations of Member States in many intergovernmental bodies on joint courses of action to address ongoing or emerging global challenges; and it advises interested Governments on the ways and means of translating policy frameworks developed in United Nations conferences and summits into programmes at the country level and, through technical assistance, helps build national capacities.

www.un.org/development/desa/youth

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Explanatory Notes

Abbreviations used in the report

apps	applications
CBT	cognitive behavioural therapy
COVID-19	coronavirus disease 2019
CSV	comma-separated values (plain text file format)
HIV	human immunodeficiency virus
IANYD	(United Nations) Inter-Agency Network on Youth Development
LGBT	lesbian, gay, bisexual, transgender
MGCY	(United Nations) Major Group for Children and Youth
NAPS	Numbers and People Synergy
NEET	not in employment, education or training
PTSD	post-traumatic stress disorder
SDG	Sustainable Development Goal
UN DESA	United Nations Department of Economic and Social Affairs
WHO	World Health Organization

Additional Notes

The designations employed and the presentation of the material in the present publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country or territory or of its authorities or concerning the delimitations of its frontiers. The term “country” as used in the text of this report also refers, as appropriate, to territories or areas. The designations of country groups in the text and the tables are intended solely for statistical or analytical convenience and do not necessarily express a judgement about the stage reached by a particular country or area in the development process. Mention of the names of firms does not imply the endorsement of the United Nations.

Executive Summary

The *World Youth Report: Youth Mental Health and Well-being* delves into the critical intersection between the mental health and overall well-being of young people, aligning with the global recognition of mental health within the 2030 Agenda for Sustainable Development.

The *Report* highlights the varied experiences of youth worldwide and identifies social determinants that significantly impact mental health, advocating for inclusive policies to foster youth resilience and well-being. It examines six dimensions of youth life, analysing factors such as education, employment, family dynamics, poverty, technology, and societal influences. In doing so, the *Report* also explores the impact of the COVID-19 pandemic on youth mental health, as well as global issues such as climate change, conflicts, and various types of disasters and humanitarian situations.

The *Report* underscores the necessity of integrated approaches, cross-sectoral collaboration, and privacy protection in data collection to effectively promote youth mental health.

Methodologically, a comprehensive literature review was carried out utilizing databases such as MEDLINE and PsycINFO to examine risk factors and mental health outcomes among young people, with relevant findings summarized and synthesized in the Report. Insights were also drawn from an expert group meeting that brought together more than 60 experts of all ages, including mental health experts from United Nations entities and the academic sector, as well as young individuals with lived experiences relating to mental health and well-being. In addition, Numbers and People Synergy (NAP) facilitated consultations with more than 2,500 youth from 137 countries ranging in age from 15 to 29. These consultations included an online perception survey as well as targeted focus group discussions. Lastly, interviews were held with nine young individuals who had been part of the consultations or had been recruited through dissemination partner networks. The interviews explored specific topics such as education, family influence, and the impact of climate change on mental health. These interviews generated nine poignant real-life youth experiences with mental health and well-being.

The *Report* underscores the pivotal role of social determinants in shaping youth mental health and well-being. It emphasizes the imperative for comprehensive interventions addressing six interlinked social determinants: education, employment, family dynamics, poverty, technology, and societal attitudes. The Report finds that the social determinants of mental health often interact and impact youth mental health in complex and interconnected ways. Disparities in mental health outcomes are linked to a broad array of inequalities, including unequal access to opportunities and resources but also differential exposure to risks. Young people may be especially susceptible to these inequalities, as this stage of life is crucial for developing social and emotional skills, forming identity, and building social relationships and roles, all of which significantly impact mental health. Additionally, stigma and discrimination against individuals with mental health conditions exacerbate negative health outcomes, limit access to healthcare, and create barriers to decent work, education, and other activities that foster resilience. Given this, the Report emphasizes the importance of addressing the cumulative impact of social and economic inequalities as they can significantly intensify poor mental health and well-being. More importantly, the *Report* advocates for inclusive policies to mitigate disparities as an inclusive approach to mental health and well-being is essential for social development, ensuring no one is left behind.

Additionally, the *Report* proposes policy recommendations, advocates for prevention and early intervention, showcases youth-led initiatives, and emphasizes the role of young people as agents of change. Specific sections of the *Report* focus on the following:

- In the section on education, the *Report* underscores the importance of fostering supportive environments within schools, promoting social-emotional learning, adequately funding mental health programmes, and implementing effective school-based mental wellness initiatives to enhance overall well-being.

Consulting youth is essential to shape policies that truly reflect their needs and aspirations. ©UN Photo/Paulo Filgueiras

- In the section on employment and youth mental health, the *Report* addresses stress, job insecurity, gender disparities, and the challenges of transitioning from education to employment. It advocates for policies to support fair remuneration, workplace inclusivity, and youth employment transitions to mitigate negative mental health outcomes.
- In the section on family contexts, the *Report* highlights the pivotal role of family dynamics in shaping youth mental health perceptions. Recommendations are provided on parental support programmes, fostering open communication, and interventions addressing family-related stressors and trauma to enhance youth mental health outcomes.
- In the section on poverty and deprivation, the *Report* emphasizes the need for interventions to address economic inequality, promote protective factors against suicide, and implement targeted interventions for marginalized youth populations.
- In the section on technology and the online environment, the *Report* advocates for digital literacy among youth and the promotion of partnerships between schools and technology companies to ensure equitable access to quality education.
- In the section on society, stigma surrounding mental health emerges as a key issue, and the *Report* recommends focusing on community awareness, normalization efforts, and improving the visibility of individuals with mental health challenges.

As action 34 of the Pact for the Future calls for Member States to "invest in the social and economic development of children and young people so that they can reach their full potential",[1] this *Report* is timely. It offers a comprehensive analysis of social determinants affecting youth mental health and well-being, advocating for inclusive policies and interventions to promote resilience and overall well-being among young people globally. Through the application of robust methodologies and the provision of real-life examples and policy recommendations, the *Report* aims to drive positive change in addressing the mental health needs of youth in varied contexts.

1 United Nations, *Pact for the Future, Global Digital Compact and Declaration on Future Generations: Summit of the Future Outcome Documents, September 2024,* action 34, p. 23, available at https://www.un.org/sites/un2.un.org/files/sotf-pact_for_the_future_adopted.pdf.

Introduction

1. Background

Mental health is defined by the World Health Organization (WHO) as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community".[2] Mental health is more than the presence or absence of a mental disorder and exists on a complex continuum. It is an integral aspect of health and is a key foundation for lifelong individual well-being and social inclusion. As such, mental health is crucial to personal, community and socioeconomic development.

The inclusion of mental health in the 2030 Agenda for Sustainable Development signals a recognition of this important global issue. Sustainable Development Goal target 3.4 specifically requests that countries, "by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being".[3]

Inclusive mental health and well-being constitute a fundamental aspect of the social dimension of sustainable development, critical for ensuring that no one is left behind. Social exclusion, inequalities, poverty and deprivation, family and community conflict, violence, and other traumatic situations and events are all risk factors for mental health conditions. Stigma and discrimination around persons with mental health conditions further contribute to negative health outcomes, reduce access to health services, and act as barriers to decent work, education and other activities that support stability.

Youth mental health experiences are extremely diverse in nature and vary greatly by context. In addition, mental health exists along a broad continuum and can improve or deteriorate based on multiple factors. Assessing and addressing mental health requires looking at all dimensions of a young person's life. According to WHO, an estimated one in seven young persons between the ages of 10 and 19 is experiencing a mental health condition,[4] and the prevalence of mental health issues among young people is increasing, in part because of social and technological changes. Evidence indicates that 75 per cent of all mental health conditions adults experience were already present by the time they were in their mid-twenties,[5] highlighting the value of a life-cycle approach since interventions introduced at younger ages are more likely than late interventions to have an impact.

Mental health services that are inclusive of young people, particularly those who are marginalized and vulnerable, can promote better health and well-being among youth, facilitating social inclusion and enabling them to live healthier and more productive lives both now and in the future. At present, gaps in mental health services persist in many countries. Even where mental health services are available, young people – particularly those who are marginalized or in vulnerable situations – still face access challenges. Social policies that promote inclusion play a key role in promoting youth well-being and mental health. Mental health policies should be more inclusive to reflect the full spectrum of youth experiences.

There is growing evidence that increasing access to mental health treatment alone will not reduce the burden of disease related to mental disorders.[6] Despite efforts in many high-income countries to increase the uptake of psychological interventions and pharmacological

2 World Health Organization (WHO), "Mental health", fact sheet, 17 June 2022, available at https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

3 WHO, The Global Health Observatory data, available at https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/sdg-target-3.4-noncommunicable-diseases-and-mental-health.

4 WHO, "Mental health of adolescents", fact sheet, 10 October 2024, available at https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health.

5 United Nations, Department of Economic and Social Affairs, "Mental health matters: social inclusion of youth with mental health condition" [sic], 21 June 2014, available at https://www.un.org/development/desa/youth/publications/2014/06/mental-health-matters-social-inclusion-of-youth-with-mental-health-condition/.

6 Harvey A. Whiteford and others, "Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010", *The Lancet*, vol. 382, No. 9904 (2013), pp. 1,575-1,586, DOI:10.1016/S0140-6736(13)61611-6.

Creating safe moments for youth helps nurture resilience. ©UN Photo/Shareef Sarhan

treatments in adolescents and adults, there have been very limited reductions in the prevalence of mental disorders.[7] On the contrary, there is evidence that the prevalence of depression in adolescents and young adults has increased in recent years.[8,9]

Given that in 75 per cent of cases mental health problems have their first onset before age 24,[10] effective prevention strategies must include a focus on adolescence. This is a key period of transition in terms of identity development, social influences, and patterns of behaviour, which are often centrally involved in the development of good mental health. These transitions and their effects on mental health depend profoundly on the conditions in which young people live and work.

There have been calls for a greater focus on prevention and mental health promotion efforts directed at young people. Calls for action are often based on reviews of evidence on the effectiveness of prevention efforts, which typically include interventions that target a small number of individual risk and protective factors.[11] These are usually based on psychological therapies such as cognitive behavioural therapy (CBT) that are typically administered to motivated people with sub-threshold symptoms and that are readily amenable to randomized controlled trials.[12,13] While e-mental-health interventions

7 Anthony F. Jorm and others, "Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries", *World Psychiatry*, vol. 16, No. 1 (2017), pp. 90-99, DOI:10.1002/wps.20388.

8 Richard A. Burns, Peter Butterworth and Dimity A. Crisp, "Age, sex and period estimates of Australia's mental health over the last 17 years", *Australian and New Zealand Journal of Psychiatry*, vol. 54, No. 6 (2020), pp. 602-608, available at DOI: https://journals.sagepub.com/doi/10.1177/0004867419888289.

9 Ramin Mojtabai, Mark Olfson and Beth Han, "National trends in the prevalence and treatment of depression in adolescents and young adults", Pediatrics, vol. 138, No. 6 (2016), e20161878, DOI:10.1542/peds.2016-1878.

10 Marco Solmi and others, "Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies", *Molecular Psychiatry*, vol. 27 (2022), pp. 281-295, available at https://doi.org/10.1038/s41380-021-01161-7.

11 Eiko I. Fried and Donald J. Robinaugh, "Systems all the way down: embracing complexity in mental health research", *BMC Medicine*, vol. 18, No. 1 (2020), p. 205, DOI:10.1186/s12916-020-01668-w.

12 Aliza Werner-Seidler and others, "School-based depression and anxiety prevention programs for young people: a systematic review and meta-analysis", *Clinical Psychology Review*, vol. 51 (2017), pp. 30-47, available at https://doi.org/10.1016/j.cpr.2016.10.005.

13 Jai K. Das and others, "Interventions for adolescent mental health: an overview of systematic reviews", *Journal of Adolescent Health*, vol. 59, No. 4S (2016), pp. S49-S60, DOI:10.1016/j.jadohealth.2016.06.020.

are increasingly popular and show promising results in research studies, dropout rates are high, particularly for self-guided interventions.[14] Moreover, studies have mostly been limited to short-term outcomes, yet the effects of such interventions tend to decrease rapidly over time.[15]

Mental disorders among youth arise as the result of a complex set of interactions between biological, psychological, family, peer, community, societal and cultural influences.[16] Young people require the scaffolding of good quality, secure, and stable social contexts, including access to decent employment and education, universal health coverage, supportive parents/guardians and families, and opportunities for community engagement. These are vital to the prevention of mental disorders and are considered to be key determinants of mental health.[17] However, reducing the burden of disease related to mental disorders among youth requires moving beyond a focus on individual risk and protective factors towards a consideration of the social patterns and structures that shape health.[18] WHO refers to the social determinants of health as "the conditions in which people are born, grow, live, work and age".[19]

Given that the youth phase is a sensitive developmental period, improving mental health requires a focus on the interactions between individual developmental processes and the social determinants of health.[20] While conditions in utero and during early childhood are important for prevention, the period of youth offers a "second chance in the second decade" for young people to maximize their well-being.[21] Recent advances in neuroscience have shed light on the changing cognitive and emotional capacities of adolescents. A dynamic period of brain development second only to infancy, youth offers a unique opportunity for flexible learning and adaptation in ways that contribute to either negative or positive mental health trajectories.[22] The onset of puberty leads to a greater capacity for social and emotional engagement, seen most notably in areas related to social relationships, social roles and one's place in social hierarchies.[23,24] Compared with other age groups, youth show a heightened response to the emotional displays of others, have a greater desire for acceptance and admiration, and have a higher sensitivity to reputational enhancement and damage.[25] It is therefore not surprising that puberty marks the transition point in risks for the onset of depression and some anxiety disorders, particularly in girls.[26]

To date, there is little consolidated evidence relating to the social determinants of youth mental health in terms of factors that contribute to the greatest burden of disease or factors linked to evidence of effective interventions. This is true for high-income countries, but the dearth of relevant data is even more pronounced for low- and middle-income countries. The recovery period following the COVID-19 pandemic has been especially challenging in this context, as many of the social determinants affecting youth mental health have been impacted by the changes surrounding the health crisis and its aftermath.

14 Eirini Karyotak and others, "Predictors of treatment dropout in self-guided web-based interventions for depression: an 'individual patient data' meta-analysis", *Psychological Medicine*, vol. 45, No. 13 (2015), pp. 2,717-2,726, DOI:10.1017/S0033291715000665.
15 Emily Stockings and others, "Preventing depression and anxiety in young people: a review of the joint efficacy of universal, selective and indicated prevention", *Psychological Medicine*, vol. 46, No. 1 (2016), pp. 11-26, DOI:10.1017/S0033291715001725.
16 Russell M. Viner and others, "Adolescence and the social determinants of health", *The Lancet*, vol. 379, No. 9826 (2012), pp. 1,641-1,652, DOI:10.1016/S0140-6736(12)60149-4.
17 George Christopher Patton and others, "Predicting female depression across puberty: a two-nation longitudinal study", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 47, No. 12 (2008), pp. 1,424-1,432, DOI:10.1097/CHI.0b013e3181886ebe.
18 Crick Lund and others, "Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews", *The Lancet Psychiatry*, vol. 5, No. 4 (2018), pp. 357-369, DOI:10.1016/S2215-0366(18)30060-9.
19 Oriel Solar and Alec Irwin, *A Conceptual Framework for Action on the Social Determinants of Health*, Social Determinants of Health Discussion Paper 2 (Policy and Practice), (Geneva, WHO, 2010), available at https://iris.who.int/bitstream/handle/10665/44489/9789241500852_eng.pdf?sequence=1.
20 Viner and others, "Adolescence and the social determinants of health".
21 George C. Patton and others, "Our future: a *Lancet* commission on adolescent health and wellbeing", *The Lancet*, vol. 387, No. 10036 (2016), pp. 2,423-2,478, DOI:10.1016/S0140-6736(16)00579-1.
22 Fried and Robinaugh, "Systems all the way down: embracing complexity in mental health research".
23 George C. Patton and Russell Viner, "Pubertal transitions in health", *The Lancet*, vol. 369, No. 9567 (2007), pp. 1,130-1,139, DOI:10.1016/S0140-6736(07)60366-3.
24 Chris Bonell and others, "Role theory of schools and adolescent health", *The Lancet Child & Adolescent Health*, vol. 3, No. 10 (2019), pp. 742-748, DOI:10.1016/S2352-4642(19)30183-X.
25 Eveline A. Crone and Ronald E. Dahl, "Understanding adolescence as a period of social-affective engagement and goal flexibility", *Nature Reviews Neuroscience*, vol. 13, No. 9 (2012), pp. 636-650, DOI:10.1038/nrn3313.
26 George C. Patton and others, "Predicting female depression across puberty: a two-nation longitudinal study", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 47, No. 12 (2008), pp. 1,424-1,432, DOI:10.1097/CHI.0b013e3181886ebe.

Factors such as social, economic, and physical environments influence mental health outcomes, with cumulative social and economic inequalities increasing mental health risks. Inclusive policies that consider individuals across varying states of mental health are essential to avoid exclusion. Holistic, multisectoral interventions that improve the conditions in which people live, work, and socialize are key to advancing mental health. WHO emphasizes the need for further interventions targeting social determinants to improve mental health outcomes.

2. Objectives and scope of the *Report*

The *World Youth Report: Youth Mental Health and Well-being* addresses the impact of social determinants on youth mental health and identifies policy responses and approaches that can reduce institutional, locational, and social barriers to promote youth resilience, inclusion, and well-being. The *Report* highlights the importance of social inclusion and social policy aspects of mental health for youth, grounded in the perspectives of a diverse group of young people gathered through a youth consultation mechanism.

The primary objectives of the *Report* are as follows:

- To promote an understanding of the diverse nature of youth mental health experiences and the socioeconomic determinants of youth mental health;
- To explore the impact of inclusive social policies on improving well-being and mental health and identify policy responses and approaches that reduce institutional and social barriers as well as unintended negative impacts to promote youth resilience, inclusion and well-being;
- To highlight the diversity of experiences of youth with mental health conditions around the world, featuring young people in a variety of settings, including youth in conflict/post-conflict settings, young migrants, and youth in low-, medium-, and high-income countries, and to suggest ways to make youth mental health policies more inclusive.

The *Report* examines six dimensions of a young person's life – education, employment, family and relationships, poverty and deprivation, technology and the online environment, and society – and explores factors that influence their well-being in each context. Based on a review and analysis of relevant literature and real-life youth experiences and perspectives, risk and enabling factors are identified and analysed to determine the role of policies and examine the interlinked nature of these policies. Cross-sectoral issues are addressed in the conclusion, with consideration given to some of the unintended consequences of distinct policies, and ways forward for an integrated approach to promoting youth well-being and mental health are suggested.

3. Methodology overview

A detailed description of the methodologies used for this *Report* can be found in the annexes to the present publication; a brief overview is provided below. It should be noted that particular attention was given to ensuring privacy protection and avoiding retraumatization in the collection of quantitative and qualitative data for the *Report*.

a. Expert group meeting

A virtual expert group meeting was organized by the Division for Inclusive Social Development of the United Nations Department of Economic and Social Affairs (UN DESA) to elicit input for the *Report*. The meeting brought together more than 60 experts, including young experts with experience of living with or overcoming mental health and well-being challenges, from diverse fields and geographic areas. Experts included academics, researchers, and policy analysts with experience in mental health, youth development, or social sciences. The discussions carried out at this expert group meeting informed the publication. The report of the meeting is available in annex I.

b. Youth consultations

A key element of the *Report* is the focus on the experiences of young people relating to their mental health and well-being, shared through stakeholder engagement and youth consultations. The consultations were conducted with young people from diverse backgrounds and geographic areas, including through youth-led and youth-focused organizations, to gather data on the topic of youth mental health and well-being.

The youth consultations were undertaken by Numbers and People Synergy (NAPS) with the support of the United Nations Major Group for Children and Youth, the Commonwealth Secretariat Youth Division, and UN DESA.

Youth are the experts of their own realities.
©UN Photo/Manuel Elías

Among other things, the youth consultations generated a number of interviews yielding real-life examples that are woven through the Report, creating a narrative which brings the policy environment to life.

Throughout these consultations, data were collected using quantitative and qualitative methods, including (a) a perception survey (online questionnaire), (b) facilitated consultations with young people, and (c) individual interviews across United Nations regional groupings with vulnerable and marginalized youth and young people who had experienced mental health conditions.

Perception survey (online questionnaire)

The online questionnaire for the perception survey was designed by NAPS. The questions, based on the social determinants of youth mental health and well-being, were collated from relevant mental health surveys already utilized in the field across six countries. The questions were further tested with young people and youth experts prior to launch. Questions were not mandatory and could be skipped at any point. The online questionnaire was available in six languages: Arabic, Chinese, English, French, Russian and Spanish.

A total of 2,949 people voluntarily responded to the online questionnaire. Although <15 and >30 years of age were included as options in the survey, the data were screened to include only individuals between the ages of 15 and 29. The post-screening data used in the current research are based on a final sample size of 2,578 respondents.

The majority of respondents (71 per cent) were female; 1 per cent identified their gender as "other". Most were heterosexual (69 per cent), with bisexual respondents being the next largest group (12 per cent), and gay, lesbian and other individuals together accounting for 6 per cent. Respondents between the ages of 20 and 24 years constituted the largest group (42 per cent), followed by those aged 25-29 years (30 per cent) and those aged 15-19 years (28 per cent). Respondents further identified themselves as migrants (5 per cent), persons with a disability (9 per cent), carers (24 per cent), or Indigenous/First Nations people (32 per cent).

Responses were received from 137 countries. The region with the most responses was Latin America and the Caribbean (accounting for 28 per cent of the total), followed by Eastern Europe (17 per cent), South-eastern Asia (12 per cent), and sub-Saharan Africa (11 per cent).

Targeted focus groups

Eight focus groups comprising 148 young people from around the world were run virtually on specific topics of interest (see **table 1**), with a view to investigating the complexities of the interaction between the various social determinants, creating additional space for commentary from marginalized groups of youth, and capturing policy recommendations for inclusive social policies from young people themselves.

Young people opted in to the focus groups via an email invitation sent through dissemination partner networks and social media channels.[27] The focus groups were limited to individuals between 16 and 29 years of age who gave informed consent for information to be collated and included in the *Report*. The groups were moderated by NAPS. Attendees included young people who identified with marginalized groups and/or who showed specific interest in the issues relating to youth mental health that had been identified by the expert group meeting.

27 The dissemination partners are listed in annex II to the present publication.

Table 1.

Focus group topics
1. Structural barriers in education (high school) for youth mental health (1 of 2)
2. Family influence on youth mental health
3. Positive experience of acceptance for youth mental health (LGBT)
4. Inequity and youth mental health
5. The digital environment and youth mental health
6. Employment, unemployment, and decent work and youth mental health
7. Structural barriers in education for youth mental health (2 of 2)
8. Climate change and youth mental health

Listening to young people is essential to understanding their mental health realities.
©UN Photo/Amanda Voisard

Interviews with young people

Nine young people were interviewed to highlight the diversity of experiences of youth with mental health conditions around the world (see **table 2**). The living situations of these youth varied widely; low-, medium- and high-income countries were represented in this group, and some of the young people resided in conflict or post-conflict settings.

Data from the interviews are embedded throughout the *Report* to highlight youth voice, localized experiences, and the interplay of social determinants.

The full methodology for the youth consultations, including the perception questionnaire itself, can be found in annex II.

Table 2.

Demographic information on nine interviewees

LOCATION	GENDER	AGE	SOCIAL DETERMINANT FOCUS
SIERRA LEONE	Male	22	Humanitarian crisis experience; child labour experience
UNITED STATES OF AMERICA	Female	23	LGBT; high socioeconomic background
CANADA	Female	24	Person with disability
AUSTRALIA	Male	19	Indigenous; out-of-home-care experience
NAMIBIA	Male	29	Justice system experience
CHINA	Female	26	Child of parent with mental illness
INDIA	Female	29	Descent-based discrimination; learning disability
TRINIDAD	Female	24	Experience of racism
UNITED KINGDOM	Female	19	Low socioeconomic background; religious discrimination

c. Literature review

A detailed explanation of the methodology used for the literature review can be found in annex III; a summary of the methodology is provided below.

A systematic search for peer-reviewed literature was conducted using the MEDLINE, PubMed and PsycInfo electronic databases. Searches were carried out using free-text keywords and controlled terms related to the following concepts: (a) risk and protective factors or structural and social determinants of mental health (with specific terms relevant to each domain); (b) mental health problems; and (c) adolescents.

Database filters were applied to identify reviews, including umbrella reviews, systematic reviews, and meta-analyses. Studies were included if they examined the onset or presence of mental illness (diagnosed by a mental health professional or identified through the assessment of symptoms on a validated scale) as an outcome. Observational studies, intervention studies and evidence summaries were included and used.

Perception Survey—General Results

Young women deserve mental health support that reflects their realities. ©UN Photo/Marco Dormino

Supportive families play a vital role in protecting young people's mental well-being.
©UN Photo/Shelley Rotner

1. Sample

This section of the *Report* contains a summary of general results from the 2,578 validated survey responses received from youth between the ages of 15 and 29. Forty-two per cent of the survey respondents were between 20 and 24 years of age. Most respondents were not migrants or refugees. The top five countries of residence (Russian Federation, Malaysia, Paraguay, Mexico and Belarus) were home to close to 1,000 of the 2,578 respondents.

Females made up the majority of respondents (71 per cent); 1 per cent selected "other" for their gender. Most identified as heterosexual (69 per cent), with bisexual respondents being the next largest group (12 per cent), and gay, lesbian and other individuals together accounting for 6 per cent of the total.

Nine per cent of the respondents had a disability, 24 per cent had unpaid carer responsibilities, and 32 per cent identified as Indigenous or First Nations people. The majority of respondents were from urban or semi-urban settings.

2. General mental health

Of the 40 per cent of respondents who had ever seen a doctor, nurse, or counsellor about their emotional or mental health, 12 per cent had met with their providers 11 or more times in the preceding 12 months (see **figures 1 and 2**). The likelihood of having seen a professional about mental health increased with age, with 43 per cent of 25- to 29-year-olds responding "yes", compared to 36 per cent of 15- to 29-year-olds. Females were more likely than males to have seen a mental health professional during this period (43 versus 30 per cent); the same was true for only 22 per cent of those identifying as "other".

"Relationships with friends" was rated highest among the five general mental health indicators shown in **figure 3**, with 44 per cent assigning ratings of "very good" or "excellent", closely followed by "relationships with family", with a combined very good/excellent rating of 43 per cent. The lowest ratings were given to "general mental health", with 43 per cent of respondents rating it "poor" or "fair", followed by "how you are coping with life" and "general well-being", rated "poor" or "fair" by 40 and 37 per cent, respectively.

As illustrated in **figure 4**, the majority of respondents said that in the preceding month they had sometimes, often, or always felt happy, satisfied, pleased, calm, peaceful,

relaxed and free of tension, and that their future was hopeful or promising, their life was interesting, they woke up fresh and rested, they expected an interesting day, and they generally enjoyed things.

While the majority of responses were in the "positive" (sometimes to always) range for all indicators, the combined proportions varied, ranging from 61 to 83 per cent. The most positive indicator was "you generally enjoyed things", with 84 per cent answering at least "sometimes"; the least positive was "you woke up fresh, rested" with 38 per cent responding "never" or "rarely".

Almost 40 per cent of the respondents answered "yes" to the survey question about having family members that experienced difficulty managing their emotions, suffered from mental health disorders, or used alcohol or drugs (see **figure 5**).

As shown in **figure 6**, the most common responses to "What would stop you speaking to someone about your own or someone else's mental health?" included the following:

- Lack of trust in other people
- Not being taken seriously
- Fear of being a "burden" to others

The respondents' greatest concerns with regard to the COVID-19 pandemic were as follows (see **figure 7**):

- Their family falling ill with COVID-19
- Disruptions to their school or career path
- Their own mental health

3. Demographic disparities in survey responses

Survey responses relating to the determinants of mental health varied among demographic cohorts. Age and sex differences have been highlighted in the main analysis above where relevant. **Figures 8 and 9** illustrate the differences in responses between the following groups:

FIGURE 1
VISITS TO MENTAL HEALTH PROFESSIONALS

Have you ever seen a doctor, nurse, or counsellor about your emotional or mental health?

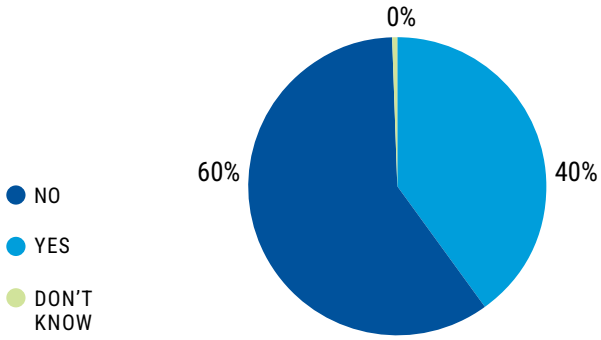


FIGURE 2
FREQUENCY OF MENTAL HEALTH VISITS

If yes, in the last 12 months, how often have you seen a doctor, nurse, or counsellor about your emotional or mental health?

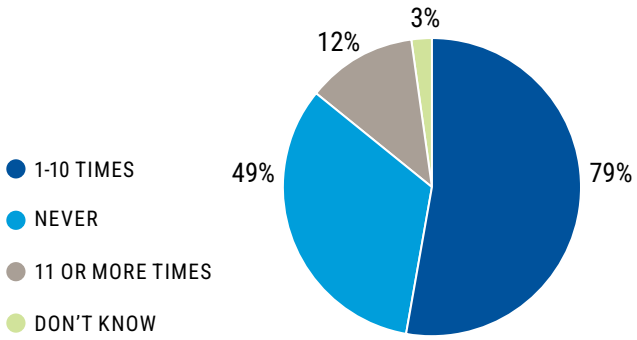
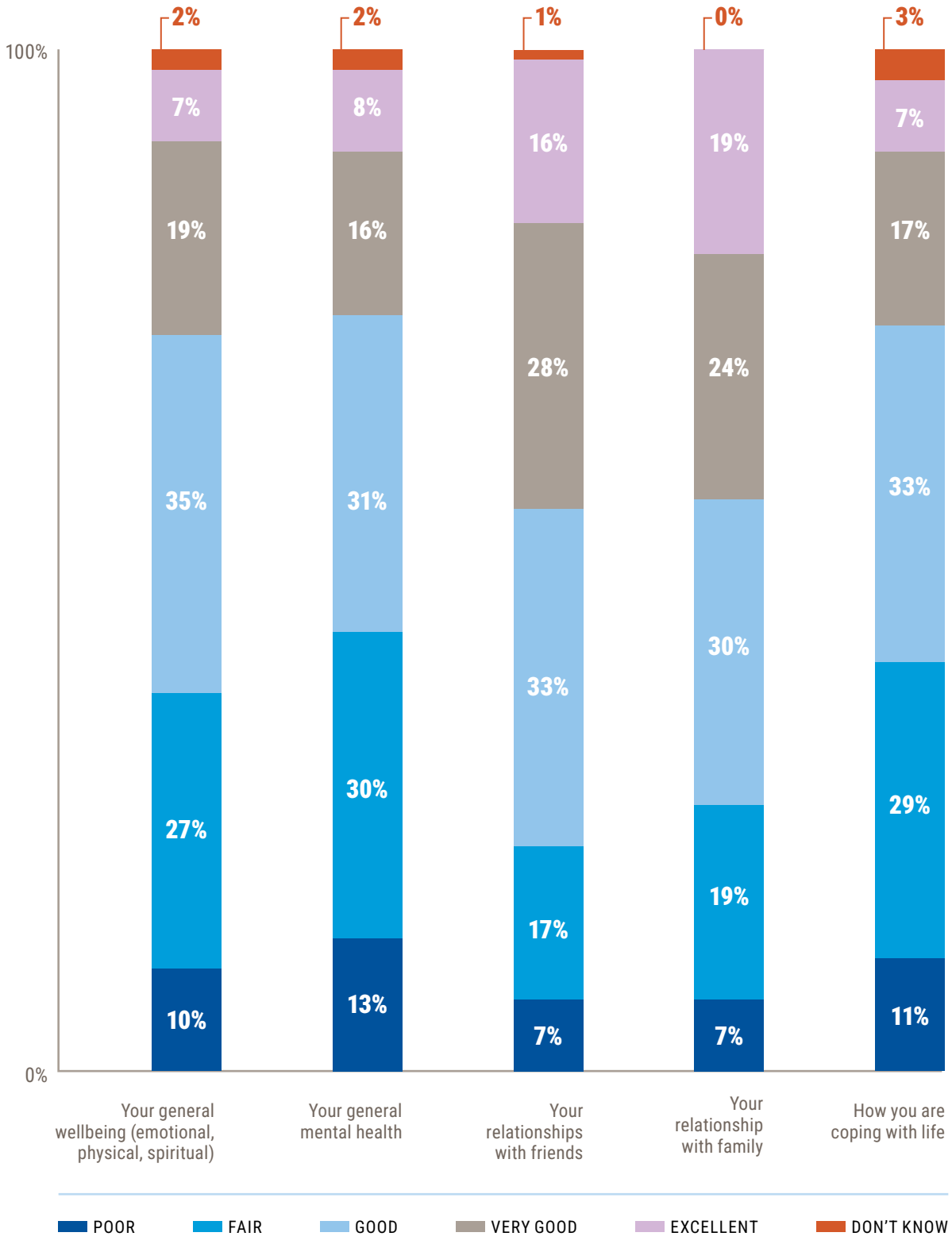


FIGURE 3 RATINGS OF WELL-BEING, MENTAL HEALTH, RELATIONSHIPS AND COPING WITH LIFE

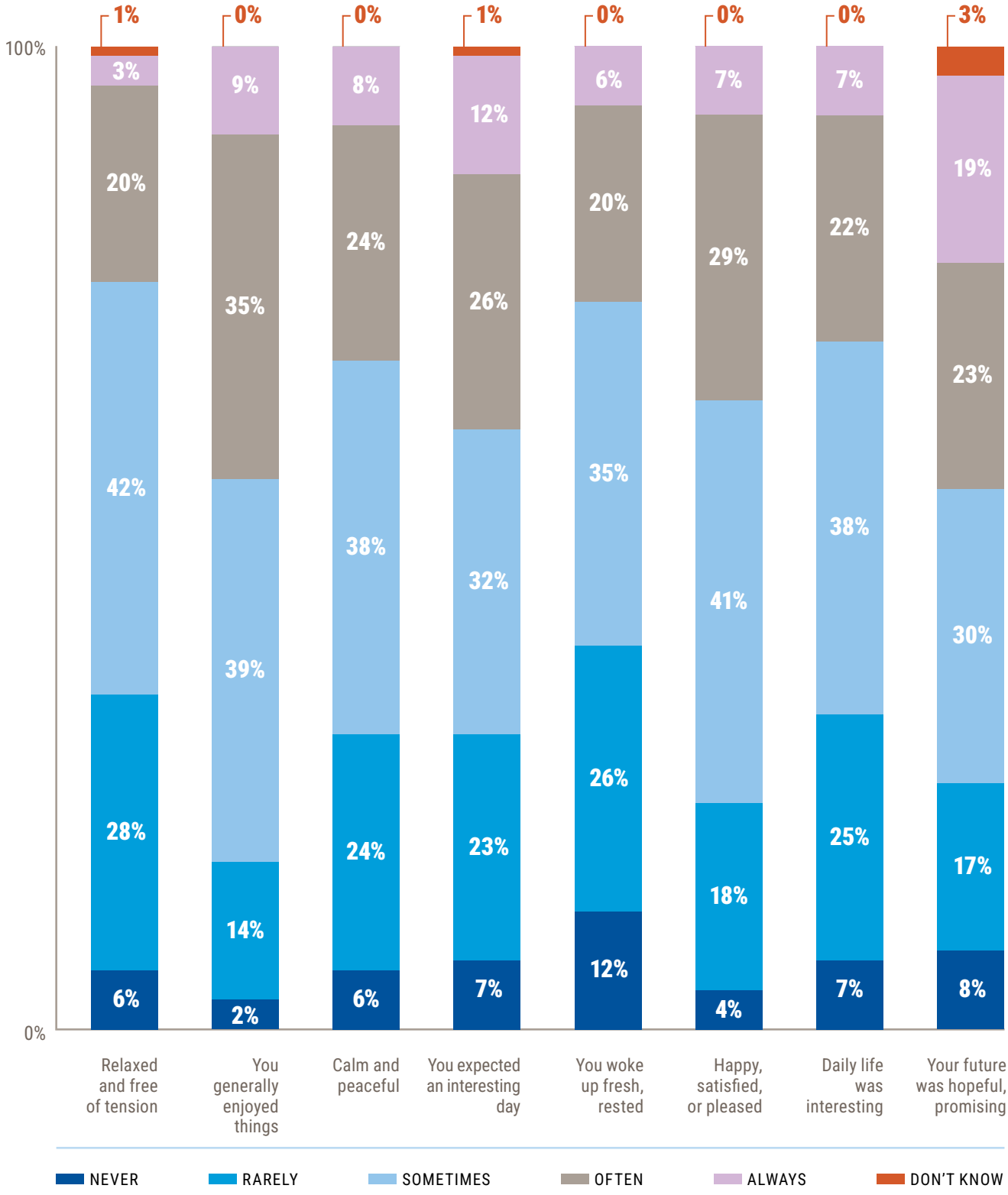
How would you rate your:



Note: Totals may not add due to rounding

FIGURE 4 FREQUENCY OF DAY-TO-DAY LIFE FEELINGS

Thinking about your day-to-day life over the past month, how much of the time have you felt:



Note: Totals may not add due to rounding

Table 3.

Subregions			
Australia and New Zealand	Latin America and the Caribbean	Northern Europe	Sub-Saharan Africa
Central Asia	Melanesia	South-eastern Asia	Western Asia
Eastern Asia	Northern Africa	Southern Asia	Western Europe
Eastern Europe	Northern America	Southern Europe	

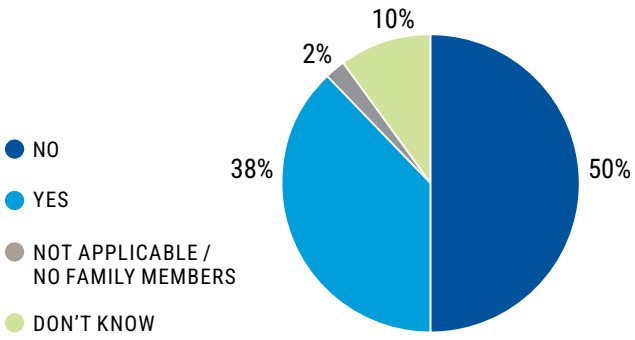
- Respondents identifying as migrants or refugees
- Respondents identifying as other than heterosexual (LGBT)
- Respondents having disabilities (physical, mental, intellectual, psychosocial, sensory, or other impairments)
- Respondents having unpaid carer responsibilities (parents, guardians, carers)
- Respondents identifying as Indigenous or First Nations people in their countries of residence

Around 55 per cent of those surveyed rated their mental health as at least "good", with the highest percentage (60 per cent) recorded for Indigenous people, followed by carers (55 per cent) and migrants/refugees (54 per cent); the least favourable results were for those identifying as LGBT (40 per cent) and persons with disabilities (31 per cent).

More than three quarters of those surveyed reported feeling happy, satisfied or pleased at least "sometimes"; among the individual cohorts, the lowest proportions were seen for those with disabilities (65 per cent) and LGBT respondents (71 per cent), and the highest proportion for Indigenous people (79 per cent).

FIGURE 5
FAMILY HISTORY OF MENTAL HEALTH DISORDERS

Do any of your family members have difficulty managing their emotions, suffer from mental health disorders, or use alcohol or drugs?



4. Subregional differences in survey responses

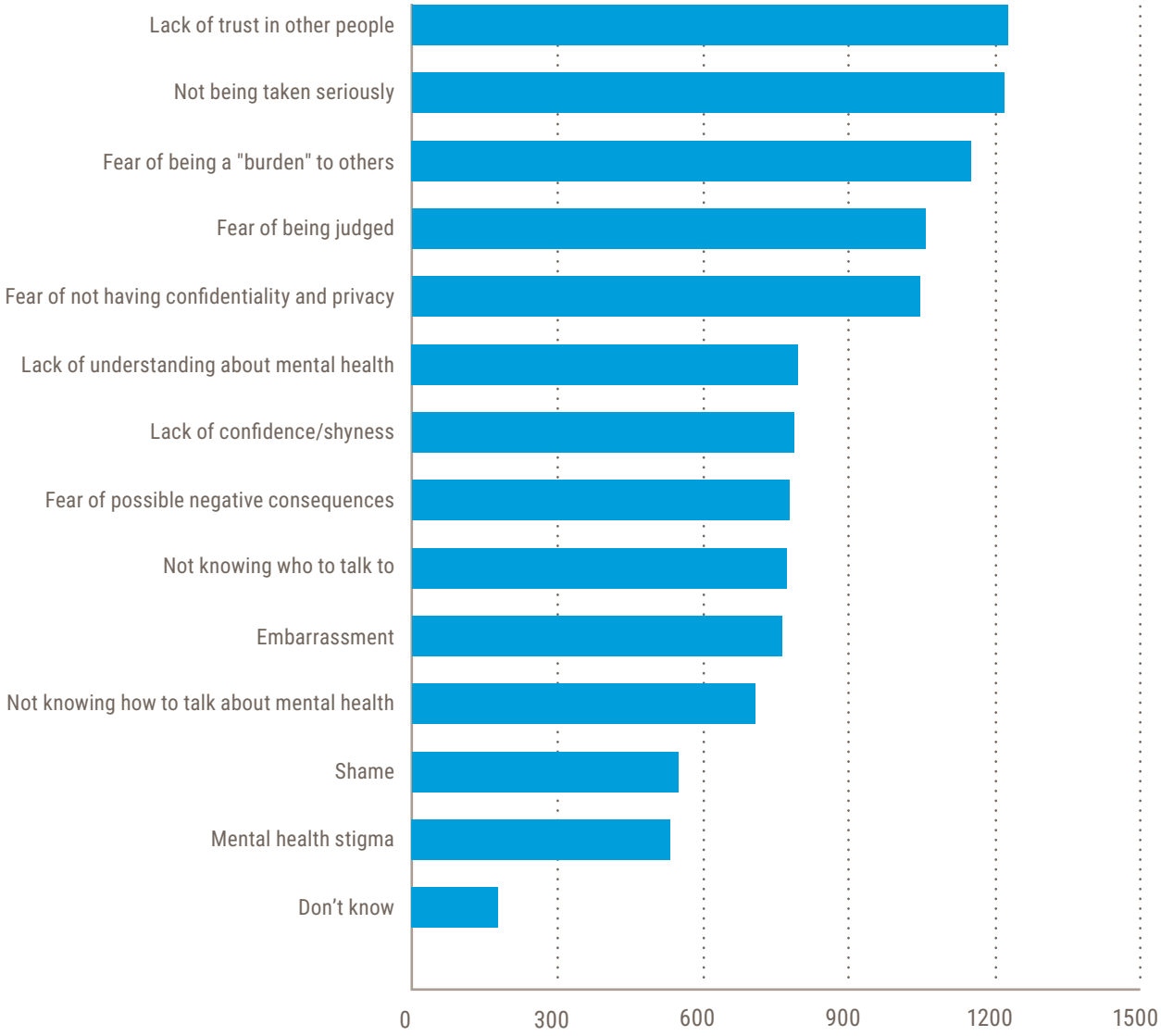
Disparities were also apparent when responses relating to the determinants of mental health were analysed by geographic subregion. Relevant results for each determinant of mental health are presented in this section. **Table 3** shows the subregional classifications used for the analysis.[28]

As indicated in **figure 10**, youth from sub-Saharan Africa, Melanesia and Eastern Asia had the highest combined proportions of "excellent" and "very good" responses to "How would you rate your general mental health?", at 44, 40 and 37 per cent, respectively. Northern Europe and Western Europe had the highest proportions of "poor" responses, at 30 and 24 per cent, respectively. The social isolation measures, disrupted education, and increased

28 Geographic subregions align with the M49 standard (see https://unstats.un.org/unsd/methodology/m49/#geo-regions).

FIGURE 6 IMPEDIMENTS TO SEEKING HELP FOR MENTAL HEALTH ISSUES

What would stop you speaking to someone about your own or someone else's mental health: (select all applicable)



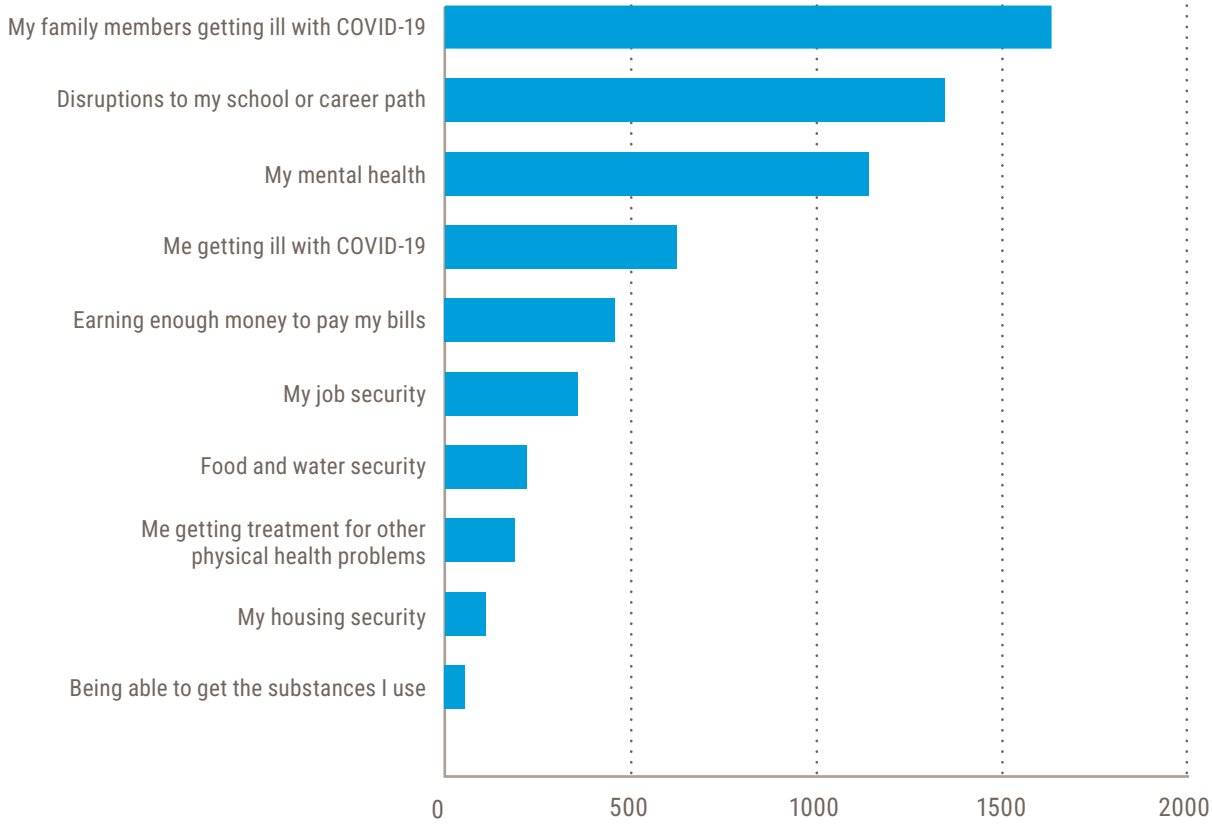
employment uncertainty experienced by Northern Europe during the COVID-19 pandemic may have had a greater impact on youth from that subregion than on those from areas that were less severely affected. The European Parliament reported that "in most European countries, the incidence of mental health problems among people aged between 15 and 24 doubled during the pandemic".[29]

Among those enrolled in education at the time of the survey or within the preceding 12 months, Melanesia and Northern Africa had the highest proportions of respondents "strongly agree" that they felt they could talk to teachers about problems at school (25 and 23 per cent, respectively); Eastern Asia had the highest combined proportion of "agree" and "strongly agree" responses (67 per cent). Respondents

29 Laurence Amand-Eeckhout, "Mental health in the EU", European Parliament briefing (European Parliamentary Research Service, July 2023), available at https://www.europarl.europa.eu/RegData/etudes/BRIE/2023/751416/EPRS_BRI(2023)751416_EN.pdf.

FIGURE 7 CONCERNS RELATING TO COVID-19

What are your greatest concerns in connection with the COVID-19 pandemic?
Select up to 3 options



from South-eastern Asia and Western Europe were the least likely to "agree" or "strongly agree" that they felt comfortable sharing concerns with teachers (see **figure 11**).

Figure 12 shows that among those who were employed, respondents from Northern America were the most likely to feel they "always had enough work" in the preceding 12 months (35 per cent), while respondents from Western Asia were the least likely (16 per cent).

As shown in **figure 13**, respondents from South-eastern Asia were the most likely to have had a time in the preceding 12 months when they wanted to talk to someone about mental health or an emotional issue but did not know where to turn (75 per cent), while respondents in Australia and New Zealand were the least likely (51 per cent).

Respondents from South-eastern Asia were most likely to respond "always" to the prompt "how I feel about myself depends on what others think of me online" (11 per cent); Eastern Asian respondents were the least likely, with none selecting this option (see **figure 14**).

As shown in **figure 15**, residents of Melanesia were most likely to respond "yes" to the question "Are there people you are in regular contact with that are detrimental to your well-being because they are a source of discomfort and stress?" (60 per cent), while respondents from Western Asia were the least likely (30 per cent).

The survey results shown in **figure 16** indicate that respondents from Eastern Asia were the most likely to feel safe in their local area (with 90 per cent answering "always" or "often"), followed by respondents from Northern America (87 per cent) and Western Europe (86 per cent). Those living in Melanesia were least likely to respond "always" or "often" (30 per cent), followed by respondents from Northern Africa (47 per cent) and Latin America and the Caribbean (54 per cent).

FIGURE 8 GENERAL MENTAL HEALTH: DEMOGRAPHIC DIFFERENCES

How would you rate your general mental health?
(Total percentage of good, very good and excellent)

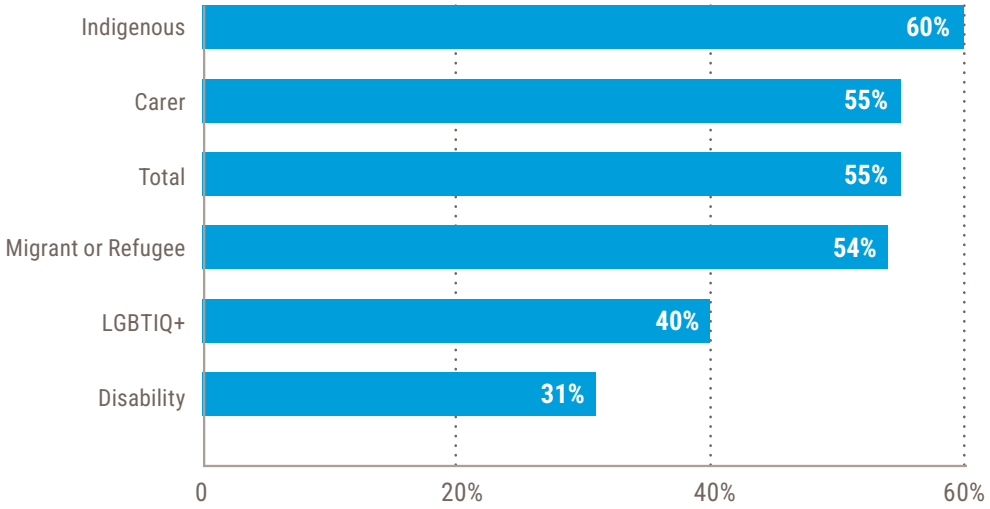


FIGURE 9 LIFE SATISFACTION: DEMOGRAPHIC DIFFERENCES

Thinking about your day-to-day life over the past month, how much of the time have you felt happy, satisfied, or pleased (at least sometimes)

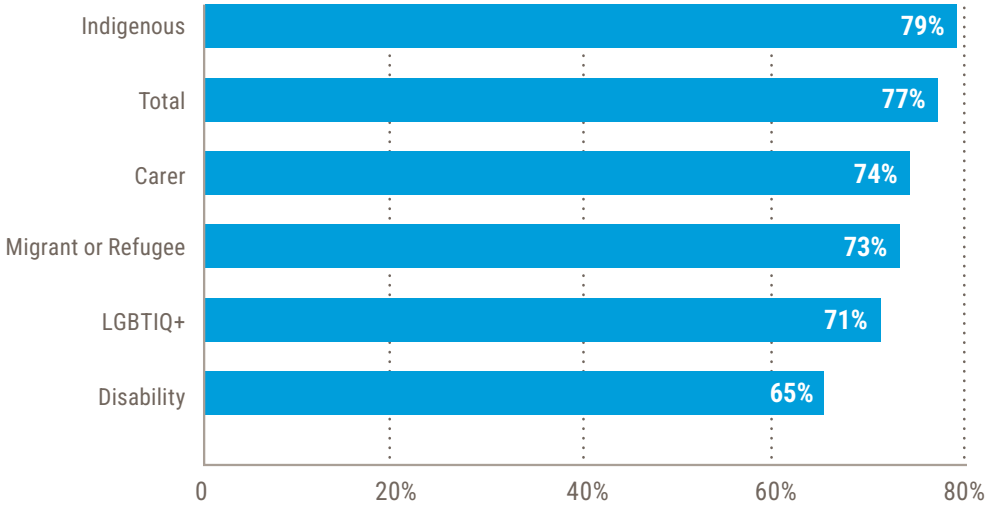
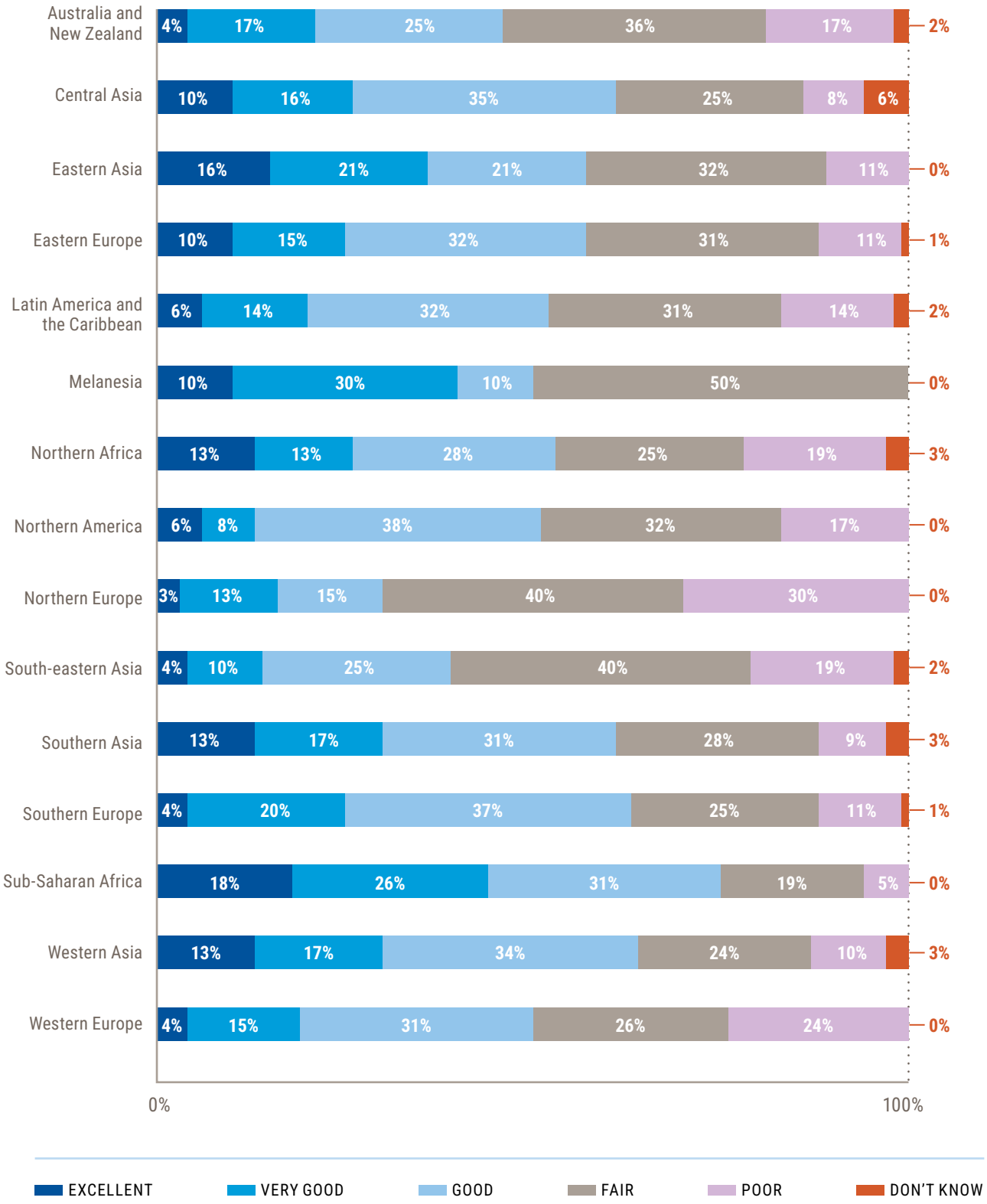


FIGURE 10 SUBREGIONAL RATINGS OF GENERAL MENTAL HEALTH

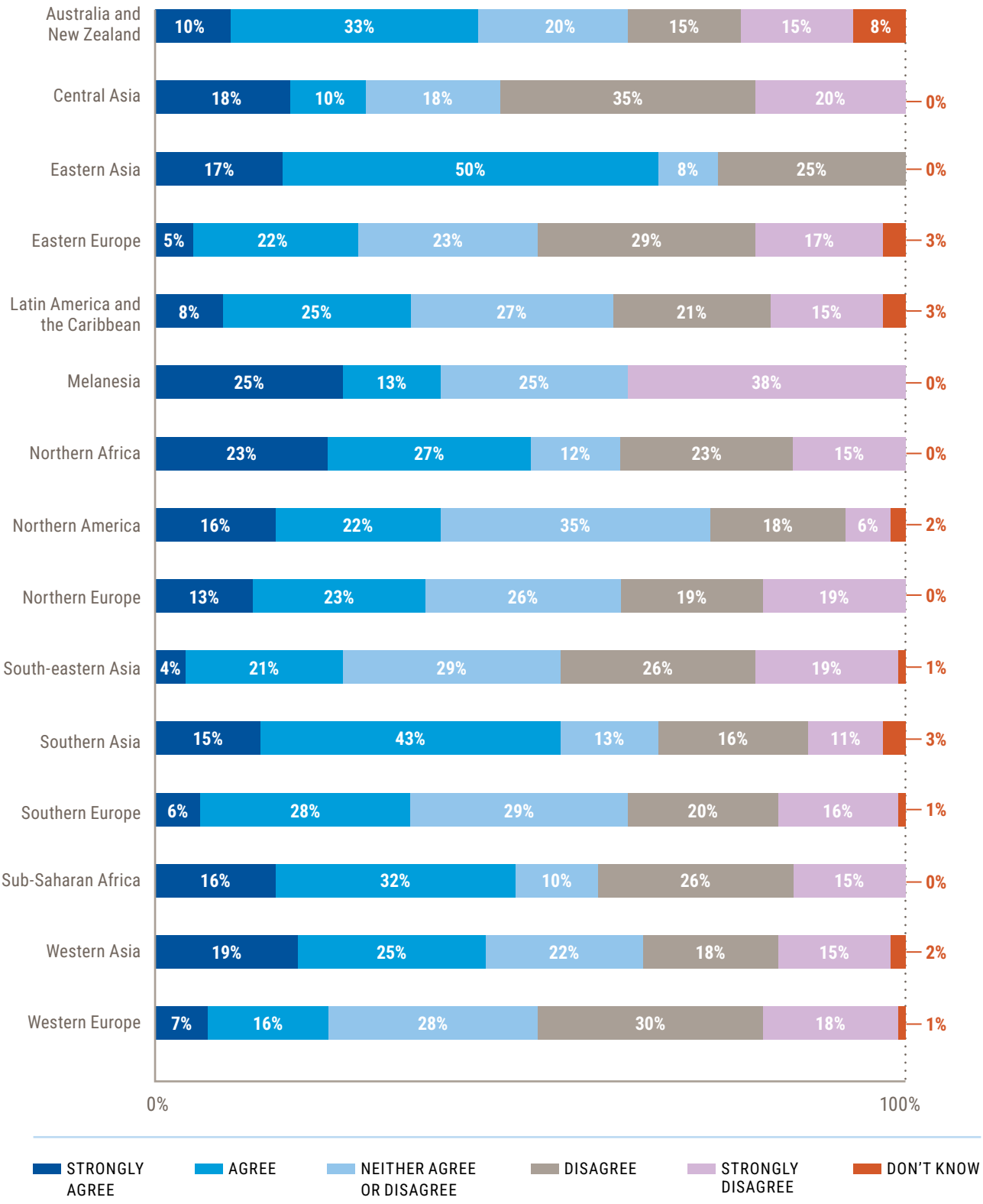
How would you rate your general mental health?



Note: Totals may not add due to rounding

FIGURE 11 SUBREGIONAL RATINGS OF FEELING ONE COULD TALK TO TEACHERS ABOUT PROBLEMS

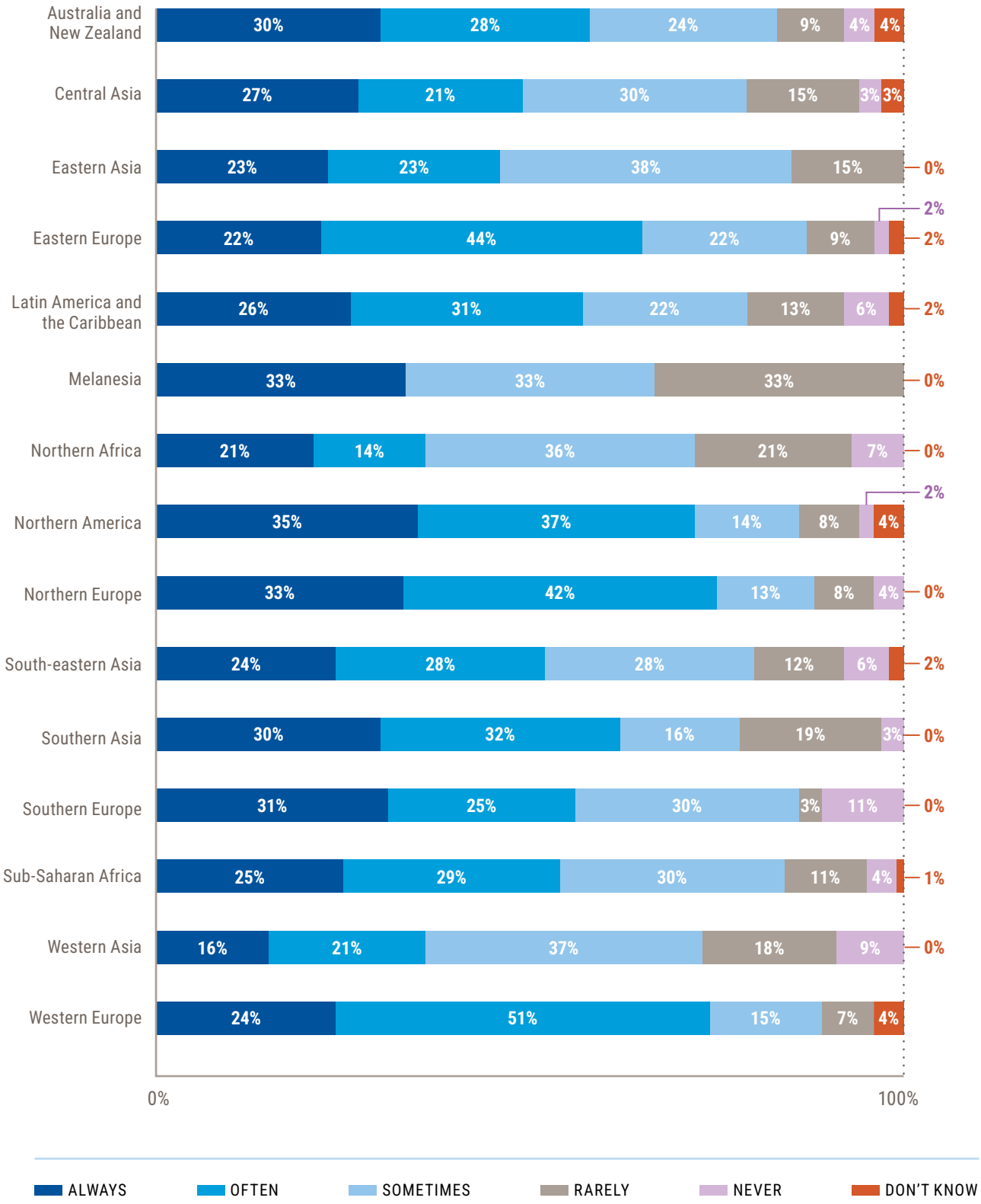
I feel I can talk to teachers about problems at school.



Note: Totals may not add due to rounding

FIGURE 12 SUBREGIONAL RATINGS OF THE FREQUENCY OF HAVING ENOUGH WORK

In the last 12 months, how frequently did you feel you had enough work?



Note: Totals may not add due to rounding

FIGURE 13 SUBREGIONAL RATINGS OF NOT KNOWING WHERE TO TURN TO TALK ABOUT MENTAL HEALTH ISSUES

In the last 12 months, was there a time when you wanted to talk to someone about a mental health or emotional issue you had, but did not know where to turn? (percentage of "yes" responses)

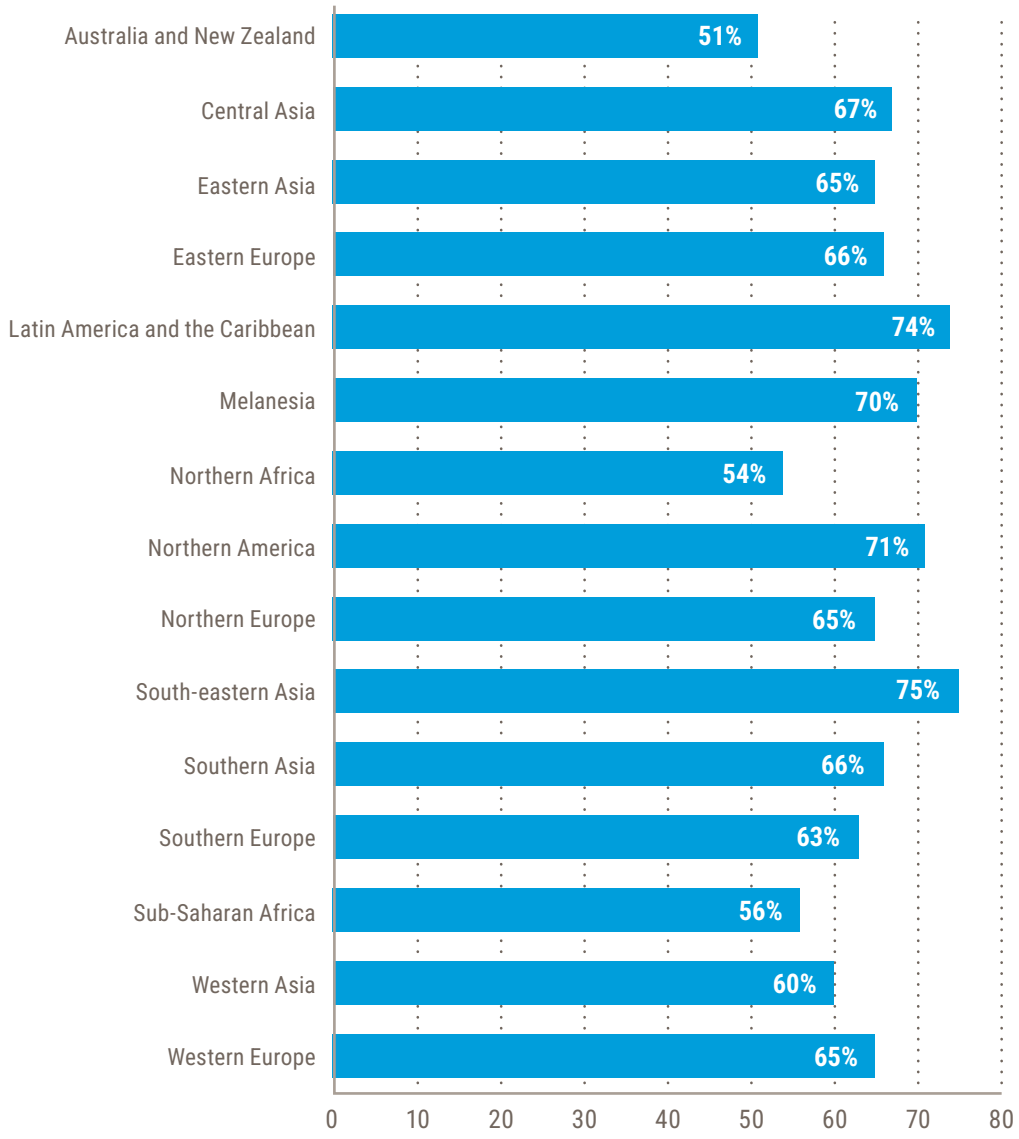
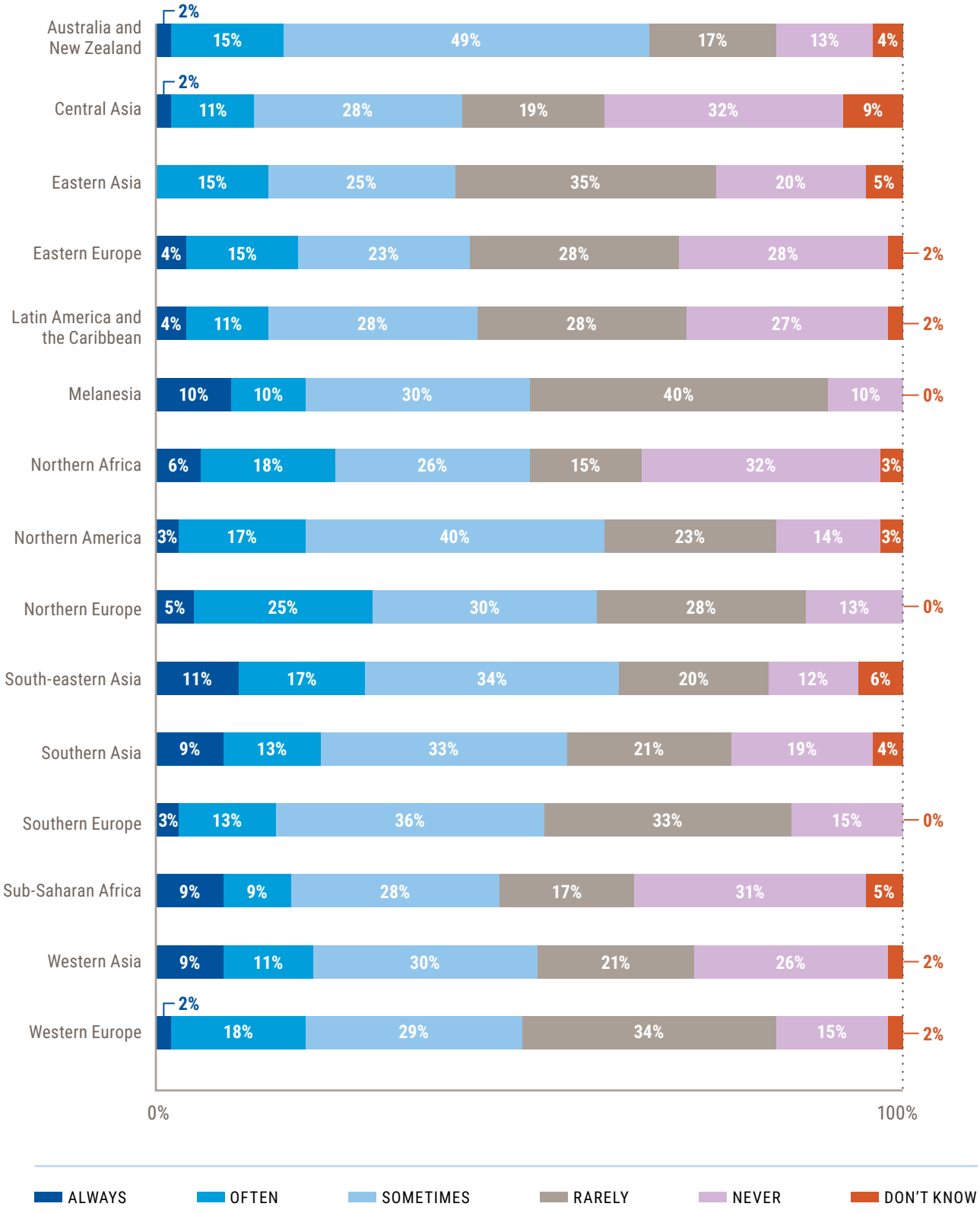


FIGURE 14 SUBREGIONAL RATINGS OF FEELINGS ABOUT SELF BASED ON OPINIONS OF OTHERS ONLINE

How I feel about myself depends on what others think of me online.



Note: Totals may not add due to rounding

FIGURE 15 SUBREGIONAL RESULTS RELATING TO CONTACT WITH PEOPLE DETRIMENTAL TO ONE'S WELL-BEING

Are there people you are in regular contact with that are detrimental to your well-being because they are a source of discomfort and stress? (percentage of "yes" responses)

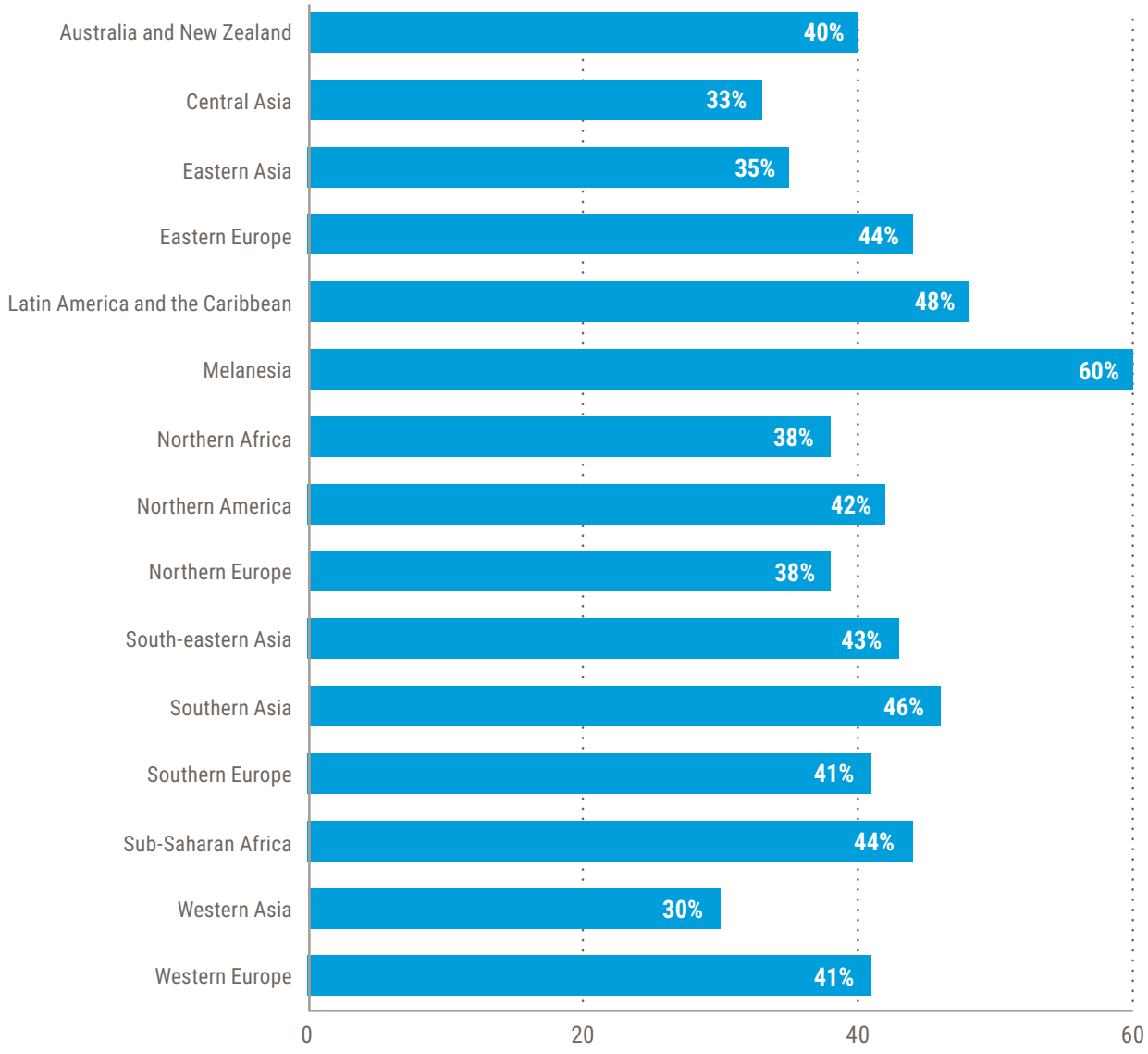
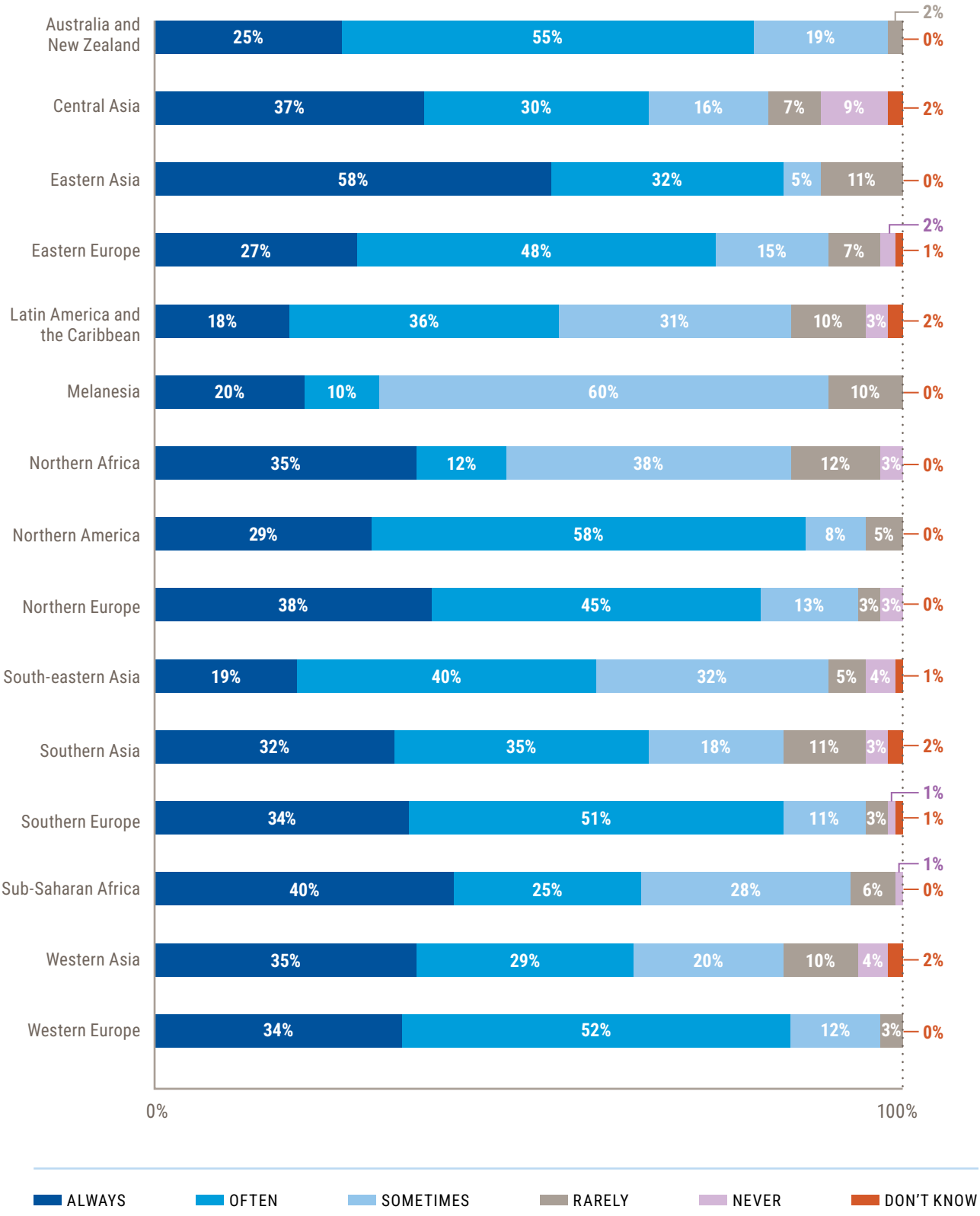


FIGURE 16 SUBREGIONAL RATINGS OF FEELING SAFE

How often do you feel safe in your local area?



Note: Totals may not add due to rounding

Social Determinants of Youth Mental Health

Youth are not just participants; they have insights that help shape more effective solution. ©UN Photo/Jean-Marc Ferré

No young person should have to risk their health or peace of mind to earn a living.
©UN Photo/Jean Pierre Laffont

In recent years, increased attention has been directed towards social determinants of health, including mental health. Research evidence indicates that mental health can be shaped to a great extent by the social, economic, and physical environments in which people live. Recent research has drawn attention to the need to focus on the cumulative effects of social and economic inequalities as they can increase mental health risks. The inclusion of people with varying states of mental health, including those with mental health conditions, is critical to ensure that no one is left behind. This section of the *Report* focuses on social determinants of young people's mental health and well-being and on socially inclusive policies that can offer support within this context.

Comprehensive multisectoral interventions that focus on improving the conditions in which people are born, live, grow, receive an education, work, stay informed, develop relationships, and interact are likely to advance mental health. WHO affirms that interventions linked to the social determinants of health, guided by holistic policies, are needed to improve mental health and well-being.

Key messages in this section will be conveyed through the following:

- *An examination of social determinants that significantly affect young people's lives and mental health.* Six social determinants and related policy spheres are explored: education, employment, families and relationships, poverty and deprivation, technology and the online environment, and society and community. These elements are inextricably linked and can have a compounding effect on youth mental health. The linkages are articulated in the section analysis, with the drivers of social determinants identified based on the consultations with youth and research findings. All six social determinants are examined, though some may feature more prominently than others. While there are other determinants of health (such as environment), those selected are generally seen to have the greatest impact on young people's lives. Leveraging the integrator role of UN DESA, the *World Youth Report* takes a holistic, multisectoral approach in identifying elements required for mainstreaming mental health into broader policymaking processes.
- *Exploration of the role and potential impact of inclusive social policies through the eyes of young people.* The perspectives and voices of youth are woven through the *Report*, with shared interviews and real-life examples creating a rich narrative that brings the

policy environment to life. Addressing youth mental health in ways that genuinely meet the needs of young people is a key priority.

The following six social determinants are believed to have a profound effect on young people's mental health:

- *Education.* Young people's experiences in schools and other learning environments affect their mental health and well-being in different ways. The quality of education, access to support, employment prospects, and personal, family and societal expectations are among the key factors within this context.
- *Employment.* The interplay between work and mental health raises issues that need to be reflected in policymaking by Governments and businesses.
- *Family and other relationships.* Family, peer and other close relationships play an important role in youth mental health, with effects that may cut across other determinants (such as education, employment, technology, and society).
- *Poverty and deprivation.* The linkages between poverty, deprivation, and mental health and well-being need to be examined to determine how mental health considerations in social policies can reflect increased inclusivity.
- *Technology and the online environment.* Experiences in the online environment and the effects of digital technology are emerging as key factors in youth mental health and well-being.
- *Society and community.* Stigma, trauma, discrimination, and other forms of social exclusion affecting youth mental health and well-being in specific contexts are well documented in the research literature and are also reflected in the data collected through the youth consultations.

The individual sections relating to the determinants listed above are focused on the following:

- Sharing findings from the surveys and consultations carried out with young people to provide a better understanding of the diversity of youth experiences relating to mental health and well-being;
- Examining obstacles and opportunities linked to the reform of social policies to make them inclusive of all youth;
- Suggesting key policy recommendations aimed at removing institutional barriers;
- Promoting a life-course approach to mental health and investment in prevention and early intervention;
- Highlighting examples to illustrate policymaking processes and identifying key entry points for incorporating inclusive, holistic approaches to addressing mental health within various social policies;
- Highlighting the role of young people as agents of change (through peer-led approaches) and featuring innovative initiatives led by young practitioners.

1. Education

a. Perception survey results

At the time the survey was administered, 70 per cent of respondents were enrolled in or attending an educational institution (a school, university, or technical and vocational education and training programme), and an additional 3 per cent had been enrolled within the preceding 12 months. The results below are based on responses from these two groups only (73 per cent of all those surveyed), though it should be noted that among those not enrolled, 9 per cent identified mental health as a reason for not being engaged in education.

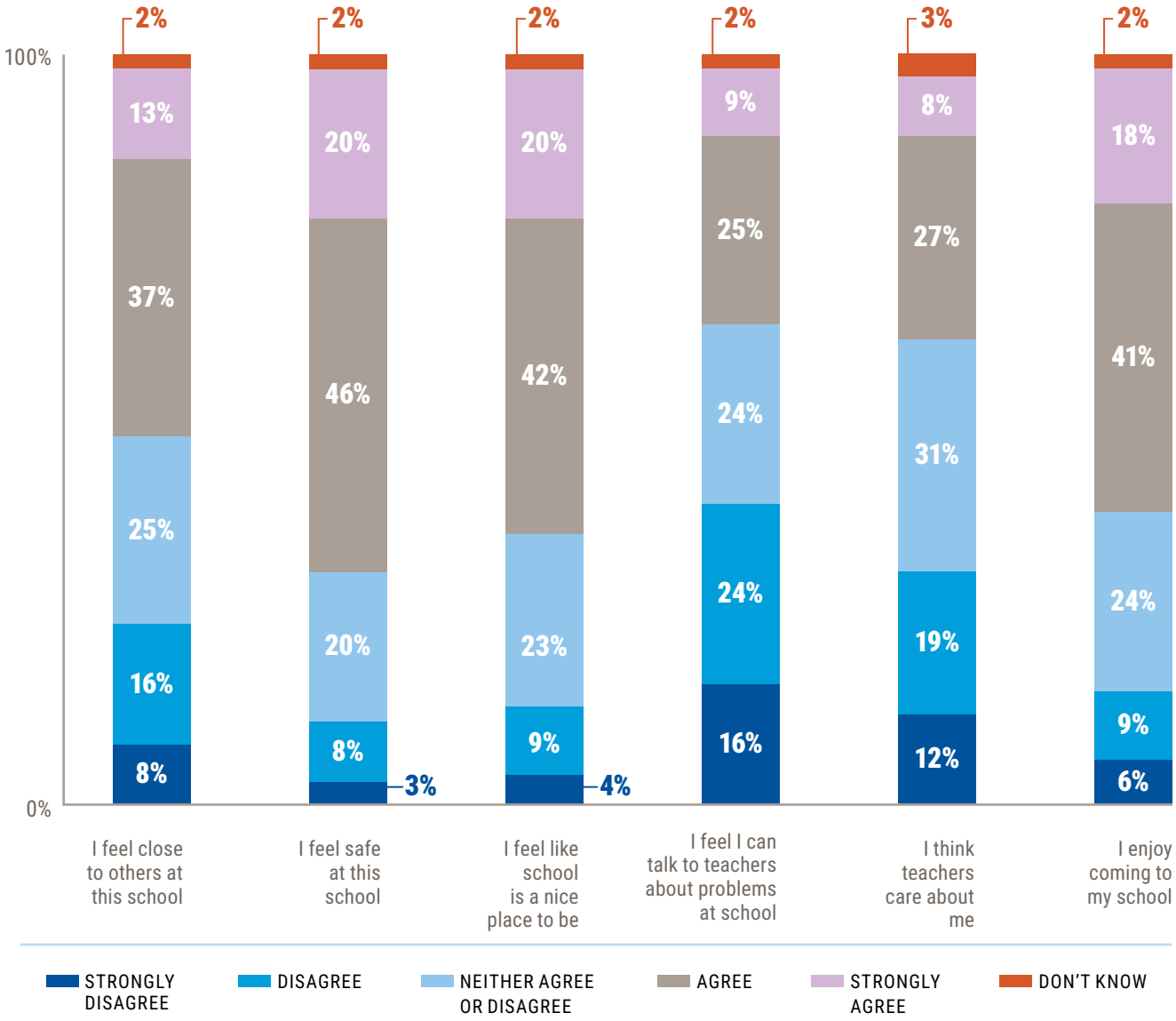
Female respondents were far more likely than male respondents to be studying (79 versus 48 per cent). Two thirds of those enrolled responded that they "agree" or "strongly agree" with the statement relating to feeling safe at school, though 40 per cent responded that they "disagree" or "strongly disagree" with the statement on feeling they could talk to teachers about problems at school (see **figure 17**).

Close to half of the respondents indicated that they had gotten angry with someone very easily in the preceding seven days, about a quarter had said things about students to make other students laugh, and more than a fifth of the students surveyed had sworn or used insulting language directed at someone (see **figure 18**).

Twenty-eight per cent of the respondents related that people at school had expressed negative opinions about them due to their emotional or mental health issues at least "sometimes" in the preceding 12 months. There was

FIGURE 17 SURVEY RESULTS RELATING TO YOUTH EXPERIENCES AT SCHOOL

Thinking about your experiences as a student at this educational institution, please rate the items below



Note: Totals may not add due to rounding

no significant difference in the responses when disaggregated by sex. Among the 28 per cent, the greatest mental health impact was linked to "engagement with studies", "relationships with friends" and "physical healthcare" (see **figure 19**).

b. Focus group results

Among the focus group participants, education was seen as a catalyst for both positive and negative impacts on mental health and well-being. The one-size-fits-all approach to education was identified as problematic in the sense that mental health was not uniformly seen as a priority for teaching staff or educational institutions compared to standard subjects and therefore not given attention during school hours. Participants reported a large gap between the supports and mental health training available in private institutions versus those available in government-funded schools. Many young

people reported that there was little to no information provided about mental health in primary or secondary schools across Member States. Some young people had experienced in-school support for students struggling with mental health, but mention was made of a risk-averse approach where the response was outsourced to external services in situations where the young people did not feel more specialized expertise was necessary. The lack of discretion and confidentiality from school support systems when a young person sought help was also identified by participants.

Stigma felt from the judgment of students, staff, education systems, and family members was seen as a barrier deterring young people from seeking mental health support. The lack of awareness about the diversity of mental health issues in the wider community, mental health being viewed as a taboo topic, and the negative images portrayed in the media were also common concerns that the respondents felt perpetuated stigma within the school system. Intergenerational differences in mental health awareness was a key concern for participants, who felt they could not speak openly with their parents/carers about mental health. Participants reported that when mental health supports were sought, their parents/carers could react poorly, leaving students less likely to seek help because of the possible continued negative reactions from their families.

Another barrier to securing mental health support was accessibility, relating to costs and waiting lists for mental health services. Participants noted in all the focus groups that the cost of getting help had constrained their ability to address mental health concerns. Some participants spoke of the usefulness of having peer-led programmes and other free supports on site in their education institutions or in partnership with local service providers.

Participants suggested making mental health information part of primary school curricula to encourage help-seeking behaviour and reduce stigma in schools. High schools and universities making regular spaces in the workload to discuss mental health was also seen as an important priority for participants. In some countries, mental health supports in schools were facilitated by other students; this was seen as a benefit, given the effectiveness of peer education, but also as a hindrance, given the potential overreliance on young people carrying the responsibility for something that often required professional assistance. It was felt that removing barriers to educational access in general – by addressing transportation needs, removing cost prohibitions, and improving inclusivity, for example – would also promote positive mental health outcomes for young people.

c. Social determinants

The experiences young people have in schools vary greatly across countries, communities, and educational institutions. While it is impossible to consolidate the empirical research on global school experiences, it is possible to examine the current evidence base to guide policy recommendations for enhancing the success of young people. Young people both influence and are influenced by their environments. The social-ecological model of human behaviour postulates that influential environmental factors include families, peers, schools, and communities.[30] Young people spend roughly eight hours per day in educational systems, making schools an important influence on youth development. Learning environments vary; schools may be large or small, public or private, underfunded or well-funded, and conducting classes inside or outside physical buildings. Quality education is a right for all young people; however, in many countries around the world, access to quality education is limited or unavailable. The relationship between education and well-being is firmly established, with young people enjoying access to quality education reporting higher levels of well-being.[31] Quality education provides students with access to teachers, information, and resources to help them become productive members of society.

Everybody has mental health; you have to learn how to take care of it.

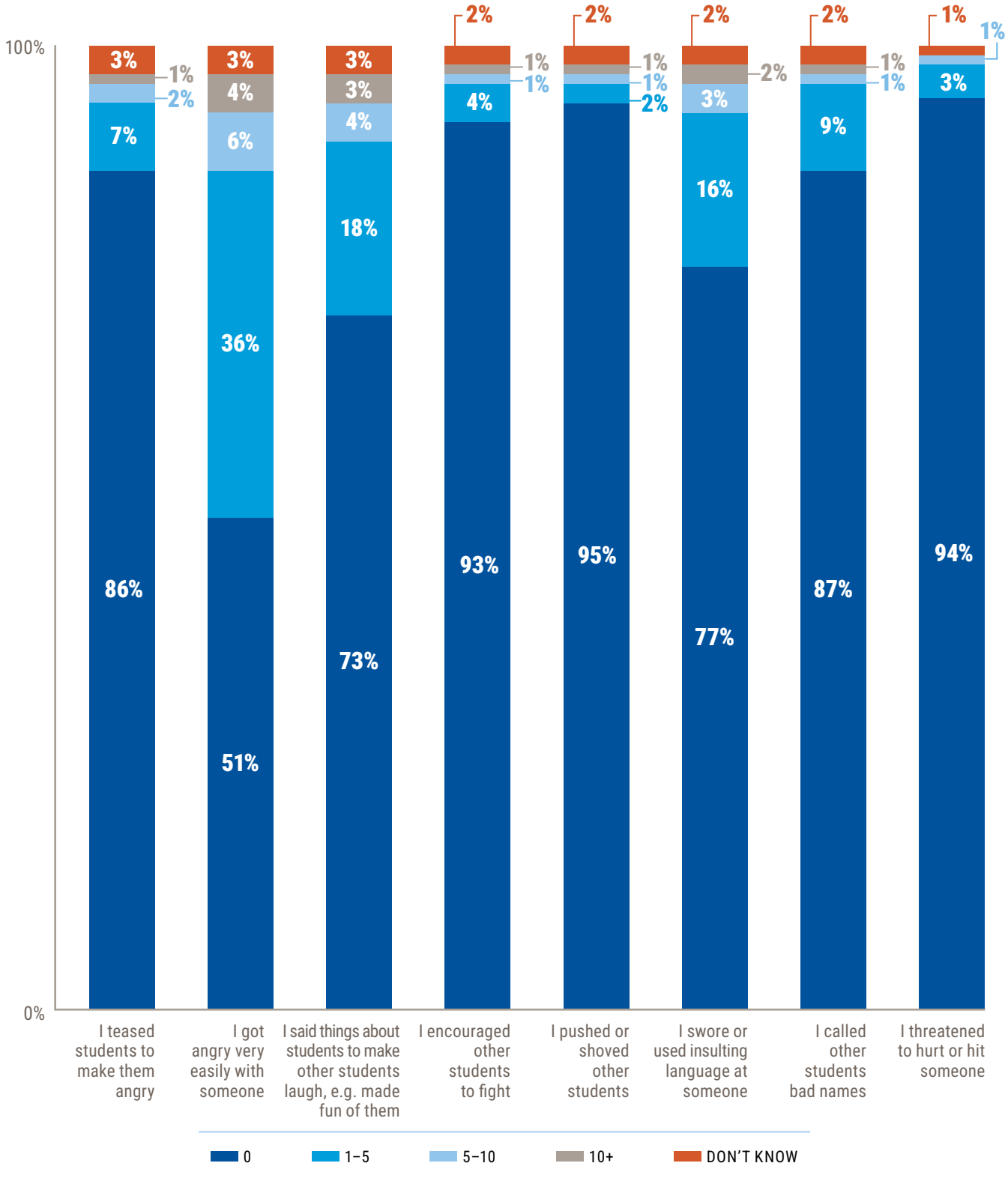
–Young person, Focus Group 1

30 Susan M. Swearer and Shelley Hymel, "Understanding the psychology of bullying: moving toward a social-ecological diathesis-stress model", *American Psychologist*, vol. 70, No. 4 (2015), pp. 344-353, DOI:10.1037/a0038929.

31 Ling Zhou, Huazhen Lin and Yi-Chen Lin, "Education, intelligence, and well-being: evidence from a semiparametric latent variable transformation model for multiple outcomes of mixed types", *Social Indicators Research*, vol. 125, No. 3 (2015), pp. 1,001-1,033, DOI:10.1007/s11205-015-0865-1.

FIGURE 18 SURVEY RESULTS RELATING TO THE FREQUENCY OF BULLYING BEHAVIOURS

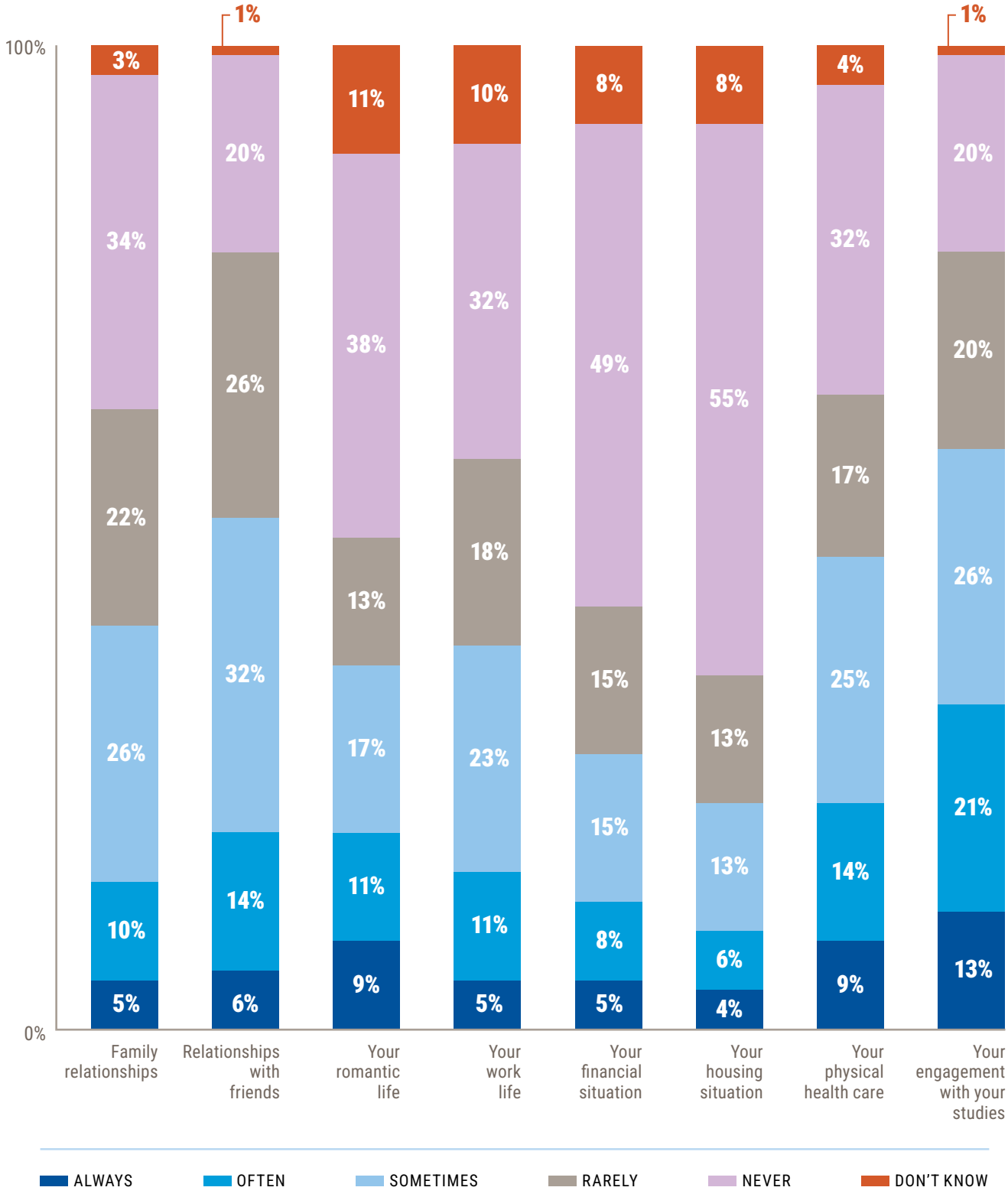
During the last 7 days, how often did you engage in each of the following behaviours at your educational institution?



Note: Totals may not add due to rounding

FIGURE 19 SURVEY RESULTS ON THE EFFECTS OF OTHERS' NEGATIVE OPINIONS

If yes, how much did these negative opinions or unfair treatment affect:



Note: Totals may not add due to rounding

Obtaining a quality education – which provides individuals with the knowledge and skills they need to lead productive lives but also plays a key role in reducing gender and wealth disparities across the globe – is one of the 17 Sustainable Development Goals set out in the 2030 Agenda for Sustainable Development. Quality education is correlated with socioeconomic status and is an important indicator for escaping poverty and engaging in meaningful work. However, more than half of the world's young people are not achieving minimum proficiency in reading and math, and as of 2023, 272 million children and youth were out of school.[32] There is much still to be done to increase access to quality education and gain a better understanding of young people's educational experiences.

School environments and mental health

There are specific circumstances and experiences that contribute to young people's success or struggles within the realm of education. In the United States of America, ethnic background has been associated with placement in special education, with the odds of being placed in special education higher for ethnic minorities than for white students.[33] There is a long history of students of colour being disproportionately placed in special education and in the juvenile justice system. Structural racism in schools is connected to negative academic, behavioural, social, and health outcomes.[34]

I've never had a positive experience with [mental health] in schools, ever. It's always been a negative interaction – not even neutral – always bad.

– Young person, Focus Group 1

Young people thrive when their communities are safe, inclusive, and full of opportunity.
©UN Photo/Evan Schneider

A study in Portugal found that immigrant and immigrant descendant children had lower levels of school achievement than did native Portuguese children and that perceived discrimination was a strong predictor of youth mental health difficulties and poor school achievement.[35] Ethnic disparities are one of the main barriers to equal access to education worldwide, with research evidence indicating that youth from various minority ethnic groups experience higher rates of school exclusion than do youth belonging to majority groups.

32 United Nations, Sustainable Development Goals, Goal 4: quality education, available at https://www.un.org/sustainabledevelopment/education/.

33 Rachel E. Fish, "Standing out and sorting in: exploring the role of racial composition in racial disparities in special education", *American Educational Research Journal*, vol. 56, No. 6 (2019), pp. 2,573-2,608, DOI:10.3102/0002831219847966.

34 Adam Alvarez, "Seeing race in the research on youth trauma and education: a critical review", *Review of Educational Research*, vol. 90, No. 5 (2020), pp. 583-626, DOI:10.3102/0034654320938131.

35 Rita Guerra and others, "School achievement and well-being of immigrant children: the role of acculturation orientations and perceived discrimination", *Journal of School Psychology*, vol. 75, No. 1 (2019), pp. 104-118, DOI:10.1016/j.jsp.2019.07.004.

For many Asian cultures, the emphasis on grades is so heavy that people often forget the different factors that result in these varying grades – especially now in the online context, where people can only do as much as their domestic situations permit them.

–Young person, Focus Group 7

Sex, gender, and gender identity are also salient to young people's success in school. Research findings indicate that boys exhibiting disruptive behaviour are three times more likely than the corresponding group of girls to be expelled from school.[36] For many sexual minority youth and gender non-binary youth, school experiences are often negative. These youth are at increased risk for being bullied, harassed and assaulted and report lower school satisfaction. A study in the United States of America found that 86.3 per cent of LGBT students had been harassed or assaulted at school, and 56.6 per cent of those students had not reported the incident to school staff for fear that the situation would become worse or that school staff would do nothing.[37] Underlying these findings is a lack of trust that many sexual minority and gender nonconforming youth feel with regard to school. They report higher rates of depression, suicidality, anxiety, and physical and sexual victimization yet are less likely to use school-based services.[38] While schools ought to be a safe haven for young people, there are still significant disparities and barriers across the world that prevent schools from being safe and supportive spaces for all youth.

Among the survey participants enrolled in education, 66 per cent responded that they "agree" or "strongly agree" with the statement relating to feeling safe at school, though 40 per cent responded that they "disagree" or "strongly disagree" with the statement related to feeling comfortable about sharing their problems with teachers at school.

Given that most youth spend the majority of their weekdays in educational environments, schools are ideally positioned to offer strong support for peer learning and psychological support. Young people are more easily reached at school than through clinic-based or public interventions, leading adolescent mental health experts to underscore the importance of youth mental health policies and interventions based in schools.[39]

It is essential to create a welcoming school environment where such support is seen as key to student success. As part of this process, various internal obstacles may need to be addressed, as school environments can be an extension of society's gender and cultural norms and may also be affected by outside factors. Such challenges are illustrated by the following:

- Some educational environments reflect societal gender-based norms that can contribute to exclusion, gender-based violence, and bullying in schools.[40] Studies conducted in the United States of America and the United Kingdom of Great Britain and Northern Ireland show that school environments that are homophobic are detrimental to the mental health of sexual and gender minorities.[41] A study in Norway

36 Claire Parker and others, "The 'Supporting Kids, Avoiding Problems' (SKIP) study: relationships between school exclusion, psychopathology, development, and attainment – a case control study", *Journal of Children's Services*, vol. 11, No. 2 (2016), pp. 91-110, DOI:10.1108/jcs-03-2015-0014.

37 Joseph G. Kosciw, *The 2019 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools* (New York, GLSEN, 2020), available at https://www.glsen.org/sites/default/files/2020-11/NSCS19-111820.pdf.

38 Kelly A. Williams, "Comparing health and mental health needs, service use, and barriers to services among sexual minority youths and their peers", *Health and Social Work*, vol. 36, No. 3 (2011), pp. 197-206, DOI:10.1093/hsw/36.3.197.

39 Stanley Kutcher and Yifeng Wei, "School mental health: a necessary component of youth mental health policy and plans", *World Psychiatry*, vol. 9, No. 2 (2020), pp. 174-175, available at https://doi.org/10.1002/wps.20732.

40 UNESCO and United Nations Girls' Education Initiative, "Why ending school-related gender-based violence (SRGBV) Is critical to sustainable development" (2015), available at https://www.ungei.org/sites/default/files/Why-ending-school-related-gender-based-violence-is-critical-to-sustainable-development-2016-eng.pdf.

41 Sharon Colvin, James E. Egan and Robert W.S. Coulter, "School climate & sexual and gender minority adolescent mental health", *Journal of Youth and Adolescence,* vol. 48, No. 10 (2019), pp. 1,938-1,951, available at https://doi.org/10.1007/s10964-019-01108-w.

found that the surveyed students who identified as transgender experienced higher psychological strain than those who were cisgender.[42]

- Decades of research have established a strong connection between frequent fighting and bullying, substandard academic achievement, and poor mental health outcomes in schools.[43] In an analysis of a national sample of students in grades 9-12 in the United States of America, researchers found that fighting and being bullied were associated with concerns about school safety, higher levels of depression, and lower academic performance.[44] The relationship between being bullied and depression was also found among young Swedish students (aged 13-16 years),[45] and this connection has been identified in multiple studies across the globe.
- In a study on the mental health of international students in Australia, survey respondents reported that they had struggled to adjust to a new environment, learn a new language, and adapt to a new culture.[46]
- During the pandemic, the disruption of education and policies such as working and studying from home meant that young girls often experienced increased burdens, including taking care of school-aged children in lockdown, giving them less time for personal growth, entertainment and self-care.[47]
- For younger single mothers still in school, the pressures of combining childcare, school and often work responsibilities can lead to poor mental health outcomes; a study in Sweden found that the younger the mother, the more likely she was to experience post-partum depression.[48]

Investing in youth mental health empowers young parents to build healthier futures for themselves and their children. ©David Blumenkrantz

Research findings such as those highlighted above show that schools might not accommodate the needs of all youth, and this can negatively affect their school attendance and performance as well as their mental and physical health and well-being.

42 Norman Anderssen and others, "Life satisfaction and mental health among transgender students in Norway", *BMC Public Health*, vol. 20, No. 138 (2020), pp. 1-11, available at https://doi.org/10.1186/s12889-020-8228-5.

43 Swearer and Hymel, "Understanding the psychology of bullying: moving toward a social-ecological diathesis-stress model".

44 Youn Kyoung Kim and others, "Risk factors of academic performance: experiences of school violence, school safety concerns, and depression by gender", *Child & Youth Care Forum*, vol. 49, No. 5 (2020), pp. 725-742, DOI:10.1007/s10566-020-09552-7.

45 Evelina Landstedt and Susanne Persson, "Bullying, cyberbullying, and mental health in young people", *Scandinavian Journal of Public Health*, vol. 42, No. 4 (2014), pp. 393-399, DOI:10.1177/1403494814525004.

46 Orygen, "International students and their mental and physical safety" (Parkville, Australia, 2020).

47 Carolina Rivera and others, "Gender inequality and the COVID-19 crisis: a human development perspective", UNDP technical report, July 2020.

48 Sara Agnafors and others, "Mental health in young mothers, single mothers and their children", *BMC Psychiatry,* vol. 19, No. 1, art. 112 (2019), available at https://doi.org/10.1186/s12888-019-2082-y.

A boy at our school recently killed himself, and the school's response was to have a one-hour mental health knowledge session and to finally set up a well-being council. However, once again, this is going to be something run by students, and we had been begging for this service for months prior to its set-up.

–Young person, Focus Group 1

There are great disparities in the quality of education and school environments. School climate is an important construct related to student success. When schools are positive places where youth feel accepted and engaged, young people are more likely to exhibit higher academic achievement. A positive school climate is a mediating factor between low socioeconomic status and academic achievement.[49] For many young people, schools provide a safe, positive space for socialization with friends and a stimulating learning environment. Schools that encourage supportive relationships, school engagement, academic rigor, high expectations, and diversity and inclusion support the development of social and emotional competence.[50] A positive school climate is based on supportive relationships between teachers and students. Schools need to be aware of the importance of maintaining a positive school climate and understand how much of an impact it has on academic achievement, academic success, graduation rates, and mental and physical health and well-being.

Building inclusive youth mental health policies means designing systems that care for all, not just some. ©UN Photo/Gregório Cunha

Addressing the whole student body, not just individuals, is critical. It will improve the general morale and make things so much easier for people before it gets to a point where they have to get outside professional help or go into the mental health system.

–Young person, Focus Group 1

49 Ruth Berkowitz and others, "A research synthesis of the associations between socioeconomic background, inequality, school climate, and academic achievement", *Review of Educational Research*, vol. 87, No. 2 (2017), pp. 425-469, DOI:10.3102/0034654316669821.

50 David Osher and Juliette Berg, "School climate and social emotional learning: the integration of two approaches" (Edna Bennet Pierce Prevention Research Center, Pennsylvania State University, 2017), available at https://www.rwjf.org/en/library/research/2018/01/school-climate-and-social-and-emotional-learning.html.

Family and societal influences on the educational experiences of youth

The experiences of young people in schools are influenced not only by the educational environment but also by their families and adult caregivers. When families are supportive of school attendance and engagement, youth are more likely to attend school. Family values that are supportive of education also help create a desire to learn and place emphasis on educational attainment. A study in the Republic of Korea found that youth from two-parent families were more likely than youth from single-parent or blended families to have high perceived academic achievement.[51] While family stability appears to be related to educational attainment, there are many compounding factors connecting family, school and mental health. In a birth cohort study conducted in Brazil, researchers found that more years of maternal schooling and higher family income mediated the relationship between gender and common mental health conditions.[52] In general, higher levels of education are correlated with higher family income levels. If educational attainment is a mechanism to help young people escape poverty, then families and society must value and support educational structures.

Anxiety, stress, and depression can really affect one's studies, as well as the pressure to always do well regardless of the situation of the country.

–Young person, Focus Group 7

Just as family support and recognition of the importance of schooling help reinforce the value of education for young people, family dysfunction can serve to disrupt this dynamic. Young people with maltreatment histories, for example, have lower educational outcomes than youth who do not have such histories.[53] A strong predictor of poor mental health is early family adversity and poverty, both of which are also associated with school exclusion.[54] Although it is known that families and adult caregivers are important sources of support for youth educational attainment, there are still some gaps in understanding these relationships, especially in developing countries. A systemic review of educational practices in developing countries found that increased community participation in conjunction with educational policies and social norms surrounding education were efficacious in improving the quality of student learning.[55] Schools cannot do this work alone. Improving linkages between schools, families and communities will enhance the quality of education, support student academic success, and promote mental and physical well-being.

Access to academic and social support

When children and youth feel empowered, safe, and welcome in school they are more likely to experience relatively high levels of physical and mental well-being. The voices of young people must be included in global health care initiatives,[56] and access to academic and social support in school will empower them to speak up and advocate for better schools, communities, and societies. Providing access to academic and social support will help facilitate emotional well-being. A study of college students in the United States of America found that emotional well-being was a significant predictor of college

51 Hanul Park and Kang-Sook Lee, "The association of family structure with health behavior, mental health, and perceived academic achievement among adolescents: a 2018 Korean nationally representative survey", *BMC Public Health*, vol. 20, art. 510 (2020), DOI:10.1186/s12889-020-08655-z.

52 Christian Loret de Mola and others, "How sex differences in schooling and income contribute to sex differences in depression, anxiety and common mental disorders: the mental health sex-gap in a birth cohort from Brazil", *Journal of Affective Disorders*, vol. 274 (2020), pp. 977-985, DOI:10.1016/j.jad.2020.05.033.

53 Elisa Romano and others, "Childhood maltreatment and educational outcomes", *Trauma, Violence, & Abuse*, vol. 16, No. 4 (2015), pp. 418-437, DOI:10.1177/1524838014537908.

54 Maria Tejerina-Arreal and others, "Child and adolescent mental health trajectories in relation to exclusion from school from the Avon Longitudinal Study of Parents and Children", *Child and Adolescent Mental Health*, vol. 25, No. 4 (2020), pp. 217-223, DOI:10.1111/camh.12367.

55 Serena Masino and Miguel Niño-Zarazúa, "What works to improve the quality of student learning in developing countries?", *International Journal of Educational Development*, vol. 48 (2016), pp. 53-65, DOI:10.1016/j.ijedudev.2015.11.012.

56 Grace Gatera and Gabriela Pavarini, "The voices of children in the global health debate", *The Lancet*, vol. 395, No. 10224 (2020), pp. 541-542, DOI: org/10.1016/S0140-6736(2)30364-0.

student success.[57] A study of first-year college students in Australia found that intrinsic motivation was positively associated with well-being and academic performance.[58] Empirical research supports the relationship between social support, academic success, and well-being. Schools that integrate social-emotional learning, social and academic support, and mental health services have a greater likelihood of providing quality education that will lay the foundation for future healthy functioning.

Ratios are very important. We have one or two counsellors in our university with almost over 5,000 students.

–Young person, Focus Group 7

Inclusive extracurricular activities foster belonging and resilience. ©Evans Itemo

Access to extracurricular activities

Related to social support in schools are opportunities to engage in extracurricular activities, including sports and other physical activities, involvement in clubs and projects, and community engagement. Not all learning takes place in classrooms, and schools are often the hub of additional activities in the community. For example, in many communities in the United States of America, high school sporting activities provide opportunities for the community to engage with schools. Musical concerts, plays, and craft fairs also connect communities to schools. When schools are engaged with communities, everyone benefits.

Engagement in extracurricular activities has been found to moderate the relationship between discrimination towards underrepresented college students and depressive symptoms, suggesting that extracurricular activities may serve as a protective factor.[59] In a 2019 study carried out in the United States of America, engagement in team sports was found to reduce the odds of being diagnosed with depression or anxiety for youth in grades 7 to 12.[60] This study used four waves of data from the National Longitudinal Study of Adolescent to Adult Health, following close to 10,000 participants over time. These benefits are not just found for youth in Western countries; involvement in sports has been found to be positively related to physical and mental well-being among Rohingya youth in Bangladesh and youth in the Republic of Korea, China,

57 Tyler L. Renshaw and others, "Bidimensional emotional health in college students: a comparison of categorical and continuous analytic approaches", *Journal of Psychopathology and Behavioral Assessment*, vol. 38 (2016), pp. 681-694, DOI:10.1007/s10862-016-9558-6.

58 Thomas Hamilton Bailey and Lisa J. Phillips, "The influence of motivation and adaptation on students' subjective well-being, meaning in life and academic performance", *Higher Education Research & Development*, vol. 35, No. 2 (2016), pp. 201-216, DOI:10.1080/07294360.2015.1087474.

59 Janelle Billingsley and Noelle M. Hurd, "Discrimination, mental health, and academic performance among underrepresented college students: the role of extracurricular activities at predominantly white institutions", *Social Psychology of Education*, vol. 22, No. 2 (2019), pp. 421-446, DOI:10.1007/s11218-019-09484-8.

60 Molly C. Easterlin and others, "Association of team sports participation with long-term mental health outcomes among individuals exposed to adverse childhood experiences", *JAMA Pediatrics*, vol. 173, No. 7 (2019), pp. 681-688, DOI:10.1001/jamapediatrics.2019.1212.

Box 1. Interview with a 24-year-old woman from Canada with a disability

A person is made up of so many different intersecting identities that influence mental well-being, like ethnicity, gender, and ability. I feel like the "ability" part takes up a lot of space and does not leave room for other identities as well.

I have a physical and visible disability. I noticed as a teenager when I was feeling anxious I would have bouts of sadness; nobody talked to me about my mental health, and I did not understand why. I could not find the words to describe how I was feeling until I got to university. During my first year of my undergraduate degree, I reflected back and realized I did have mental health challenges that were not identified. I considered why that was, and the conclusion that I came to was that folks with disabilities are often left out of the conversation in terms of mental health because, as somebody with a physical disability, that is our prime identity, and there is not really anything else that could go wrong.

I just saw anxiety and sadness as normal for teenagers. I had a lot of anxiety around getting good grades and doing well in school because I put pressure on myself to do well. My parents wanted to support me in any way they could, but they never really identified any mental health challenges. Whenever I would feel stressed about an exam they would say "study harder" or "just devote more time to learning the material and you will feel less stressed". That did not really resonate with me, and I found even after I would do the exams that the feeling of anxiety and specifically performance anxiety would really stick with me. I did not know to seek help; I did not know that there were supports out there. I had a lot of different appointments that were physical focused, making sure I was getting to the physio and doing active movement, but none of it was mental-health centred. There was not really any way to get the support I needed.

Navigating the medical system is quite stressful. When you turn 18 (in Canada), you transfer from paediatric care into an adult system. I had a specialized care team that I had known and grown up with for a lot of my life, and it was taken away. Suddenly it fell on me to advocate for myself when I turned 18, even though I had no experience or practice at doing so. Persons with disabilities can take a longer time to do things, and sometimes the medical system is not as forgiving. You may have to cancel an appointment because a ride did not show up. Navigating a new building, getting to a medical appointment having to retell my entire medical history, and doing that repeatedly with several different doctors was very stressful.

My friends do the best they can to support me, which has come out of many conversations I have had with them. I would remind them "if you see me struggling to get my jacket off, offer to help rather than coming in and doing it for me", "respect me as a person", "respect that I have my own ways of doing things", and "I know you mean well and want to help, but sometimes I just need a few more minutes and I am able to do it". Now they ask, "What do you need right now?" That is really empowering to me because that gives me autonomy to say "here is what I need" to decide it on my own terms, instead of them deciding for me.

As Chinese-Canadians, we have a stigma around mental health. My parents still are not really comfortable talking to me about my anxiety and periods of sadness. Depression was a thing 30 years ago, but they did not have the language to communicate it. It was a representation of the society at that time, the culture, and their upbringing, which all play a big part, but the conversation about mental health is starting to be a lot more prevalent in our generation.

There are lots of barriers for persons with disabilities to find employment, whether it is the stigma around disability, questions around whether we are able to do certain work tasks, or how employers think about us. If we disclose our disability, it does impact how potential employers think about us. We have to think about how we advocate for accommodations in the workplace to make sure that we are able to have our needs met. This is not saying that we are lazy or we are just not working hard enough. That is the rhetoric that is so common. All of these extra considerations do factor into our mental well-being and our sense of hope for a future.

One of the benefits of COVID-19 has been the move online. I have had to rely on social media to stay

connected with my friends because of my disability so the fact that this pandemic happened and we were all socially distancing and having to communicate over Zoom is something I have experience with. If I am going to be an active member in my community, which I really want to be, it involves showing up to places that are not accessible and can take me an hour and a half to get to. Never mind the preparations I have to do beforehand in the planning. I have to do a lot just to get to a one-hour meeting, but now I am able to attend a lot more things online without leaving my house, and it is really positive. The disability community are excited because finally the wider society seems to understand what we have been saying for so many years: working from home is a viable option for employees. It creates a lot more accessibility for people like me to participate in the workforce.

Persons with disabilities are underemployed or unemployed at a lot higher rate than those who do not have a disability. This includes folks with mental health challenges as well as those with visible or invisible disabilities. I am concerned about whether I am going to be able to find a job, and that absolutely takes a toll on my well-being. It factors into what am I going to be able to do for the future, how am I going to provide for myself, and how am I going to be sustaining myself when I know the odds are against me for gaining employment.

There is a lack of awareness of the intersection between disability and mental health. If I am seeking mental health support, I have to educate my therapist, or whoever I am seeking help with, because they do not understand that intersection. Mostly, I think I am not going to bother to seek help or I will deal with it on my own because I do not want to go through the burden – and arguably trauma – that it entails to retell the story again and again. The stigma that perpetuates the "helpless" narrative is so entrenched about the disability community and is something I struggle with. I want to be seen as an independent person like everyone else who gets that service.

and Japan.[61, 62] A meta-analysis of 29 articles on the effects of athletic activity on youth from the ages of 12 to 18 found that participation in sports reduced depressive and anxious symptoms in young people in the United States of America, Canada, Iceland, Slovenia, Nigeria, Spain, Australia, Japan, and European countries.[63] Extant evidence points to the importance of engagement in extracurricular activities for mental health.

Access to mental health support

Experiencing mental health conditions has been linked to poor attendance, increased truancy, and higher school dropout rates. Studies from eight countries in Northern America, Europe, and Asia found that depression was associated with absenteeism, truancy, and poor school attendance.[64] Sadly, many youth who are able to access mental health support in schools have difficulty getting to school, given their mental health status. A large United Kingdom population-based birth cohort study found that mental health and behavioural problems were associated with low school engagement, confirming findings that existing mental health problems are barriers to accessing quality education.[65] Young people experiencing mental health difficulties also face barriers in accessing mental health services. The lack of mental health funding,

61 Md. Salek Ahmed, Mahmuda Mahmuda and A.N.M. Mahmudul Alam, "Sports and physical activity in psychosocial interventions with adolescent groups of the Rohingya community in Bangladesh: potential, limitations and critical factors for success", *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, vol. 17, No. 2 (2019), pp. 284-289, DOI:10.4103/INTV.INTV_51_19.

62 Eun-Young Lee and others, "Preferred leisure type, value orientations, and psychological well-being among East Asian youth", *Leisure Sciences*, vol. 39, No. 4 (2017), pp. 1-21, available at https://doi.org/10.1080/01490400.2016.1209139.

63 Michael J. Panza and others, "Adolescent sport participation and symptoms of anxiety and depression: a systematic review and meta-analysis", *Journal of Sport and Exercise Psychology*, vol. 42, No. 3 (2020), pp. 201-218, DOI:10.1123/jsep.2019-0235.

64 Katie Finning and others, "The association between child and adolescent depression and poor attendance at school: a systematic review and meta-analysis", *Journal of Affective Disorders*, vol. 245 (2019), pp. 928-938, DOI:10.1016/j.jad.2018.11.055.

65 A. Paget and others, "Which children and young people are excluded from school? Findings from a large British birth cohort study, the Avon Longitudinal Study of Parents and Children (ALSPAC)", *Child: Care, Health and Development*, vol. 44, No. 2 (2017), pp. 285-296, DOI:10.1111/cch.12525.

Recognizing the diversity of youth experiences is essential to designing effective mental health policies. ©UN Photo/Amanda Voisard

shortage of trained mental health providers, and poor coordination between schools and community agencies are major barriers to young people accessing mental health treatment.[66] An additional barrier for many countries is the failure to prioritize youth mental health as a major public health concern. Without national support for mental health training, funding, and service delivery, young people will struggle to access the services they need. Even when evidence-based treatments are available, the average waiting time for outpatient appointments is close to three months,[67] which is another barrier to seeking mental health treatment. Worldwide, one of the main barriers to accessing mental health treatment is stigma.

I've had a positive experience for myself. For exams, I had to get extra time for my anxiety, and the school supported me in that. I also talk to a teacher trained in mental health every week, and she's really helped me with my anxiety and depression.

–Young person, Focus Group 1

One way to reduce the stigma around mental health is to start conversations early, when children are younger, in order to normalize the discussion of mental health problems. In an evaluation of a large-scale school-based mental health programme in Chile that has operated nationally for 15 years, researchers followed close to 40,000 youth and found that students who experienced improvement in their mental health made greater academic progress than did students whose mental health did not improve or worsened.[68] School-based mental health services appear to be an important mechanism for reducing the stigma surround mental illness, improving mental health, and promoting physical and mental well-being.

66 Praveetha Patalay and others, "Mental health provision in schools: priority, facilitators and barriers in 10 European countries", *Child and Adolescent Mental Health*, vol. 21, No. 3 (2016), pp. 139-147, DOI:10.1111/camh.12160.

67 Helle Wessel Andersson, "Factors associated with waiting time for access to mental health services for children and adolescents in Norway", *Child Care in Practice*, vol. 10, No. 1 (2010), pp. 47–56, DOI:10.1080/1357527042000188089.

68 J. Michael Murphy and others, "Mental health predicts better academic outcomes: a longitudinal study of elementary school students in Chile", *Child Psychiatry & Human Development*, vol. 46 (2014), pp. 245-256, DOI:10.1007/s10578-014-0464-4.

Box 2. Interview with a 19-year-old woman from the United Kingdom with a low socioeconomic background and experience of religious discrimination

I am from a working-class Asian background. I live with my family in a deprived area of London, and we do not talk about things like mental health. I was diagnosed with depression, anxiety and an eating disorder, but my family do not talk about my mental health with the extended family, even though we talk about everything else. The reason they said I was losing weight was not an eating disorder but the start of my period, or my anxiety was related to exams so we just would not talk about it. Even my older sister, who is close in age to me, does not know how to talk to me about mental health.

In my culture, if you wanted to talk about mental health, you would say you are having a bad day, but we would not talk about depression or anxiety. When I got to secondary school, there were a few lessons where they touched on mental health and who to talk to if you were struggling. It felt like teachers were scared to talk about it because they did not want to get involved or did not want to make something into an issue that they would have to deal with. In one class, a student opened up to his peers about how he was struggling. The supervisor got annoyed because he had to do paperwork to report what he said. That made me question whether I should share how I was feeling because I did not want the teacher to be annoyed at me for making them do paperwork, too.

For a long time, I did not tell anyone how I was feeling or what I was doing. I did not want them to tell my parents and get them involved because then they would worry. One day, I decided to talk to a teacher, and they sent me to counselling. I told my mom that the teacher forced me to go so she would not know I had asked for help. Then when I started counselling, at around 15, my mom was in every single one of our sessions, and finally I said I wanted to go alone so I could talk to the counsellor properly. It was only when my mom saw young children going into the counselling session without their parents that she stayed out of my sessions.

I went to an all-girls school, and when people found out about my anxiety, people were mean. Some of the students tried to get me to talk about what was going on, not to support me, but to gossip about me. It was really hard. It felt like the whole school hated me. The school had a Learning Support Unit, where you could get support. They were helpful to plan how to do school and manage your time but encouraged us to get help from the outside. We were pretty lucky to have that kind of support because not every school has that kind of unit.

I did not get a phone until I was 16, which had major impacts on my mental health. Other girls would go home and speak to peers online, so they made friends and created support networks. I always struggled with making friends and had never been a part of a friendship group, and I think part of the reason for that was because I did not get to speak to anyone when I got home. It also meant that I did not have Instagram, Snapchat, or Facebook when everyone else was spending all their time doing that. In some ways I think that was a good thing. I think my parents made the right decision not to give me a phone at 12 like so many other people do. Although it was great to not have a phone and struggle with the "online/offline" world when I was young, I still struggled because at most points in secondary school, I did not have friends.

Work is not a supportive environment for me. I wear a hijab and wear baggy clothes for the sake of modesty. My work ordered a uniform for me that was extra small and too tight. When I explained I did not want to wear it, they made me feel uncomfortable about my culture. They have also asked really inappropriate questions about my religious beliefs so I have felt self-conscious and sad. I was simply abiding by my religion's rules yet I was made to feel like I had done something wrong. My manager has mental health challenges so I thought she would be understanding. However, she does not seem to care about anyone else's issues, which has caused me to feel like I am back in secondary school. Once again, I feel like I cannot speak or trust anyone as the information I share will be treated like work gossip.

Ensuring access to mental health support in difficult settings is vital to protecting youth well-being. ©UN Photo/Fabienne Vinet

I think that adults would talk about youth mental health in a negative way, often thinking that youth are being overdramatic or making a larger problem out of things they may not see as a problem. I feel as though they underestimate the differences between the generations, and mental health gets caught in the crosshairs.

–Young person, Focus Group 1

In a study of 1,466 schools across 10 European countries, researchers found that interventions such as physical activity and behavioural support were commonly implemented. What was striking was that in 40.3 per cent of the schools assessed there was not a designated space for mental health support, 35.5 per cent did not have group therapy, and 26.9 per cent did not provide mental health education.[69] While school-wide interventions can help improve the school climate, there is an urgent need to recognize that youth with mental health conditions require more intensive interventions, including psychoeducation about mental health and evidence-based therapies.

The increased availability of telehealth services may help improve access to mental health treatment. In the United States of America, insurance companies are more likely now than in past years to cover such services. While telehealth options have the potential to provide mental health support to a greater number of people, there are barriers such as Internet access and insurance reimbursement that need to be addressed through cooperative efforts by consumer advocacy groups, mental health providers, telecommunications companies, and governmental agencies.[70]

The connection between mental illness and substance use and abuse

Research has largely concluded that there is a bidirectional relationship between mental health and substance use and abuse. Substance abuse during youth often co-occurs with mental health disorders, creating a cycle of dependency and mental health challenges that persist over time.[71] For some, substance use precedes mental illness, and for others, substance use is a coping mechanism for dealing with mental illness. Studies in the United States of America have found that drug use is complex, with cigarette smoking, marijuana use, alcohol use, or illicit drug use predicting polysubstance use.[72]

69 Patalay and others, "Mental health provision in schools: priority, facilitators and barriers in 10 European countries".

70 Kaye L. McGinty and others, "Telepsychiatry and e-mental health services: potential for improving access to mental health care", *Psychiatric Quarterly*, vol. 77, No. 4 (2006), pp. 335-342, DOI:10.1007/s11126-006-9019-6.

71 Kathleen R. Merikangas and Vetisha McClair, "Epidemiology of substance use disorders", *Human Genetics*, vol. 131, No. 6 (2012), pp. 779-789, DOI:10.1007/s00439-012-1168-0.

72 Robert L. DuPont and others, "Drug use among youth: national survey data support a common liability of all drug use", *Preventive Medicine*, vol. 113 (2018), pp. 68-73, DOI:10.1016/j.ypmed.2018.05.015

Mental health strategies must include early interventions to prevent substance use and support youth at risk. ©Sebastian Wangui

Research evidence points to a clear association between youth, substance use and mental health. This relationship is not limited to Western countries. In a study of youth in Morocco, alcohol use was connected to older youth, being male, and pre-existing depressive disorders.[73] Drug use among Chinese students is twice as high as that among the general population of Chinese adults, and methamphetamine use is increasing among youth in the Republic of Korea, Japan, and China.[74, 75] Adverse childhood experiences have been linked to increased substance use and abuse among Mexican youth.[76]

While the bidirectional relationship between substance use and mental health has been established in studies across multiple countries, these connections are complex, and the impact of this nexus can be far-reaching. Poor family supervision, peer group drug use, and depressed affect were risk factors for high school students in Myanmar, suggesting the additional influence of family and peer factors on substance use and mental health.[77] Substance use and abuse have been linked to chronic absenteeism from school, which is connected to low educational attainment – and by extension, limited employment prospects.[78]

Illicit drug acquisition and use among youth is inextricably linked to delinquency, mental health issues, and involvement in the criminal justice system. Drug use often coexists with other risky behaviours, such as theft, violence, or gang activity, with young people engaging in delinquent acts to sustain their drug habits. The relationship between substance use and delinquency exposes youth to the criminal justice system, where punitive approaches can exacerbate rather than address mental health challenges. Many youth in the justice system suffer from untreated mental health conditions, including anxiety, depression, and trauma, which are often worsened by substance abuse.

The focus of the criminal justice system on punishment rather than rehabilitation can negatively affect youth mental health. Incarceration and detention settings often lack adequate mental health services, leading to the further deterioration of psychological well-being.[79] Additionally, the stigma of a criminal record, combined with pre-existing mental health and substance use issues,

73 Lamyaa Ben El Jilali and others, "Prevalence of alcohol consumption and alcohol use disorders among middle and high school students in the province of Khemisset, Morocco: a cross-sectional study", *International Journal of Adolescence and Youth*, vol. 25, No. 1 (2020), pp. 638-648, DOI:10.1080/02673843.2019.1700807.

74 Zhongwei Jia and others, "Prevalence of drug use among students in mainland China: a systematic review and meta-analysis for 2003–2013", *Drug and Alcohol Dependence*, vol. 186 (2018), pp. 201-206, DOI:10.1016/j.drugalcdep.2017.12.047.

75 Nam ji Kwon and Eunyoung Han, "A commentary on the effects of methamphetamine and the status of methamphetamine abuse among youths in South Korea, Japan, and China", *Forensic Science International*, vol. 286 (2018), pp. 81-85, DOI:10.1016/j.forsciint.2018.02.022.

76 Corina Benjet and others, "Chronic childhood adversity and stages of substance use involvement in adolescents", *Drug and Alcohol Dependence*, vol. 131, No. 1-2 (2013), pp. 85-91, DOI:10.1016/j.drugalcdep.2012.12.002.

77 Nanda Myo Aung Wan, Wendy Kliewer and David W. Sosnowski, "Sex differences in risk for substance use among high school students in Myanmar", *International Perspectives in Psychology*, vol. 8, No. 1 (2018), pp. 38-52., DOI:10.1037/ipp0000093.

78 Maxim Gakh and others, "The relationship between school absenteeism and substance use: an integrative literature review", *Substance Use & Misuse*, vol. 55, No. 3 (2020), pp. 491-502, DOI:10.1080/10826084.2019.1686021.

79 Linda A. Teplin and others, "The Northwestern Juvenile Project: overview", *OJJDP Juvenile Justice Bulletin* (United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention, February 2013), available at https://www.prisonlegalnews.org/media/publications/northwestern_juvenile_project_juvenile_detainee_mental_health_2013.pdf.

can limit access to future opportunities for education, employment, and social reintegration, perpetuating cycles of marginalization and offending.[80]

There is growing recognition of the need for holistic rehabilitative interventions that address both the mental health and substance use needs of delinquent youth. Such interventions, which provide therapeutic support and emphasize rehabilitation over punishment, can help break the cycle of drug use, delinquency, and poor mental health outcomes, offering young people a path towards recovery and reintegration into society.[81]

Early substance use increases the risk of developing dependency, which can result in long-lasting changes in brain function and emotional regulation, leading to conditions such as anxiety and depression and associated cognitive impairments.[82] Addressing substance use early is therefore crucial for mitigating its enduring impact on mental health.

Substance use, dependency, and abuse among young people have profound implications for mental health, with effects that often extend beyond adolescence into adulthood. The disruption of social, educational, and emotional development during this critical period further exacerbates these effects, with long-term consequences that can include impaired interpersonal relationships and reduced life satisfaction in adulthood.[83]

Education disruption and mental health

The COVID-19 pandemic put education, employment, family, and other societal systems to the test, disrupting access to quality education, health and social services, and decent work worldwide. Millions of people were forced to quarantine, isolate, and miss school and work, which had an impact on mental health. One study found that the prevalence of post-traumatic stress disorder (PTSD) was four times higher among children who had been quarantined than among those who had not.[84] An analysis of past health emergencies or epidemics (such as SARS-CoV-1, Ebola, MERS,[85] and the anthrax threat), natural disasters, and the COVID-19 pandemic found that alcohol use, PTSD, anxiety, and anger were among the psychological effects typically associated with crises.[86] A cross-sectional study conducted in China two weeks after the onset of the COVID-19 pandemic found that 40.4 per cent of youth were exhibiting psychological problems.[87] Complicating the relationship between crises and mental health conditions is that during pandemics, quarantines, and associated periods of uncertainty, access to mental health care is also severely curtailed. This means that young people have limited resources for help and often suffer in silence. Research from Israel indicates that building resilience after crises must be integrated across schools, medical centres, and communities.[88] The social ecology in which young people reside must establish and maintain a framework for providing safety and social support. When young people feel safe and have the supportive social structures needed to strengthen resilience and promote problem-solving, they can cope more effectively with disasters and their aftermath.

The long-term impact of the COVID-19 pandemic on youth mental health is not yet known, though preliminary evidence suggests that it will be significant. In the United States of America, COVID-19 exacerbated minority health disparities, with people of colour dying at higher rates

80 David B. Wilson, Ajima Olaghere and Catherine S. Kimbrell, "Effectiveness of restorative justice principles in juvenile justice: a meta-analysis" (Washington, D.C., United States Department of Justice, George Mason University, 2017).

81 Jamie J. Fader, *Falling Back: Incarceration and Transitions to Adulthood among Urban Youth*, Critical Issues in Crime and Society Series (Rutgers, New Jersey, Rutgers University Press, 2013).

82 Ralph Hingson and others, "Alcohol-induced blackouts as predictors of other drinking related harms among emerging young adults", *Alcoholism: Clinical and Experimental Research*, vol. 40, No. 4 (2016), pp. 776-784, DOI:10.1111/acer.13010.

83 Megan S. Schuler, Sara A. Vasilenko and Stephanie T. Lanza, "Age-varying associations between substance use behaviors and depressive symptoms during adolescence and young adulthood", *Drug and Alcohol Dependence*, vol. 157 (2015), pp. 75-82, DOI:10.1016/j.drugalcdep.2015.10.005.

84 Samantha K. Brooks and others, "The psychological impact of quarantine and how to reduce it: rapid review of the evidence", *The Lancet*, vol. 395, No. 10227 (2020), pp. 912-920, DOI:10.1016/S0140-6736(20)30460-8.

85 Severe acute respiratory syndrome coronavirus, Ebola virus disease, and Middle East respiratory syndrome.

86 Emily Esterwood and Sy Atezaz Saeed, "Past epidemics, natural disasters, COVID19, and mental health: learning from history as we deal with the present and prepare for the future", *Psychiatric Quarterly*, vol. 91, No. 4 (2020), pp. 1,121-1,133, DOI:10.1007/s11126-020-09808-4.

87 Leilei Liang and others, "The effect of COVID-19 on youth mental health", *Psychiatric Quarterly*, vol. 91, No. 3 (2020), pp. 841-852, DOI:10.1007/s11126-020-09744-3.

88 Daniel Hamiel and others, "Comprehensive child-oriented preventive resilience program in Israel based on lessons learned from communities exposed to war, terrorism and disaster", *Child & Youth Care Forum*, vol. 42 (2013), pp. 261-274, DOI:10.1007/s10566-013-9200-7.

than other populations.[89] It was postulated that increases in suicide rates among young people were connected to the pandemic and the ensuing economic crisis. Worldwide, countries were concerned about the higher risks of physical and sexual violence during the pandemic since young people were at home with potential abusers. With the curtailment of in-person health visits during the pandemic, many mental health services moved online and were delivered through videoconferencing, which might have allowed more people to seek treatment.[90] A recent study of university students aged 18-25 years in the United States of America found that those who participated in campus wellness programmes were less affected by the pandemic than were students not engaged in such programmes.[91]

Effective school programming for mental wellness

As mentioned previously, most youth are in schools or other educational environments for up to eight hours per day. Thus, adults who work with young people in school settings are a logical source of support for the promotion of mental wellness. Ideally, educational environments should employ mental health professionals such as psychologists, counsellors, social workers, and psychiatrists. However, funding remains a significant issue for schools, and while it is clear that educational attainment is the goal of learning institutions and that mental illness negatively impacts educational attainment, resources may not be sufficient or optimally allocated to address this dynamic. On the positive side, there is evidence from research conducted around the globe that supports the efficacy of school-based mental health interventions. A comprehensive review assessing the scope, scale, and dose[92] of school-based mental health programmes that collectively reached more than 27 million children worldwide over the span of a decade found that these programmes had a significant positive effect on emotional, behavioural, and academic outcomes. Importantly, the researchers were able to determine that the effects of these programmes were positive for countries at varied income levels, including low- and middle-income countries.[93]

It is evident that mental health programmes delivering services across multiple years of a young person's life are associated with longer-term and more positive impacts on mental health and wellness. Mental wellness interventions have been found to have a positive impact on Aboriginal men in Australia and to improve the school climate in Zambia, subjective indicators of well-being among Turkish university students, and well-being among Chinese university students.[94, 95, 96, 97] As more countries implement school-based mental health programming, researchers will be able to apply larger-scale and more sophisticated methodologies to unpack factors related to the influence of quality education on the mental wellness of young people worldwide.

89 Jonathan Purtle, "COVID-19 and mental health equity in the United States", *Social Psychiatry & Psychiatric Epidemiology*, vol. 55, No. 8 (2020), pp. 969-971, DOI:10.1007/s00127-020-01896-8.

90 Pieter J. Hoekstra, "Suicidality in children and adolescents: lessons to be learned from the COVID-19 crisis", *European Child & Adolescent Psychiatry*, vol. 29 (2020), pp. 737-738, DOI:10.1007/s00787-020-01570-z.

91 William E. Copeland and others, "Impact of COVID-19 pandemic on college student mental health and wellness", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 60, No. 1 (2021), pp. 134-141, DOI:10.1016/j.jjac.2020.08.466.

92 "Dose" refers to how much an intervention has been delivered or received (in terms of amount, length or frequency, for example).

93 Michael Murphy and others, "Scope, scale, and dose of the world's largest school-based mental health programs", *Harvard Review of Psychiatry*, vol. 25, No. 5 (2017), pp. 218-228, DOI:10.1097/hrp.0000000000000149.

94 Mary Whiteside and others, "Connecting and strengthening young aboriginal men: a family wellbeing pilot study", *Australian Social Work*, vol. 69, No. 2 (2016), pp. 241-252, DOI:10.1080/0312407X.2015.1137101.

95 Joseph M. Zulu and others, "Integrating psychosocial support for children in the education sector in Zambia: lessons from the programme implementation process", *Community Mental Health Journal*, vol. 56, No. 7 (2020), pp. 1,215-1,224, DOI:10.1007/s10597-020-00682-9.

96 Mine Muyan-Yılık and Ayhan Demir, "A pathway towards subjective well-being for Turkish university students: the roles of dispositional hope, cognitive flexibility, and coping strategies", *Journal of Happiness Studies*, vol. 21 (2020), pp. 1,945-1,963, DOI:10.1007/s10902-019-00162-2.

97 Larry Auyeung and Phoenix Kit Han Mo, "The efficacy and mechanism of online positive psychological intervention (PPI) on improving well-being among Chinese university students: a pilot study of the best possible self (BPS) intervention", *Journal of Happiness Studies*, vol. 20 (2019), pp. 2,525-2,550, DOI:10.1007/s10902-018-0054-4.

The rigidness and one-size-fits-all approach in the curriculum really stressed me out at first. But then my university catered to me and gave me personalized support.

–Young person, Focus Group 7

d. Policy recommendations

- *School environments and mental health.* Ongoing assessments of school climate should be conducted, with assessment results used to improve the school environment for all.
- *The influence of family and society on education.* Schools, families and communities need to create welcoming and supportive spaces for all students regardless of gender identity, sexual orientation, socioeconomic status, immigration status, or ethnicity.
- *Access to academic and social support.* Schools should prioritize social-emotional learning and support, expanding mental health awareness and providing training that focuses on self-care and help-seeking skills. Teachers should receive the training and tools they need to identify indicators of poor mental health and guide students towards available mental health support and services. Schools should conduct a thorough evaluation of their mental health interventions to ensure that they are culturally appropriate, diverse, and inclusive. Support should be provided for youth-led initiatives to raise awareness and normalize help-seeking behaviour surrounding mental health.
- *Access to mental health support.* Governments should adequately fund educational, social, emotional, and mental health programming within schools. Schools and communities should take full advantage of telehealth services to expand access to mental health support. It is essential that young people be engaged as co-creators of school mental health programming so that they have a say in identifying and addressing genuine mental health concerns.
- *Access to extracurricular activities.* Schools should systematically examine their extracurricular activities to ensure that they support positive physical and mental health outcomes. All students should be encouraged to engage in these activities, which can benefit young people and their schools as well as the wider community.
- *The impact of substance use and abuse on mental health.* Schools need to recognize the connection between adverse childhood experiences, substance use and abuse, and mental health and develop appropriate measures to address this dynamic. School wellness initiatives should include substance use and abuse prevention and intervention programming that brings in adult caregivers and facilitates the involvement of peer groups.
- *Education disruption and mental health.* Public health crises and other large-scale disruptions affect all aspects of the social ecology, including families, schools, work, communities, and societies. Communication and coordination among these systems is critical for ensuring effective responses.

School programmes can foster supportive environments that promote student mental health. ©UN Photo/Mark Garten

- *Effective school programming for mental wellness.* Providing mental health support for youth and their families can help disrupt intergenerational cycles of child maltreatment, abuse, and neglect. Schools and educational environments that integrate academic and social support are likely to experience higher levels of educational attainment and more positive indicators of well-being.

2. Employment

a. Perception survey results

Only 46 per cent of the survey participants had engaged in paid work in the two years preceding the survey. The following results are based on answers from this group of respondents only:

- Seventy-two per cent reported that they had experienced stress, strain, or pressure at work at least "sometimes" during the preceding four weeks of employment. The responses were roughly similar for males and females (70 and 73 per cent, respectively).
- A quarter of those surveyed responded that they had "always" had enough work in the preceding 12 months, 24 per cent felt that job security was "always" good, and 19 per cent shared that their wage was "always" fair (see figure 20). Wage fairness was rated lower by females (18 per cent) than by males (21 per cent).
- Slightly more than a third of the respondents related they had been exposed to hostility in the workplace at least "sometimes" during the 12 months preceding the survey; the combined proportion of sometimes/often/always responses was much higher for those identifying their gender as "other" (78 per cent) than for females (37 per cent) or males (31 per cent).

b. Focus group results

Workplace security and inclusiveness and fair renumeration were viewed by focus group participants as important determinants of mental health. Having a job that did not undermine individual values and that also provided adequate pay and benefits was a high priority for participants.

Most participants reported that secondary and tertiary education did not prepare students for the transition to the workforce. Mention was made of some universities providing assistance with interview preparation. However, none of the participants could recall information or support being given on how to handle the mental health implications of transitioning into the workforce or dealing with periods of unemployment.

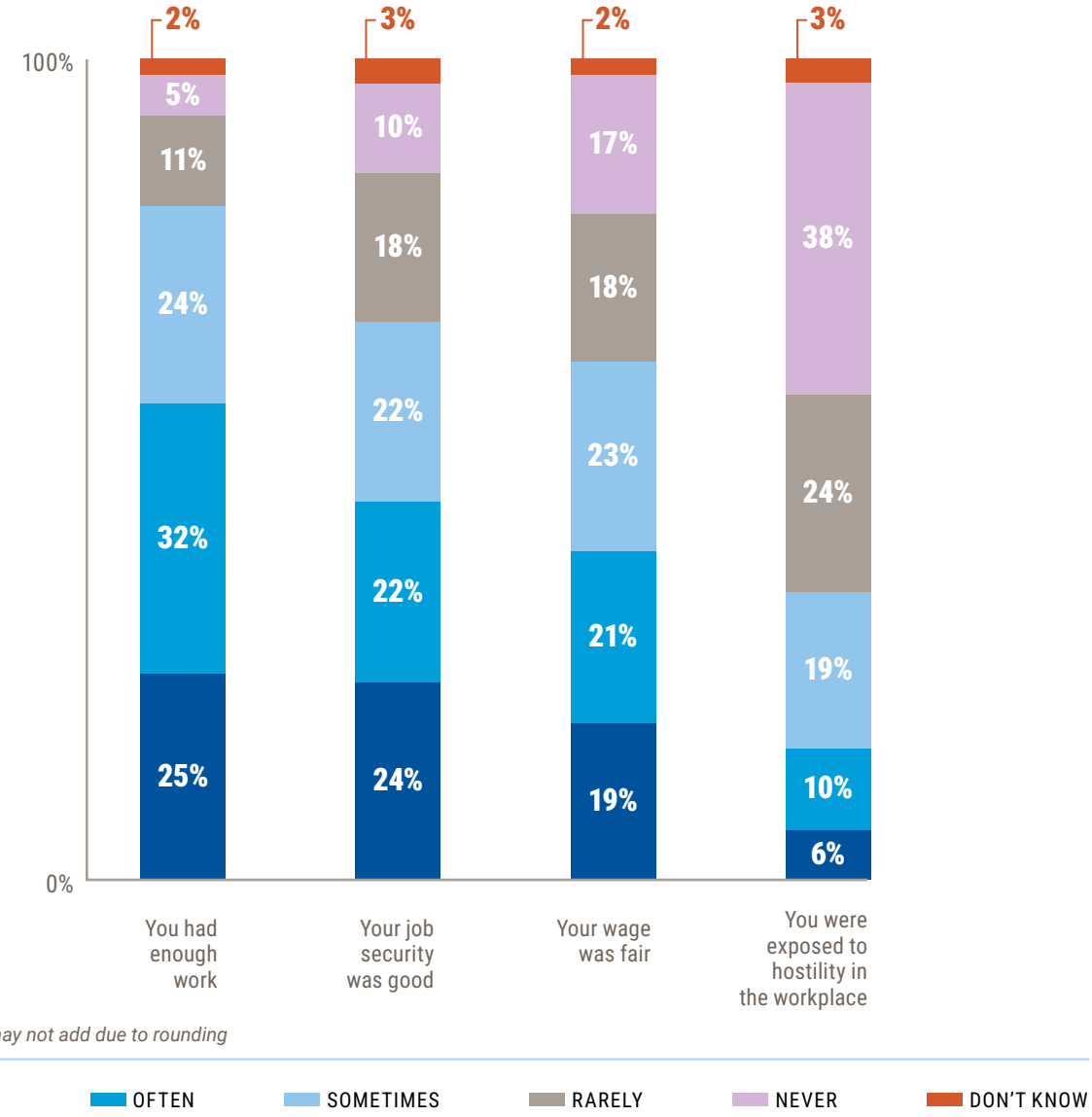
The classic conundrum of needing experience to get a job and needing a job to get experience was a key concern for many participants. Youth unemployment and underemployment was seen to be a serious problem in many countries. Participants noted that finding local jobs could be challenging and that youth sometimes needed to leave their communities and regions to secure work. It was reported that the limited jobs targeted at young people often did not value young people's skills and abilities.

Unemployment was reported to have a very negative impact on youth mental health. The inability to gain independence from families without paid employment was a key concern for many participants. Long periods of stress, constant rejections, and anxiety during periods of unemployment were reported. The participants related that the fear of falling behind their peers and the social expectation of independence impacted their sense of

Decent work is essential to safeguarding the mental health of young people. ©UN Photo/Mark Garten

FIGURE 20 FEELINGS AND EXPERIENCES RELATING TO CURRENT EMPLOYMENT

In the last 12 months, how frequently did you feel:



Note: Totals may not add due to rounding

self-worth and identity. For some participants, cultural expectations were such that they felt they could not seek help during periods of poor mental health while unemployed and that they should stay silent.

Unpaid internships and volunteering were viewed both positively and negatively by participants. Opportunities to gain experience and build skills were seen as positive for mental health; however, the option of unpaid work was seen to be possible only for students with high socioeconomic standing and was therefore considered exclusionary for many young people. Volunteering and community activism were reported to provide a sense of belonging and doing something of value, which contributed to improving mental health.

c. Social determinants

Work plays a critical role in mental and physical well-being.[98, 99] For many adults and older youth, work is one of the primary determinants of socioeconomic position, and decent work (work that is safe and secure, provides a fair income, and offers prospects for personal development) plays a key role in social connectedness and the development of identity, self-esteem, and self-sufficiency. Access to decent work enables young people to provide for their families in ways that can contribute to the upward mobility of families and communities. Employment that is decent, steady and stable is particularly salient for young people, as it provides the foundations for future health, functioning in society, and economic success.

Decent work is a job with fair hours, is secure, and respects the person.

–Young person, Focus Group 6

Although the global youth population has grown considerably, increased participation in secondary and tertiary education has led to declines in labour force participation rates for young people in many countries.[100] While higher levels of education have produced a more highly skilled workforce in certain areas, there are also more young people vying for jobs; recent statistics indicate that around 267 million youth aged 15-24 years are not in employment, education or training (NEET). Many of those unemployed or underemployed are young women, who are more likely than young men to have difficulty finding decent work and in some cases contribute to the economy through unpaid work. Young people in many countries face challenges in transitioning from education to the workforce or to new jobs. This is particularly the case in urbanized emerging markets in Asia, Northern and Southern Africa, Eastern and Southern Europe, and Latin America.[101]

New technologies are disrupting labour markets across the world by both eliminating and creating jobs, and many education systems are struggling to keep up with the pace of change in order to prepare young people for the workforce. While short-term unemployment may be expected for young people entering the job market, long periods of unemployment limit career development, result in the erosion of skills learned in the education system, and may be seen negatively by potential employers. Some young people may never catch up to their peers in terms of expected salaries for their skills and experience – a phenomenon known as "wage scarring".

Education does not prepare you for the transition to work. They don't prepare you for the struggle of not getting a job, but if you are lucky enough, some universities prepare you for the interview process and that's about it.

–Young person, Focus Group 6

Even young people who are employed face significant challenges, particularly in low- and middle-income countries. Around 30 per cent of employed youth continue to live in moderate or extreme poverty, and over 75 per cent of young workers are engaged in informal employment, where poor job security, low wages, and limited chances for on-the-job training limit their ability to access better, more formal work opportunities. Jobs held by young people are also more likely to be associated with poor physical or psychosocial working conditions, presenting risks to mental health. For young people with existing mental health conditions, unsupportive, unsuitable or hazardous workplaces may exacerbate problems,

98 Richard Wilkinson and Michael Marmot, eds., *Social Determinants of Health: The Solid Facts*, 2nd ed. (Geneva, WHO, 2003), available at https://iris.who.int/server/api/core/bitstreams/5d15a937-5558-4f72-8fbd-90381d6f8528/content.

99 Anthony D. LaMontagne and others, "Job stress as a preventable upstream determinant of common mental disorders: a review for practitioners and policymakers", *Australian e-Journal for the Advancement of Mental Health*, vol. 9, No. 1 (2014), pp. 17-35, DOI:10.5172/jamh.9.1.17.

100 International Labour Organization (ILO), *Global Employment Trends for Youth 2020: Technology and the Future of Jobs* (Geneva, International Labour Office, 2020), available at https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40dgreports/%40dcomm/%40publ/documents/publication/wcms_737648.pdf.

101 ILO, "Breaking gender barriers for young women and men", newsroom, 11 August 2008, available at https://www.ilo.org/resource/news/breaking-gender-barriers-young-women-and-men.

Unemployment takes a toll on youth mental health.
©UN Photo/Nektarios Markogiannis

perpetuating cycles of unemployment, engagement in precarious work, or difficulties within the workplace that hinder learning and career progression and negatively affect well-being.

Conditions surrounding the COVID-19 pandemic likely accelerated these trends, causing major disruptions to education, training, and work-based learning. Job seekers and new labour market entrants faced increased difficulties, the quality of employment deteriorated, and job and income losses were significant.[102]

With these factors at play, mental health risks for young people are likely to arise from difficulties surrounding the transition from education to employment, the lack of appropriate technical and social-emotional skills, job insecurity and employment instability, and hazardous or poor-quality work environments. This section focuses on how employment status, job quality and security, and parent migration affect youth mental health and well-being.

Unemployment

Global youth unemployment is estimated at 13.6 per cent, with young people almost three times more likely than adults to be unemployed.[103] However, there is considerable regional variation, with rates ranging from under 9 per cent in Northern America and sub-Saharan Africa to 30 per cent in Northern Africa. The significance of and response to unemployment can differ across economic and other contexts, which further shape the developmental trajectories of young people, including for mental health and well-being. For example, the provision of social welfare benefits or enrolment in further education may be typical responses in industrial economies, while a return to farming and food production, often with a young person's family of origin, may be a response in more agricultural economies.

Unemployment heavily impacts a person's mental health, especially if that person is struggling financially. Unemployment leaves the person hopeless about the future and what the future holds.

–Young person, Focus Group 6

Evidence suggests that unemployment increases the risk of poor physical and mental health and suicide, with stronger negative effects on mental health in economically less developed countries, countries characterized by unequal income distribution, and countries with relatively weak unemployment protection systems.[104, 105] Analysis

102 ILO, "An update on the youth labour market impact of the COVID-19 crisis", briefing note, 2 June 2021, available at https://www.ilo.org/resource/brief/update-youth-labour-market-impact-covid-19-crisis.

103 ILO, "Preventing exclusion from the labour market: tackling the COVID-19 youth employment crisis", ILO policy brief, 27 May 2020, available at https://www.ilo.org/publications/preventing-exclusion-labour-market-tackling-covid-19-youth-employment.

104 Karsten I. Paul and Klaus Moser, "Unemployment impairs mental health: meta-analyses", *Journal of Vocational Behavior*, vol. 74, No. 3 (2009), pp. 264-282, available at https://doi.org/10.1016/j.jvb.2009.01.001.

105 Allison Milner, A. Page and Anthony D. LaMontagne, "Cause and effect in studies on unemployment, mental health and suicide: a meta-analytic and conceptual review", *Psychological Medicine*, vol. 44, No. 5 (2013), pp. 909-917, DOI:10.1017/S0033291713001621.

of the causal relationship between unemployment and mental health is complicated by the fact that the relationship is likely to be bidirectional, with poor mental health also increasing the risk of unemployment.

Youth unemployment in my country is quite high. The graduates are actually in a worse situation.

–Young person, Focus Group 6

While most of the research in this area has focused on the general adult population, a recent systematic review investigated the links between unemployment and mental health in young people 16-30 years of age in high-income countries.[106] Seventeen studies were included, with five from Sweden and others from Northern America, Europe, Australia and New Zealand. Various mental health outcomes were apparent, with the most common being depression and anxiety symptoms. Study results showed an association between unemployment among young people and poor mental health, though the relationship was not as strong in longitudinal studies that took mental health at baseline into account. Additional high-quality studies are needed to explore and confirm these findings.

Other studies have also found associations between unemployment and poor mental health. A meta-analysis of studies of Chinese youth found self-reported anxiety to be correlated with unemployment rates.[107] Overall, however, evidence supporting the association between unemployment and poor mental health in youth from low- and middle-income countries has been lacking. In reviews investigating rates of mental health problems and suicide in these countries – including a systematic review of studies from the Arab region where unemployment (in conjunction with poverty and extended periods of armed conflict) was postulated to be a contributing factor for youth depression – unemployment has often been proposed as a key explanatory factor, but the associations have not been explicitly tested.[108, 109, 110]

Unemployment impacts negatively on my mental health. Not having a job makes me question myself, whether I am a qualified individual. It decreases my confidence, limits my independence because of lack of finances, and at this stage, I feel like I am behind people my age.

–Young person, Focus Group 6

Moore and others conducted a review of randomized controlled trials of interventions designed to mitigate the effects of unemployment, debt, or austerity measures in the general population.[111] Job skills training seminars showed some promise in improving mental health, particularly for those with elevated depression symptoms; however, the effects on employment were mixed.

Job insecurity and hazardous employment

Globally, up to 75 per cent of working youth are engaged in informal employment, which is often associated with precarious working conditions, a lack of legal and social protections, and limited opportunities for training and career progression. Informal employment among youth is most prevalent in sub-Saharan Africa and Southern Asia, standing at close to 96 per cent. Even in high-income countries, where the share of wage employment tends to

106 Vicky H.M. Bartelink and others, "Unemployment among young people and mental health: a systematic review", *Scandinavian Journal of Public Health*, vol. 48, No. 5 (2019), pp. 544-558, DOI:10.1177/1403494819852847.

107 Ziqiang Xin, Li Zhang and Dong Liu, "Birth cohort changes of Chinese adolescents' anxiety: a cross-temporal meta-analysis, 1992-2005", *Personality and Individual Differences*, vol. 48, No. 2 (2010), pp. 208-212, DOI:10.1016/j.paid.2009.10.010.

108 Latefa A. Dardas, Donald E. Bailey, Jr., and Leigh Ann Simmons, "Adolescent depression in the Arab region: a systematic literature review", *Issues in Mental Health Nursing*, vol. 37, No. 8 (2016), pp. 569-585, DOI:10.1080/01612840.2016.1177760.

109 Riaz Uddin and others, "Suicidal ideation, suicide planning, and suicide attempts among adolescents in 59 low-income and middle-income countries: a population-based study", *The Lancet Child and Adolescent Health*, vol. 3, No. 4 (2019), pp. 223-233, DOI:10.1016/S2352-4642(18)30403-6.

110 Dardas, Bailey and Simmons, "Adolescent depression in the Arab region: a systematic literature review".

111 Theresa Moore and others, "Interventions to reduce the impact of unemployment and economic hardship on mental health in the general population: a systematic review", *Psychological Medicine*, vol. 47, No. 6 (2017), pp. 1,062-1,084, DOI:10.1017/S0033291716002944.

be relatively high, the prevalence of less secure forms of employment among young people has increased rapidly in recent years, largely as a result of the expansion of the gig economy.[112] While there are very few studies on the impact of job insecurity on mental health in young people, studies of the broader population point to increased risks of anxiety and depression;[113] some studies highlight the impact of the COVID-19 pandemic within this context.

A systematic review and meta-analysis of longitudinal studies on the links between precarious employment and mental health among Chinese youth showed that self-reported job insecurity was associated with an increased risk of depression and anxiety.[114] In an analysis of dose-response effects, there was some evidence for the effect of temporary employment on mental health and no effect for unpredictable work hours, though the evidence was limited. Most of the studies assessed were conducted in adult samples (those over the age of 18) in the general population, so the relevance of various findings to working youth specifically was not established.

I was unemployed for a whole year, and that made me feel quite frustrated. I was so stressed because I had to borrow money from my parents. I could hardly pay any bills for myself. I felt hopeless, and at one point I gave up on applying for jobs.

–Young person, Focus Group 6

Two of the studies included in the review and meta-analysis were restricted to young adult populations at baseline. One of the studies compared self-reported mental health for Swedish youth aged 18 to 34 years in precarious employment to that for the same cohort in non-precarious employment over 10 years.[115] Analyses showed that precarious employment predicted poor mental health (after excluding individuals with mental health problems at baseline and adjusting for age, gender, social support, social capital and economic difficulties in childhood). Another study examined the impact of temporary versus permanent employment on depressive symptoms up to six years later in a nationally representative sample of young people aged 27-35 years in the United States of America.[116] The study found that the prevalence of depressive symptoms was more than 50 per cent higher for those exposed to temporary work at any in time in the previous two years than for members of the general population.

Decent work supports young people's dignity, purpose, and mental well-being.
©UN Photo/Rick Bajornas

112 ILO, *Global Employment Trends for Youth 2020: Technology and the Future of Jobs.*

113 Jose Antonio Llosa and others, "Job insecurity and mental health: a meta-analytical review of the consequences of precarious work in clinical disorders", *Anales de Psicologia*, vol. 32, No. 2 (2018), pp. 211-223, DOI:10.6018/analesps.34.2.281651.

114 Yuerong Liu and Darcey H. Merritt, "Examining the association between parenting and childhood depression among Chinese children and adolescents: a systematic literature review", *Children and Youth Services Review*, vol. 88 (2018), pp. 316-332, DOI: 10.1016/j.childyouth.2018.03.019.

115 Catrina Canivet and others, "Precarious employment is a risk factor for poor mental health in young individuals in Sweden: a cohort study with multiple follow-ups", *BMC Public Health*, vol. 16, art. 687 (2016), DOI:10.1186/s12889-016-3358-5.

116 Geneviève Gariépy, Helena Honkaniemi and Amélie Quesnel-Vallée, "Social support and protection from depression: systematic review of current findings in Western countries", *The British Journal of Psychiatry*, vol. 209, No. 4 (2016), pp. 284-293, DOI:10.1192/bjp.bp.115.169094.

With the improvements made in the physical work environment in high-income countries, attention has shifted to risks associated with the psychosocial work environment. There is strong evidence that a poor psychosocial work environment can increase the risk of mental health problems, particularly depression.[117, 118] Research in this area, most of which is linked to studies in the general adult population, has focused on the following:

- Workplace bullying;
- Job strain (high job demands combined with low control or decision latitude at work);[119]
- Low support from and poor-quality interpersonal relationships with supervisors or colleagues;[120]
- Effort-reward imbalance, which is defined as a mismatch between the effort expended at work and the rewards received;[121]
- Organizational justice in relation to decision-making procedures and interpersonal relationships.[122]

A recent systematic review of studies examining the effect of work-related stressors on the mental health of young workers included three cross-sectional studies and six longitudinal cohort studies.[123] Evidence from cross-sectional studies showed that "adverse work conditions, including working overtime, job boredom, low skill variety, low autonomy, high job insecurity, and lack of reward were associated with poor mental health" among young workers, and evidence from longitudinal studies "showed that high job demands, low job control, effort-reward imbalance, and low work support (men only) were associated with poor mental health".[124] The evidence points to the importance of interventions to improve the job quality and work environments of young people.

In workplaces, as in school environments, bullying has been established as a risk factor for poor mental health. A review of studies examining the associations between school or workplace bullying and PTSD showed equally strong associations whether the exposure to bullying was at school or in the workplace. [125]

Female sex workers are at increased risk of poor mental health due to factors such as poverty, gender inequality, marginalization, and discrimination. A recent review of studies of the risk factors for mental health problems in female sex workers (with an average age of 28.9 years) in low- and middle-income countries showed higher rates of depression, anxiety, PTSD and suicidality.[126] "Meta-analyses found significant associations between violence experience and depression, violence experience and recent suicidal behaviour, alcohol use and recent suicidal behaviour, illicit drug use and depression, depression and inconsistent condom use with clients, and depression and HIV infection."[127] Evidence-based mental health interventions for female sex workers are urgently required to address the present treatment gap, along with efforts aimed at the prevention and treatment of key risk factors such as violence and harmful alcohol and drug use.

Work-related migration

Migration has an impact on the mental health and well-being of children and youth. The majority of studies on this subject focus on families migrating together

117 Stephen Stansfeld and Bridget Candy, "Psychosocial work environment and mental health – a meta-analytic review", *Scandinavian Journal of Work, Environment & Health*, vol. 32, No. 6 (2006), pp. 443-462, DOI:10.5271/sjweh.1050.
118 Jens Peter Ellekilde Bonde, "Psychosocial factors at work and risk of depression: a systematic review of the epidemiological evidence", *Occupational and Environmental Medicine*, vol. 65, No. 7 (2008), pp. 438-445, DOI:10.1136/oem.2007.038430.
119 Anthony D. LaMontagne and others, "Job strain – attributable depression in a sample of working Australians: assessing the contribution to health inequalities", *BMC Public Health*, vol. 8, art. 181 (2008), DOI:10.1186/1471-2458-8-181.
120 Karen Nieuwenhuijsen, David Bruinvels and Monique Frings-Dresen, "Psychosocial work environment and stress-related disorders, a systematic review", *Occupational Medicine (Lond)*, vol. 60, No. 4 (2010), pp. 277-286, DOI:10.1093/occmed/kqq081.
121 Johannes Siegrist and Jian Li, "Associations of extrinsic and intrinsic components of work stress with health: a systematic review of evidence on the effort-reward imbalance model", *International Journal of Environmental Research and Public Health*, vol. 13, No. 4 (2016), art. 432, DOI:10.3390/ijerph13040432.
122 M. Kivimäki and others, "Organisational justice and health of employees: prospective cohort study", *Occupational and Environmental Medicine*, vol. 60, No. 1, discussion 33-4 (2003), pp. 27-33, DOI:10.1037/e336062004-001.
123 Phillip C.F. Law and others, "A systematic review on the effect of work-related stressors on mental health of young workers", *International Archives of Occupational and Environmental Health*, vol. 93, No. 5 (2020), pp. 611-622, DOI: 10.1007/s00420-020-01516-7.
124 Ibid., abstract.
125 Morten Nielsen and others, "Post-traumatic stress disorder as a consequence of bullying at work and at school. A literature review and meta-analysis", *Aggression and Violent Behavior*, vol. 21 (2015), pp. 17-24, DOI:10.1016/j.avb.2015.01.001.
126 Tara S. Beattie and others, "Mental health problems among female sex workers in low- and middle-income countries: a systematic review and meta-analysis", *PLoS Medicine*, vol. 17, No. 9 (2020), DOI:10.1371/journal.pmed.1003297.
127 Ibid., abstract.

Mental health policies must be inclusive.
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rather than on children and youth that remain in their home settings. The children who are separated from their parents are sometimes referred to as "left-behind children".

The mental health effects on children and youth of parents migrating to other countries in search of better economic opportunities is an emerging field of research. Initial research results show that parental migration can lead to depression, anxiety, feelings of abandonment, and low self-esteem among offspring remaining in the country of origin.[128, 129, 130, 131]

Migration out of Eastern Europe has left several million children in the care of grandparents, other relatives, or in some cases neighbours. The literature describes how these children frequently suffer from emotional neglect, since their primary caretakers are unavailable. One study reports that adolescents left behind in Eastern Europe are more prone to experiencing loneliness and school problems because the surrogate care does not meet their emotional needs.[132]

Some countries in the Caribbean have high rates of parental migration to Northern America and Europe. The children are raised by relatives or sometimes in child-headed homes and often experience feelings of insecurity and instability. In such environments, children may have difficulty developing a clear sense of identity and may also feel alienated from their parents. This leads to feelings of rejection or being "second-best" to whatever new family structures or lives have been built abroad by their parents.[133]

In Eastern Europe, the Caribbean, and other areas dealing with similar family migration dynamics, the lack of regular parental presence increases the potential for adolescent risk behaviours – such as substance abuse, early sexual activity, and involvement in delinquent behaviour – as coping mechanisms for emotional distress. Remittances from parents may meet material needs but cannot replace emotional bonds fostered through day-to-day interaction and care.

Migration that separates parents and children effectively weakens the social supports that children traditionally rely upon to help them deal with transnational family dynamics. Lacking community support and appropriate health interventions, these children remain at continued risk for long-term psychological harm that ultimately impairs their academic performance, social relationships, and well-being.

128 Jian Cheng and Ye-Huan Sun, "Depression and anxiety among left-behind children in China: a systematic review", *Child: Care, Health and Development*, vol. 41, No. 4 (2015), pp. 515-523, DOI:10.1111/cch.12221.

129 Xiaoyue Sun, Mengtong Chen and Ko Ling Chan, "A meta-analysis of the impacts of internal migration on child health outcomes in China", *BMC Public Health,* vol. 16, No. 1 (2016), art. 66, DOI:10.1186/s12889-016-2738-1.

130 Wei Wu and others, "Meta-analysis of the mental health status of left-behind children in China", *Journal of Paediatrics and Child Health*, vol. 55, No. 3 (2019), pp. 260-270, DOI:10.1111/jpc.14349.

131 Yuan-Yuan Wang and others, "The prevalence of depressive symptoms in 'left-behind children' in China: a meta-analysis of comparative studies and epidemiological surveys", *Journal of Affective Disorders*, vol. 244 (2019), pp. 209-216, DOI:10.1016/j.jad.2018.09.066.

132 Khatia Antia and others, "Effects of international labour migration on the mental health and well-being of left-behind children: a systematic literature review", *International Journal of Environmental Research and Public Health*, vol. 17, No. 12 (2020), art. 4335, available at https://www.mdpi.com/1660-4601/17/12/4335.

133 Rachel Marcus and others, "Children who stay behind in Latin America and the Caribbean while parents migrate" (Panama, UNICEF Latin America and Caribbean Regional Office, 2023), available at https://www.unicef.org/lac/media/40976/file/children-who-stay-behind.pdf.

This reality also applies to internal migration. Many countries have seen profound transitions from agriculture-based, locally focused economies to industry-based export economies, accompanied by growth in the population living in cities. China is perhaps the most striking example of this, with up to 25 per cent of children left in the care of other family members when parents migrate to urban centres. The impact of migration on mental health is not limited to those left behind; those migrating away from their children or families are affected as well. A review of studies of the mental health of young adult migrant workers in China found higher levels of poor mental health for this group than for the general population, with younger age associated with increased risk.

A comprehensive review of studies assessing the impact of parental migration on all key areas of child and youth health across in low- and middle-income countries found that, compared with children of non-migrants, left-behind children and youth had an increased risk of depression, suicidal ideation, and anxiety.[134] While a small number of individual studies found positive health effects associated with parental migration, overall there was no evidence of benefit across any of the health outcomes. More research is needed to better understand the mental health needs of left-behind children and the role of alternate family structures.

Objective 5 of the Global Compact for Safe, Orderly and Regular Migration makes reference to the importance of family reunification and the "right to family life and the best interests of the child"; however, as keeping migrant families together is not always possible, it is crucial to ensure that left-behind children and youth receive the support they need. Interventions aimed at reducing the mental health risks to left-behind children should include community action, legislation, and technology that can improve the connectedness of families. National policies for migrant workers and for the provision of services for children with absent parents should allow time for migrant workers to visit and communicate with their families. Global mental health initiatives need to consider better ways to support left-behind children and their families.

Summary

While evidence for the impact of work-related factors on youth mental health is relatively limited and studies are much more likely to focus on the general adult population, there is some evidence that unemployment, job insecurity and unstable employment, as well as hazardous or poor-quality work environments, pose risks to young people's mental health and well-being. Child labour and female sex work are also associated with a higher prevalence of mental health problems. Recommendations from the reviewed literature for reducing the psychological impacts of child labour include regulation (including imposing minimum age requirements rather than outright bans), poverty reduction, and school support.

Further research involving longitudinal studies can help shed more light on the bidirectional relationship between decent work and mental health outcomes. There needs to be a focus on the transition to employment, which has become increasingly difficult in countries with high youth unemployment, particularly since the COVID-19 pandemic. As is the case for other areas of youth mental health, studies from low- and middle-income countries are largely lacking.

A growing body of evidence, particularly from China, outlines the stark impacts of work-related migration on the children left behind and points to the need for policies and interventions to address this.

d. Policy recommendations

- *Unemployment.* Steps should be taken to improve research and data collection on the transition from schooling to employment, on the mental health impacts of the changing nature of labour markets (particularly in the context of the digital revolution), and on the mental health impacts of interventions designed to improve employment and job quality. Programmes promoting mental wellness should be developed and implemented, with a focus on youth navigating the transition from school to the labour market as well as unemployed and underemployed youth.

134 Gracia Fellmeth and others, "Health impacts of parental migration on left-behind children and adolescents: a systematic review and meta-analysis", *The Lancet*, vol. 392, No. 10164 (2018), pp. 2,567-2,582, DOI:10.1016/S0140-6736(18)32558-3.

- *Job insecurity and hazardous employment.* Programmes should be implemented to address the mental health impacts of job insecurity and hazardous employment, with particular attention given to regulatory action, poverty reduction, and school support. Workplace policies should be promoted and implemented to improve psychosocial work environments. Programmes developed to address the mental health impacts of sex work should incorporate access to mental health services and prioritize the prevention and treatment of key risk factors such as violence and harmful alcohol and drug use.
- *Work-related migration.* Policies and programmes should be implemented to reduce the impact of work-related migration on left-behind children; for example, community action, legislation, and technology could be leveraged to improve the connectedness of families, with provisions made to allow time for visits.

Supportive families play a vital role in protecting young people's well-being. ©UN Photo/Isaac Billy

3. Families and relationships

a. Perception survey results

Forty-four per cent of the survey respondents indicated there were people with whom they were in regular contact that were detrimental to their well-being because they were a source of discomfort and stress. Thirty per cent indicated they "never" talked about their problems or feelings with at least one of their parents, guardians, or carers (see **figure 21**); males were most likely to offer this response (33 per cent), followed by females (29 per cent) and those identifying their gender as "other" (16 per cent). Eighty per cent of the respondents indicated that they had felt at least once or twice in the 12 months prior to the survey that they belonged to a community (see **figure 22**); for this survey question, males were least likely to respond "never" (11 per cent), followed by females (14 per cent) and those identifying their gender as "other" (26 per cent).

b. Focus group results

Family and other relationships play an important role in how young people feel about themselves. The lack of a shared language to communicate their concerns and ideas about mental health was seen an issue for most of the focus group participants. Increased mental health awareness, mostly through social media and community campaigns, was seen to be an important factor in the divide between the generations, with participants reporting a mismatch between their parents' generation and their own in relation to mental health literacy. Family members who did not have the words to understand or explain the implications of anxiety would instead label young people as bored, lazy, or sensitive, for example. Addressing this mismatch between the generations so that space could be created to talk without judgment and to seek help and advice was seen as a key priority for many participants.

Focus group participants related that family expectations and the pressure to succeed in both employment and education had an impact on their mental health. How family expectations were communicated and the ability to adjust those expectations based on a young person's capacities and circumstances were seen as important to positive mental health. High expectations of achievement from the family were connected to feelings of burnout and poor mental health. Parents' or carers' ability to care for their own mental health was also seen as a factor in young people's sense of well-being.

Friends played a pivotal role in participants' well-being. Many participants reported that talking to friends, whether online or in person, was central to improving their mental health. The online environment was seen to have both positive and negative implications for mental health; hyper-comparison on social media and online bullying were problematic, but staying in touch with friends and seeing encouraging stories of mental health from peers had a positive effect on participants.

c. Social determinants

Families are the main setting within which individuals are born, grow and develop and from which youth make the transition to their adult lives. In recent decades, economic development has led to changes in family structure and stability and in patterns of transition to the next generation of families. A shift to smaller families, which has allowed parents to invest more resources in each child, has led to higher levels of participation in education and delayed transition to marriage and parenting, meaning that the family-of-origin environment is arguably more important now than in the past.[135]

Family structures are becoming increasingly diverse. While most children live at home with two parents or guardians (hereinafter referred to as parents), single-parent families are becoming more common and traditional multigenerational families less common. In high-income countries in particular, this is driven by the rising trend towards cohabitation rather than marriage and increasing divorce rates. These changes are associated with higher risks of economic adversity, lower rates of participation in education, and family instability later in life. In low- and middle-income countries there are additional factors that impact family structure, including parental migration, which is relatively common in China, or parent deaths from HIV, which occur at relatively high rates in sub-Saharan Africa. Growing numbers of youth are living with extended family members. Cultural differences in the emphasis placed on the family unit in terms of respect, support, obligation and reference may also impact mental health. This is exemplified by a recent review of studies showing the protective effects of *familismo* among young people from cultures in Latin America and the Caribbean.[136]

Evidence relating to the impact of major social and economic changes on youth mental health and well-being is limited, and there is a need for further research into both the positive and negative effects of family structure, stability, and patterns of transition on youth mental health and well-being outcomes.

One of the positive things my family did for my mental health was allowing me to have my own opinion and ask questions.

–Young person, Focus Group 2

While most of the evidence on family dynamics and mental health and well-being relates to younger children, there have been some studies centred around youth. These focus primarily on factors in the immediate family context, such as interparental conflict and parenting styles. Evidence linked to poverty and family norms that promote gender inequality and their impact on youth mental health is considered elsewhere in the present publication.

Family structure, separation and bereavement

Some evidence suggests that mental health problems, including depression, are more prevalent among the children of dissolved families than among those of intact families, though the effects are likely to be small and may be explained by other factors, such as maternal parenting style, a history of childhood emotional problems,[137]

135 George C. Patton and others, "Our future: a Lancet commission on adolescent health and wellbeing", *The Lancet*, vol. 387, No. 10036 (2016), pp. 2,423-2,478, DOI:10.1016/S0140-6736(16)00579-1.

136 Esmeralda Valdivieso-Mora and others, "A systematic review of the relationship between familism and mental health outcomes in Latino population", *Frontiers in Psychology*, vol. 7, art. 1632 (2016), DOI:10.3389/fpsyg.2016.01632. *Familismo* represents a core cultural value among those of Latin American origin or descent, emphasizing strong family ties, loyalty and interdependence.

137 Tania L. King and others, "Expressions of masculinity and associations with suicidal ideation among young males", *BMC Psychiatry*, vol. 20, art. 228 (2020), pp. 1-10, available at https://doi.org/10.1186/s12888-020-2475-y.

FIGURE 21 CONNECTIONS TO FAMILY

How often do you talk about your problems or feelings with at least one of your parents/guardians/carers?

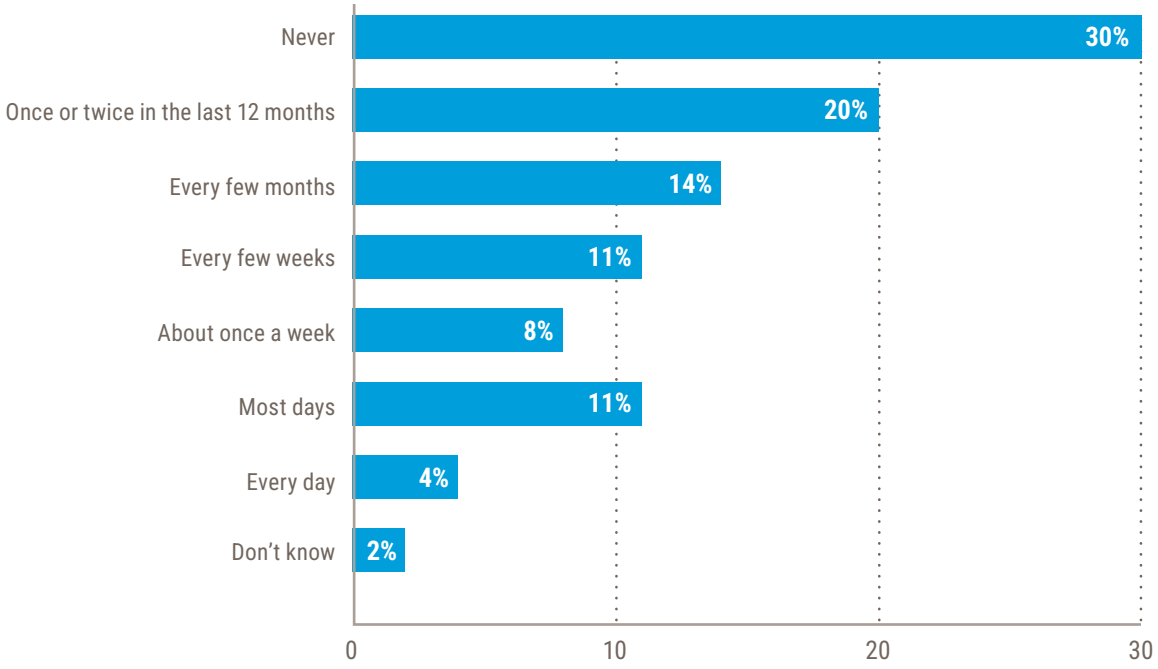
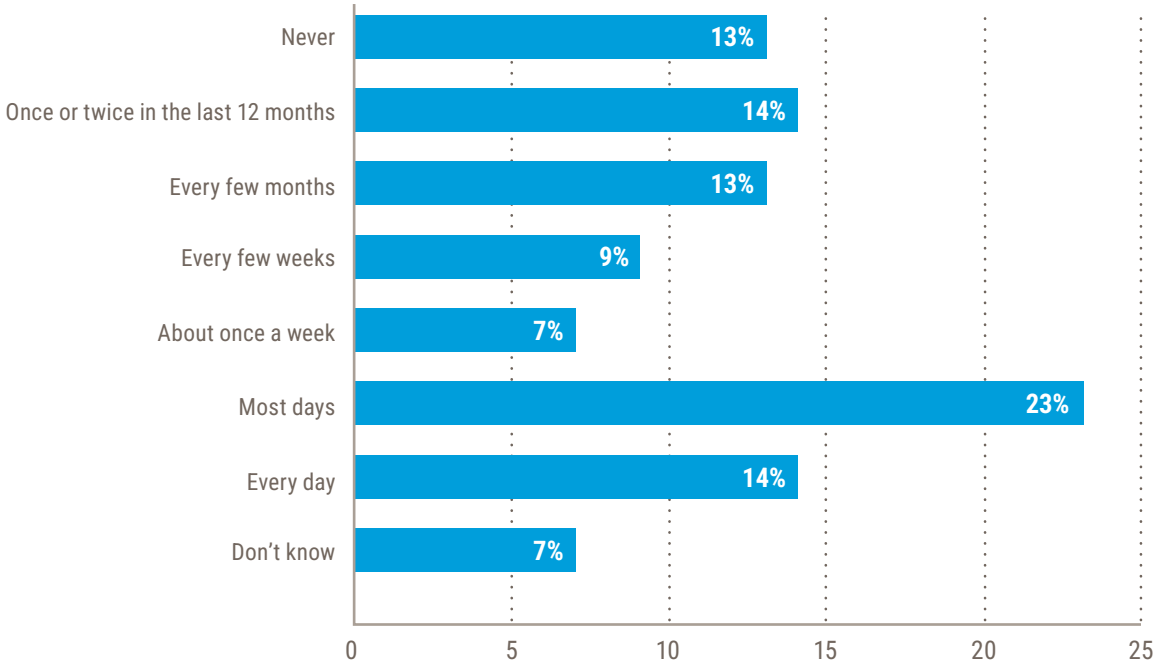


FIGURE 22 CONNECTIONS TO COMMUNITY

In the last 12 months, how often did you feel that you belonged to a community (like a social group, your neighbourhood, your city, or your school)?



Resilience grows when young people receive the care they need. ©Dennis Otieno Onyango

In some ethnic households, mental health can be seen as taboo or may be seen as a lack of religiosity more because some of the issues that are defined and present in the Western world are not seen the same "back home".

–Young person, Focus Group 4

or conflict between separated co-parents.[138] There is evidence that co-parental agreement, cooperation and support are beneficial for child and youth mental health. In terms of gender differences, a recent review found evidence that parental separation was associated with increased suicide risk among young men but not among young women.

Other reviews have examined links between other family factors and mental health in youth, concluding that polygamy[139] and international adoption[140] are associated with increased risk. However, these studies are generally of lower quality, and the effects may be better explained by other factors, such as family conflict and socioeconomic status.

In high-income countries, about 3-4 per cent of children are affected by the loss of a parent or guardian through death before the age of 18; in low- and middle-income countries, the corresponding rates are likely higher. The loss of one or both parents is associated with an increased risk of mental health problems among children and youth, including anxiety, depression, and a perceived lack of control over what happens in their lives. However, it is likely that the cause of bereavement and certain pre- and post-loss features – including the socioeconomic and cultural contexts in which bereaved youth live – may have a greater impact than bereavement itself. A recent review of the outcomes of cancer bereavement in children and youth found high levels of adjustment,[141] though suicide bereavement may be associated with a higher risk of poor mental health (see below). A recent systematic review of interventions targeting bereaved youth – including group interventions for children and youth, family interventions, guidance for parents, and camp activities for youth – showed beneficial effects, including lower levels of mental health symptoms in children and youth.[142]

138 Diogo Lamela and Bárbara Figueiredo, "Coparenting after marital dissolution and children's mental health: a systematic review", *Jornal de Pediatria*, vol. 92, No. 4 (2016), pp. 331-342, DOI:10.1016/j.jped.2015.09.011.

139 Mohammad Ahmad Al-Sharfi, Karen Pfeffer and Kirsty Miller, "The effects of polygamy on children and adolescents: a systematic review", *Journal of Family Studies*, vol. 22, No. 3 (2015), pp. 272-286, DOI:10.1080/13229400.2015.1086405.

140 Kristin Gärtner Askeland and others, "Mental health in internationally adopted adolescents: a meta-analysis", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 56, No. 3 (2017), 203-213.e1, DOI:10.1016/j.jaac.2016.12.009.

141 Rachel Hoffmann, Julia Kaiser and Anette Kersting, "Psychosocial outcomes in cancer-bereaved children and adolescents: a systematic review", *Psychooncology*, vol. 27, No. 10 (2018), pp. 2,327-2,338, DOI:10.1002/pon.4863.

142 Ann-Sofie Bergman, Ulf Axberg and Elizabeth Hanson, "When a parent dies – a systematic review of the effects of support programs for parentally bereaved children and their caregivers", *BMC Palliative Care*, vol. 16, No. 1 (2017), p. 39, DOI:10.1186/s12904-017-0223-y.

My parents come from East Africa and back home they don't talk about depression or anxiety so when we talk about our [mental] health it is not taken seriously because it's not something that they're familiar with.

–Young person, Focus Group 4

There is evidence that children who have lost a parent to suicide are at greater risk of suicide themselves.[143] Research findings suggest that maternal suicidal behaviour is a more potent risk factor than paternal suicide[144] and that children are more vulnerable than youth and adults. However, there is no evidence of a stronger association in either male or female children or youth. An exploration of the impact of suicide bereavement on youth showed that the closeness of the relationship prior to the death, rather than the type of relationship, was the strongest determinant of the impact of the loss, and that the closeness and quality of remaining relationships played a role in buffering the impact of the loss.[145]

Parenting styles and relational quality

Adolescence is characterized by shifts in parent-child relationships as young people seek greater autonomy and independence and may engage in risky behaviours. Parental capacity to manage these changes has implications for mental health and well-being. Parenting style may be defined the constellation of attitudes, goals, and patterns of child-rearing that shape the emotional climate of the parent-child relationship and remain constant across different life situations.[146] Parenting styles may vary with different family structures. Research in this area has largely focused on the following parenting approaches and concepts:[147]

- *Authoritarian parenting* is highly directive, with parents expecting their child to be unquestioningly obedient and using punitive measures to control the child's behaviour.
- *Authoritative parenting* involves parents establishing rules that respect the young person's maturity and independence and communicating the reasons underlying these rules to the adolescent.
- *Autonomy granting* involves parental encouragement of the youth's opinions and choices, acknowledgement of the adolescent's independent perspectives on issues, and solicitation of the adolescent's input on decisions and solutions to problems.
- *Monitoring* refers to parents' knowledge of their youth's activities, whereabouts and friends.
- *Warmth* describes a sense of positive regard expressed by the parent toward the youth, pleasant interactions shared between parent and youth, or parental involvement in the youth's activities.
- *Overinvolvement* indicates parental interference with children's age-normative autonomy and emotional independence and the encouragement of excessive dependence on the parent. It includes psychological manipulation and may involve the use of coercive or hostile parenting techniques to control or intrude upon the youth's psychological experiences.
- *Parental hostility* may be expressed through criticism, manipulation, humiliation, punishment, or conflict.

143 Galit Geulayov and others, "The association of parental fatal and non-fatal suicidal behaviour with offspring suicidal behaviour and depression: a systematic review and meta-analysis", *Psychological Medicine*, vol. 42, No. 8 (2012), pp. 1,567-1,580, DOI:10.1017/S0033291711002753.

144 Sarah Margaret Goodday and others, "Exposure to parental psychopathology and offspring's risk of suicide-related thoughts and behaviours: a systematic review", *Epidemiology and Psychiatric Sciences*, vol. 28, No. 2 (2019), pp. 179-190, DOI:10.1017/S2045796017000397.

145 Karl Andriessen and others, "Pre- and postloss features of adolescent suicide bereavement: a systematic review", *Death Studies*, vol. 40, No. 4 (2016), pp. 229-246, DOI:10.1080/07481187.2015.1128497.

146 Nancy Darling and Laurence Steinberg, "Parenting style as context: an integrative model", *Psychological Bulletin*, vol. 113, No. 3 (1993), pp. 487-496, DOI:10.1037/0033-2909.113.3.487.

147 Marie Bee Hui Yap and others, "Parental factors associated with depression and anxiety in young people: a systematic review and meta-analysis", *Journal of Affective Disorders*, vol. 156 (2014), pp. 8-23, DOI:10.1016/j.jad.2013.11.007.

My parents are going off of what information they have. And they're doing their best because when they were my age there was no talking about mental health whatsoever. I see the effort that they put into having the difficult conversations.

–Young person, Focus Group 2

Reviews of studies examining the links between parenting styles and youth mental health show that parental warmth, parental monitoring, and autonomy granting are linked to lower levels of anxiety, depression and suicidal ideation.[148, 149, 150, 151] Psychological control, hostility, and the use of harsh punishments to direct behaviour are associated with increased mental health risks, particularly with regard to depression, anxiety and self-harm.[152] Studies examining links between parenting styles and specific mental health problems such as PTSD have found some similar patterns, [153, 154] though the evidence is less clear regarding the risks for obsessive-compulsive disorder.[155]

Reviews of evidence on the links between parent-youth relationships (including youth relationships with fathers), family connectedness and support, and eating disorders show similar patterns of risk and protection.[156] Studies examining the role of family factors in increasing the risk of eating disorders point to the importance of avoiding comments about weight, and some studies indicate that higher family meal frequency is associated with reduced risk.[157]

Faith-based communities can play a key role in supporting youth mental health through compassion and inclusion.
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While most of the evidence for links between parenting styles and mental health comes from high-income countries, there is also evidence from some low- and

148 Yap and others, "Parental factors associated with depression and anxiety in young people: a systematic review and meta-analysis".

149 Ana Beatriz Bozzini and others, "Factors associated with risk behaviors in adolescence: a systematic review", *Revista Brasileira de Psiquiatria*, vol. 43, suppl. 1 (2020), DOI:10.1590/1516-4446-2019-0835.

150 Arantxa Gorostiaga and others, "Parenting styles and internalizing symptoms in adolescence: a systematic literature review", *International Journal of Environmental Research and Public Health*, vol. 16, No. 17, art. 3192 (2019), DOI:10.3390/ijerph16173192.

151 Lori Shore and others, "Review: longitudinal trajectories of child and adolescent depressive symptoms and their predictors – a systematic review and meta-analysis", *Child and Adolescent Mental Health*, vol. 23, No. 2 (2018), pp. 107-120, DOI:10.1111/camh.1222.

152 Fatima Valencia-Agudo and others, "Nonsuicidal self-injury in community adolescents: a systematic review of prospective predictors, mediators and moderators", *Journal of Adolescence*, vol. 65, No. 1 (2018), pp. 25-38, DOI:10.1016/j.adolescence.2018.02.012.

153 Victoria Williamson and others, "The role of parenting behaviors in childhood post-traumatic stress disorder: a meta-analytic review", *Clinical Psychology Review*, vol. 53 (2017), pp. 1-13, DOI:10.1016/j.cpr.2017.01.005.

154 David Trickey and others, "A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents", *Clinical Psychology Review*, vol. 32, No. 2 (2012), pp. 122-138, DOI:10.1016/j.cpr.2011.12.001.

155 Gustaf Brander and others, "Systematic review of environmental risk factors for obsessive-compulsive disorder: a proposed roadmap from association to causation", *Neuroscience & Biobehavioral Reviews*, vol. 65 (2016), pp. 36-62, DOI:10.1016/j.neubiorev.2016.03.011.

156 Christopher J. Gale, Elizabeth R. Cluett and Cathy Laver-Bradbury, "A review of the father-child relationship in the development and maintenance of adolescent anorexia and bulimia nervosa", *Issues in Comprehensive Pediatric Nursing*, vol. 36, No. 1-2 (2013), pp. 48-69, DOI:10.3109/01460862.2013.779764.

157 Megan E. Harrison and others, "Systematic review of the effects of family meal frequency on psychosocial outcomes in youth", *Canadian Family Physician / Medecin de Famille Canadien*, vol. 61, No. 2 (2015), pp. e96-e106.

middle-income countries. A review of studies conducted in China on risk and protective factors for mental health found authoritative parenting styles to be associated with reduced risk of depression and authoritarian parenting styles to be associated with increased risk, though cultural differences – such as youth in Western countries having a greater expectation of autonomy than youth in non-Western countries – may complicate the interpretation of findings in a broader context.[158] Poor parent-child communication, poor family functioning, and poor family cohesion have also been shown to increase the risk of youth depression in China, with greater effects on younger youth.[159] Family-related risks for suicidality among young people in China include having a single or remarried parent, experiencing study pressure, poor academic achievement, and stressful life events, including the suicide of a relative.[160]

Mental health issues were stigmatized for such a long time in my region; most young people here don't open up to their families. There's also a drive to enforce the image of a "perfect existence", and this prevents people from speaking to their friends as well.

–Young person, Focus Group 5

A review of studies on the risk and protective factors for mental health among youth in India highlighted some risk factors similar to those identified in other countries, including female gender, academic difficulties, parental fights, strained familial relationships, school absenteeism, school dropout, and other education-related factors.[161] Context-specific factors requiring further investigation included mother's working status, studying in a government institution, and belonging to a nuclear family as risk factors and praying as a coping skill. Parental involvement and higher levels of family well-being were identified as protective factors. A review of risk factors for depression among youth in the Islamic Republic of Iran found associations with poor interparental relationships, poor youth-parent relationships, adverse parenting styles, low level of parental education, and poor academic performance.[162]

A review of the risk and protective factors for youth self-harm in low- and middle-income countries showed similar patterns, with family conflict, links to peer groups with members indulging in self-harm, truancy, and school absenteeism increasing the risk.[163] Protective factors included having an understanding family, having friends, and higher school achievement. A review of risk factors for self-harm among young people in sub-Saharan Africa found increased risks related to family conflict and to emotional and physical abuse.[164]

There is evidence that parenting programmes are beneficial for reducing anxiety, depression[165] and behaviour problems,[166] though the great majority of studies have focused on infants and younger children. There is a need

158 Liu and Merritt, "Examining the association between parenting and childhood depression among Chinese children and adolescents: a systematic literature review".

159 Xinfeng Tang and others, "Psychosocial risk factors associated with depressive symptoms among adolescents in secondary schools in mainland China: a systematic review and meta-analysis", *Journal of Affective Disorders*, vol. 263, No. 2 (2020), pp. 155-165, DOI:10.1016/j.jad.2019.11.118.

160 Ying Li, Yafei Li and Jia Cao, "Factors associated with suicidal behaviors in mainland China: a meta-analysis", *BMC Public Health*, vol. 12, art. 524 (2012), DOI:10.1186/1471-2458-12-524.

161 Shilpa Aggarwal and Michael Berk, "Evolution of adolescent mental health in a rapidly changing socioeconomic environment: a review of mental health studies in adolescents in India over last 10 years", *Asian Journal of Psychiatry*, vol. 13, No. 7 (2014), pp. 3-12, DOI:10.1016/j.ajp.2014.11.007.

162 Homeira Sajjadi and others, "A systematic review of the prevalence and risk factors of depression among Iranian adolescents", *Global Journal of Health Science*, vol. 5, No. 3 (2013), p. 16, DOI:10.5539/gjhs.v5n3p16.

163 Shilpa Aggarwal and others, "Youth self-harm in low- and middle-income countries: systematic review of the risk and protective factors", *International Journal of Social Psychiatry*, vol. 63, No. 4 (2017), pp. 359-375, DOI:10.1177/0020764017700175.

164 Emmanuel N-B Quarshie, Mitch G. Waterman and Allan O. House, "Self-harm with suicidal and non-suicidal intent in young people in sub-Saharan Africa: a systematic review", *BMC Psychiatry*, vol. 20, art. 234 (2020), DOI:10.1186/s12888-020-02587-z.

165 Marie B. Yap and others, "Parents in prevention: a meta-analysis of randomized controlled trials of parenting interventions to prevent internalizing problems in children from birth to age 18", *Clinical Psychology Review*, vol. 50 (2016), pp. 138-158, DOI:10.1016/j.cpr.2016.10.003.

166 Ionut Stelian Florean and others, "The efficacy of Internet-based parenting programs for children and adolescents with behavior problems: a meta-analysis of randomized clinical trials", *Clinical Child and Family Psychology Review*, vol. 23, No. 4 (2020), pp. 510-528, DOI:10.1007/s10567-020-00326-0.

Box 3. Interview with a 22-year-old man from Sierra Leone with humanitarian crisis experience and child labour experience

Life has been very tough for me. I have had experiences of depression, drunk dangerous amounts of alcohol, had an eating disorder, been physically abused, and been bullied and harassed at school, and during the ten years of civil war I experienced severe stress and anxiety.

Employment greatly impacts on a youth's mental health. For those with mental health problems, being employed can be an important step to recovery, improving self-esteem and confidence while reducing psychological distress. Trying to find work has had boring moments, scary moments, and angry moments. It is not a flat line of unvarying personal fulfilment. There is no "job of my life" out there waiting to be found. Finding work in Sierra Leone for young people is very tough. If you do not have political connections people will not employ you. The labour market is increasingly becoming temporary or part-time; often jobs have no benefits and inadequate pay. A decent salary allows you to build assets, but the change in the labour market over recent years has taken this opportunity away, impacting particularly heavily on youth who have not had an education.

I have found that an excess of Internet or social media can create a heightened level of psychological arousal. This has resulted in reduced sleep, failure to eat for a long period of time, and limited physical activity. All of these possibly led to experiencing physical and mental health problems such as cyberbullying, depression, low family relationships and anxiety. Many things keep me returning to social media, including isolation, self-absorption, feeling inadequate about my life or appearance, self-image issues, and fear of missing out. However, there have also been positive experiences through social media, as I can reach out and see how my loved ones are doing. I can share personal stories and photos and remind myself of the important people in my life. Sharing inspiring stories makes me feel confident and positive about my life.

I always thought that being mentally ill made me a bad person, even broken. However, when I reached recovery, I was able to see everything that my illness taught me. I have learnt compassion, empathy, appreciation, and resilience. I realized it made me a better person in the end. I have come to realize that I have a responsibility to individuals and communities, and as a leader within the communities, to advocate for children and youth across the country to have access to quality mental health services for children, youth and all the country. This is to promote the prevention of mental health issues.

I have learned to manage my mental health through connecting with other people, managing stress, thinking before I act, striving for balance in my life, taking care of my physical health, and becoming aware of my emotions and reactions. I have found the way to help someone experiencing mental health issues is to learn the facts about mental illness and share them with family, friends, work colleagues and classmates. It is best to get to know people with personal experience of mental illness so you learn to see them for the person they are rather than their illness.

for further research in the area of parenting programmes for youth and in countries and regions outside Northern America, Europe, and Australia and New Zealand. Similar gaps exist in the area of parenting programmes to prevent body dissatisfaction and eating disorders.[167] Recent primary studies conducted with youth samples have shown improvements in externalizing problems[168] and in depressive and anxiety symptoms.[169]

There is growing evidence that interparental relationships play a key role in youth mental health outcomes, including depression, anxiety, and self-harm.[170, 171] A recent meta-analysis of 169 studies of different aspects of the interparental relationship and internalizing problems in children and youth highlighted the importance of general relationship quality; conflict frequency; the extent of hostile, disengaged and unconstructive conflict behaviour; and the amount of child-related conflicts.[172] Results also showed that children and young people in families in which the quality of the relationship between parents was low were at similar risk for developing internalizing problems to children exposed to more hostile conflict. The risks appeared to be greater for girls than for boys. While there were no major age differences in the findings, the study authors noted that some youth may become more aware of difficulties in the parental relationship as development gains are made in their social-cognitive skills and social-affective processing.[173]

Children of parents with a mental illness

Having a parent with a mental illness is a well-established risk factor for mental health problems in childhood and adolescence. Children of parents with anxiety and depressive disorders are at increased risk of depression and anxiety,[174] and similar findings have been reported for PTSD.[175, 176] Having a sibling with a mental health problem may also increase the risk.[177]

A recent meta-analysis that assessed the risk for anxiety disorders among offspring of parents with anxiety disorders showed increased risks for both anxiety and depression, with greater risk for the former than the latter.[178] The risk was significant for some anxiety disorders in offspring (generalized anxiety disorder, separation anxiety disorder, and specific phobia) but not others (panic disorder and social anxiety disorder).

For depression, associations have been seen in relation to both fathers[179] and mothers,[180] with evidence suggesting that youth depression and anxiety is equally related to paternal and maternal mental health. However, a review of studies of the associations between paternal and

167 Laura M. Hart and others, "Parents and prevention: a systematic review of interventions involving parents that aim to prevent body dissatisfaction or eating disorders", *International Journal of Eating Disorders*, vol. 48, No. 2 (2015), pp. 157-169, DOI:10.1002/eat.22284.

168 Betty Sao-Hou Lai and others, "Disasters and depressive symptoms in children: a review", *Child & Youth Care Forum*, vol. 43, No. 4 (2014), pp. 489-504, DOI:10.1007/s10566-014-9249-y.

169 Marie Bee Hui Yap and others, "A tailored web-based intervention to improve parenting risk and protective factors for adolescent depression and anxiety problems: postintervention findings from a randomized controlled trial", *Journal of Medical Internet Research*, vol. 20, No. 1 (2018), e17, DOI:10.2196/jmir.9139.

170 Marie Yap and others, "Parental factors associated with depression and anxiety in young people: a systematic review and meta-analysis", *Journal of Affective Disorders*, vol. 156 (2014), pp. 8-23, DOI:10.1016/j.jad.2013.11.007.

171 Fatima Valencia-Agudo and others, "Nonsuicidal self-injury in community adolescents: a systematic review of prospective predictors, mediators and moderators", *Journal of Adolescence*, vol. 65, No. 1 (2018), pp. 25-38, DOI:10.1016/j.adolescence.2018.02.012.

172 Willemijn van Eldik and others, "The interparental relationship: meta-analytic associations with children's maladjustment and responses to interparental conflict", *Psychological Bulletin*, vol. 146, No. 7 (2020), pp. 553-594, DOI:10.1037/bul0000233.

173 Evaline A. Crone and Ronald E. Dahl, "Understanding adolescence as a period of social-affective engagement and goal flexibility", *Nature Reviews Neuroscience*, vol. 13, No. 9 (2012), pp. 636-650, DOI:10.1038/nrn3313.

174 Patricia Moreno-Peral and others, "Risk factors for the onset of panic and generalised anxiety disorders in the general adult population: a systematic review of cohort studies", *Journal of Affective Disorders*, vol. 168C (2014), pp. 337-348, DOI:10.1016/j.jad.2014.06.021.

175 Adam Morris, Crystal Gabert-Quillen and Doug Delahanty, "The association between parent PTSD/depression symptoms and child PTSD symptoms: a meta-analysis", *Journal of Pediatric Psychology*, vol. 37, No. 10 (2012), pp. 1,076-1,088, DOI:10.1093/jpepsy/jss091.

176 Elisa van Ee, Rolf Kleber and Marian Jongmans, "Relational patterns between caregivers with PTSD and their nonexposed children: a review", *Trauma, Violence, & Abuse*, vol. 17, No. 2 (2016), pp. 186-203, DOI:10.1177/1524838015584355.

177 Nylanda Ma and others, "The quality of family relationships for siblings of children with mental health problems: a 20-year systematic review", *Journal of Family Studies*, vol. 23, No. 3 (2016), pp. 309-332, DOI:10.1080/13229400.2015.1108994.

178 Peter Lawrence, Kou Murayama and Cathy Creswell, "Systematic review and meta-analysis: anxiety and depressive disorders in offspring of parents with anxiety disorders", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 58, No. 1 (2019), pp. 46-60, DOI:10.1016/j.jaac.2018.07.898.

179 Shaun Sweeney and Angus MacBeth , "The effects of paternal depression on child and adolescent outcomes: a systematic review", *Journal of Affective Disorders*, vol. 205, No. 2 (2016), pp. 44-59, DOI:10.1016/j.jad.2016.05.073.

180 Sherryl Hope Goodman and others, "Maternal depression and child psychopathology: a meta-analytic review", *Clinical Child and Family Psychology Review*, vol. 14, No. 1 (2011), pp. 1-27, DOI:10.1007/s10567-010-0080-1.

youth mental health showed that the studies were mostly cross-sectional and of mixed quality.[181] A review of studies of the association between maternal depression and child and youth mental health point to higher levels of internalizing and mental health problems as well as lower levels of positive affect and behaviour, with all associations small in magnitude.[182]

Most of these studies focused on children or early youth, with stronger effects seen in girls and in children of younger ages, possibly because children first exposed at a later stage of development may have experienced more years of healthy development prior to exposure or are exclusively dependent on their mothers. Moreover, with increasing cognitive maturity, older children may be better able to understand their mothers' symptoms and may have developed better emotional regulation and social information processing skills.

As it is essential to consider the mental health of fathers as well as mothers in the prevention of mental health problems in youth, ensuring that support is available for fathers may be particularly important in the context of gender disparities in rates of help-seeking.

Children of parents with bipolar disorder and schizophrenia are at higher risk of mental health problems than are children of parents without these disorders. A meta-analysis of associations between parent mental illness (schizophrenia, bipolar disorder and major depression) and the risk of mental health problems in youth showed that children of parents with specific mental illnesses had higher rates of the mental health problems present in the parents and also of other types of mental health issues.[183] The risk of mood disorders was significantly increased among children of parents with schizophrenia, and the risk of schizophrenia was significantly higher in children of parents with bipolar disorder but not among children whose parents suffered from depression.

A more recent review of 17 studies showed that children of parents with bipolar disorder were nine times more likely than children of non-bipolar parents to have a bipolar-type disorder, almost two and a half times more likely to develop a non-bipolar affective disorder, and more than twice as likely to develop at least one anxiety disorder.[184] However, these risks may be no higher than those for children of parents with other mental health problems.[185] A review of studies aimed at identifying characteristics of the family environment associated with increased risk showed that the most consistent finding was lower parent-reported cohesion in families that included a parent with bipolar disorder than in families with no parental psychiatric disorders.[186] However, no difference in the family environment was found between parents with bipolar disorder and parents with other disorders.

Other studies have assessed the impact on children and youth of mothers with borderline personality disorder.[187] Associations have been seen, with adverse offspring outcomes including borderline personality disorder symptoms, depression, and internalizing problems, with the relationship mostly explained by maladaptive parenting styles and maternal emotional dysfunction. There is a need for higher-quality prospective studies in this area.

Systematic reviews and meta-analyses of interventions designed to reduce the risk of mental health problems in children of parents with a mental illness have found them to be both substantively effective[188, 189] and

181 Alice Wickersham and others, "The association between paternal psychopathology and adolescent depression and anxiety: a systematic review", *Journal of Adolescence*, vol. 79, No. 1 (2020), pp. 232-246, DOI:10.1016/j.adolescence.2020.01.007.

182 Goodman and others, "Maternal depression and child psychopathology: a meta-analytic review".

183 Daniel Rasic and others, "Risk of mental illness in offspring of parents with schizophrenia, bipolar disorder, and major depressive disorder: a meta-analysis of family high-risk studies", *Schizophrenia Bulletin*, vol. 40, No. 1 (2014), pp. 28-38, DOI:10.1093/schbul/sbt114.

184 Phoebe Lau and others, "Prevalence of psychopathology in bipolar high-risk offspring and siblings: a meta-analysis", *European Child and Adolescent Psychiatry*, vol. 27, No. 7 (2018), pp. 823-837, DOI:10.1007/s00787-017-1050-7.

185 Emma K. Stapp and others, "Parental bipolar disorder, family environment, and offspring psychiatric disorders: a systematic review", *Journal of Affective Disorders*, vol. 268 (2020), pp. 69-81, DOI:10.1016/j.jad.2020.03.005.

186 Ibid.

187 Julie Eyden and others, "A systematic review of the parenting and outcomes experienced by offspring of mothers with borderline personality pathology: potential mechanisms and clinical implications", *Clinical Psychology Review*, vol. 47 (special issue s54) (2016), pp. 85-105, DOI:10.1016/j.cpr.2016.04.002.

188 Eliane Siegenthaler, Thomas Munder and Matthias Egger, "Effect of preventive interventions in mentally ill parents on the mental health of the offspring: systematic review and meta-analysis", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 51, No. 1 (2012), pp. 8-17, e8, DOI:10.1016/j.jaac.2011.10.018.

189 Martina Thanhauser and others, "Do preventive interventions for children of mentally ill parents work? Results of a systematic review and meta-analysis", *Current Opinion in Psychiatry*, vol. 30, No. 4 (2017), pp. 283-299, DOI:10.1097/YCO.0000000000000342.

Youth well-being depends on inclusive growth that leaves no one behind.
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cost-effective.[190] Such interventions typically include individual, group, and family sessions and aim to reduce the risk of depression by increasing knowledge about depression within the family and building resilience to stress among parents and/or children. Interventions vary with regard to the family members who are involved (parents/children), the age range of the children included, and the length of the intervention.

The most recent meta-analysis included 68 studies on children and youth, with results showing significant small effects of interventions in preventing the onset of mental health problems and in reducing internalizing symptoms. In contrast to a previous meta-analysis,[191] the later study showed that these effects increased significantly over time, mostly among younger youth.[192]

Most of the studies reviewed involved younger youth in high-income countries. Future studies should address cultural adaptation and incorporate evaluations of interventions in other countries and cultures.

Violence and abuse

There is robust evidence that exposure to adversity in childhood – including physical or sexual abuse, neglect, maltreatment, or family violence – increases the risk of mental health problems and suicide.[193, 194, 195, 196] Intergenerational effects have also been found, with children of mothers who experienced childhood adversity facing a higher risk of developing mental health conditions themselves.[197]

Evidence suggests that the types of youth-specific violence that increase the risk of poor mental health outcomes include date violence, sexual assault, and interpersonal violence, with studies from both high-income and low- and middle-income countries showing increased risks for depression, anxiety, PTSD, eating disorders and

190 David McDaid and A-La Park, "Investing in mental health and well-being: findings from the DataPrev project", *Health Promotion International*, vol. 26 (suppl. 1) (2011), pp. i108-i139, DOI:10.1093/heapro/dar059.

191 Siegenthaler, Munder and Egger, "Effect of preventive interventions in mentally ill parents on the mental health of the offspring: systematic review and meta-analysis".

192 Thanhauser and others, "Do preventive interventions for children of mentally ill parents work? Results of a systematic review and meta-analysis".

193 Bethan Carter and others, "Mediators and effect modifiers of the causal pathway between child exposure to domestic violence and internalizing behaviors among children and adolescents: a systematic literature review", *Trauma, Violence, & Abuse*, vol. 23, No. 2 (2022), pp. 594-604, DOI:10.1177/1524838020965964.

194 Adam B. Miller and others, "The relation between child maltreatment and adolescent suicidal behavior: a systematic review and critical examination of the literature", *Clinical Child & Family Psychology Review*, vol. 16, No. 2 (2013), pp. 146-472, DOI:10.1007/s10567-013-0131-5.

195 Oon Him Peh, Attilio Rapisarda and Jimmy Lee, "Childhood adversities in people at ultra-high risk (UHR) for psychosis: a systematic review and meta-analysis", *Psychological Medicine*, vol. 49, No. 7 (2019), pp. 1,089-1,101, DOI:10.1017/S003329171800394X.

196 Jutta Lindert and others, "Sexual and physical abuse in childhood is associated with depression and anxiety over the life course: systematic review and meta-analysis", *International Journal of Public Health*, vol. 59, No. 2 (2014), pp. 359-372, DOI:10.1007/s00038-013-0519-5.

197 Yingying Su, Carl D'Arcy and Xiangfei Meng, "Intergenerational effect of maternal childhood maltreatment on next generation's vulnerability to psychopathology: a systematic review with meta-analysis", *Trauma, Violence, & Abuse*, vol. 23, No. 1 (2022), pp. 152-162, DOI:10.1177/1524838020933870.

suicidality.[198, 199, 200] Girls are at higher risk than boys of severe mental health outcomes.

Interventions that promote knowledge and help build on young people's tendency to seek help from friends with information about support services for youth who disclose abuse may be helpful, though evidence for effective interventions is largely lacking; this is particularly the case for violence in non-heterosexual relationships – an area in which more research is needed. A meta-analysis of 23 school-based interventions designed to prevent or reduce teen dating violence found significant improvements in knowledge and attitudes but not in behaviours.[201] However, mental outcomes were not examined.

Sibling bullying in adolescence is also associated with poor mental health.[202] A review of evidence suggests that parenting quality and behaviour are the intrafamilial factors most strongly associated with bullying between siblings, which also increases the risk of being involved in peer bullying. Sibling bullying is independently associated with emotional problems such as distress, depression, and self-harm. The effects appear to be cumulative, with those children bullied by both siblings and peers far more likely than those bullied by siblings or peers only to experience emotional problems, probably because they have no safe place to go to escape from bullying. Parenting interventions and programmes that focus on improving sibling relationships are likely to be important in addressing this issue.

Youth in out-of-home and foster care and youth experiencing homelessness

Youth in care are at higher risk than the general youth population of poor mental health and suicide.[203, 204] A recent review of research on the development of children and youth in care concluded that foster care neither positively nor negatively impacted child and youth mental health outcomes, which is an issue of concern given that children entering care are more likely to be dealing with mental health problems.[205] Meta-analyses of comparisons between foster care and residential care showed greater mental health benefits associated with foster care.[206]

Young people experiencing homelessness are at increased risk of poor mental health. A recent review of evidence for a wide variety of interventions that address this found benefits of individual and family therapies in improving depression, while motivational interviewing, skill-building programmes, and case management showed inconsistent effects on mental health.[207] Females often experienced more benefit than males. There was very little mention of important considerations such as sexual orientation status – a notable gap as LGBT youth are disproportionately represented in the homeless population. There was also very limited evidence on the mental health impacts of structural interventions such as housing and case management.

198 Stella Taquette and Denise Leite Maia Monteiro, "Causes and consequences of adolescent dating violence: a systematic review", *Journal of Injury & Violence Research*, vol. 11, No. 2 (2019), pp. 137-147, DOI:10.5249/jivr.v11i2.1061.

199 Christine Barter and Nicky Stanley, "Inter-personal violence and abuse in adolescent intimate relationships: mental health impact and implications for practice", *International Review of Psychiatry*, vol. 28, No. 5 (2016), pp. 485-503, DOI:10.1080/09540261.2016.1215295.

200 Kirsten E. MacGregor and others, "A systematic review of short and medium-term mental health outcomes in young people following sexual assault", *Journal of Child & Adolescent Mental Health*, vol. 31, No. 3 (2019), pp. 161-181, DOI:10.2989/17280583.2019.1665533.

201 Taquette and Monteiro, "Causes and consequences of adolescent dating violence: a systematic review".

202 Dieter Wolke, Neil Tippett and Slava Dantchev, "Bullying in the family: sibling bullying", *The Lancet Psychiatry*, vol. 2, No. 10 (2015), pp. 917-929, DOI:10.1016/S2215-0366(15)00262-X.

203 Rhiannon Evans and others, "Comparison of suicidal ideation, suicide attempt and suicide in children and young people in care and non-care populations: systematic review and meta-analysis of prevalence", *Children and Youth Services Review*, vol. 82 (2017), pp. 122-129, DOI:10.1016/j.childyouth.2017.09.020.

204 Antti Kääriälä and Heikki Hiilamo, "Children in out-of-home care as young adults: a systematic review of outcomes in the Nordic countries", *Children and Youth Services Review*, vol. 79 (2017), pp. 107-114, DOI:10.1016/j.childyouth.2017.05.030.

205 Anouk Goemans, Mitch van Geel and Paul Vedder, "Over three decades of longitudinal research on the development of foster children: a meta-analysis", *Child Abuse & Neglect*, vol. 42 (2015), pp. 121-134, DOI:10.1016/j.chiabu.2015.02.003.

206 Dongdong Li, Grace S. Chng and Chi Meng Chu, "Comparing long-term placement outcomes of residential and family foster care: a meta-analysis", *Trauma, Violence, & Abuse*, vol. 20, No. 5 (2019), pp. 653-664, DOI:10.1177/1524838017726427.

207 Jean Zhuo Wang and others, "The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: a systematic review", *BMC Public Health*, vol. 19, art. 1528 (2019), DOI:10.1186/s12889-019-7856-0.

Box 4. Interview with an Indigenous 19-year-old man from Australia with out-of-home-care experience

I was removed from my family home and placed into the foster care system when I was two-and-a-half years old. I was put into a long-term foster placement, but at 12 years old the placement broke down due to behaviour relating to my trauma and my not really knowing how to deal with my situation. I would be fine until it came time to have access with my family and I would start playing up. Seeing domestic violence in my family situation took a toll on me, and I had to put myself first and stop access with my family. I was placed into residential care for a few years and left when I was 16 years old. I moved interstate to live with my aunty, but there were no supports so that placement broke down and then I moved in with family and friends.

Living in residential care was a living nightmare. I was living in a house with three other kids with behavioural issues. Just trying to deal with everyone's intense dynamics was really stressful. I was not allowed to simply go for a walk, and I felt trapped. A lot of the staff were not working to support us but were just there for the money and did not really care about us.

When I was in foster care, I had lots of support from people and non-government organizations. One of my problems was that I would get too attached to my caseworker and then that worker would leave. I started lashing out; I take full responsibility for that to this day. I went to see a counsellor, but I never told anyone about being suicidal or things like that. I kept everyone in the dark and I never really got along with counsellors, so I would go to one or two sessions and that would be the end. The only person I trusted was a worker who was not attached to the child welfare department or non-government organization, so I felt like my information would be safe.

School was really hard for me. The socializing aspect of school, getting involved and having to prove yourself to everyone, was difficult. I ended up truanting every class because I could not be bothered to deal with all of the pressure. However, work has been a very positive experience. I was able to get an Aboriginal school-based traineeship with an airline. I started working for a team for just over a year until COVID-19 shut down the industry. I got to do a lot of different things in my role. It was really rewarding, and I liked to work. I liked knowing I was doing something that was going to benefit me, and I was doing really well until the airports shut down.

I have always kept my mental health struggles to myself. I do not go around telling people what I am going through because I am used to dealing with it on my own. I have a role to advocate for young people in care with a peak organization. I like to advocate for other people's issues and help them solve them. In relation to mental health supports, I know that there are resources and information available out there, but I have not specifically gone on the Internet to look them up for myself. I am just someone who would rather deal with things by myself.

I do not go around telling people I am Aboriginal. I do not think it is something I should have to "come out" with, like religion or sexuality. If I meet someone who works with Aboriginal people or identifies as Aboriginal, I will tell them, but there is a lot of discrimination in Australia so I do not feel like I should have to tell people.

A lot of Indigenous people do have mental health problems, and the Government seems to know that. If the Government wanted to improve the mental health of Aboriginal people and earn their respect, I think changing the date [of Australia Day] would make a difference. Not removing Aboriginal kids from the community, helping young people to engage in our communities, and finding supports to help them to stay with their communities will make a big difference.

If you have problems finding affordable housing that you feel is safe and good for your mental health, then that is going to impact other areas that just continue to sort of pile up and impact our lives.

–Young person, Focus Group 4

d. Policy recommendations

- *Family structure, separation and bereavement.* Workshops should be offered to parents/carers to help them identify markers of poor mental health in their children and develop the skills needed to address the issues. Interventions and programmes should be designed and implemented to reduce the adverse mental health impacts on young people who have lost a parent, live in homes with a high level of conflict, live with parents with whom they have a low-quality relationship, live in out-of-home care, or are experiencing homelessness, as they are likely to be at higher risk of poor mental health.
- *Parenting styles and relational quality.* Trial parenting programmes – culturally adapted to take into account expectations of autonomy, gender norms, and other relevant factors – should be offered in low-resource settings. Community programmes should be created to encourage intergenerational communication about mental health.
- *Children of parents with a mental illness.* Action should be taken to ensure wide implementation of programmes for children of parents with a mental illness, including group- and family-based interventions.
- *Violence and abuse.* Steps should be taken to ensure the broad implementation of programmes that focus on gender equality and respectful relationships to reduce sexual assault, dating violence and the related mental health-related impacts, including in non-heterosexual relationships. Parenting programmes should incorporate a component on sibling relationships to reduce the risk of sibling bullying.
- *Children and youth in out-of-home and foster care and youth experiencing homelessness.* Efforts need to be made to improve research and data collection on the impacts of out-of-home, foster care and homelessness on youth mental health and well-being outcomes, both positive and negative.

4. Poverty and deprivation

a. Perception survey results

Sixty-seven per cent of respondents answered "yes" to the survey question asking whether there had been a time in the preceding 12 months when they wanted to talk to someone about a mental health or emotional issue they had but did not know where to turn.

As illustrated in **figure 23**, the most common reasons keeping respondents from getting the help they felt they needed in the preceding 12 months included the following:

- They wanted to work out the problem on their own or with help from family or friends.
- They were not sure if they needed help.
- They thought the problem would resolve itself.

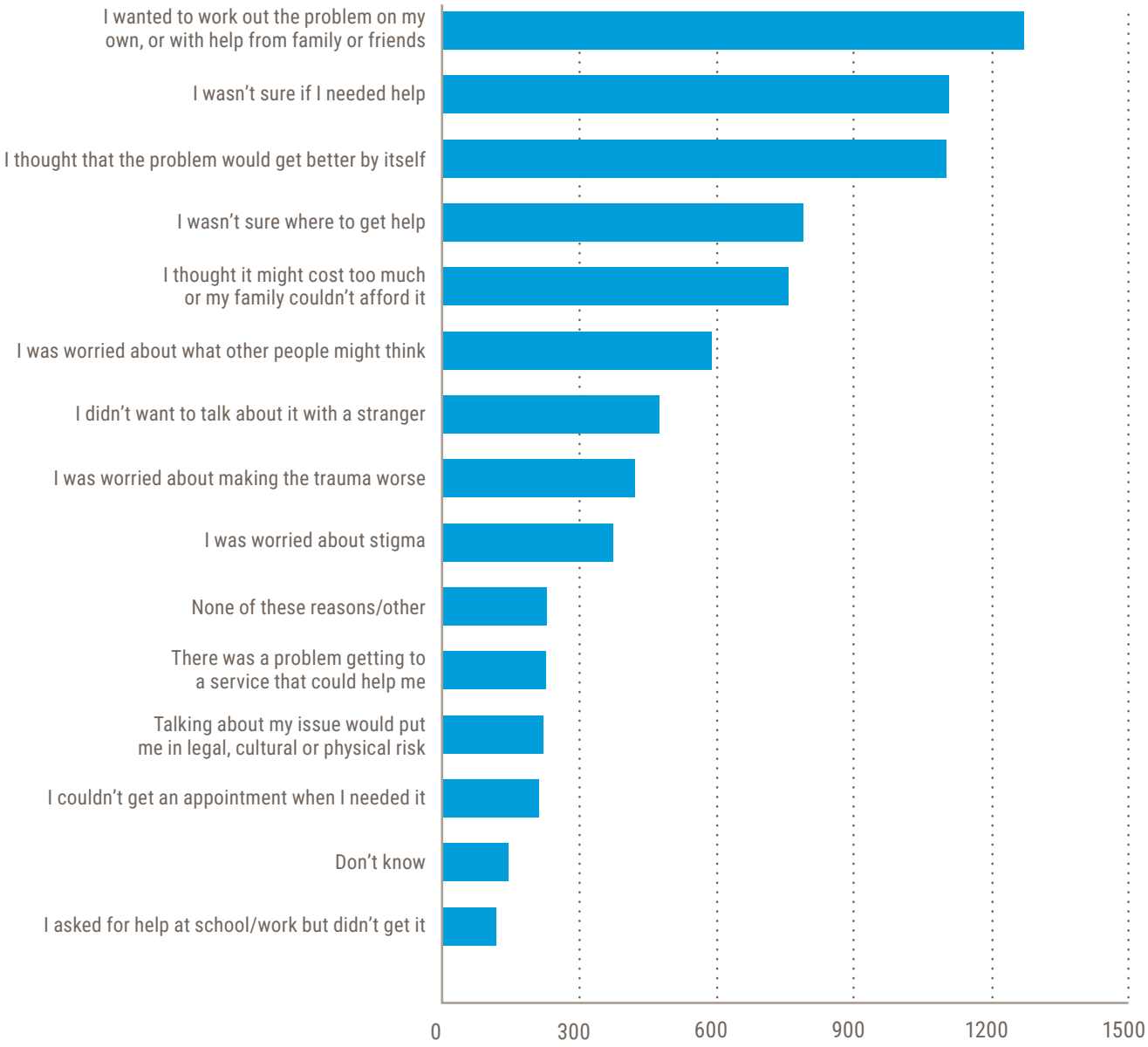
Sixty-nine per cent of the survey participants responded that they "never" went to school, work or to bed hungry because there was not enough food at home, but 3 per cent shared that this occurred "often" or "always" (see **figure 24**). While 80 per cent indicated that accommodation was not a problem for them, 1 per cent of the respondents reported that they were homeless (see **figure 25**).

b. Focus group results

Barriers linked to other social determinants – including education, employment and the digital environment – were attributed to a lack of inclusivity for those experiencing poverty. Participants in the focus groups were very concerned about the impact of inequity on mental health around the world, highlighting implications for access to education, employment, transportation, housing, services, recreation, and social interactions. Participants reported limitations for access to mental health supports for

FIGURE 23 REASONS FOR NOT SEEKING HELP

In the past 12 months did any of the following reasons keep you from getting the help you felt you needed? (Select all that apply)

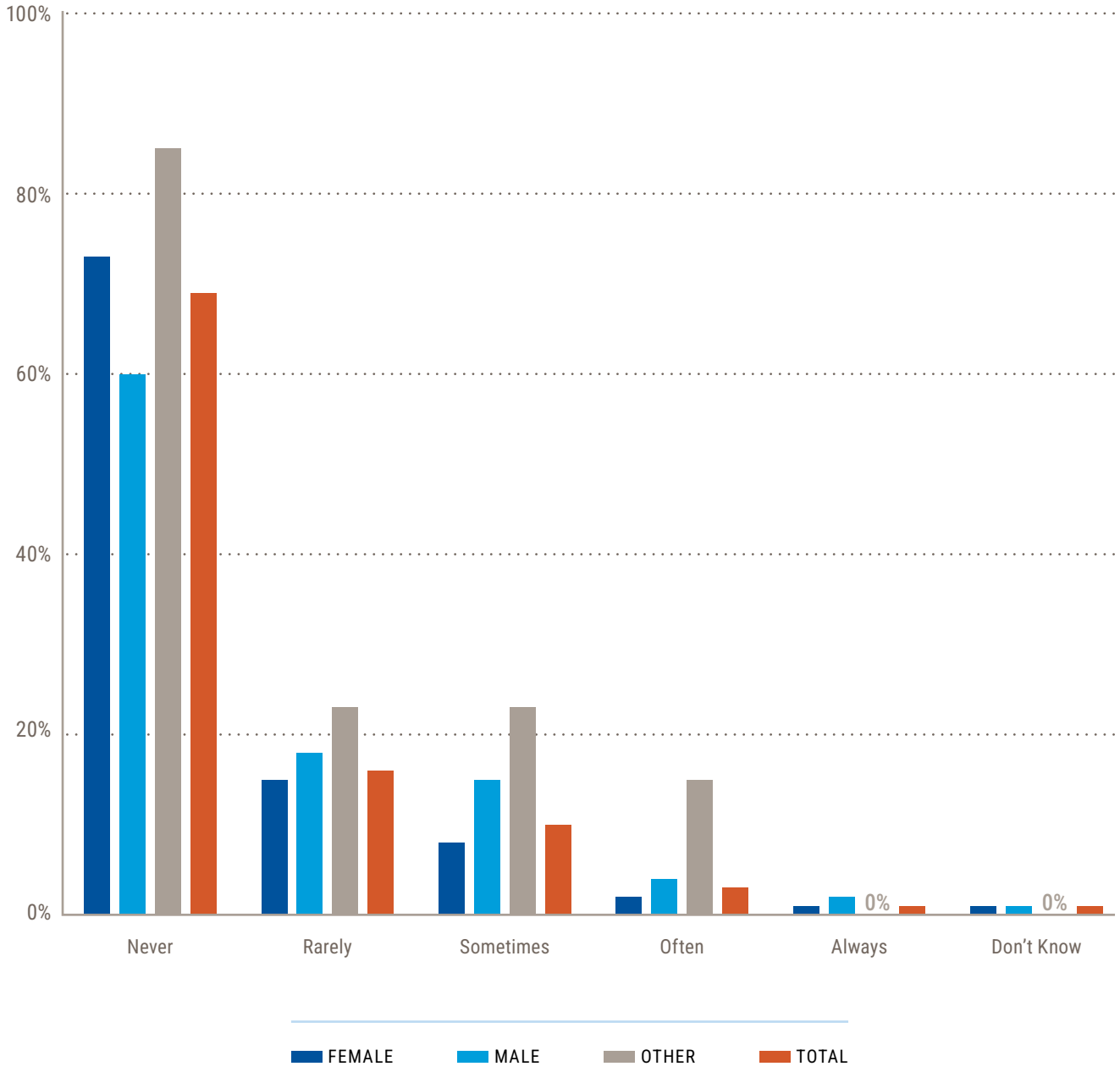


specific groups in their communities due to financial, geographic, and stigma-related constraints.

The socioeconomic status of a family unit was believed to have an impact on the prioritization of mental well-being. Some participants shared that the poverty their family experienced meant that basic needs were the focus, and mental health was seen to be something wealthier or "Western" communities were concerned about. This perspective made it hard for young people to gain support for their mental health, as it was not seen as important in the family home. The impact of migration on mental health was also mentioned; skills from the home country not being recognized in the new country and the need to start from scratch were reported to have a significant impact on the sense of identity and self-worth of all family members.

FIGURE 24 HUNGER AND INSUFFICIENT FOOD RESOURCES

Some young people go to school, work or to bed hungry because there is not enough food at home. How often does this happen to you?



During the COVID-19 pandemic, the lack of access to stable Internet, employment, and services was a significant issue for many young people. Participants reported that the widening inequities in these areas took a toll on their mental health and interfered with their ability to seek help. Actions that might ordinarily bolster mental health were largely restricted during the pandemic, which left many participants struggling with declining mental health.

c. Social determinants

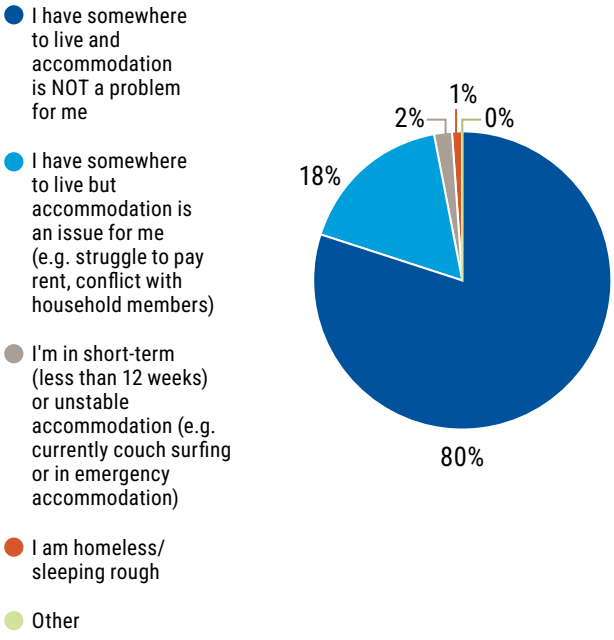
Children and young people are disproportionately affected by poverty. Approximately 1 billion children "lack necessities as basic as nutrition or clean water",[208] and It is estimated that an additional 150 million children were plunged into multidimensional poverty (with no access to essential services) during the first year of the COVID-19 pandemic.[209] The impact of poverty and deprivation on the mental health of youth – and on the mental health of the next generation – is an issue of considerable concern worldwide.

Numerous studies have assessed associations between a range of measures of poverty and deprivation and mental health outcomes, with most showing that poverty and deprivation are linked to poor mental health.[210, 211, 212] The relationship may be stronger for externalizing problems (such as antisocial aggressive behaviour directed at others) than for internalizing problems (such as anxiety or depression).[213, 214]

Poverty and deprivation are associated with poor mental health through multiple interrelated mechanisms. Effects on mental health may be direct, deriving from factors such as undernutrition, or may be mediated through a broad range of mechanisms at multiple levels. At the individual level such effects could be mediated by the security provided by safe housing or the stimulation provided by access to toys and books, at the relational level mediating factors might include exposure to parental stress or the presence of positive peer relationships, and at the institutional level living in a disadvantaged neighbourhood or lacking access to healthcare constitute mediating variables.[215]

FIGURE 25 YOUTH HOUSING STATUS

Which describes your current living situation?



208 Chloe Hall, "Defining child poverty", Poverty Child programmes, 4 January 2023, available at https://povertychild.org/defining-child-poverty/.

209 UNICEF, "Impact of COVID-19 on multidimensional child poverty", guidance, 16 September 2020, available at https://data.unicef.org/resources/impact-of-covid-19-on-multidimensional-child-poverty/#:~:text=Approximately%20150%20million%20additional%20children,Save%20the%20Children%20and%20UNICEF.

210 Nicole L. Letourneau and others, "Socioeconomic status and child development: a meta-analysis", *Journal of Emotional and Behavioral Disorders*, vol. 21, No. 3 (2013), pp. 211-224, DOI:10.1177/1063426611421007.

211 Franziska Reiss, "Socioeconomic inequalities and mental health problems in children and adolescents: a systematic review", *Social Science & Medicine*, vol. 90 (2013), pp. 24-31, DOI:10.1016/j.socscimed.2013.04.026.

212 Shiyou Wu and others, "Welfare participation and depression among youth in the United States: a systematic review", *Children and Youth Services Review*, vol. 94 (2018), pp. 354-367, DOI:10.1016/j.childyouth.2018.09.018.

213 Ibid.

214 Patrycja J. Piotrowska and others, "Socioeconomic status and antisocial behaviour among children and adolescents: a systematic review and meta-analysis", *Clinical Psychology Review*, vol. 35 (2015), pp. 47-55, DOI:10.1016/j.cpr.2014.11.003.

215 Hirokazu Yoshikawa, J. Lawrence Aber and William R. Beardslee, "The effects of poverty on the mental, emotional, and behavioral health of children and youth: implications for prevention", *American Psychologist*, vol. 67, No. 4 (2012), pp. 272-284, DOI:10.1037/a0028015.

Access to extracurricular activities can play an important role in supporting the mental health of young people facing multiple challenges.
©UN photo/Isaac Billy

These factors interact in complex ways not only with other social determinants (such as gender inequality, exposure to hazardous work, or child labour), but also with the developmental processes that occur throughout childhood and adolescence.

Adolescence is a time of identify formation during which social status plays a central role; low social status as a result of poverty may be associated with discrimination and other disadvantages (including exposure to violence), all of which have been associated with poor mental health in young people.[216, 217, 218]

Because of the many challenges they face, children and youth raised in poverty may struggle to accumulate the "health capital" that contributes to educational attainment, positive peer relationships and the development of social and emotional skills, and the ability to parent later in life. As a consequence, poverty early in life is strongly associated with intergenerational cycles of poverty and the transmission of mental health risks.[219] These interactions highlight the impact that both absolute poverty (the level of income necessary to maintain basic living standards) and relative poverty or deprivation (the level of income necessary to maintain minimum living standards relative to the standards of a society or country) can potentially have on mental health.

Studies in this area have used various measures of poverty, including socioeconomic status (a theoretical construct measured by income/wealth, education, and occupation), inequality (the unequal distribution of income and opportunity between different groups in society) and area-level or neighbourhood disadvantage (a cluster of factors that make it difficult for people living in certain areas to achieve positive life outcomes).

Socioeconomic status

A search for associations between various indicators of socioeconomic status and mental health outcomes for children and youth aged 4-18 years identified 55 studies, 52 of which indicated an inverse relationship between socioeconomic status and mental health problems in children and youth.[220] Research findings indicated that socioeconomically disadvantaged children and youth were two to three times more likely than those of higher socioeconomic status to develop mental health problems. Persistently low socioeconomic status was strongly related to the onset of mental health problems, and low household income and low parental education were the strongest predictors of poor mental health. The impact of low socioeconomic status on mental health appeared to be stronger in early childhood than in adolescence, but no consistent gender effects were seen.

216 Evelina Landstedt and Ylva B. Almquist, "Intergenerational patterns of mental health problems: the role of childhood peer status position", *BMC Psychiatry*, vol. 19, art. 286 (2019), pp. 1-10, DOI:10.1186/s12888-019-2278-1.

217 Michael T. Schmitt and others, "The consequences of perceived discrimination for psychological well-being: a meta-analytic review", *Psychological Bulletin*, vol. 140, No. 4 (2014), pp. 921-948, DOI:10.1037/a0035754. Epub 2014 Feb 17.

218 Père Castellvi, Andrea Miranda-Mendizabal and Oleguer Parés-Badell, "Exposure to violence, a risk for suicide in youths and young adults: a meta-analysis of longitudinal studies", *Acta Psychiatrica Scandinavica*, vol. 135, No. 3 (2017), pp. 195-211, DOI:10.1111/acps.12679.

219 Tina L. Cheng, Sara B. Johnson and Elizabeth Goodman, "Breaking the intergenerational cycle of disadvantage: the three generation approach", *Pediatrics*, vol. 137, No. 6 (2016), e20152467, DOI:10.1542/peds.2015-2467.

220 Reiss, "Socioeconomic inequalities and mental health problems in children and adolescents: a systematic review".

Studies of associations between changes in socioeconomic status and youth mental health offer mixed results.[221] A small number of studies show that when families move out of poverty, child mental health improves. One such study identified associations between income increases resulting from the opening of a casino on an American Indian reservation and improvements in mental health (externalizing but not internalizing problems in younger adolescents).[222] A study using data from the National Longitudinal Study of Youth in the United States of America, with repeated measures of income status and mental health among children aged 4-14 years across a 13-year time interval, also showed that improvements in household income reduced mental health problems. Additional analyses showed that the effect of initial household income on the rate of change in child depression attenuated as children grew older, whereas for antisocial behaviour the effects became stronger over time.[223]

A review of evidence of the pathways between low socioeconomic status and youth health (including mental health) outcomes identified several significant risk factors, including economic stress, chaos in the home, and violence in the community. Some evidence suggested that these risk factors were mediated by parent depression, conflict between parents, and poor parenting practices.[224, 225] Youth with a sense of purpose in life, higher self-esteem, and healthy coping mechanisms appeared to be at lower risk of poor mental health in spite of living in areas of greater socioeconomic disadvantage. The review also showed that gender moderated many of the relationships, with one study from the United States of America showing that socioeconomic status was related to poor mental health in male youth through associations with poor parenting practices and involvement in a peer group engaging in risky behaviours, while this was not the case for young women.

Other indicators of poverty and deprivation associated with mental health problems include welfare participation,[226] food insecurity,[227] and homelessness.[228] Food insecurity appears to exert different effects on mental health depending on age.[229] In adolescence, it is associated with poor mental health and suicide, with the risk mediated by poor maternal mental health, which may also be either a predictor or an outcome of food insecurity. Homelessness is both a cause and a consequence of poor mental health.[230] A review of studies of prevalence rates for mental illness diagnoses in homeless youth in both high-income and low- and middle-income countries found higher rates of depression, PTSD, anxiety and substance use disorders for this group than for non-homeless youth or the general population.[231]

Economic inequality

Recent decades have seen dramatic rises in income inequality in most countries, with potential adverse mental health impacts, particularly among people with lower incomes.[232] A time-series analysis of socioeconomic inequality data from the Health Behaviour in School-aged Children study, conducted in 34 Northern American and European countries in 2002, 2006, and 2010, showed that socioeconomic inequality had increased in many

221 Katie Stirling, John W. Toumbourou and Bosco Rowland, "Community factors influencing child and adolescent depression: a systematic review and meta-analysis", *Australian and New Zealand Journal of Psychiatry*, vol. 49, No. 10 (2015), pp. 869-886, DOI:10.1177/0004867415603129.
222 Elizabeth Jane Costello and others, "Relationships between poverty and psychopathology: a natural experiment", *JAMA: The Journal of the American Medical Association*, vol. 290, No. 15 (2003), pp. 2,023-2,029, DOI:10.1001/jama.290.15.2023.
223 Lisa Strohschein, "Household income histories and child mental health trajectories", *Journal of Health and Social Behavior*, vol. 46, No. 4 (2005), pp. 359-375, DOI:10.1177/002214650504600404.
224 Bethany Devenish, Merrilyn Hooley and David Mellor, "The pathways between socioeconomic status and adolescent outcomes: a systematic review", *American Journal of Community Psychology*, vol. 59, No. 1-2 (2017), pp. 219-238, DOI:10.1002/ajcp.12115.
225 Sophie Wickham and others, "The effect of a transition into poverty on child and maternal mental health: a longitudinal analysis of the UK Millennium Cohort Study", *The Lancet Public Health*, vol. 2, No. 3 (2017), pp. e141-e148, DOI:10.1016/S2468-2667(17)30011-7.
226 Wu and others, "Welfare participation and depression among youth in the United States: a systematic review".
227 Priya Shankar, Rainjade Chung and Deborah A. Frank, "Association of food insecurity with children's behavioral, emotional, and academic outcomes: a systematic review", *Journal of Developmental & Behavioral Pediatrics*, vol. 38, No. 2 (2017), pp. 135-150, DOI:10.1097/DBP.0000000000000383.
228 Sandra Feodor Nilsson, Merete Nordentoft and Carsten Hjorthøj, "Individual-level predictors for becoming homeless and exiting homelessness: a systematic review and meta-analysis", *Journal of Urban Health*, vol. 96, No. 5 (2019), pp. 741-750, DOI:10.1007/s11524-019-00377-x.
229 Shankar, Chung and Frank, "Association of food insecurity with children's behavioral, emotional, and academic outcomes: a systematic review".
230 Nilsson, Nordentoft and Hjorthoj, "Individual-level predictors for becoming homeless and exiting homelessness: a systematic review and meta-analysis".
231 Sharon Medlow, Emily Klineberg and Kate Steinbeck, "The health diagnoses of homeless adolescents: a systematic review of the literature", *Journal of Adolescence*, vol. 37, No. 5 (2014), pp. 531-542, DOI:10.1016/j.adolescence.2014.04.003.
232 Wagner Silva Ribeiro and others, "Income inequality and mental illness-related morbidity and resilience: a systematic review and meta-analysis", *The Lancet Psychiatry*, vol. 4, No. 7 (2017), pp. 554-562, DOI:10.1016/S2215-0366(17)30159-1.

domains of youth health (including mental health) and that these trends coincided with unequal income distribution between rich and poor people.[233]

Living in the north [of Canada], inequality often shows up in conversations about lack of access and lack of opportunities, services and resources.

–Young person, Focus Group 4

A recent meta-analysis of studies investigating the association between income inequality and the population prevalence of depression showed a greater risk of depression in populations with higher income inequality than in those with lower income inequality.[234] Effects appeared to be greater among women and in low-income populations. Five of the studies included in the review were of young people, and the majority were undertaken in high-income countries. In three of the five studies, inequality was positively associated with depression, with one study showing an impact for girls only; in another study the association was equivocal, and in the remaining study no association was seen. The authors also carried out a scoping review of mechanisms, concluding that the relationship between income inequality and depression was primarily mediated through psychological stress at the individual level and through adverse impacts of social comparison and low social capital at the neighbourhood level.

More recently, Vilhjalmsdottir and others conducted a study involving more than 24,000 Icelandic youth to ascertain whether changes in community income inequality affected emotional distress.[235] After adjusting for individual and community factors, it was found that declines in community income inequality were significantly associated with decreases in anxiety but not in depressive symptoms. However, potential mediators of the relationship, such as social capital, were not tested.

Indicators of income inequality may vary based on demographic factors. Among the youth surveyed for the current publication, carers were the most likely to go to school, work or bed hungry at least "sometimes" (26 per cent) and to have problems with their current living situation (66 per cent), followed by migrants and refugees (with corresponding rates of 23 and 68 per cent).

Suicide

A recent meta-analysis of studies of worldwide suicide rates among individuals aged 10-19 years assessed the relationships between economic quality (based on World Bank income group classifications) and inequality (as measured by the Gini coefficient).[236] The results showed that economic quality and inequality were not related to suicide mortality rates overall or by age or sex. However, economic inequality was positively correlated with a higher ratio of male to female suicides in 15- to 19-year-olds. While further research is needed, these studies provide additional evidence that the mental health impacts of inequality may be greater for young men than for young women. It is worth noting that most of the 45 countries covered in the review were high- and upper-middle-income countries, and that only national-level data were used, precluding the examination of the extent and impact of economic heterogeneity within the countries studied.

Neighbourhood risk factors

Evidence for associations between neighbourhood socioeconomic disadvantage and youth mental health is mixed, with some studies in the general population

233 Frank J. Elgar and others, "Socioeconomic inequalities in adolescent health 2002-2010: a time-series analysis of 34 countries participating in the Health Behaviour in School-aged Children study", *The Lancet*, vol. 385, No. 9982 (2015), pp. 2,088-2,095, DOI:10.1016/S0140-6736(14)61460-4.

234 Vikram Patel and others, "Income inequality and depression: a systematic review and meta-analysis of the association and a scoping review of mechanisms", *World Psychiatry*, vol. 17, No. 1 (2018), pp. 76-89, DOI:10.1002/wps.20492.

235 Arndis Vilhjalmsdottir and others, "Decreasing income inequality and adolescent emotional distress: a population-based case study of Icelandic adolescents 2006–2016", International Journal of Public Health, vol. 64, No. 2 (2019), pp. 253-263, DOI:10.1007/s00038-018-1193-4.

236 Catherine R. Glenn and others, "Annual research review: a meta-analytic review of worldwide suicide rates in adolescents", *Journal of Child Psychology and Psychiatry*, vol. 61, No. 3 (2020), pp. 294-308, DOI:10.1111/jcpp.13106.

finding associations and others not.[237] A review of evidence of associations between neighbourhood risk factors and mental health problems in young people aged 10-20 years found that a higher level of neighbourhood socioeconomic poverty was associated with depression as well as suicidal thoughts and attempts, with potentially greater impacts for boys than for girls.[238] However, a more recent meta-analysis did not find any association between community disadvantage and depression in young people once other factors had been controlled for.[239] This finding was recently supported by a prospective study examining associations of neighbourhood social fragmentation, income inequality, and median household income with depressive symptoms in a nationally representative sample of youth in the United States of America over six years.[240] Results showed no significant associations between any measure of neighbourhood disadvantage and depressive symptoms; given the geographic diversity of the sample, this might reflect non-existent relationships or undetectable relationships.

A review of studies examining area-level socioeconomic disadvantage and its association with suicidal behaviour and self-harm in Europe found strong evidence of an association, particularly for men.[241] Although these studies are not focused on youth, they are considered relevant given the evidence that suicide is now the second leading cause of death among 15- to 29-year-olds globally.[242]

Stable housing is essential for protecting youth mental health and well-being. ©Iddah Akinyi

Interventions designed to address poverty and deprivation

While there is ample evidence of the associations between various measures of poverty and deprivation and poor mental health, there is relatively little evidence for the mental health impact of policies and programmes that address these determinants in youth.

There is emerging evidence of the impact of cash transfers on mental health and well-being in low- and middle-income countries, though most of the studies focus on adult populations.[243] Effects may be stronger for life satisfaction than for depression, and unconditional cash transfers appear to have a larger impact than do conditional cash transfers. There is some evidence that impacts appear to diminish over time, though this may not always be the case. A national unconditional cash transfer programme in Kenya was linked to a significant reduction in depressive symptoms in orphaned and vulnerable youth over a period of four years, particularly

237 Robin Richardson and others, "Neighborhood socioeconomic conditions and depression: a systematic review and meta-analysis", *Social Psychiatry and Psychiatric Epidemiology*, vol. 50, No. 11 (2015), pp. 1,641-1,656, DOI:10.1007/s00127-015-1092-4.

238 Sarah Curtis and others, "Neighbourhood risk factors for common mental disorders among young people aged 10-20 years: a structured review of quantitative research", *Health & Place*, vol. 20 (2013), pp. 81-90, DOI:10.1016/j.healthplace.2012.10.010.

239 Stirling, Toumbourou and Rowland, "Community factors influencing child and adolescent depression: a systematic review and meta-analysis".

240 Risë B. Goldstein and others, "Neighbourhood disadvantage and depressive symptoms among adolescents followed into emerging adulthood", *Journal of Epidemiology and Community Health*, vol. 73, No. 7 (2019), pp. 590-597, DOI:10.1136/jech-2018-212004.

241 Joanne-Marie Cairns, Eva Graham and Clare Bambra, "Area-level socioeconomic disadvantage and suicidal behaviour in Europe: a systematic review", *Social Science & Medicine*, vol. 192 (2017), pp. 102-111, DOI:10.1016/j.socscimed.2017.09.034.

242 WHO, "Mental health, brain health and substance use: suicide data", available at https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/ (accessed on 9 March 2020).

243 Joel McGuire, Caspar Kaiser and Anders M. Bach-Mortensen, "A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle- income countries", *Nature Human Behaviour*, vol. 6, No. 3 (2022), pp. 1-12, DOI:10.1038/s41562-021-01252-z .

in males.[244] In a review of interventions aimed at reducing youth depression in low- and middle-income countries, Davaasambuu and others identified three microfinance/economic interventions, with meta-analysis of the effects showing significant short-term reductions in depression symptoms.[245]

There is evidence from studies using a range of measures that poverty and deprivation are associated with poor mental health. While most of the work in this area has been conducted in the adult population, a growing number of studies report similar findings for youth. Current evidence appears to point to stronger relationships between socioeconomic status and poor youth mental health than between economic inequality and poor youth mental health.

Further work is needed to establish the relationships between more wide-ranging aspects of poverty and specific mental health outcomes in order to understand where best to target policy actions and programmes. There is also a need for more studies of the mediators and moderators of the associations between poverty and deprivation and poor youth mental health. Improving knowledge of the specific modifiable influences on youth mental health that are unequally distributed across socioeconomic groups can inform efforts to reduce the transgenerational transmission of socioeconomic status inequalities related to health.

The knowledge gap is particularly acute in low- and medium-income countries; most of the current evidence is drawn from studies in high-income countries.[246] Studies typically measure poverty using indicators such as individual economic status and unemployment status, with factors such as debt, relative poverty, absolute poverty, economic crisis, and national income not given the same level of consideration. Many studies assess family socioeconomic status but pay less attention to younger youth within families, their educational achievements, or their social standing among peers. Studies of the impact of poverty on suicide are complicated by the stigma and criminalization of suicidal behaviour in some countries. Steps should be taken to address these barriers in order to improve data collection and advocate for action aimed at preventing suicide.[247]

As mentioned previously, there is clear evidence of associations between poverty and poor mental health but relatively little evidence of the effects of poverty reduction policies and programmes on youth mental health. Cash transfers in low- and middle-income countries show promise for poverty alleviation, and there is a need to further explore the mental health benefits of this type of intervention, particularly for youth, as the impact on young people and adults may not be the same.[248] Given that the association between socioeconomic disadvantage and poor mental health in youth is moderated by the family environment, especially the quality of parenting and parental mental health, interventions designed to improve parenting and support parents with a mental illness are also likely to pay a role in reducing the impact of poverty on youth mental health. School-based interventions, including those focused on social and emotional learning, are also likely to be important.

There are a number of steps Governments and other stakeholders can take to mitigate the adverse impacts of economic inequality on youth mental health. Economic policies that incorporate mechanisms such as universal basic income and progressive taxation can be implemented to promote the fair distribution of income, and opportunities for educational attainment can be expanded. Ensuring that mental health care is a key component of universal health coverage is also likely to be essential for reducing the risk of poor mental health further exacerbating poverty.[249] For youth in particular, digital interventions may play a role, though care should be taken to avoid increasing inequities as some young people from marginalized groups may not have access to relevant

244 Kelly Kilburn and others, "Effects of a large-scale unconditional cash transfer program on mental health outcomes of young people in Kenya", *Journal of Adolescent Health*, vol. 58, No. 2 (2016), pp. 223-229, DOI:10.1016/j.jadohealth.2015.09.023.

245 Sarantsetseg Davaasambuu and others, "Effects of interventions to reduce adolescent depression in low- and middle-income countries: a systematic review and meta-analysis", *Journal of Psychiatric Research*, vol. 123 (2020), pp. 201-215, DOI:10.1016/j.jpsychires.2020.01.020.

246 Jason Bantjes and others, "Poverty and suicide research in low-and middle-income countries: systematic mapping of literature published in English and a proposed research agenda", *Cambridge Prisms: Global Mental Health*, vol. 3, No. 32 (2016), pp. 1-18, DOI:10.1017/gmh.2016.27.

247 Ibid.

248 Julia R. Pozuelo and others, "Cash transfers in adolescence: a developmental perspective", *The Lancet Child & Adolescent Health*, vol. 4, No. 3 (2020), pp. 177-178, DOI:10.1016/S2352-4642(19)30432-8.

249 Patel and others, "Income inequality and depression: a systematic review and meta-analysis of the association and a scoping review of mechanisms".

technologies. Tackling stigma, which acts as a barrier to engagement with services and exacerbates social and economic exclusion, is also likely to be important.[250] Interventions that build social networks and reduce social isolation and individual interventions to promote resilience may also have a positive impact.

d. Policy recommendations

- *Socioeconomic status.* Action should be taken to strengthen social policies aimed at reducing the impact of poverty on families, with particular attention directed towards access to parenting programmes, interventions to reduce family conflict and violence, and support for parents with a mental illness.
- *Economic inequality.* There is a need for economic policies that promote the fair distribution of income through mechanisms such as universal basic income and progressive taxation. Providing universal health coverage and expanding access to education are other key strategies for addressing economic inequality. Consideration should be given to the wider implementation of (preferably unconditional) cash transfer programmes for youth (alongside the evaluation of impacts). Steps should be taken to ensure equal access to mental health services, especially in rural regions.
- *Suicide.* Policies and programmes should be implemented that promote protective factors such as higher self-esteem, a sense of purpose in life, and healthy coping mechanisms. Attention should be given to addressing poverty-related risks in suicide prevention interventions, particularly for young men.
- *Neighbourhood risk factors.* Policies and programmes should be implemented to reduce the impact of poverty in economically marginalized groups, including young people who are homeless, use substances, are involved in the youth justice system, or are engaged in sex work.
- *Interventions to address the impacts of poverty and deprivation on mental health.* Whole-school approaches to supporting mental health should be adopted to ensure that healthy social-emotional and physical environments are maintained, with education (including social and emotional learning) programmes provided for young people, families, and the wider community. Actions aimed at addressing the social determinants of mental health should include improving access to affordable housing, universal health care, support services, transportation, and secure employment.

5. Technology and the online environment

a. Perception survey results

For one of the survey questions, participants were asked whether they had engaged in specific activities within the preceding 12 months to help them manage any emotional or behavioural issues they may have had or to avoid experiencing such issues. The most common responses were that they did more of the things they enjoyed, exercised more or took up a sport, or sought support from friends (see **figure 26**). A couple of the response options included specific reference to digital engagement, while others may or may not have involved digital interaction, depending on the circumstances.

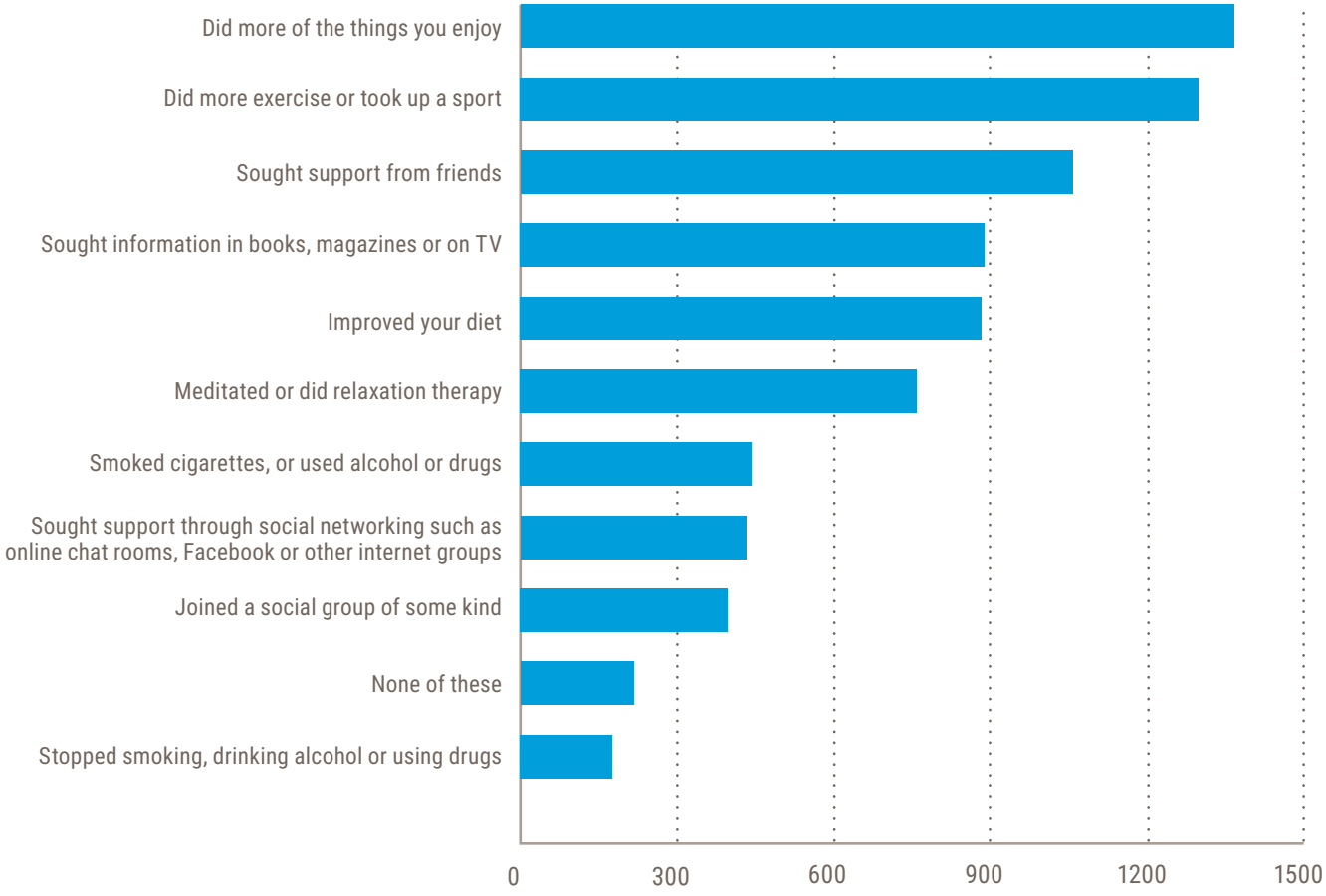
Close to half of the respondents reported that how they felt about themselves depended on what others thought of them online at least "sometimes" (see **figure 27**). Age did not have a significant impact on responses, with 48-49 per cent of those between the ages of 15 and 29 offering responses of "sometimes", "often" or "always". Those identifying their gender as "other" were significantly more likely to respond "always" and less likely to respond "never".

For the survey question asking participants how often they had experienced cyberbullying within the preceding 12 months, 75 per cent responded "never", 15 responded "once or twice", and less than 1 per cent indicated that they had been bullied online every day (see **figure 28**).

250 Graham Thornicroft and others, "Evidence for effective interventions to reduce mental-health-related stigma and discrimination", *The Lancet*, vol. 387, No. 10023 (2016), pp. 1,123-1,132, DOI:10.1016/S0140-6736(15)00298-6.

FIGURE 26 ACTIONS UNDERTAKEN BY YOUTH TO HELP MANAGE EMOTIONAL AND BEHAVIOURAL ISSUES

In the past 12 months have you done any of the following things to help manage any emotional or behavioural issue you may have, or to avoid having issues? (check all relevant)



Those identifying their gender as "other" were more likely to respond with higher-frequency options, with around a third indicating that they had been cyberbullied "most days". There were no significant variations in responses based on age.

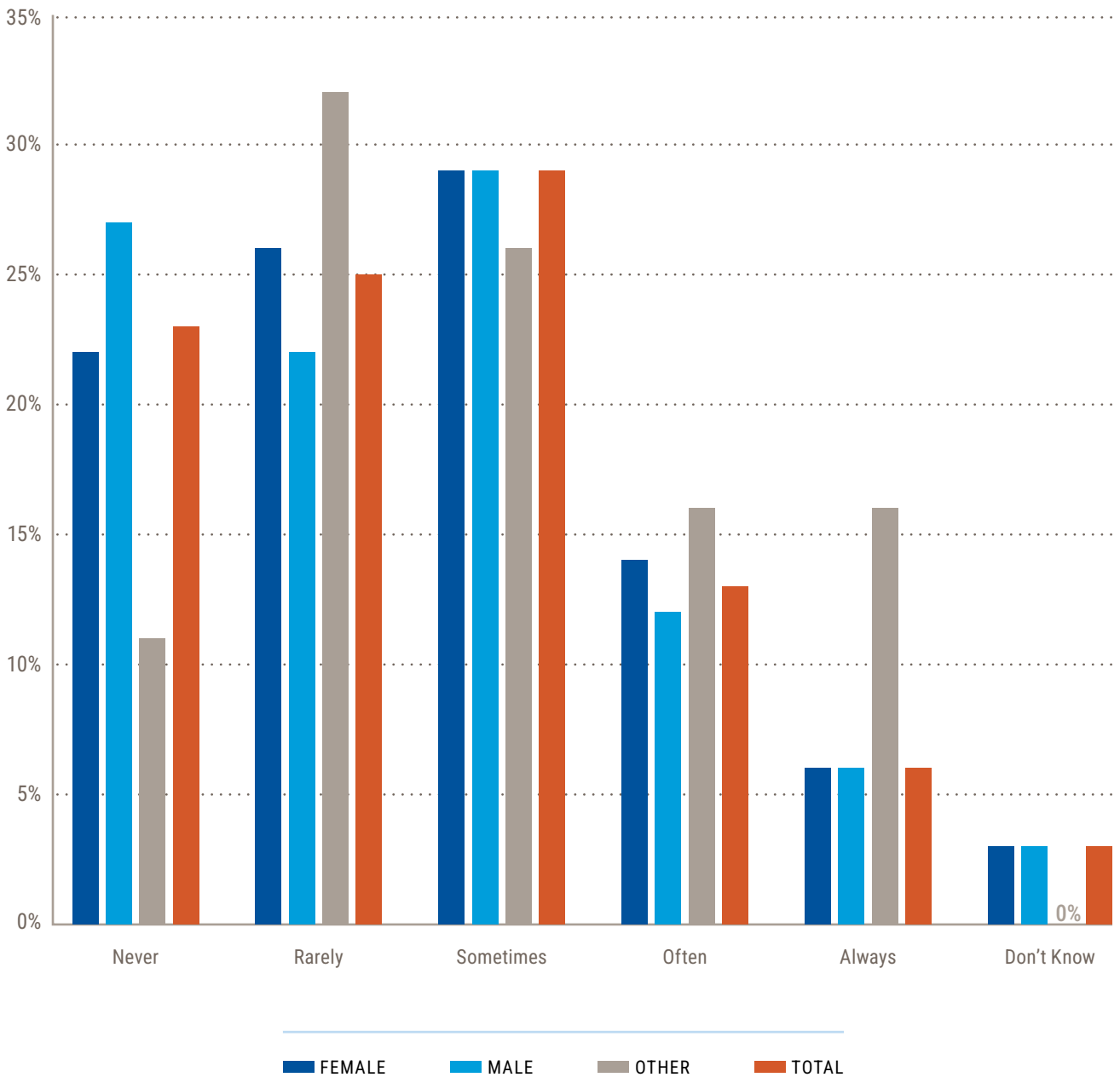
When asked about the types of Internet-based services used within the preceding 12 months to get help for or information about an emotional or behavioural issue, the most frequently selected options were "information about mental health services" and "online assessment tool", though "none of the above" was also among the top responses (see **figure 29**).

b. Focus group results

The young focus group participants found the differentiation between the "online world" and the "real world" problematic, maintaining that because social interactions, education, employment, mental health support, and engagement in society happened online in tandem with the local context, the online environment and physical environment were both their "real world". Within the online environment, young people expressed their values, took action on issues, sought help from peers and professionals, discovered their identities, and grew and developed as human beings. These actions were possible without the support or direction of adults or physical institutions.

FIGURE 27 FEELINGS ABOUT ONESELF BASED ON THE OPINIONS OF OTHERS ONLINE

How I feel about myself depends on what others think of me
(indicate how often you feel this way)



Inclusive digital spaces nurture belonging, creativity, and well-being of young people. ©UN Photo/Isaac Billy

Focus group participants reported a range of positive impacts from engaging online. The unlimited access to information about mental health and finding like-minded people or communities with similar experiences were viewed as having the most significant positive impacts on mental health. Young people were able to access services online that were not available in their local areas. Social interactions, whether with local friends or online friends, took place on social media platforms and through the Internet. Young people reported learning skills relating to communication, emerging technologies, new hobbies, advocacy, and self-care online. These skills were seen as valuable for their lives but also for future employment.

The online environment was viewed as an easy entry point for accessing mental health supports. The availability of mental health apps and websites managed by professional bodies allowed young people to learn about mental health and well-being and address related concerns anonymously. Anonymity was a key factor for many participants in seeking information on and support for mental health. The availability of options for interaction (such as text, email, chat, forums, and posting platforms) enabled engagement with various forms of support and made services more inclusive.

While acknowledging the many positive aspects of digital connectivity, participants also expressed concerns about the negative impacts the online environment had on their mental health. Long periods in front of screens leading to a sedentary lifestyle and hyper-comparison or social competition were the largest concerns. Social media acting as "echo chambers", where users had access to only one side of an argument, was of great concern, though participants reported actively seeking out alternate platforms where they were exposed to other ideas and opinions.

The COVID-19 pandemic highlighted the connectivity possible through the online environment while also creating a stronger sense of isolation since all interactions were virtual and participants felt an acute lack of the physical interaction they had enjoyed before the pandemic. The growing discussions around mental health were viewed as positive overall, but there were also mounting concerns about "self-diagnosis" and friends turning to each other for support rather than reliance on professional services or supports to address mental health concerns.

Online engagement and youth experiences

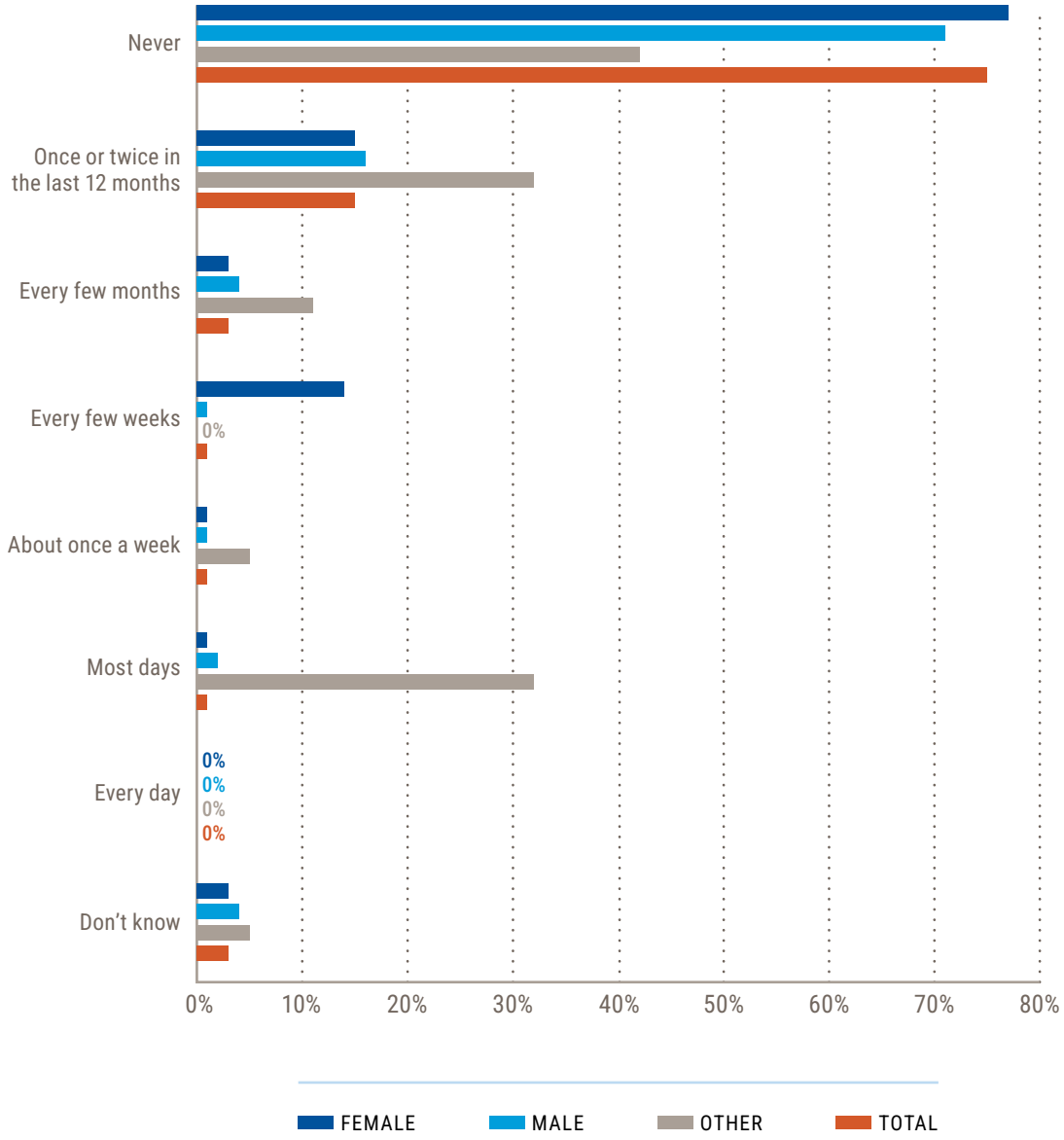
Online engagement is a broad term that captures the interaction between people and online environments accessible via mobile phones, computers, and gaming systems. Youth experiences in the online environment are being actively explored and analysed, with researchers engaged in vigorous debate over the impact of digital engagement and the use of contemporary technologies such as computers and mobile phones on young people's mental health.[251] According to Perry and Singh,[252] advances in technology in the past few decades have changed the landscape of child development in many communities, with children spending more time on screens and gaming. This has led to the development of proposed

251 Elia Abi-Jaoude, Karline Treurnicht Naylor and Antonio Pignatiello, "Smartphones, social media use and youth mental health", *Canadian Medical Association Journal*, vol. 192, No. 6 (2020), pp. e136–e141, DOI: 10.1503/cmaj.190434.

252 Benjamin Ian Perry and Swaran Singh, "A virtual reality: technology's impact on youth mental health", *Indian Journal of Social Psychiatry*, vol. 32, No. 3 (2016), pp. 222-226, DOI:10.4103/0971-9962.193190.

FIGURE 28 FREQUENCY OF CYBERBULLYING

In the last 12 months, how often were you cyberbullied?

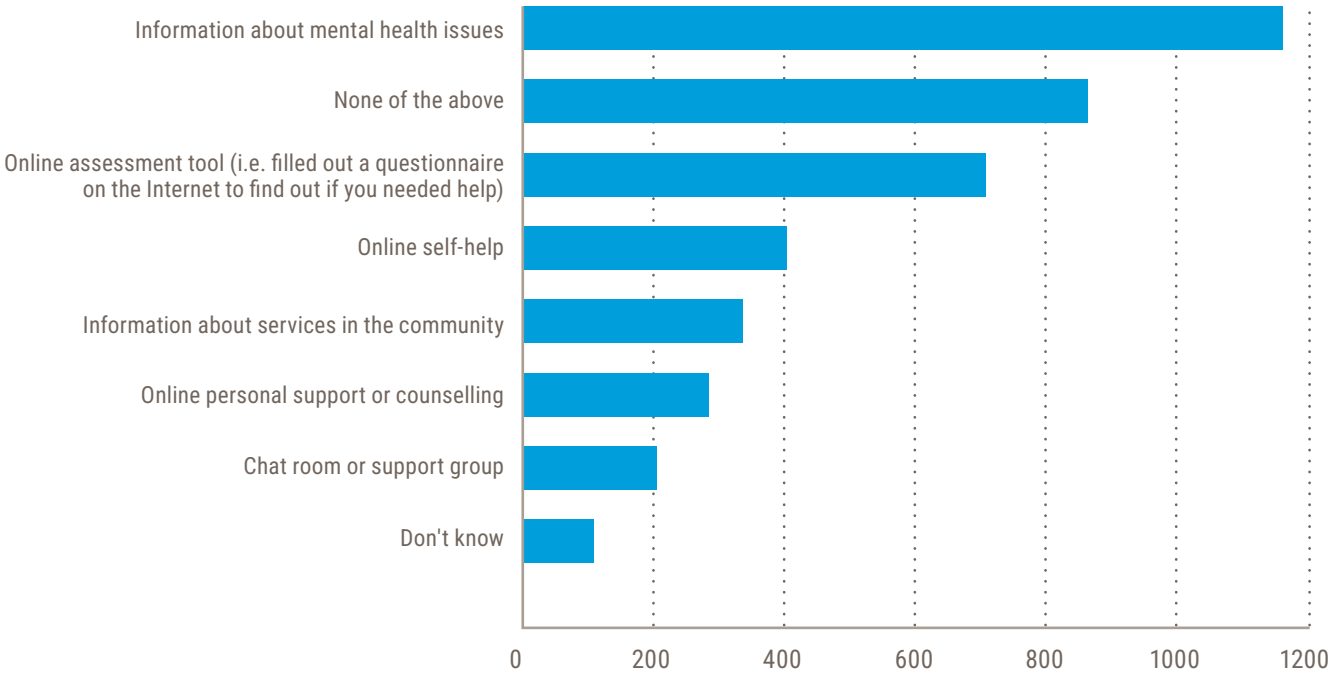


disorders such as Internet Gaming Disorder, which is listed as "a condition for further study" in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders.[253] Increased accessibility to computers, smartphones, and gaming systems has meant that more youth are engaging with others online, and researchers are now taking a closer look at youth experiences and interactions within the digital realm and assessing the attendant positive and negative impacts. Technology use can be a double-edged sword. In the context of the COVID-19 pandemic, electronic devices were used to spread unfounded rumors, induce anxiety and even create panic, but they also allowed increasingly isolated communities to stay informed, keep in touch with family and friends, take

253 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (Arlington, Virginia, 2013).

FIGURE 29 THE USE OF INTERNET-BASED SERVICES FOR EMOTIONAL OR BEHAVIOURAL ISSUES

In the past 12 months have you used any of the following Internet-based services to get help or information about emotional or behavioural issue (check all relevant)



classes online, and work from home. Digital access made continued social contact possible under stay-at-home orders, offering a source of relief for many.[254]

During the pandemic, I started to work more on myself, working on my headspace, being mindful and aware of how I feel, how I'm managing my reactions and my behaviour. I also saw social media accounts where people shared the message "it's okay to not be okay".

–Young person, Focus Group 3

Even before the global health crisis and worldwide shut-down of most schools, online engagement had become more the norm than the exception, and this trend only deepened during and after the pandemic. For some time, schools and colleges have offered classes online in countries across the globe, with digital video platforms such as Skype, Teams and Zoom enabling virtual connectivity. Smartphones and apps such as WeChat have allowed users to communicate around the world. While technology has allowed young people to stay in touch with friends, relatives, classmates, teachers, and employers, it has also introduced new risks and threats that can undermine their mental health. Research on the relationship between online environments and youth social-emotional well-being is an important and emerging area of inquiry and analysis.

254 Dana Rose Garfin, "Technology as a coping tool during the coronavirus disease 2019 (COVID-19) pandemic: implications and recommendations", *Stress and Health*, vol. 36, No. 4 (2020), pp. 555-559, DOI:10.1002/smi.2975.

During the pandemic, I lost more of my traditional forms of helping my mental health but learned some new techniques that helped me, like creating art and knitting.

–Young person, Focus Group 2

c. Social determinants

Research relating to online engagement and youth mental health and wellness has been inconsistent in terms of definitive findings regarding positive and negative effects. Some studies have found that mental health outcomes tend to be poorer among young people who spend a great deal of time on social media. A study of more than 4,000 youth in the United Kingdom found that the more time young people spent on social media, the greater the risks were for depression, self-harm, and lower self-esteem, particularly among females.[255] However, as pointed out by the focus group participants, it is difficult to separate or distinguish between offline and online interactions among youth, as young people typically view online and offline behaviours as analogous. A 2018 study conducted in the United Kingdom found that young people did not make a distinction between their online and offline lives.[256] Many youth view their smartphones as an extension of how they communicate and socialize. Whether communication occurs offline or online is irrelevant to young people who have grown up with smartphones, computers, and the Internet.

I think it's quite misleading for us to treat the digital and real world as if they were discrete, separate things; for young people, they are one and the same.

–Young person, Focus Group 5

Social stressors such as peer victimization are found in both online and offline environments. Youth who have experienced peer victimization have social skills competence deficits in both environments, which is believed to influence both online and offline engagement.[257] Improving social skills competence can help youth navigate both the offline and online world. Young people with strong social skills, resilience, grit, flexibility, and problem-solving capabilities are less likely to fall prey to peer victimization and better equipped to withstand its effects.

Online is where we socialize and access information and services, with respect not just to mental health, but also to education, news and media, legal affairs, accommodation and more.

–Young person, Focus Group 5

Research on time spent on social media suggests that while moderate usage is not related to negative psychosocial outcomes, high usage is. A 2019 study indicated that high social media usage predicted higher depressive symptoms, panic disorder symptoms, delinquent behaviours and family conflict, as well as lower family and friend support.[258] The study also examined social media

255 Amber Barthorpe and others, "Is social media screen time really associated with poor adolescent mental health? A time use diary study", *Journal of Affective Disorders*, vol. 274 (2020), pp. 864-870, DOI:10.1016/j.jad.2020.05.106.

256 Laura Gray, "Exploring how and why young people use social networking sites", *Educational Psychology in Practice*, vol. 34, No. 2 (2018), pp. 175-194, DOI:10.1080/02667363.2018.1425829.

257 Felice Resnik and Amy Bellmore, "Connecting online and offline social skills to adolescents' peer victimization and psychological adjustment", *Journal of Youth and Adolescence*, vol. 48 (2019), pp. 386-398, DOI:10.1007/s10964-018-0953-z.

258 Anna Vannucci and Christine McCauley Ohannessian, "Social media use subgroups differentially predict psychosocial well-being during adolescence", *Journal of Youth and Adolescence*, vol. 48, No. 8 (2019), pp. 1,469-1,493, DOI:10.1007/s10964-019-01060-9.

Digital technology can expand access to quality education and support youth well-being.
©UN Photo /Rick Barjornas

usage by platform and found that females were more likely to use Instagram, Facebook and Pinterest, while males were more likely to use Twitter and discussion boards. Research conducted in Belgium corroborated findings linking high social media usage to adverse psychological impacts.[259] While these cross-sectional studies suggest that high social media usage can be detrimental to a young person's mental health, this finding is inconsistent with the results of an eight-year longitudinal study, which found that time spent on social media was not associated with increased mental health issues for young people between the ages of 13 and 20.[260] A large study carried out in the United States of America and the United Kingdom found that young girls spent more time per day on mobile phones, social media, texting, and computer usage, while boys spent more time gaming and on other electronic devices. Consistent with other research, higher online engagement for both sexes was associated with poorer mental health.[261] The digital gender divide is complex, but it has been posited that more females than males may be able to benefit from the positive effects technology can have on mental health.[262]

The digital world creates opportunities for young people to learn and communicate. The negative impact is addiction to it, having a sedentary lifestyle, different struggles between socializing and trying to become famous, and being controlled by the "likes" and "follows".

–Young person, Focus Group 5

As mentioned above, some research has found that social media use is not predictive of increased mental health risks.[263] While high social media usage has been linked to poorer mental health outcomes in a number of studies, some of the evidence is mixed. A large study across 29 regions in Northern America, Europe, and the Middle East using data from the 2017/2018 Health Behaviour in School-aged Children survey found that high social media usage was related to lower life satisfaction, lower family support, and greater psychological complaints but was also associated with more friend support, and the researchers suggested that high social media use

259 Helena Bruggeman and others, "Does the use of digital media affect psychological well-being? An empirical test among children aged 9 to 12", *Computers in Human Behavior*, vol. 101 (2019), pp. 104-113, DOI:10.1016/j.chb.2019.07.015.

260 Sarah M. Coyne and others, "Does time spent using social media impact mental health?: an eight year longitudinal study", *Computers in Human Behavior*, vol. 104 (2020), DOI:10.1016/j.chb.2019.106160.

261 Jean M. Twenge and Gabrielle N. Martin, "Gender differences in associations between digital media use and psychological well-being: evidence from three large datasets", *Journal of Adolescence*, vol. 79 (2020), pp. 91-102, DOI:10.1016/j.adolescence.2019.12.018.

262 UN Women, "Op-ed: We cannot allow COVID-19 to reinforce the digital gender divide", 6 May 2020, available at https://www.unwomen.org/en/news/stories/2020/5/op-ed-ed-phumzile-COVID-19-and-the-digital-gender-divide.

263 Chloe Berryman, Christopher J. Ferguson and Charles Negy, "Social media use and mental health among young adults", *Psychiatric Quarterly*, vol. 89, No. 2 (2018), pp. 307-314, DOI:10.1007/s11126-017-9535-6.

might be normative youth behavior.[264] If the distinction between young people's online and offline worlds is fluid, then the social support a young person receives online might be one reason high social media usage is associated with greater friend support. Young people create chat rooms, Instagram groups, and social media hangouts, just as they might get together at a coffee shop or mall, meet on a street corner, or walk to school together. This example highlights some of the positive effects of the online environment on youth mental health and wellness.

There are many factors that influence the relationship between online engagement and youth mental health. Strong relationships with families and peers and engagement in extracurricular activities may serve as protective factors between online engagement and mental health. Some studies carried out in 2018 found that children whose parents had control over their social media reported better mental health, and this relationship was mediated by less time spent on social media.[265, 266] Another study found that youth in grades 8-12 in the United States of America who spent more time in offline than online activities reported fewer mental health issues.[267] It is important that adult caregivers, teachers, and adults who work with youth encourage young people to balance their online and offline engagement, as finding a healthy balance is connected to youth mental wellness.

Communities on social media like Reddit, Facebook and Twitter that uplift people are helpful for the mental health of young people, especially when they don't have people they can talk to near them.

–Young person, Focus Group 5

Online environments, cyberbullying and youth mental health

For more than five decades, researchers across the globe have studied the involvement of children and youth in bullying; in recent years, much of the research has been focused on cyberbullying. Evidence suggests a positive correlation between the amount of time spent online and the likelihood of being involved in cyberbullying.[268] A meta-analysis of sex differences in cyberbullying found that males were more likely than females to be involved, though age moderated the effect, with females engaging in more cyberbullying in younger adolescence and males engaging in more cyberbullying in older adolescence.[269] A large study of students in grades 6-12 in Canada found that cyberbullying was associated with more emotional problems for girls and more behavioural problems for boys.[270] Most research has indicated that the experience of being cyberbullied has a negative impact on youth mental health.

The consensus among researchers is that while there are four forms of bullying (relational, verbal, physical and

264 Maartje Boer and others, "Adolescents' intense and problematic social media use and their well-being in 29 countries", *Journal of Adolescent Health*, vol. 66 (6S) (2020), pp. S89-S99, DOI:10.1016/j.jadohealth.2020.02.014.

265 Jasmine Fardouly and others, "Parental control of the time preadolescents spend on social media: links with preadolescents' social media appearance comparisons and mental health", *Journal of Youth and Adolescence*, vol. 47 (2018), pp. 1,456-1,468, DOI:10.1007/s10964-018-0870-1.

266 Ibid.

267 Jean M. Twenge and others, "Increases in depressive symptoms, suicide-related outcomes, and suicide rates among U.S. adolescents after 2010 and links to increased new media screen time", *Clinical Psychological Science*, vol. 6, No. 1 (2017), pp. 3-17, DOI:10.1177/2167702617723376.

268 Christin R. Müller, Jan Pfetsch and Angela Ittel, "Ethical media competence as a protective factor against cyberbullying and cybervictimization among German school students", *Cyberpsychology, Behavior, and Social Networking*, vol. 17, No. 10 (2014), pp. 644-651, DOI:10.1089/cyber.2014.0168.

269 Christopher Barlett and Sarah M. Coyne, "A meta-analysis of sex differences in cyber-bullying behavior: the moderating role of age", *Aggressive Behavior*, vol. 40, No. 5 (2014), pp. 474-488, DOI:10.1002/ab.21555.

270 Soyeon Kim and others, "Cyberbullying victimization and adolescent mental health: evidence of differential effects by sex and mental health problem type", *Journal of Youth and Adolescence*, vol. 47 (2018), pp. 661-672, DOI:10.1007/s10964-017-0678-4.

electronic), online bullying is not substantively different from offline bullying.[271] The impact of all forms of bullying on mental health has been well-documented.[272] It has been determined, however, that being a victim of both in-person and online bullying (poly-victimization) is more detrimental to a young person's mental health than is exposure to one or the other.[273] Experiencing both offline and online bullying causes the most psychological harm – likely because victims feel they have no escape from their tormentors.

While increased online engagement may be associated with negative behaviours such as cyberbullying, there are also positive outcomes linked to online environments. Young people who have limited access to peers or reside in rural areas might feel that their world is bigger through online connectivity. Researchers have found that for non-binary and LGBT youth, online communities can provide support and a sense of belonging they might not have in their offline lives.[274] For young people who are isolated or marginalized, the online world can provide important social interaction and support they may not have access to in their day-to-day lives. The online environment represents an extension and expansion of their social world and can offer an important avenue for protecting mental health and wellness.

None of us really gets how to best figure out this digital versus real world overlap. And that comes across in the policymaking, which results in all these holes, falling through the gaps, where we try to treat digital world problems as being purely digital world problems and fail to take into account the fact that a lot of these problems exist in the real world as well, have real world consequences and impacts, and potentially require real world solutions.

–Young person, Focus Group 5

Digital technology and quality education

The role of digital technology – including social media, online games and educational programs, multimedia, computers and mobile phones – in facilitating and providing access to quality education is the focus of ongoing research. Rates of digital technology use vary widely across countries and regions, largely owing to connectivity and access constraints. In many rural areas, Internet and WiFi services are unavailable. Cost can also be a factor in many areas. Digital infrastructure can require extensive financial resources to set up and maintain, and customer subscription services and electronic devices may be expensive. The ability to purchase technology is also a global equity issue, with wealthier countries having

271 Evelina Landstedt and Susanne Persson, "Bullying, cyberbullying, and mental health in young people", *Scandinavian Journal of Public Health*, vol. 42, No. 4 (2014), pp. 393-399, DOI:10.1177/1403494814525004.

272 Shane R. Jimerson, Susan M. Swearer and Dorothy L. Espelage, *Handbook of Bullying in Schools: An International Perspective* (New York, Routledge, 2010).

273 Zachary R. Myers and others, "Cyberbullying and traditional bullying: the experiences of poly-victimization among diverse youth", *International Journal of Technoethics*, vol. 8, No. 2 (2017), pp. 42-60, DOI:10.4018/IJT.2017070104.

274 Ellen Selkie and others, "Transgender adolescents' uses of social media for social support", *Journal of Adolescent Health*, vol. 66, No. 3 (2020), pp. 275-280, DOI:10.1016/j.jadohealth.2019.08.011.

Box 5. Interview with a 23-year-old LGBT woman from the United States of America with a high socioeconomic background

I had the perfect storm with my mental health issues. In middle school, I was kind of chubby, which is ultimately not a huge deal, but I went to a private school in New York. I was also the only Black person in my class, so I had a lot of appearance-based insecurities. I also developed a neurological disease that I did not know I had for another four years after I started showing symptoms. At the same time, I developed a pretty severe eating disorder. All these things combined became a storm that was impossible to diagnose. As a result, I was hospitalized for depression and anxiety, which in hindsight was part of my neurological disease. Sometimes it is really hard to tell if you are tired or sad, and combined with the eating disorder, I was in and out of the hospital over 25 times in the course of three and a half years.

I was first hospitalized in the beginning of my sophomore year of high school. I was forced to go to the guidance counsellor twice a week, which made it hard coming back to school because they sort of treated me like a criminal. I was not allowed to go out at lunch with other students; I had to eat in the principal's office. I was put on house restrictions when I returned from the hospital, which felt really unfair because I did not do anything wrong. At the end of the year I was asked not to return to the school, which meant leaving the school I had been at since I was 4 years old. All of my friends were in that environment, all my connections, everyone I knew was there. I was now substantially isolated, which made my mental health worse.

My family was overall pretty supportive. My father is West African. It took him a while to know how to talk to me about my mental health concerns and to understand the seriousness of what was going on with me. I could have died; I definitely got to that point with my eating disorder, being medically hospitalized. He struggled to understand the severity of my issues, which I think was mostly cultural. My mom was really supportive. The only issue we had was her "compassion fatigue"; she was taking care of everything in terms of financials, logistics and picking me up from therapy and doctor's appointments. I only saw my father once or twice a year, so my mom did everything and eventually she hardened a bit from it all. I do not blame her for that; I would be frustrated as well.

I prefer not to disclose my mental health status in the work environment for many reasons. The law is on my side so I can disclose whatever I want. I do not want to share it at the beginning because I do not want to set up a possible negative expectation. I would rather make a good impression and then let them know when I am ready. I like to impress work colleagues with my work, then tell them I have issues, which shocks them and becomes a positive thing. Also, I find that most people have a very poor understanding of mental illness, especially eating disorders. They are oversimplified in a way that I find really difficult to understand because it is the most deadly of mental illnesses. I have scars from self-harm [that] mostly are not obvious, but some are raised and visible. I had one employer ask me about it directly, which was completely inappropriate. I was shocked. There is a lot of work to be done in terms of changing public rhetoric around a lot of these issues. I have seen a lot of people who have literally died because they just did not receive the proper support and resources.

When I was a teenager, I had an Internet blog where I amassed a substantial following. It was one of the only reasons I was able to make it through that time period because I had an overwhelming sea of positive feedback for doing something mediocre online. In the midst of my eating disorder, depression and anxiety, I could not see the outside world. I wanted it to be my identity, then I started trying to recover, and I had to decide whether I would defend this identity or break out of it. It can quickly turn into an echo chamber and become negative, especially for young people, which is why I deleted my blog.

I still love the Internet. I have spent my entire life online. It is the most incredible tool and I am obsessed with it. I had my time when I was Internet famous, so now I just like to browse. I do not need to accrue a following. I already did that, and I did not like it that much. I have noticed that there is a problem with people on the Internet self-diagnosing mental illnesses, when I do not think that they actually have them. It can be a positive stepping stone to advocating for your own treatment, but you need to go to a doctor for diagnosis. You need to get medication … [and] proper therapy and treatment. There is nothing on the Internet that can cure you if you have a legitimate mental illness. You need to get professional support because it is a real health problem. It is the same as if you broke your leg; you need to go to physical therapy and get some pain medication.

greater access than developing countries to computers, smartphones and gaming systems and to the technology needed to use them.

Research on the developmental effects of digital technology and its impact on academic achievement is still in its infancy. Studies have found ethnic disparities in access to digital technologies, with predominately wealthy and white majority schools tending to have the highest levels of access.[275] Students with disabilities can benefit from digital technology through increased access to educational environments via distance learning. A study conducted in the United Kingdom found that students with autism spectrum disorders performed the same as their non-disabled peers in the digital environment and that distance learning might be a better, more accessible mode of education for people with certain developmental challenges or mental health conditions.[276] In many respects, digital technology can be an important equalizer in ensuring quality education for all. A study on the use of digital technology in rural, underserved schools in Pakistan found that students in these schools had higher scores than those in urban schools when a mobile application was used for learning Urdu grammar.[277] Much research still needs to be done to examine the effects of digital technology on education and the role it can play in supporting quality education. It is promising that online environments can expand young people's worlds, and when equal access to digital technology becomes a reality, quality education can become available to all.

Given the proliferation of digital technologies worldwide, it is important for educators and young people to have a comprehensive understanding of the social media applications in widespread use. The Cyberbullying Research Center has a list of the 68 social media applications most popular among youth, providing descriptions of what the applications are used for, minimum age requirements, and which age groups are most likely to access them.[278] Worldwide, social media metrics have indicated that the most widely used social networking sites are Facebook, YouTube, Instagram, TikTok, and Douyin, and the social media applications used most frequently are WhatsApp, Facebook Messenger, WeChat, QQ, and Skype.[279] Digital technologies are constantly changing, and research on their role and accessibility in education and their contribution to quality education is ongoing.

It is important to develop countrywide strategies for increasing access to digital technologies. It is also important to protect the mental health, safety and well-being of youth interacting with online environments and to take advantage of opportunities to leverage digital technology for quality education.

d. Policy recommendations

- *Online environments, cyberbullying, and youth mental health.* Interventions are needed that allow parents and adult caregivers to understand the developmental impact of online environments on youth and to become more aware of the risks and benefits associated with digital engagement. Young people should receive information and training that strengthens their awareness of and ability to manage the risks and benefits of engaging online, equips them with the knowledge and skills required to protect their personal data, and promotes balance in their online and offline social interactions. Policies should emphasize that technology companies have a responsibility to build in monitoring and support mechanisms to guard against bullying and harassment; however, policies can also build on the fact that young people themselves can contribute to healthy online environments by promoting and engaging in positive behaviours. Funding should be provided for academic research focused on exploring and identifying the positive impacts of online engagement for young people, especially marginalized youth.

275 Jacob Hardesty, Jacob McWilliams and Jonathan Plucker, "Excellence gaps: what they are, why they are bad, and how smart contexts can address them … or make them worse", *High Ability Studies*, vol. 25, No. 1 (2014), pp. 71-80, DOI:10.1080/13598139.2014.907646.

276 John T.E. Richardson, "Academic attainment in students with autism spectrum disorders in distance education", *Open Learning: The Journal of Open, Distance and e-Learning*, vol. 32, No. 1 (2017), pp. 81-91, DOI:10.1080/02680513.2016.1272446.

277 Sharifullah Khan, "Mitigating the urban-rural educational gap in developing countries through mobile technology-supported learning", *British Journal of Educational Technology*, vol. 50, No. 2 (2018), pp. 735-749, DOI:10.1111/bjet.12692.

278 Cyberbullying Research Center, "Most popular social media apps", updated 10 February 2025, available at https://cyberbullying.org/most-popular-social-media-apps.

279 Vincos Blog, social media statistics, available at https://vincos.it/social-media-statistics/. Skype services, rated among the most frequently used at the time this information was compiled, were discontinued in May 2025.

- *The role of digital technology in quality education.* Schools should teach social-emotional skills so that students develop the resilience, grit and flexibility needed to solve problems in online and offline environments. Schools should partner with technology companies to support equal access to quality education.

6. Society and community

a. Perception survey results

Slightly more than half of the survey participants responded that they had felt confident about thinking or expressing their own ideas and opinions "every day" or "most days" within the preceding 12 months (see **figure 30**). Eight per cent of the respondents felt they had "rarely" or "never" been able to stand up for what they believed in (see **figure 31**).

Ten per cent of the respondents indicated that they "rarely" or "never" felt safe in their local area, while 27 per cent reported "always" feeling safe (see **figure 32**). Males were slightly more likely than females to report that they "often" or "always" felt safe (69 versus 65 per cent), though only 32 per cent of those identifying their gender as "other" selected one of these options.

b. Focus group results

The stigma around mental health was a key issue for young people in the focus groups. The negative portrayal of mental health constituted a major barrier preventing or discouraging young people from seeking help for their mental health concerns. The participants were concerned that they would face discrimination from society if they struggled with their mental health. They reported judgment expressed in communication online and from parents, peers, the media, and the Government.

Mention was also made of cultural implications linked to discussing mental health. Participants felt that talking about mental health would be easier in countries where the subject was addressed in schools and within the community. Discussions through the media or awareness-raising programmes were seen as positive. Many participants from lower- to middle-income countries felt that mental health was viewed as a "Western world" problem and thus did not feel that their communities would respond positively to discussions around mental health.

The pressure to be "positive" about life was a point of contention for many young people in the focus groups. Participants reported expectations of happiness and satisfaction with life due to the contrast with past generations' situations. Young people felt that it was impossible to have conversations with family members, teachers and community members and admit that they were struggling with their mental health. Many participants reported having imposter syndrome with regard to their achievements due to the lack of diverse role models in their fields or communities. They shared that they experienced feelings of isolation, anxiety and depression at times when they were expected to be positive, contributing to a decline in their mental health.

Improving community awareness about mental health and self-care was suggested as a way to address the stigma surrounding mental health. Conversations about mental health on social media and the Internet have helped normalize the subject, but participants felt that their parents' generation was not being included in those conversations and that more should be done to normalize mental health in the wider community. Improving the visibility of people with mental health challenges in the larger community was also suggested as a way to reduce stigma.

c. Social determinants

This section includes an assessment of evidence on associations between broader societal factors and poor mental health. The factors explored include gender inequality, discrimination and marginalization (on the basis of gender, sexuality, ethnic minority status or religion), religiosity and spiritualty, environmental challenges, and conflict. Inequalities in mental health outcomes arise as a result of differential exposure to risks, opportunities and resources – and from systems of social organization that characterize some groups as inferior based on gender, sexual identity or ethnic background.

Because there are often considerable interlinkages between social determinants, different types of

inequalities can interact in complex ways.[280] For example, gender discrimination, low socioeconomic status and ethnic minority status have been shown to converge to produce a range of poor health outcomes.[281] Emerging research focused on the intersectionality of identities and how they interact to create systems of discrimination and disadvantage is beginning to shed light on these complexities.[282] In natural disaster or conflict situations, inequalities are likely to be exacerbated. Young people may be particularly vulnerable to intersecting inequalities, as they are at a stage of life when the development of social and emotional skills, the emergence of identity, and social relationships and social roles are particularly salient and strongly influence mental health.

I'm thinking in terms of stigma, when it comes to our intersectional identities, whether it's race, religion, age, or ability, the intersections of our identity all bring about different forms of treatment. And I'm sure we all know to a certain extent that not everyone gets treated the same way.

–Young person, Focus Group 4

Gender inequality and restrictive gender norms

Gender inequality and restrictive gender norms, which typically privilege the male or masculine over the female or feminine, are powerful determinants of health and well-being.[283] While the historical legacy of gender injustice means that women and girls are most likely to experience the health-related consequences of gender inequality, rigid gender norms actually undermine the health and well-being of men, women, and gender minorities.

There is evidence that gender socialization – the process of learning and internalizing socially and culturally prescribed roles, behaviours, expectations and norms associated with gender – begins before birth and is influenced by families, peer groups, and schools. With the onset of puberty, these differences are likely to be more strongly reinforced, with boys expected to prove their toughness, strength and independence and girls expected to attract male attention. It is also at this stage that girls' opportunities and freedoms are restricted while those for boys expand. This divergence is particularly striking in low- and middle-income countries.

Gender inequality and restrictive gender norms have direct and indirect impacts on health, including mental health. In a 2019 study, Heise and others present "a consolidated conceptual framework that shows how individuals born biologically male or female develop into gendered beings, and how sexism and patriarchy intersect with other forms of discrimination, such as racism, classism and homophobia, to structure pathways to poor health". The authors provide "ample evidence showing the far-reaching consequences of these pathways, including how gender inequality and restrictive gender norms impact health through differential exposures, health-related behaviours and access to care, as well as how gender-biased health research and health-care systems reinforce and reproduce gender inequalities, with serious implications for health".[284] Research and data collection systems can also play into this inequality dynamic.

280 Aditi Iyer, Gita Sen and Piroska Östlin, "The intersections of gender and class in health status and health care", *Global Public Health*, vol. 3 (suppl. 1) (2008), pp. 13-24, DOI:10.1080/17441690801892174.

281 Tyson H. Brown and others, "Using multiple-hierarchy stratification and life course approaches to understand health inequalities: the intersecting consequences of race, gender, SES, and age", *Journal of Health and Social Behavior*, vol. 57, No. 2 (2016), pp. 200-222, DOI:10.1177/0022146516645165.

282 Pratima A. Patil and others, "Which girls, which boys? The intersectional risk for depression by race and ethnicity, and gender in the U.S.", *Clinical Psychology Review*, vol. 66 (2018), pp. 51-68, DOI:10.1016/j.cpr.2017.12.003.

283 Lori Heise and others, "Gender inequality and restrictive gender norms: framing the challenges to health", *The Lancet*, vol. 393 (10189) (2019), pp. 2,440-2,454, DOI:10.1016/S0140-6736(19)30652-X.

284 Ibid., abstract.

FIGURE 30 ABILITY TO EXPRESS THOUGHTS AND OPINIONS

In the past 12 months, how often did you feel confident to think or express your own ideas and opinions?

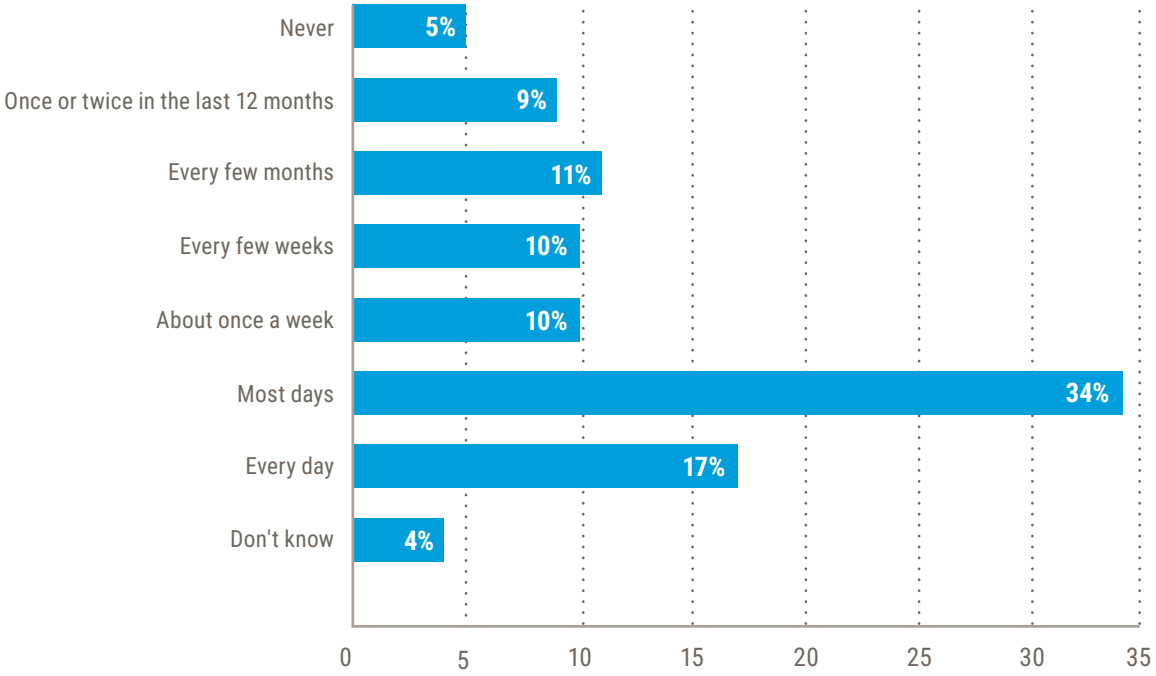


FIGURE 31 ABILITY TO STAND UP FOR ONESELF

I am able to stand up for myself and what I believe in:

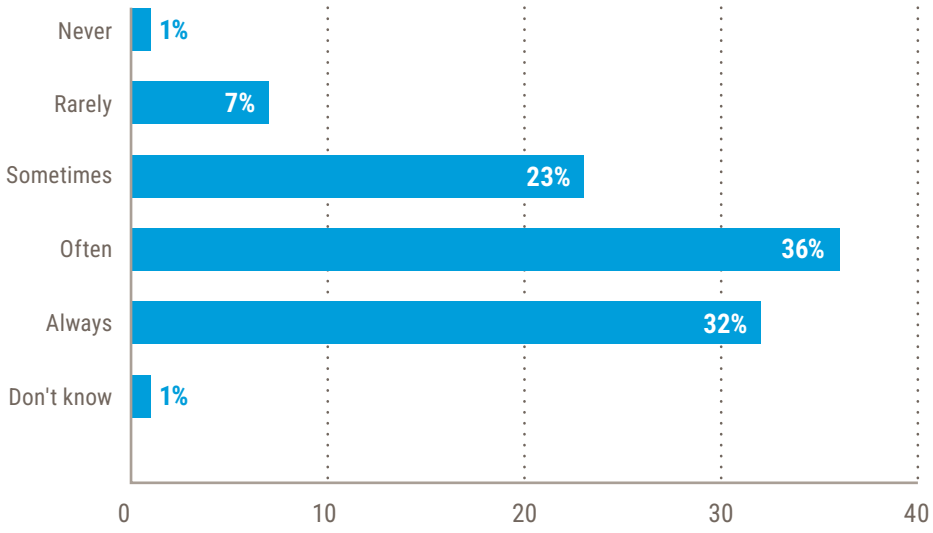
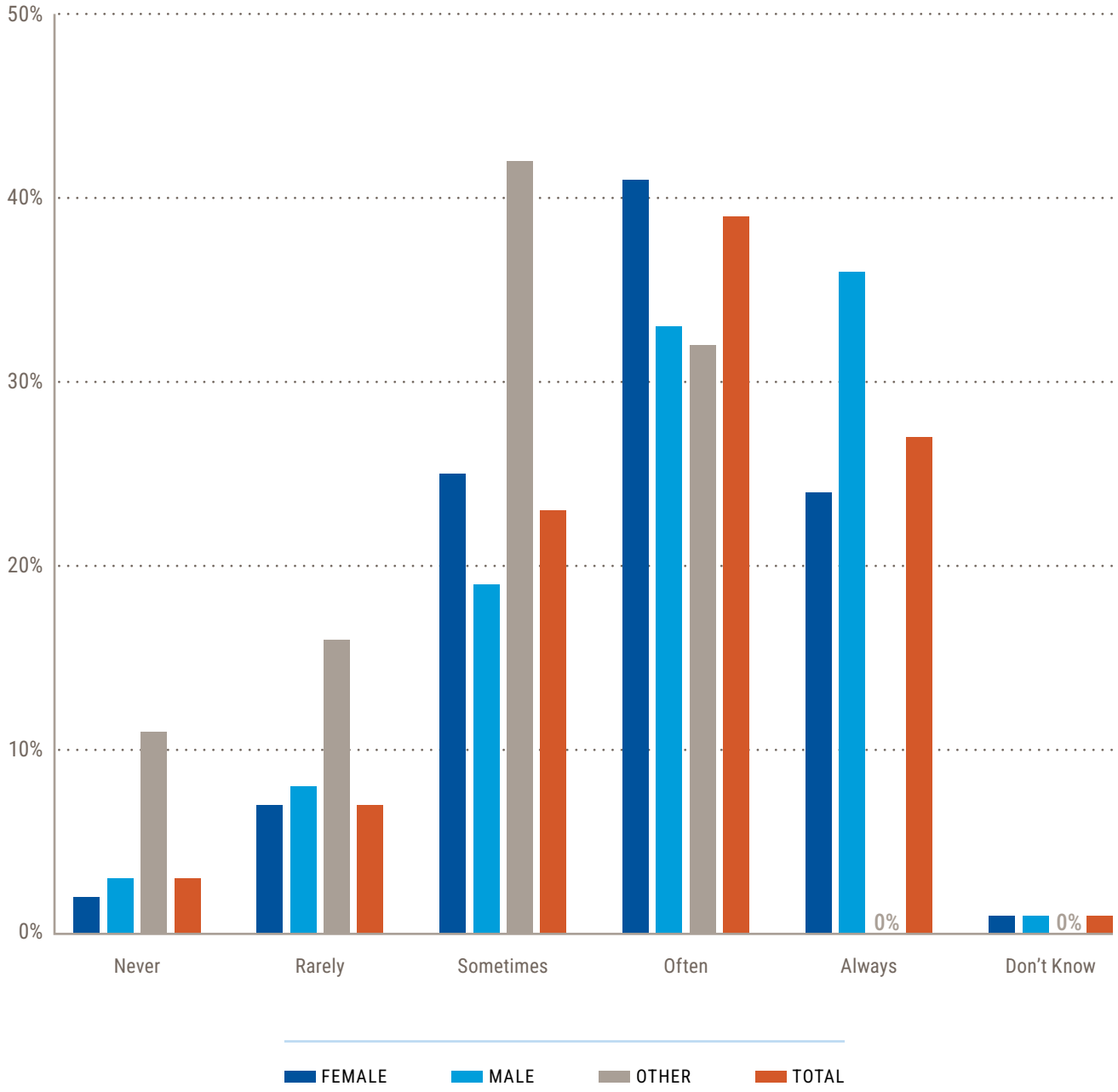


FIGURE 32 FEELING SAFE

How often do you feel safe in your local area?



Box 6. Interview with a 29-year-old woman from India with a learning disability and experience of descent-based discrimination

I am a child of an inter-caste couple. In my country it is hard for people to break caste barriers, and those in inter-caste marriages pay a considerable psychosocial price. Even though my family was functional and very loving, I navigated social stigma and intergenerational trauma.

Most of my teachers were upper-caste men and women. Students were regularly beaten for not submitting homework on time. My classmates and I were stratified based on marks by teachers who were never trained to work with neurodiverse kids. I remember spending a lot of my time outside the classroom, standing on my knees as a punishment for not scoring well on tests. I learned what it meant to sit in the classroom with a learning disability and walk back home as a girl.

My school trained me to accept instructions from people in authority who never understood my lived experience. It was a microcosm of my world. During lunch break, many of my classmates refused to share food with me. There were clear, tangible, and invisible divisions within the classroom. Like most children, I did not have the vocabulary to think through gender, caste, disability, and how they all merged in my experience of life. I did not know why the class leader was always a boy and why some of us felt ashamed of opening our lunch boxes. However, I always knew my place within the classroom.

My mother realized I needed help when none of my teachers did. I find it incredible that she helped me navigate my disability all through school and college. She was intuitively connected to me and had a beautiful way of reframing many of my struggles. It was only after I left India to do my master's that I was formally diagnosed. I never could get diagnosed in India. All of the local therapists were upper-caste men who told me to "just be strong". I never could identify with them, and they never could see just how strong I really was. It took me three years of active searching to find a therapist who listened and empowered me. I now work with a great Black therapist on the other side of the world. On the Internet, people I had never met taught me the need to relentlessly invest in my joy, even as teachers, classmates, colleagues, the media, and laws continue to limit me. This access to awareness and community has been a blessing.

Gender differences in mental health appear in early adolescence.[285] Gender-specific risk factors for poor mental health in girls can include unequal access to resources, decision-making power, and education; gender-based violence; and discriminatory practices such as child marriage.[286] Some of the risk factors affecting girls – including violence; child, early and forced marriage; sexual abuse and exploitation; limitations on reproductive control; exclusion from education, employment and decision-making; and unequal chore burdens and caretaking responsibilities – are particularly influential during adolescence.[287] For boys, the endorsement of stereotypical masculine norms has been associated with substance abuse, delinquency, the perpetuation of interpersonal violence, and reduced help-seeking.[288]

In a longitudinal study of more than 3,000 Australian youth, King, Singh and Milner found that egalitarian

285 Janet S. Hyde and Amy H. Mezulis, "Gender differences in depression: biological, affective, cognitive, and sociocultural factors", Harvard Review of Psychiatry, vol. 28, No. 1 (2020), pp. 4-13, DOI:10.1097/HRP.0000000000000230.

286 Chisina Kapungu and Suzanne Petroni, "Understanding & tackling the gendered drivers of poor adolescent mental health" (Washington, D.C., International Center for Research on Women, 2017), available at https://www.icrw.org/wp-content/uploads/2017/09/ICRW_Unicef_MentalHealth_WhitePaper_FINAL.pdf.

287 Suzanne Petroni, Vikram Patel and George Patton, "Why is suicide the leading killer of older adolescent girls?" *The Lancet*, vol. 386, No. 10008 (2015), pp. 2,031-2,032, DOI:10.1016/S0140-6736(15)01019-3.

288 Anne E. Rhodes and others, "Antecedents and sex/gender differences in youth suicidal behavior", *World Journal of Psychiatry*, vol. 4, No. 4 (2014), pp. 120-132, DOI:10.5498/wjp.v4.i4.120.

gender-role attitudes were associated with better overall mental health in females and with fewer conduct problems in both males and females.[289] There were no significant associations for emotional problems. In a prospective cohort study of young boys, greater conformity with violence and self-reliance norms was associated with higher odds of suicidal ideation, and greater conformity with norms related to heterosexuality was associated with reduced odds of reporting suicidal ideation.[290] This research suggests that conformity with certain social norms and expectations can have a serious impact on the mental health of young males. These findings add to existing evidence that conformity with what are typically defined as "masculine" norms can have deleterious effects on mental health in adult males. Recognizing and addressing these associations at a relatively early stage has important long-term implications; as noted by the study authors, "maximizing adolescent health is key to optimizing adult health and well-being".[291]

While progress has been made in addressing gender inequality in recent decades, many challenges remain, not least in addressing the associated or consequent health outcomes. In a 2020 study, Levy and others reviewed the characteristics of successful programmes targeting gender inequality and restrictive gender norms for the health and well-being of children and young adults.[292] They identified 61 evaluations of 59 programmes that were mostly concentrated in sub-Saharan Africa, Southern Asia and Northern America and mainly measured health indicators related to reproductive health, violence or HIV. Only 45 of the evaluations measured significant improvements in health or gender-related indicators, only 10 showed evidence of or the potential for broader norm change, and only 13 examined health outcomes (with just one relating to mental health, focusing on anxiety).

It is notable that most of the research in the area of gender inequality and mental health is centred around individuals rather than targeting systemic factors that perpetuate gender inequality. Reducing the mental health impacts of gender inequality and restrictive gender norms is likely to require multisectoral action and engagement with national Governments, global health institutions, civil society organizations, academia, and the corporate sector. Efforts in this area should focus on health outcomes, workplace reforms, the funding of civil society actors and social movements, the elimination of gender bias in data collection, and the implementation of accountability mechanisms.[293]

I am a woman, and I am a Black woman. For me, every space I've been in, I've always been the minority. When I tell people that I am pursuing a master's degree they look at me like, "Oh, really? You?" When I want to apply for certain position, sometimes I feel as though maybe I shouldn't, even though I have the experience. I always feel like I am not enough.

–Young person, Focus Group 4

289 Tania L. King, Ankur Singh and Allison Milner, "Associations between gender-role attitudes and mental health outcomes in a nationally representative sample of Australian adolescents", *Journal of Adolescent Health*, vol. 65, No. 1 (2019), pp.72-78, DOI:10.1016/j.jadohealth.2019.01.011.

290 Tania L. King and others, "Expressions of masculinity and associations with suicidal ideation among young males", *BMC Psychiatry*, vol. 20, No. 228 (2020), pp. 1-10, available at https://doi.org/10.1186/s12888-020-2475-y.

291 Patil and others, "Which girls, which boys? The intersectional risk for depression by race and ethnicity, and gender in the U.S.".

292 Jessica K. Levy and others, "Characteristics of successful programmes targeting gender inequality and restrictive gender norms for the health and wellbeing of children, adolescents, and young adults: a systematic review", *The Lancet Global Health*, vol. 8, No. 2 (2020), pp. e225-e236, DOI:10.1016/S2214-109X(19)30495-4.

293 Geeta Rao Gupta and others, "Gender equality and gender norms: framing the opportunities for health", *The Lancet*, vol. 393, No. 10190 (2019), pp. 2,550-2,562, DOI:10.1016/S0140-6736(19)30651-8.

Mental health in young people experiencing or at risk of discrimination and marginalization

Discrimination, marginalization and victimization due to minority status are associated with a greater risk of experiencing poor mental health and other adverse outcomes. These negative experiences can occur in a range of settings, including the home, the workplace, school, and the broader community. It is important to note that ethnic or sexual minority status is not itself the cause of higher rates of mental health problems, but rather the experiences of discrimination. For LGBT young people, the risk of poor mental health is related to the discordance between their sexual identity and prevailing attitudes and gender norms. For ethnic minorities, there is evidence that risks arise from factors such as discrimination (including structural discrimination), systemic racism, colonization, and intergenerational effects.[294] Examining the unique features relating to these factors in adolescence (as distinct from childhood or adulthood) can help guide intervention efforts.

My mental health concerns come from a lack of feeling like I fit in because I don't think I'm good enough. I have to conform myself to different spaces, and I think that may come from inequality, but it also comes from inequality that I have internalized from what I have seen.

–Young person, Focus Group 4

Reducing inequalities is key to improving the well-being of all young people.
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LGBT young people

The transition from childhood to adulthood may present particular mental health challenges for LGBT youth, who are also at increased risk for suicide. LGBT is often used in the research literature as an umbrella term that includes distinct and sometimes overlapping groups with a diverse range of experiences and needs – some of which have implications for mental health and well-being. Most of the studies reviewed for the *Report* examined sexual orientation and its relationship to mental health; relatively few examined mental health related to sex or gender (for example, intersex or transgender youth) or the diversity within and intersectionality between sex, sexuality and gender.

Reviews of studies linking sexual minority status with a wide range of mental health outcomes revealed increased risks for depression, anxiety, attempted suicide, and suicide in young males and females, with some evidence

294 Christian Young and others, "Psychosocial factors associated with the mental health of indigenous children living in high income countries: a systematic review", *International Journal for Equity in Health*, vol. 16, art. 153 (2017), DOI:10.1186/s12939-017-0652-5.

of higher risks in males.[295, 296] These associations were consistent across geographic regions and were particularly strong in more recent and higher-quality studies. The results showed that all sexual minority subgroups were at increased risk, but in the majority of studies bisexual individuals were identified as those at highest risk. These findings, particularly for young women, align with those of other studies focusing on specific mental health outcomes, including depression,[297, 298] self-injury and suicide,[299, 300, 301, 302, 303, 304, 305, 306] and eating disorders.[307] Minority gender status has been linked to increased risk of suicidal thoughts and attempts[308, 309] and non-suicidal self-injury.[310]

A review of psychosocial risk and protective factors for depression among LGBT youth identified internalized LGBT-related oppression, stress from hiding and managing a socially stigmatized identity, maladaptive coping, parental rejection, abuse and other traumatic events, negative interpersonal interactions, negative religious experiences, school bullying victimization, and violence victimization in community settings as risk factors.[311] Prominent protective factors included a positive LGBT identity, self-esteem, social support from friends, and family support.[312, 313] Another review identified similar risk and protective factors for suicidality in young men who have sex with men.[314]

There is evidence that family and peer victimization contribute significantly to the higher rates of mental health problems and suicidality among sexual minority youth; studies assessing risks of abuse and family victimization consistently find higher rates for this group of young people than for their heterosexual peers.[315, 316] A recent review of studies of mental health impacts of family victimization found significant associations

295 Martin Plöderl and Pierre Tremblay, "Mental health of sexual minorities: a systematic review", *International Review of Psychiatry*, vol. 27, No. 5 (2015), pp. 367-385, DOI:10.3109/09540261.2015.1083949.

296 Joanna Semlyen and others, "Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys", *BMC Psychiatry*, vol. 16, art. 67 (2016), DOI:10.1186/s12888-016-0767-z.

297 Mathijs Fg. Lucassen and others, "Sexual minority youth and depressive symptoms or depressive disorder: a systematic review and meta-analysis of population-based studies", *Australian and New Zealand Journal of Psychiatry*, vol. 51, No. 8 (2017), pp. 774-787, DOI:10.1177/0004867417713664.

298 Michael P. Marshal and others, "Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review", *Journal of Adolescent Health*, vol. 49, No. 2 (2011), pp. 115-123, DOI:10.1016/j.jadohealth.2011.02.005.

299 Brendan J. Dunlop and others, "Bisexuality and non-suicidal self-injury (NSSI): a narrative synthesis of associated variables and a meta-analysis of risk", *Journal of Affective Disorders*, vol. 276 (2020), pp. 1,159-1,172, DOI:10.1016/j.jad.2020.07.103.

300 Ester di Giacomo and others, "Estimating the risk of attempted suicide among sexual minority youths: a systematic review and meta-analysis", *JAMA Pediatrics*, vol. 172, No. 12 (2018), pp. 1,145-1,152, DOI:10.1001/jamapediatrics.2018.2731.

301 Richard T. Liu and others, "Prevalence and correlates of non-suicidal self-injury among lesbian, gay, bisexual, and transgender individuals: a systematic review and meta-analysis", *Clinical Psychology Review*, vol. 74 (2019), DOI:10.1016/j.cpr.2019.101783.

302 Kristen L. Batejan, Stephanie M. Jarvi and Lance P. Swenson, "Sexual orientation and non-suicidal self-injury: a meta-analytic review", *Archives of Suicide Research*, vol. 19, No. 2 (2015), pp. 131-150, DOI:10.1080/13811118.2014.957450.

303 Andrea Miranda-Mendizabal and others, "Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis", *The British Journal of Psychiatry: The Journal of Mental Science*, vol. 211, No. 2 (2017), pp. 77-87, DOI:10.1192/bjp.bp.116.196345.

304 Tyler Hatchel, Joshua R. Polanin and Dorothy L. Espelage, "Suicidal thoughts and behaviors among LGBTQ youth: meta-analyses and a systematic review", *Archives of Suicide Research*, vol. 25, No. 1 (2021), pp. 1-37, DOI:10.1080/13811118.2019.1663329.

305 Casey T. Luong, Lynn Rew and Matthew Banner, "Suicidality in young men who have sex with men: a systematic review of the literature", *Issues in Mental Health Nursing*, vol. 39, No. 1 (2018), pp. 37-45, DOI:10.1080/01612840.2017.1390020.

306 Erman Yıldız, "Suicide in sexual minority populations: a systematic review of evidence-based studies", *Archives of Psychiatric Nursing*, vol. 32, No. 4 (2018), pp. 650-659, DOI:10.1016/j.apnu.2018.03.003.

Liu and others, "Prevalence and correlates of non-suicidal self-injury among lesbian, gay, bisexual, and transgender individuals: a systematic review and meta-analysis".

307 Paolo Meneguzzo and others, "Eating disorders symptoms in sexual minority women: a systematic review", *European Eating Disorders Review*, vol. 26, No. 4 (2018), pp. 275-292, DOI:10.1002/erv.2601.

308 di Giacomo and others, "Estimating the risk of attempted suicide among sexual minority youths: a systematic review and meta-analysis".

309 Hatchel, Polanin and Espelage, "Suicidal thoughts and behaviors among LGBTQ youth: meta-analyses and a systematic review".

310 Liu and others, "Prevalence and correlates of non-suicidal self-injury among lesbian, gay, bisexual, and transgender individuals: a systematic review and meta-analysis".

311 William J. Hall, "Psychosocial risk and protective factors for depression among lesbian, gay, bisexual, and queer youth: a systematic review", *Journal of Homosexuality*, vol. 65, No. 3 (2018), pp. 263-316, DOI:10.1080/00918369.2017.1317467.

312 Ibid.

313 Alida Bouris and others, "A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: time for a new public health research and practice agenda", *The Journal of Primary Prevention*, vol. 31, No. 5-6 (2010), pp. 273-309, DOI:10.1007/s10935-010-0229-1.

314 Luong, Rew and Banner, "Suicidality in young men who have sex with men: a systematic review of the literature".

315 Briana L. McGeough and Paul R. Sterzing, "A systematic review of family victimization experiences among sexual minority youth", *The Journal of Primary Prevention*, vol. 39, No. 5 (2018), pp. 491-528, DOI:10.1007/s10935-018-0523-x.

316 Mark S. Friedman and others, "A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals", *American Journal of Public Health*, vol. 101, No. 8 (2011), pp. 1,481-1,494, DOI:10.2105/AJPH.2009.190009.

between abuse and poor mental health, depression, and PTSD, with young people from ethnic minorities identified as being at even greater risk.[317] There was also some evidence that bisexual young people were at greater risk for physical abuse than were their gay and lesbian peers. Factors associated with higher rates of family victimization included younger age at sexual minority milestones (first awareness, disclosure, same-sex sexual contact) and the higher prevalence of sexual-minority-specific risk factors (sexuality disclosure, gender non-conformity) and non-sexual-minority-specific risk factors (delinquent behaviours, parental drinking). Sexual minority females who experienced childhood physical or sexual abuse were at greater risk than abused sexual minority males for sexual assault later in life.[318]

LGBT youth are also at higher risk than their heterosexual counterparts for peer victimization, both at school and online.[319, 320, 321] Other risks include internalized LGBT-related oppression, stress from hiding and managing a socially stigmatized identity, maladaptive coping, negative religious experiences, and violent victimization in community settings.[322, 323, 324] Prominent protective factors include a positive LGBT identity, self-esteem, social support from friends, family support, and effective coping strategies.[325, 326]

Knowledge around this topic is limited by the fact that relevant studies are mostly cross-sectional and carried out in high-income countries. More research on sexual minority youth and mental health is needed in low- and middle-income countries, though the difficulty of doing such research in countries where LGBT young people are even more highly stigmatized and in some cases at risk of legal sanctions must be acknowledged. More evidence is needed on the mental health of transgender and intersex youth, together with more research that recognizes the full spectrum of sex, sexuality, and gender diversity.

The findings summarized here underline the importance of safe, respectful and inclusive environments (including families, schools, the wider community and the policy context) for LGBT youth, as well as the need for access to support from both peers and adults.[327] Reducing stigma is critical. LGBT youth have more positive well-being outcomes when they are in supportive school environments, have positive relationships with their peers and teachers, and generally do not face discrimination but can expect adult intervention if it does occur.[328] There is evidence from studies in the general adult population that LGBT individuals who live in areas or are part of religious communities where same-sex marriage is not supported experience poorer mental health.[329, 330, 331]

317 McGeough and Sterzing, "A systematic review of family victimization experiences among sexual minority youth".
318 Ibid.
319 Roberto L. Abreu and Maureen C. Kenny, "Cyberbullying and LGBTQ youth: a systematic literature review and recommendations for prevention and intervention", *Journal of Child & Adolescent Trauma*, vol. 11, No. 1 (2017), pp. 81-97, DOI:10.1007/s40653-017-0175-7.
320 Alicia Fedewa and Soyeon Ahn, "The effects of bullying and peer victimization on sexual-minority and heterosexual youths: a quantitative meta-analysis of the literature", *Journal of GLBT Family Studies*, vol. 7, No. 4 (2011), pp. 398-418, DOI:10.1080/1550428X.2011.592968.
321 Kate L. Collier and others, "Sexual orientation and gender identity/expression related peer victimization in adolescence: a systematic review of associated psychosocial and health outcomes", *The Journal of Sex Research*, vol. 50, No. 3-4 (2013), pp. 299-317, DOI:10.1080/00224499.2012.750639.
322 Hall, "Psychosocial risk and protective factors for depression among lesbian, gay, bisexual, and queer youth: a systematic review".
323 Collier and others, "Sexual orientation and gender identity/expression related peer victimization in adolescence: a systematic review of associated psychosocial and health outcomes".
324 Sarah E. Valentine and Jillian C. Shipherd, "A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States", *Clinical Psychology Review*, vol. 66 (2018), pp. 24-38, DOI:10.1016/j.cpr.2018.03.003.
325 Ibid.
326 Kari McDonald, "Social support and mental health in LGBTQ adolescents: a review of the literature", *Issues in Mental Health Nursing*, vol. 39, No. 1 (2018), pp. 16-29, DOI:10.1080/01612840.2017.1398283.
327 Clare J. Wilson and Laura A. Cariola, "LGBTQI+ youth and mental health: a systematic review of qualitative research", *Adolescent Research Review*, vol. 5, No. 6 (2020), pp. 187-211, DOI:10.1007/s40894-019-00118-w.
328 Tecelli Domínguez-Martínez and Rebeca Robles, "Preventing transphobic bullying and promoting inclusive educational environments: literature review and implementing recommendations", *Archives of Medical Research*, vol. 50, No. 8 (2019), pp. 543-555, DOI:10.1016/j.arcmed.2019.10.009.
329 Maurice N. Gattis, Michael R. Woodford and Yoonsun Han, "Discrimination and depressive symptoms among sexual minority youth: Is gay-affirming religious affiliation a protective factor?" *Archives of Sexual Behavior*, vol. 43, No. 8 (2014), pp. 1,589-1,599, DOI:10.1007/s10508-014-0342-y.
330 Francisco Perales and Abram Todd, "Structural stigma and the health and wellbeing of Australian LGB populations: exploiting geographic variation in the results of the 2017 same-sex marriage plebiscite", *Social Science & Medicine*, vol. 208 (2018), pp. 190-199, DOI:10.1016/j.socscimed.2018.05.015.
331 Alexander K. Tatum, "The interaction of same-sex marriage access with sexual minority identity on mental health and subjective wellbeing", *Journal of Homosexuality*, vol. 64, No. 5 (2017), pp. 638-653, DOI:10.1080/00918369.2016.1196991.

Box 7. Interview with a 29-year-old man from Namibia with experience with the justice system

When I was 14 years old, I made some bad mistakes that led to being incarcerated for six years. This was a very difficult time in my life. They were very dark days, being held in maximum security. People are forced into sexual activities, and there are bullies influencing you and a lot of pressures in prison. In those times, I reminded myself "I am still alive" and I heard from older inmates that one day I would go home. I took part in the rehabilitation programmes and classes given to help us and give us courage to keep going. While I was in prison, my grandpa, who raised me and was the only father I had known, passed away. I felt responsible, because I felt that my conviction had killed him. It was a very difficult time to have to deal with it alone.

After committing the crime at 14 I had to wait to go to court until I was 18. During this time, there was a lot of stigma and forced isolation from teachers and school-mates because of my crime. I dropped out of school and went home to my family, but they thought I was a curse to them. Many of my family members were disgusted and disappointed in me. They hated me. Some of my family would stop their children from being near me. When I was introduced by my family, they would talk about my crime to other people rather than just introduce me. I suffered greatly during this time, and I even tried to commit suicide many times. It is very difficult to be accepted by the community especially when you are not playing a positive role in their lives. People like to judge, criticize, and point fingers while they are pretending to be perfect angels in the community. I felt like I had destroyed their lives and brought suffering to my elders.

Many people did not accept me when I returned from prison. People are very judgmental, but I turned it around quickly. I shared with people exactly what I did and what happened to me. I use my story to help other young people to not make the same mistake that I had made. Now I am accepted in my community and trusted by people in the Government. I am now a good example to the community, and that feels very good.

When we are young, instead of asking advice from our parents, we ask advice from our friends – another person who is 14 years old. What kind of positive advice is the person going to give you when they are young? We used to give each other the wrong information about the things in the world. When we felt bad or experienced depression we did not know where to go to find help. Often young people do not know that some of the things that they are doing are crimes. We thought engaging in criminal activity or engaging in violence was a way to show we were strong. Instead, it shows that you are weak and that you cannot think clearly. That is why I speak to young people about my experience. I am trying to help break the cycle of crimes and violence in our society and stop other young people from going through the suffering that I experienced.

Many young people are being undermined at home, being called names, and it leads to a lack of self-esteem. People with low of self-esteem are often the ones bullied by their peers, and then they become people who bully others because of their low self-esteem. I have seen for myself that self-esteem starts at home and good morals are built from there. I think society has unrealistic expectations of boys. Instead of pulling them down, we should always support them and give them opportunities to do good things in school. Everyone can make mistakes, and some will fall into crime, but that is not who they are. They have worth and can change.

I have seen that criminal activity is not always deliberate; frankly, some people may just have nothing to eat. We must pull people out of poverty with education and help with their daily needs. I believe that young people are the "changers of the family". They can change the poverty in their lives and break the cycle for generations to come. I have changed for my family and my community; so can other young people.

Box 8. Interview with a 24-year-old woman from Trinidad with experience of racism

Mental health is a very taboo topic in the Caribbean. It seems like we do not take it seriously in the region. I have struggled with depression from the time I was eight years old. In my early primary school years, I went to a private school that had predominantly Black students, but when I started to have trouble at school my mom transferred me to another school that was predominantly Caucasian students. This was the first time I realized that I stood out and was different. It was a culture shock, but also the racism I experienced was a huge shock to me.

I started to really struggle. I became suicidal but I did not know the term suicidal at that time. I had a horrible day at school, and I wrote a letter to my uncle and I said I wanted to kill myself, but I did not want anyone to know so I ripped it up. My uncle found it and showed it to my mom, who then enrolled me in therapy. My mom did not really understand what I was going through at the time, but my grandma knew that I had difficulties, so she accepted me for me, which was really helpful during that time.

I always suppressed my feelings. I just did not want to be a bother. I did not want anybody to know I was struggling. I just wanted to fit in and did not want to create tensions for my family. High school was also difficult. Because I was tortured in primary school for five years, I carried a lot of rejection with me. When I got to high school, I overanalysed everything because I was hypersensitive from the previous trauma. It was a struggle for me. I did not know myself. I could not really find myself or my place because I had never fit in before. The school did not do anything to support me during this period.

I hated myself. I wanted, and tried a number of times, to commit suicide because I felt like I was ugly and wrong somehow. It felt like no one would love me. I was also dealing with molestation. I am the darkest skinned in my family, and people compared me to my mom because she is lighter than me. Your race is not something you can control.

When I moved to another country, people accepted me. I found that social media became a place where people celebrated my skin colour and the way I looked. I have got a lot of interaction from people and have a strong following on social media. I have noticed in the past two years everyone on social media is jumping onto the "mental health trend". Before, I would have suffered in silence, but when I was diagnosed with borderline personality disorder last year I went offline for a while to work myself out. I started to share a bit about my journey. When I have said, "I suffer with anxiety, which is a symptom of my disorder", people have messaged me and asked for support for their own mental health issues. I think talking about this is good, but I not sure if I am ready to share everything. I want to figure myself out first and become aware of all of my triggers before I put myself out there completely. I think I will come to the point where I can say, "I have a disorder because when I was younger, I had trauma, I suffered racism, and I was suicidal, but let us move past that and let us fix things together".

Young people from minority groups

Discrimination is receiving growing attention as a determinant of poor mental health,[332] with evidence of potentially stronger effects in young people.[333] Racism may impact mental health in the form of structural racism, cultural racism, or individual-level discrimination.[334] As with gender norms, norms related to ethnic background become embedded in later childhood and adolescence, and the effects persist across the life course.[335] Racism may increase the risk of poor mental health through exposure to stress-related experiences, disparities in access to education and employment, overrepresentation in the criminal justice system, and reduced access to healthcare.

Most research has focused on associations between discrimination or prejudice in interpersonal interactions and mental health outcomes. A recent meta-analysis that included more than 200 studies showed that greater perceptions of ethnic discrimination were linked to more depressive and internalizing symptoms, greater psychological distress, poorer self-esteem, lower academic achievement and engagement, less academic motivation, greater engagement in externalizing behaviours, risky sexual behaviours and substance use, and more associations with deviant peers.[336] There was also some evidence of stronger effects in early adolescence, while results on the impact of gender were mixed.[337, 338] The majority of studies have been conducted in the United States of America, and the impacts are less well understood for children in other minority groups, including Indigenous young people.

There is a need for further research into cultural and structural forms of racism as drivers of health inequalities, including poor mental health outcomes.[339] There is also a need for longitudinal studies and further research on various aspects of the measurement and definition of discrimination, as well as more exploration of who is most at risk for ethnic discrimination and what contexts buffer or exacerbate such risks. For example, some studies have shown that people who more closely identify with an oppressed minority group are more likely to perceive discrimination experiences than are those who identify less with such a group.[340]

Research should explore ethnicity beyond demographic categories to identify and examine variations in the development of youth identity and the impact of discrimination on mental health outcomes.[341] There is also a need to give more attention to multiple, intersecting identities linked to migration, acculturation, and gender to better understand the relational and cumulative impact of these identities so that groups at higher risk of mental health problems can be identified with greater accuracy.[342]

332 Daniela Fonseca de Freitas and others, "Psychological correlates of perceived ethnic discrimination in Europe: a meta-analysis", *Psychology of Violence*, vol. 8, No. 6 (2018), pp. 712-725, DOI:10.1037/vio0000215.

333 Naomi Priest and others, "A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people", *Social Science & Medicine*, vol. 95 (2013), pp. 115-127, DOI:10.1016/j.socscimed.2012.11.031.

334 David R. Williams, Jourdyn A. Lawrence and Brigette A. Davis, "Racism and health: evidence and needed research", *Annual Review of Public Health*, vol. 40 (2019), pp. 105-125, DOI:10.1146/annurev-publhealth-040218-043750.

335 Maria Trent, Danielle G. Dooley and Jacqueline Douge, "The impact of racism on child and adolescent health", *Pediatrics*, vol. 144, No. 2 (2019), e20191765, DOI:10.1542/peds.2019-1765.

336 Aprile D. Benner and others, "Racial/ethnic discrimination and well-being during adolescence: a meta-analytic review", *American Psychologist*, vol. 73, No. 7 (2019), pp. 855-883, DOI:10.1037/amp0000204.

337 Patil and others, "Which girls, which boys? The intersectional risk for depression by race and ethnicity, and gender in the U.S."

338 Debbiesiu L. Lee and Soyeon Ahn, "The relation of racial identity, ethnic identity, and racial socialization to discrimination-distress: a meta-analysis of Black Americans", *Journal of Counseling Psychology*, vol. 60, No. 1 (2013), pp. 1-14, DOI:10.1037/a0031275.

339 Margaret T. Hicken and others, "Racial inequalities in health: framing future research", *Social Science & Medicine*, vol. 199, No. 42 (2018), pp. 11-18, DOI:10.1016/j.socscimed.2017.12.027.

340 Lee and Ahn, "The relation of racial identity, ethnic identity, and racial socialization to discrimination-distress: a meta-analysis of Black Americans".

341 Clare R. Evans and Natasha Erickson, "Intersectionality and depression in adolescence and early adulthood: a MAIHDA analysis of the national longitudinal study of adolescent to adult health, 1995-2008", *Social Science & Medicine*, vol. 220 (2019), pp. 1-11, DOI:10.1016/j.socscimed.2018.10.019.

342 Patil and others, "Which girls, which boys? The intersectional risk for depression by race and ethnicity, and gender in the U.S.", abstract.

How the world views people who look like me and how the media world projects "Blackness" innately affects how I internalize my worth. It really affects me mentally.

–Young person, Focus Group 4

Patil and others conducted a systematic review of 25 studies that applied an intersectional lens to the assessment of risk and protective factors for depression in minority youth in the United States of America. Studies were included if they examined "the role of racial and ethnic identity and gender for minority groups and how marginalization may be associated with differential outcomes in depression symptomology",[343] though they were also rated and selected based on the extent to which they had "intentionally operationalized intersectionality through theoretical frameworks, study design, sampling and analyses".[344] The review found that minority youth experiences with discrimination were common. Overall, being female was associated with a higher risk of depression, but the level of risk varied depending on the intersecting identities. While the risk associated with female gender was higher, the intersection with ethnic identity had an influence on depression for both males and females. These findings are indicative of the complexity of such relationships.

Indigenous youth

A systematic review of evidence on the incidence of suicide in Indigenous populations worldwide indicated that Indigenous people living in high-income countries were at higher risk than their non-Indigenous counterparts for poor mental health and suicide, though equal or lower risk was shown in some Indigenous communities in terms of suicide. Almost 90 per cent of the studies reviewed indicated that the Indigenous age cohort with the highest rates of suicide were young people between the ages of 15 and 24.[345] A review of evidence for modifiable psychosocial risk and protective factors common to Indigenous children and youth living in Australia, New Zealand, Canada, and the United States of America showed that poor family cohesion and adverse childhood experiences were most strongly associated with poor mental health outcomes;[346] other risk factors included youth substance use, experiences of discrimination, and negative parental behaviour. Strong and supportive family and peer relationships, high self-esteem, and optimism were associated with more positive mental health outcomes. Evidence indicated that Indigenous offspring in high-income countries who had parents with psychiatric difficulties were more likely to experience internalizing and externalizing problems than were those who had parents without mental health problems.[347]

While it is possible that mental health risks are greater for Indigenous children than for their non-Indigenous counterparts (owing to the effects of intergenerational trauma, for example),[348] few studies have investigated these relationships in paediatric samples with non-Indigenous comparison groups or with mental health assessment tools validated for use in Indigenous populations.[349] The generalizability of most study findings

343 Ibid.

344 Ibid.

345 Nathaniel J. Pollock and others, "Global incidence of suicide among Indigenous peoples: a systematic review", *BMC Medicine*, vol. 16, No. 1 (2108), art. 145, available at https://doi.org/10.1186/s12916-018-1115-6.

346 Christian Young and others, "Psychosocial factors associated with the mental health of indigenous children living in high income countries: a systematic review", *International Journal for Equity in Health*, vol. 16, No. 153 (2017), art. 153, available at https://doi.org/10.1186/s12939-017-0652-5.

347 Sawayra Owais and others, "Psychopathology in the offspring of Indigenous parents with mental health challenges: a systematic review: Psychopathologie des descendants de parents autochtones ayant des problèmes de santé mentale: une revue systématique", *Canadian Journal of Psychiatry*, vol. 66, No. 6 (2021), pp. 517-536, DOI:10.1177/0706743720966447.

348 Joseph P. Gone and others, "The impact of historical trauma on health outcomes for indigenous populations in the USA and Canada: a systematic review", *American Psychologist*, vol. 74, No. 1 (2019), pp. 20-35, DOI:10.1037/amp0000338.

349 Owais and others, "Psychopathology in the offspring of Indigenous parents with mental health challenges: a systematic review: Psychopathologie des descendants de parents autochtones ayant des problèmes de santé mentale: une revue systématique".

Belonging and representation are vital to youth mental health and well-being.
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may be constrained by the dearth of evidence from low- and middle-income countries. One systematic review conducted in 2017 on the prevalence of anxiety and depression in Indigenous people of the Americas found only three studies from Latin America (from Chile, Brazil and Guatemala), with none focusing on youth.[350]

A small number of culturally tailored interventions for the prevention of self-harm and suicide in Indigenous youth have been carried out in high-income countries (mainly in Australia, Canada, and the United States of America) in the form of community or education programmes or gate-keeping training.[351, 352, 353] While evidence for gatekeeper training is promising overall,[354] the quality of the study methodology used to evaluate these interventions is weak (using an uncontrolled design, for example), which substantially limits the conclusions that can be drawn regarding efficacy.[355]

Evidence derived using research methodologies validated for use in Indigenous populations and additional data on Indigenous youth in low- and middle-income countries[356] are needed to guide intervention efforts. Indigenous people should be engaged in all stages of intervention and policy design and delivery, with steps taken to ensure that strategies and efforts are community-led, strengths-based and trauma-informed.[357, 358] Ongoing structural and social discrimination, abuse, and inequities should also be addressed.

Religiosity and spirituality

Approximately 84 per cent of the world's population report having a religious affiliation, which may be a powerful social determinant of health.[359] Much of the research in the area of mental health has focused on depression and suicide and suggests that religious

350 Steve Kisely and others, "The prevalence of depression and anxiety disorders in indigenous people of the Americas: a systematic review and meta-analysis", *Journal of Psychiatric Research*, vol. 84 (2017), pp. 137-152, DOI:10.1016/j.jpsychires.2016.09.032.

351 Anton C. Clifford, Christopher M. Doran and Komla Tsey, "A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand", *BMC Public Health*, vol. 13, art. 463 (2013), DOI:10.1186/1471-2458-13-463.

352 Bushra Farah Nasir and others, "The need for a culturally-tailored gatekeeper training intervention program in preventing suicide among Indigenous peoples: a systematic review", *BMC Psychiatry*, vol. 16, art. 357 (2016), DOI:10.1186/s12888-016-1059-3.

353 Alyssa F. Harlow, India Bohanna and Alan Clough, "A systematic review of evaluated suicide prevention programs targeting indigenous youth", *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, vol. 35, No. 5 (2014), pp. 310-321, DOI:10.1027/0227-5910/a000265.

354 Nasir and others, "The need for a culturally-tailored gatekeeper training intervention program in preventing suicide among indigenous peoples: a systematic review".

355 Clifford, Doran and Tsey, "A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand".

356 Andres J. Azuero and others, "Suicide in the Indigenous population of Latin America: a systematic review", *Revista Colombiana de Psiquiatría*, vol. 46, No. 4 (2017), pp. 237-242, DOI:10.1016/j.rcp.2016.12.002.

357 Nathaniel J. Pollock and others, "Global incidence of suicide among Indigenous peoples: a systematic review", *BMC Medicine*, vol. 16, No. 1, art. 145 (2018), DOI:10.1186/s12916-018-1115-6.

358 Joanne M. Dickson and others, "A systematic review of the antecedents and prevalence of suicide, self-harm and suicide ideation in Australian Aboriginal and Torres Strait Islander youth", *International Journal of Environmental Research and Public Health*, vol. 16, No. 17, art. 3154 (2019), DOI:10.3390/ijerph16173154.

359 Tyler J. VanderWeele, "Religion and health: a synthesis", in *Spirituality and Religion within the Culture of Medicine: from Evidence to Practice*, Michael J. Balboni and John R. Peteet, eds. (Oxford, United Kingdom, Oxford University Press, 2017), available at https://content.sph.harvard.edu/wwwhsph/sites/603/2019/01/ReligionHealthSynthesis.pdf.

affiliation is protective, exerting its effects through a range of mechanisms, including social support, lower levels of risky behaviours, greater self-regulation, hope and optimism, and a sense of meaning and purpose.

Studies have shown that religiosity is associated with positive mental health outcomes, including lower rates of suicide and self-harm (particularly in the context of religious beliefs that discourage suicide).[360, 361] A meta-analysis examining associations between spirituality and religiosity and psychological outcomes in youth showed significant associations with mental health, including reduced depression and enhanced well-being and self-esteem.[362] The relationship between higher levels of spirituality or religiosity and lower levels of depression was stronger for youth than for young adults and for Caucasian youth relative to young people of other ethnicities.

Although the positive effects are frequently highlighted in the research, there are some studies suggesting that negative religious coping (feeling persecuted, for example) is associated with poor mental health outcomes, including self-harm.[363] Further work is needed to explore associations for youth who are at higher risk of self-harm and may be less likely to benefit from certain aspects of religiosity.

There is some evidence from the United States of America suggesting that interventions incorporating spiritual or religious components may help in moderating PTSD and depressive symptoms in urban minority youth exposed to violence or traumatic events.[364]

Most of the research on the links between spirituality/religiosity and mental health outcomes has been conducted in English-speaking Christian populations in high-income countries, with relatively few studies carried out in populations with other religious beliefs – though there is some evidence that religiosity among Arab Muslims is associated with lower levels of anxiety.[365] The research gap is particularly acute for non-Christian youth in low- and middle-income countries.

Natural disasters and climate change

Natural disasters such as floods, tornados, hurricanes and earthquakes are destructive, potentially traumatic events, and many types of natural disasters are expected to occur with increasing frequency due to climate change. Even now, they are relatively common and affect millions of young people every year, placing them at risk of mental health disorders such as PTSD, depression, anxiety, sleep and attachment disorders, and substance use, with variations in prevalence estimates attributed to factors such as disaster type and scale, timing, and the degree of exposure.[366] Indirect factors such as family stress, displacement, the disruption of social support networks, material losses, and the loss of family and friends following the experience of a traumatic event also impact mental health. After disasters, many young people report post-traumatic symptoms, with female gender significantly associated with risk.[367, 368] There is also evidence that proximity (including experiences of being trapped, injured or bereaved or witnessing injury or death), perceived threat (even when not proximate), distress at the time of the disaster, and chronic events are most strongly

360 Alison M. Haney, "Nonsuicidal self-injury and religiosity: a meta-analytic investigation", *American Journal of Orthopsychiatry*, vol. 90, No. 1 (2020), pp. 78-89, DOI:10.1037/ort0000395.

361 Naziha S. AbdAleati, Norzarina Mohd Zaharim and Yasmin Othman Mydin, "Religiousness and mental health: systematic review study", *Journal of Religion and Health*, vol. 55, No. 6 (2016), pp. 1,929-1,937, DOI:10.1007/s10943-014-9896-1.

362 Julie E. Yonker, Chelsea A. Schnabelrauch and Laura G. Dehaan, "The relationship between spirituality and religiosity on psychological outcomes in adolescents and emerging adults: a meta-analytic review", *Journal of Adolescence*, vol. 35, No. 2 (2011), pp. 299-314, DOI:10.1016/j.adolescence.2011.08.010.

363 Haney, "Nonsuicidal self-injury and religiosity: a meta-analytic investigation".

364 Jill Witmer Sinha and Lisa B. Rosenberg, "A critical review of trauma interventions and religion among youth exposed to community violence", *Journal of Social Service Research*, vol. 39, No. 4 (2013), pp. 436-454, DOI:10.1080/01488376.2012.730907.

365 Ahmed M. Abdel-Khalek and others, "The relationship between religiosity and anxiety: a meta-analysis", *Journal of Religion and Health*, vol. 58, No. 5 (2019), pp. 1,847-1,856, DOI:10.1007/s10943-019-00881-z.

366 Susie E.L. Burke, Ann V. Sanson and Judith Van Hoorn, "The psychological effects of climate change on children", *Current Psychiatry Reports*, vol. 20, No. 5, art. 35 (2018), DOI:10.1007/s11920-018-0896-9.

367 Jami M. Furr and others, "Disasters and youth: a meta-analytic examination of posttraumatic stress", *Journal of Consulting and Clinical Psychology*, vol. 78, No. 6 (2010), pp. 765-780, DOI:10.1037/a0021482.

368 Arash Akhavan Rezayat and others, "Evaluating the prevalence of PTSD among children and adolescents after earthquakes and floods: a systematic review and meta-analysis", *Psychiatric Quarterly*, vol. 91, No. 4 (2020), 1,265-1,290, DOI:10.1007/s11126-020-09840-4.

Box 9. Interview with a 26-year-old woman from China with a parent experiencing mental illness

I lived in a small city with both of my parents until I was six, when my parents got divorced. My mom has schizophrenia and my dad got to the point that he could not handle her mental illness anymore. Although I lived full time with my dad, my mom never stopped trying to see me. She wanted to have custody of me, but that was not possible because of her illness. My dad stopped me from seeing her so she would appear at inappropriate times; she would show up at my school and be disruptive. I knew the reason she was acting in this way was just because she wanted to see me.

Schizophrenia is something everybody can see. There is a huge stigma against serious mental illness in my community. In the city where I grew up, if you have depression, people mind less; to them, it does not seem that important. Schizophrenia is different; it does not sound very good, and it does not look very good. Even though we have been together for five years, my boyfriend's parents do not agree with us being together because they think our children have the possibility of developing a mental illness. They said to their son, "Are you such a loser that you cannot find anyone better?" I sometimes blame myself, asking why I do not have a good social status or a fortune so that I can prove to them that I am capable. I do not have a mental illness myself, but there is still discrimination based on my family's mental illness in China. Mental illness can be genetic; it can be something very negative that happened to you and it is not your fault.

When I was in the sixth grade, my primary school teacher was cruel to me in front of the whole class of students. She said, "What is your problem? You are like your mom, who is a psycho?" It was really horrible. I could not talk with my parents. I should have been able to talk to my Dad, but I could not tell him what I was feeling because I knew he already felt bad that our family was not an ideal environment to grow up in. I worried if I told him how I was feeling he would blame himself. I could not do that.

I never talked to anyone about my situation or how I was feeling until I was about 24. I was studying in university and shared with a lecturer who understood the neuroscience of mental illness. I finally met someone I thought I could trust, so I shared that my mom had a mental illness. I also talked with my boyfriend. He was very supportive, but I could not say everything to him. Sometimes I feel like I am causing too much trouble for people. I think I always wanted to share my story and feelings, but I did not find anyone that gave me a sense of security. Most of my friends think I am a very positive person. I am half positive and half negative, but I hide the negative part and only show it when I am alone.

Until about four years ago, I often had the thought that I did not want to live anymore. It was more frequent when I was much younger. Since middle school I felt that the world was miserable and I would never have a child because I did not want them to experience what I had been through. I thought that I would never be happy or have a good life. My mental health problems as an adult are related to what I experienced when I was younger. Those first 10 years of my life had a huge impact on my well-being.

I developed an eating disorder in middle school which carried through until I was in university. I could not stop myself from eating a lot of food because of the stress I was experiencing. I felt like I was a loser; I did not know what it was and could not understand why I kept doing it. I was never taught about eating disorders. The education on mental health in my schools was limited and theoretical. It would have helped me if I had learned about this in school. When I was in middle school and high school, teachers and parents knew little about mental health. Negative emotions were always perceived as a matter of too much pressure, and the advice given to us was often "don't be stressed out" and "relax". In the university I tried to seek help from psychologists, but that was just too expensive, and there was no way I could pay for that. I knew a friend who sought help from the mental health centre in the university. I believe in recent years progress has been made in this respect.

I always tried to think about how I could improve my mental health and get rid of this mess. The Internet has been a very positive tool for improving my mental health. When I had a question about myself, why I behaved a particular way or could not control how I was feeling, I was able to research on the Internet. I learned how to avoid

my negative emotions. I tried to be a positive person and improve my mental health. Suddenly, after doing this for a while, it all became a lot clearer, and I felt like I could feel different than I had in the past.

Getting a job offer in another country has changed the way I think about my life. I had dreamed of studying or working in Europe since I was a young girl. I studied hard at school, learned the language, and practised whenever I could. Then one day I received an offer to work at a big organization in Europe. I had always thought I could not do anything, that I brought problems to all the people around me, and that whoever got married to me was taking on a huge responsibility. Now I feel so much better about myself; I feel like I am lucky.

associated with risk.[369] More recent studies, which show increased risks in those not immediately injured or threatened, have led some experts to point to the role of mass media in disseminating coverage of disasters to a wider audience, extending exposure beyond those in the immediate proximity.

Much attention has been focused on post-traumatic stress, but there is evidence that young people exposed to natural disasters are also at higher risk for other poor mental health outcomes, including internalizing problems such as depression.[370] In their recent meta-analysis, Rubens, Felix and Hambrick[371] noted that the relationship between disaster exposure and internalizing problems other than post-traumatic stress was stronger in lower-resource settings. Poor social support may also be a risk factor for depression.[372] These findings point to the need for treatment interventions focusing on post-traumatic stress as well as on a broader range of mental health consequences, including depression, panic, anxiety, and aggressive behaviours.[373] Evidence regarding associations with suicidality is unclear, with very few studies targeting young people.[374, 375]

Climate change is arguably the most serious health threat facing humanity.[376] The effects of climate change on physical and mental health may be direct (through events such as natural disasters), indirect (through migration, exposure to violence, overpopulation in cities, vicarious trauma, or impairments to physical health such as vector-borne diseases), or existential (based on increased awareness of climate change and its long-term global consequences, for example);[377, 378] these circumstances can lead to what is sometimes referred to "climate anxiety" or "eco-anxiety".[379] Children and youth, especially in low-resource settings or geographically susceptible

369 Burke, Sanson and Van Hoorn , "The psychological effects of climate change on children".

370 Betty S. Lai and others, "Disasters and depressive symptoms in children: a review", *Child & Youth Care Forum*, vol. 43, No. 4 (2014), pp. 489-504, DOI:10.1007/s10566-014-9249-y.

371 Sonia L. Rubens, Erika D. Felix and Erin P. Hambrick, "A meta-analysis of the impact of natural disasters on internalizing and externalizing problems in youth", *Journal of Traumatic Stress*, vol. 31, No. 3 (2018), pp. 332-341, DOI:10.1002/jts.22292.

372 Bihan Tang and others, "A meta-analysis of risk factors for depression in adults and children after natural disasters", *BMC Public Health*, vol. 14, art. 623 (2014), DOI:10.1186/1471-2458-14-623.

373 R.C. Brown and others, "Psychosocial interventions for children and adolescents after man-made and natural disasters: a meta-analysis and systematic review", *Psychological Medicine*, vol. 47, No. 11 (2017), pp. 1,893-1,905, DOI:10.1017/S0033291717000496.

374 Kairi Kõlves, Keili Kõllves and Diego De Leo, "Natural disasters and suicidal behaviours: a systematic literature review", *Journal of Affective Disorders*, vol. 146, No. 1 (2013), pp. 1-14, DOI:10.1016/j.jad.2012.07.037.

375 Hamid Jafari and others, "Risk factors for suicidal behaviours after natural disasters: a systematic review", *The Malaysian Journal of Medical Sciences*, vol. 27, No. 3 (2020), pp. 20-33, DOI:10.21315/mjms2020.27.3.3.

376 Nick Watts and others, "Health and climate change: policy responses to protect public health", *The Lancet*, vol. 386, No. 10006 (2015), pp. 1,861-1,914, DOI:10.1016/S0140-6736(15)60854-6.

377 Burke, Sanson and Van Hoorn , "The psychological effects of climate change on children".

378 Vera Clemens, Eckart von Hirschhausen and Jörg M. Fegert, "Report of the Intergovernmental Panel on Climate Change: implications for the mental health policy of children and adolescents in Europe – a scoping review", *European Child & Adolescent Psychiatry*, vol. 31, No. 5 (2022), pp. 701-713, DOI:10.1007/s00787-020-01615-3.

379 Judy Wu, Gaelen Snell and Hasina Samji, "Climate anxiety in young people: a call to action", *The Lancet Planetary Health*, vol. 4, No. 10 (2020), pp. e435-e436, DOI:10.1016/S2542-5196(20)30223-0.

areas, are particularly vulnerable population groups and will carry the largest burden of the negative consequences of climate change over their lifetime.[380]

I have a lot of anxiety about the future. I am afraid that tomorrow I will suffocate because of the pollution that people are creating, and I don't have a solution for that. I can't solve it, my parents can't solve it, a lot of people around me can't solve it, and it's in the hands of people that don't listen. This is really bad for my mental health.

–Young person, Focus Group 8

Evidence relating to the existential effects of climate change is limited, though most of the studies on this topic have been conducted with young people. In their review of the psychological effects of climate change on children, Burke, Sanson and Van Hoorn[381] identified a very small number of surveys and studies in which children and youth expressed worry, fear, anxiety, sadness, and anger about the impact of climate change and environmental problems on their current and future lives, including the belief that the world would end in their lifetime due to these threats. However, other reviews have shown that while young people generally have comparable or greater interest in and concern about climate change than do older individuals, they are less fatalistic about its consequences and believe that it is a solvable problem that can be addressed through changes in human behaviour.[382]

Protecting the planet and protecting youth mental health go hand in hand. ©UN photo/Manuel Elías

Climate anxiety is a chronic fear of the negative impacts of the climate crisis. You might get it by listening to stories of others' experiences or by watching the news about what is happening in different parts of the world that are experiencing negative climate impacts. Climate anxiety will empower you to take an action or might actually lead you to a fatalistic or defeatist mindset.

–Young person, Focus Group 8

380 Burke, Sanson and Van Hoorn , "The psychological effects of climate change on children".

381 Ibid.

382 Adam A. Corner and others, "How do young people engage with climate change? The role of knowledge, values, message framing, and trusted communicators", *Wiley Interdisciplinary Reviews: Climate Change*, vol. 6, No. 5 (2015), pp. 523-534, DOI:10.1002/wcc.353.

There is some evidence from primary studies exploring protective factors for youth mental health in the context of existential threats linked to climate change.[383, 384, 385] Studies conducted with Swedish youth indicate that meaning-focused coping (including drawing on beliefs, values and goals to live with the reality of a problem) may mitigate the effects of climate change as a psychological stressor.[386, 387] In a study conducted with Inuit youth from the Nunatsiavut region in Canada, youth-specific protective factors for mental health and well-being in the context of climate change included being on the land, connecting to Inuit culture, relationships with family and friends, strong communities, and staying busy.[388] Further research into the factors that protect against climate anxiety is needed, particularly in low- and middle-income countries, where young people are likely to be disproportionately impacted by the effects of climate change.[389]

Responding to climate anxiety, I took it upon myself to spotlight the difficulties faced by vulnerable groups due to climate change. I brought their issues to the notice of my local authorities and pressurized them to allocate climate funds to address the environmental degradation immediately. That has helped me a little, but there is still a lot to be done.

–Young person, Focus Group 8

Forced migration and refugees

The past two decades have seen the most significant forced migration and displacement of individuals affected by conflicts since World War II. Forced migrants are at increased risk of mental health problems, including psychological distress,[390] PTSD, anxiety, depression, psychosis,[391] self-harm[392] and suicide,[393] though prevalence rates for these problems vary considerably across

383 Ibid.

384 Susan Jean Strife, "Children's environmental concerns: expressing ecophobia", *The Journal of Environmental Education*, vol. 43, No. 1 (2012), pp. 37-54, DOI:10.1080/00958964.2011.602131.

385 Maria Ojala, "Coping with climate change among adolescents: implications for subjective well-being and environmental engagement", *Sustainability*, vol. 5, No. 5 (2013), pp. 2,191-2,209, DOI:10.3390/su5052191.

386 Maria Ojala, "Regulating worry, promoting hope: How do children, adolescents, and young adults cope with climate change?", *International Journal of Environmental & Science Education*, vol. 7, No. 4 (2012), pp. 537-561, available at https://doi.org/10.1080/17405629.2022.2108396.

387 Ojala "Coping with climate change among adolescents: implications for subjective well-being and environmental engagement".

388 Joanna Petrasek MacDonald and others, "Protective factors for mental health and well-being in a changing climate: perspectives from Inuit youth in Nunatsiavut, Labrador", *Social Science & Medicine*, vol. 141 (2015), pp. 133-141, DOI:10.1016/j.socscimed.2015.07.017.

389 S. Nazrul Islam and John Winkel, "Climate change and social inequality", DESA Working Paper, No. 152 (ST/ESA/2017/DWP/152), October 2017, available at https://www.un.org/esa/desa/papers/2017/wp152_2017.pdf.

390 Israel Bronstein and Paul Montgomery, "Psychological distress in refugee children: a systematic review", *Clinical Child and Family Psychology Review*, vol. 14, No. 1 (2011), pp. 44-56, DOI:10.1007/s10567-010-0081-0.

391 M.C. Castillejos, Carlos Martín-Pérez and Berta Moreno-Küstner, "A systematic review and meta-analysis of the incidence of psychotic disorders: the distribution of rates and the influence of gender, urbanicity, immigration and socio-economic level", *Psychological Medicine*, vol. 48, No. 13 (2018), pp. 2,101-2,015, DOI:10.1017/S0033291718000235.

392 Anna Gargiulo and others, "Self-harming behaviours of asylum seekers and refugees in Europe: a systematic review", *International Journal of Psychology*, vol. 56, No. 2 (2021), pp. 189-198, DOI:10.1002/ijop.12697.

393 Jacob Spallek and others, "Suicide among immigrants in Europe – a systematic literature review", *The European Journal of Public Health*, vol. 25, No. 1 (2015), pp. 63-71, DOI:10.1093/eurpub/cku121.

populations.[394, 395, 396, 397] Having a migrant background itself is not a risk factor for poor mental health; any relationship is likely due to factors occurring before, during or after migration. Pre-migration factors include exposure to war, torture or persecution, and the death of parents or other close relatives; migration-period and post-migration factors include life-threatening journeys, long-lasting asylum procedures and family separation, and uncertain residential status.[398, 399]

A meta-analysis of studies of prevalence rates for mental health problems in young refugees and asylum-seekers in five countries (Germany, Malaysia, Norway, Sweden and Türkiye) showed high rates of PTSD (22.71 per cent), anxiety (15.77 per cent), and depression (13.81 per cent) relative to non-migrant populations. Rates for these mental health problems were all higher among those displaced for less than two years than for those displaced for more than two years. PTSD rates were higher for those with insecure visa status and temporary residence, while rates for depression and anxiety disorders were higher among those with refugee visa status and community residence. A number of studies suggest that unaccompanied refugee minors (particularly females) may be at particularly high risk of depression, PTSD,[400] and self-harm.[401] There is a need for longitudinal studies to further explore the relationships between refugee experiences and different mental health problems.[402]

When you are displaced and you feel like you don't belong anywhere, it starts to really impact your mental health. You don't quite see yourself or your identity represented in that space. You are so new to that cultural context, you don't really know how you fit in or where you can start to fit in.

–Young person, Focus Group 4

A number of studies have identified unemployment, discrimination (including bullying[403]) and poor social support as risk factors.[404, 405] Older youth and those with prior psychopathology may also be at increased risk.[406] A review of emotional and behavioural problems among migrant children and youth in Europe found that higher rates of mental health problems were mediated by factors such as family functioning, living situation, cultural identity,

394 Naser Morina and others, "Psychiatric disorders in refugees and internally displaced persons after forced displacement: a systematic review", *Frontiers in Psychiatry*, vol. 9, art. 433 (2018), DOI:10.3389/fpsyt.2018.00433.

395 Jens-R. Henkelmann and others, "Anxiety, depression and post-traumatic stress disorder in refugees resettling in high-income countries: systematic review and meta-analysis", *BJPsych Open*, vol. 6, No. 4 (2020), e68, DOI:10.1192/bjo.2020.54.

396 Nadia Vossoughi and others, "Mental health outcomes for youth living in refugee camps: a review", *Trauma, Violence, & Abuse*, vol. 19, No. 5 (2018), pp. 528-542, DOI:10.1177/1524838016673602.

397 Christina Kien and others, "Prevalence of mental disorders in young refugees and asylum seekers in European countries: a systematic review", *European Child & Adolescent Psychiatry*, vol. 28, No. 10 (2019), pp. 1,295-1,310, DOI:10.1007/s00787-018-1215-z.

398 Stephanie Tam, Shea Houlihan and G.J. Melendez-Torres, "A systematic review of longitudinal risk and protective factors and correlates for posttraumatic stress and its natural history in forcibly displaced children", *Trauma, Violence, & Abuse*, vol. 18, No. 4 (2017), pp. 377-395, DOI:10.1177/1524838015622437.

399 Reem El Baba and Erminia Colucci, "Post-traumatic stress disorders, depression, and anxiety in unaccompanied refugee minors exposed to war-related trauma: a systematic review", *International Journal of Culture and Mental Health*, vol. 11, No. 2 (2018), pp. 194-207, DOI:10.1080/17542863.2017.1355929.

400 Lea-Marie Mohwinkel and others, "Gender differences in the mental health of unaccompanied refugee minors in Europe: a systematic review", *BMJ Open*, vol. 8, No. 7 (2018), e022389, DOI:10.1136/bmjopen-2018-022389.

401 Gargiulo and others, "Self-harming behaviours of asylum seekers and refugees in Europe: a systematic review".

402 Rebecca Blackmore and others, "Systematic review and meta-analysis: the prevalence of mental illness in child and adolescent refugees and asylum seekers", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 59, No. 6 (2020), pp. 705-714, DOI:10.1016/j.jaac.2019.11.011.

403 Kevin Pottie and others, "Do first generation immigrant adolescents face higher rates of bullying, violence and suicidal behaviours than do third generation and native born?", *Journal of Immigrant and Minority Health*, vol. 17, No. 5 (2015), pp. 1,557-1,566, DOI:10.1007/s10903-014-0108-6.

404 Anne Sofie Borsch and others, "Health, education and employment outcomes in young refugees in the Nordic countries: a systematic review", *Scandinavian Journal of Public Health*, vol. 47, No. 7 (2019), pp. 735-747, DOI:10.1177/1403494818787099.

405 Wai Kai Hou and others, "Everyday life experiences and mental health among conflict-affected forced migrants: a meta-analysis", *Journal of Affective Disorders*, vol. 264 (2020), pp. 50-68, DOI:10.1016/j.jad.2019.11.165.

406 Tam, Houlihan and Melendez-Torres, "A systematic review of longitudinal risk and protective factors and correlates for posttraumatic stress and its natural history in forcibly displaced children".

acceptance and integration in the host country, level of education, and socioeconomic status.[407]

A review of suicide rates for immigrants in Europe found that those from regions in which suicide rates were relatively high (Northern and Eastern Europe) and young female immigrants from Türkiye, Eastern Africa and Southern Asia were at higher risk than non-migrants, possibly due to language barriers, intergenerational acculturation conflicts, or involuntary or arranged marriage situations.[408, 409]

A meta-analysis of studies of the links between daily stressors (such as housing or neighbourhood contexts, accommodation difficulties, employment-related issues, and access to social or mental health services) and poor mental health in forced migrants revealed associations with higher levels of general distress and psychiatric symptoms.[410] Effect sizes were also stronger for children and youth than for adults, and there were stronger effects in developing host countries relative to developed host countries. The associations of prior trauma with post-migration anxiety, depressive, and PTSD symptoms were fully mediated by experiences with daily stressors. These studies, which found that unfavourable everyday life experiences in host countries could have stronger impacts on mental health than previous traumatic experiences, point to the importance of addressing the post-migration environment alongside person-level factors. Multilevel, cross-sectoral intervention models that address the broader contexts in which youth operate – including family, educational, occupational and wider cultural contexts – are essential for preventing poor mental health outcomes.[411]

Tackling poverty through inclusive policies strengthens youth resilience and well-being.
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Areas of armed conflict

Armed conflicts are associated with mental health outcomes ranging from transient psychological distress to a higher prevalence of mental health problems, notably PTSD and depression.[412, 413] A review of literature on the mental health of children and youth living in areas of armed conflict in the Middle East found that the increased prevalence of mental, behavioural and emotional problems was associated with a higher number of conflict-related traumatic experiences, older age, gender (with girls showing higher levels of psychological symptoms and boys showing more behavioural problems),

407 Esmahan Belhadj Kouider, Ute Koglin and Franz Petermann, "Emotional and behavioral problems in migrant children and adolescents in Europe: a systematic review", *European Child & Adolescent Psychiatry*, vol. 23, No. 6 (2014), pp. 373-391, DOI:10.1007/s00787-013-0485-8.

408 Jacob Spallek and others, "Suicide among immigrants in Europe – a systematic literature review", *European Journal of Public Health*, vol. 25, No. 1 (2015), pp. 63-71, DOI:10.1093/eurpub/cku121.

409 Daniel W.L. Lai, Lun Li and Gabrielle Daoust, "Factors influencing suicide behaviours in immigrant and ethno-cultural minority groups: a systematic review", *Journal of Immigrant and Minority Health*, vol. 19, No. 3 (2017), pp. 755-768, DOI:10.1007/s10903-016-0490-3.

410 Hou and others, "Everyday life experiences and mental health among conflict-affected forced migrants: a meta-analysis".

411 Mina Fazel and Theresa S. Betancourt, "Preventive mental health interventions for refugee children and adolescents in high-income settings", *The Lancet Child & Adolescent Health*, vol. 2, No. 2 (2018), pp. 121-132, DOI:10.1016/S2352-4642(17)30147-5.

412 Khuzama Hijal Shaar, "Post-traumatic stress disorder in adolescents in Lebanon as wars gained in ferocity: a systematic review", *Journal of Public Health Research*, vol. 2, No. 2 (2013), e17, DOI:10.4081/jphr.2013.e17.

413 L. Dimitry, "A systematic review on the mental health of children and adolescents in areas of armed conflict in the Middle East", *Child: Care, Health and Development*, vol. 38, No. 2 (2012), pp. 153-161, DOI:10.1111/j.1365-2214.2011.01246.x.

socioeconomic adversity, lower social support, and lower religiosity.[414] A review of studies on resilience and mental health in children and youth affected by armed conflict in low- and middle-income countries found that mental health problems other than PTSD were best predicted by family-level variables (such as parental monitoring and support), whereas PTSD was best predicted by exposure to traumatic events.[415]

In their review of studies of children and youth exposed to the Israeli-Palestinian conflict, Slone and others[416] found a small increased risk of psychological distress. They also assessed the impact of direct exposure, proximity to the conflict, and media exposure, with the results showing that all types of exposure were associated with higher levels of psychological distress and that the effect of proximity on distress was stronger than that of direct exposure. Further research should explore the impact of media exposure, in particular that related to social media.

Child soldiers – whether engaged as combatants or supporters (such as porters, cooks or servants) – are likely to be at particularly high risk of poor mental health outcomes. They may be forced to perpetrate violence as well as being victims themselves and may also face social stigma on their return to society. A review of the mental health impacts of being a child soldier showed that abduction, younger age of conscription, longer conscription duration, exposure to violence, gender, and community stigma were associated with increased internalizing and externalizing mental health problems.[417] Family acceptance, social support, and educational/economic opportunities were shown to be associated with improved psychosocial adjustment.

There is a need for further research into the impact of armed conflict on the mental health of youth, in particular longitudinal studies that allow for the assessment of longer-term impacts and those that use validated cross-cultural instruments for assessing mental health, as well as more integrated community-based approaches to study design and research monitoring.

A review of evidence on interventions for children and youth affected by armed conflict in low- and middle-income countries found beneficial effects on depression and PTSD.[418] The most frequently mentioned intervention types were cognitive behavioural strategies, psychoeducation, and creative expressive approaches such as drama, music, role-playing, and drawing. However, there is relatively little research on social considerations in basic humanitarian services and security or on interventions focused on parents and families.

Sex trafficking

The commercial sexual exploitation and sex trafficking of children and youth present considerable risks for a range of health issues, including PTSD, depression, and suicidality.[419, 420, 421] As many trafficked children have also experienced prior abuse and trauma, including emotional, physical and sexual abuse, policy responses need to consider the complex consequences of cumulative trauma. There have also been calls to explore the potential for post-traumatic growth and positive coping abilities in this population.[422]

While the majority of research has focused on sex trafficking in women and young women, a recent review of the impacts on sexually exploited boys showed

414 Ibid.
415 Wietse A. Tol, Suzan Song and Mark J.D. Jordans, "Annual research review: resilience and mental health in children and adolescents living in areas of armed conflict – a systematic review of findings in low- and middle-income countries", *Journal of Child Psychology and Psychiatry*, vol. 54, No. 4 (2013), pp. 445-460, DOI:10.1111/jcpp.12053.
416 Michelle Slone and others, "The Israeli-Palestinian conflict: meta-analysis of exposure and outcome relations for children of the region", *Children and Youth Services Review*, vol. 74 (2017), pp. 50-61, DOI:10.1016/j.childyouth.2017.01.019.
417 Theresa S. Betancourt and others, "Psychosocial adjustment and mental health in former child soldiers – systematic review of the literature and recommendations for future research", *Journal of Child Psychology and Psychiatry*, vol. 54, No. 1 (2013), pp. 17-36, DOI:10.1111/j.1469-7610.2012.02620.x.
418 Mark J.D. Jordans, Hugo Pigott and Wietse A. Tol, "Interventions for children affected by armed conflict: a systematic review of mental health and psychosocial support in low- and middle-income countries", *Current Psychiatry Reports*, vol. 18, No. 1, art. 9 (2016), DOI:10.1007/s11920-015-0648-z.
419 PhuongThao Le and others, "Health issues associated with commercial sexual exploitation and sex trafficking of children in the United States: a systematic review", *Behavioral Medicine*, vol. 44, No. 3 (2018), pp. 219-233, DOI:10.1080/08964289.2018.1432554.
420 L. Ottisova and others, "Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review", *Epidemiology and Psychiatric Sciences*, vol. 25, No. 4 (2016), pp. 317-341, DOI:10.1017/S2045796016000135.
421 Patrick A. Palines and others, "Comparing mental health disorders among sex trafficked children and three groups of youth at high-risk for trafficking: a dual retrospective cohort and scoping review", *Child Abuse & Neglect*, vol. 100 (2020), 104196, DOI:10.1016/j.chiabu.2019.104196.
422 Le and others, "Health issues associated with commercial sexual exploitation and sex trafficking of children in the United States: a systematic review".

that markers of childhood adversity – such as poverty, exposure to substance-using parents, unstable parental relationships, and experiences of sexual, physical, or emotional abuse – were more common among boys who had been exploited than among those who had not.[423]

The inclusion of youth in mental health policy processes would help to drive changes in a collaborative, intergenerational manner.

–Young person, Focus Group 5

Additional thoughts

The literature on key societal determinants of mental health supports associations between a range of factors and poor mental health. These include discrimination and marginalization on the basis of gender, sexual orientation and ethnic background and the impacts of natural disasters, conflict, forced migration, and sex trafficking. Religiosity and spirituality appear to be protective.

While some solid evidence has been gathered, there are still considerable limitations in the available literature. Most studies are cross-sectional and have been carried out in a relatively limited range of contexts. This is particularly true for determinants such as discrimination on the basis of gender identity, sexuality, or ethnic background; it is worth noting that the majority of relevant research focuses on the links between discrimination or prejudice in interpersonal interactions and mental health outcomes, with relatively few studies focusing on the cultural and structural forms of racism as drivers of mental health inequalities. For all of the social determinants explored in this section – and others yet to be identified – there is a need for studies to consider a broad range of contexts outside Europe and the United States of America, for more longitudinal studies, and for the integration of mental health outcome measures in the studies carried out.

Intervention studies are also needed, with particular attention given to the rigour of the design. Many intervention studies are characterized by weak study designs, reliance on self-report measures, highly variable consent and follow-up rates, and the absence of economic or cost analyses. Notwithstanding these limitations, there is evidence that effective treatments for children and youth after man-made and natural disasters (secondary prevention measures) include cognitive behavioural therapy and narrative exposure therapy.[424] Multilevel, cross-sectoral intervention models that address the contexts in which youth live, including family, educational, occupational and broader cultural contexts, can further strengthen efforts to prevent poor mental health outcomes.[425] These interventions may be better conceptualized as treatments and do not target social determinants (such as access to safe housing or building dams to reduce the risk of flooding) that may be addressed more effectively at a population level.

Some of the reviews highlighted in this section emphasized the need to consider the limitations of Western diagnostic frameworks in the measurement of mental health. For example, in their review of mental health in child soldiers, Tol, Song and Jordans[426] included details of an ethnographic study in northern Uganda in which it was initially observed that many children did not seem to suffer psychological complaints. This apparent lack of mental health impacts was later understood as being "related to cultural values regarding respect for others who suffered in silence and not wanting to hurt others who suffered. Complaints were more freely expressed in the form of somatic symptoms, for which tranquilizers were used."[427]

423 Melissa Moynihan and others, "A systematic review of the state of the literature on sexually exploited boys internationally", *Child Abuse & Neglect*, vol. 76 (2018), pp. 440-451, DOI:10.1016/j.chiabu.2017.12.003.

424 R.C. Brown and others, "Psychosocial interventions for children and adolescents after man-made and natural disasters: a meta-analysis and systematic review", *Psychological Medicine*, vol. 47, No. 11 (2017), pp. 1,893-1,905, DOI:10.1017/S0033291717000496.

425 Fazel and Betancourt, "Preventive mental health interventions for refugee children and adolescents in high-income settings".

426 Tol, Song and Jordans, "Annual research review: resilience and mental health in children and adolescents living in areas of armed conflict – a systematic review of findings in low- and middle-income countries".

427 Ibid.

Further research is needed on resilience and strengths-based approaches.
©UN photo/Mark Garten

There is also a need for further research into resilience and adaption and incorporating strengths-based approaches in the face of adversity, given the evidence that most individuals in groups at risk of marginalization or exposed to stressful life events do not experience mental health problems.

d. Policy recommendations

- *Gender inequality and restrictive gender norms.* Research and data collection can be improved by incorporating mental health measures into interventions designed to address gender inequality. Policies and programmes should be implemented to address the adverse mental health impacts of conforming to "masculine" norms.
- *Mental health among young people at risk of discrimination and marginalization, LGBT youth, young people from minority groups, and Indigenous youth.* Steps should be taken to improve research and data collection on mental health in young people at risk of discrimination and marginalization, including Indigenous youth, LGBT youth, young people from ethnic minority groups, refugees and migrants, and young people who have been trafficked. Improvements are also needed in research and data collection on multiple intersecting identities, including sexual and gender minority status, ethnic minority status, and migration or refugee status. Policies and programmes should be implemented to address the victimization, stigma and discrimination faced by LGBT youth, including from legal systems, education systems, families, peers, and health and other services. Action is needed to ensure that mental health professionals receive training on cultural and sexuality sensitivities.
- *Religiosity and spirituality.* Research and data collection on the positive and negative mental health impacts of religiosity and spirituality in young people should be improved.
- *Natural disasters and climate change.* Efforts should be made to improve research and data collection on the mental health impacts of natural disasters and climate change. Programmes should be implemented to address these impacts, focusing not only on PTSD but also on depression, panic, anxiety, and aggressive behaviours. Public health information should be developed and disseminated to contribute to the normalization of conversations about climate change and mental health.
- *Forced migration and refugees.* Policies and programmes should be implemented that address the post-migration environment as well as individual-level and family-level factors.
- *Areas of armed conflict.* Action should be taken to improve research and data collection on the mental health impacts of humanitarian interventions focused on families and communities.
- *Sex trafficking.* Steps should be taken to improve research and data collection on young people's resilience and adaption in the face of adversity, with emphasis on exploring strengths-based approaches.

Conclusion

Ending discrimination is key to improving mental health and well-being of all young people. ©UN Photo/Marco Dormino

This *Report* has explored the role that key social determinants – education, employment, families and relationships, poverty and deprivation, technology and the digital environment, and society and community – play in youth well-being and mental health. These social determinants are deeply interlinked and form a complex web of influences on the mental health and well-being of young people.

Schools and other educational settings can play a foundational role by providing supportive environments that promote social-emotional learning and mental wellness. Programmes and initiatives offered within or through schools not only help students cope with academic pressures but also equip them with skills for emotional resilience, which are vital as they transition into the workforce. Without mental health support in schools, students may struggle with stresses that carry over into their professional lives.

The quality of work and employment transitions also shape youth mental health. Issues such as job insecurity, gender disparities, and workplace stress can exacerbate mental health problems, particularly for youth navigating their first jobs. Fair remuneration and inclusive work environments can mitigate these risks, while precarious employment may trigger anxiety or depression. The transition from school to work is often stressful, and the absence of mental health support in either space can lead to compounded stress.

Family dynamics play a central role in shaping youth mental health. Supportive family structures, open communication, and addressing family-related stressors such as trauma or economic struggles are crucial for positive mental health outcomes. If family environments are unstable, youth may experience additional stress, which can compound the pressures they face in education and employment.

Poverty and deprivation are major social determinants that intersect with all other factors. Economic inequality often correlates with poorer mental health outcomes, and youth in marginalized or low-income groups face higher risks of mental health disorders. Targeted interventions to reduce economic inequality and provide suicide prevention support are critical to addressing mental health challenges in these populations.

Technology and online environments are becoming increasingly influential in youth mental health. While they provide platforms for education and social connection, they also present risks such as cyberbullying or addiction. Promoting digital literacy and facilitating the formation of partnerships between schools and technology companies can help create safer and more equitable online environments, supporting youth mental health.

Society significantly influences youth mental health through factors such as stigma, cultural attitudes, and social support. Stigma surrounding mental health can deter young people from seeking help, leading to untreated conditions and feelings of isolation. Cultural norms regarding emotional expression often dictate how youth cope with stress, potentially resulting in the harmful internalization of their struggles. Social support networks play a protective role, as strong community ties can mitigate mental health risks.

The interconnections and combined effects of these social determinants highlight the need for holistic, multisector approaches and policies to support youth mental health.

In the section focusing on societal impacts, the Report emphasizes that climate change has profound implications for youth mental health, exacerbating anxiety, depression, and other mental health issues. Many young people are experiencing heightened levels of eco-anxiety – overwhelming feelings of fear and helplessness about the future linked to the ongoing climate crisis. The increasing frequency and severity of natural disasters can result in trauma and loss, which are detrimental to mental well-being. The disruptions caused by climate-related events, especially in education and social interactions, can lead to feelings of isolation and instability among youth. As the impacts of climate change continue to evolve, addressing the associated mental health challenges will be crucial for supporting the well-being of future generations.

The health of future generations is central to the Pact for the Future, adopted during the United Nations Summit of the Future, held in New York on 22 and 23 September 2024. The Pact emphasizes the importance of creating opportunities for young people to thrive in a rapidly changing world. It calls for mental health to be integrated into national youth development policies to ensure that

young people are resilient and equipped to navigate evolving challenges. The Pact also calls for expanded investments in education, skills development, and mental health support for youth, acknowledging that these areas are vital for their well-being and future contributions to society.

Overall, the Pact for the Future seeks to create a global framework that supports youth development and well-being, recognizing that mental health is a crucial factor for their success in shaping the future. By addressing the root causes of mental health challenges among young people – such as economic insecurity, education gaps, and social exclusion – the Pact aligns with the broader United Nations goal of fostering a healthy, empowered, and resilient youth population.

The *Report* is intended to support efforts to reach this goal. Informed by research and consultations with young people, it offers tangible next steps to promote intergenerational dialogue about well-being and mental health and provides recommendations on research and policy approaches that can contribute to improving youth mental health and well-being.

Mainstreaming youth mental health in policymaking processes is key to the holistic approach called for in this Report. Holistic is not synonymous with one-size-fits-all but rather describes the alignment of social policies towards a multisectoral approach and the effective use of the wider social policy toolbox that Governments have at their disposal, including policies and programmes that can shape the social determinants of mental health and take mental health considerations into account in defining social policies in various areas. Improving youth mental health and well-being requires that youth-oriented policies be integrated within an overall life-course approach in social policies.

The research and youth consultations that have informed this *Report* highlight the diverse nature of youth mental health experiences across the world and the linkages between the drivers of social determinants.

The young people consulted for the *Report* recognized the scale of this undertaking. They took the time to prioritize the social determinants of mental health they would like to see addressed by Governments and service providers (see **figure 33**), ranking them as follows:

1. Education
2. Poverty and deprivation
3. Family and relationships
4. Employment
5. Society and community
6. Technology and the digital environment

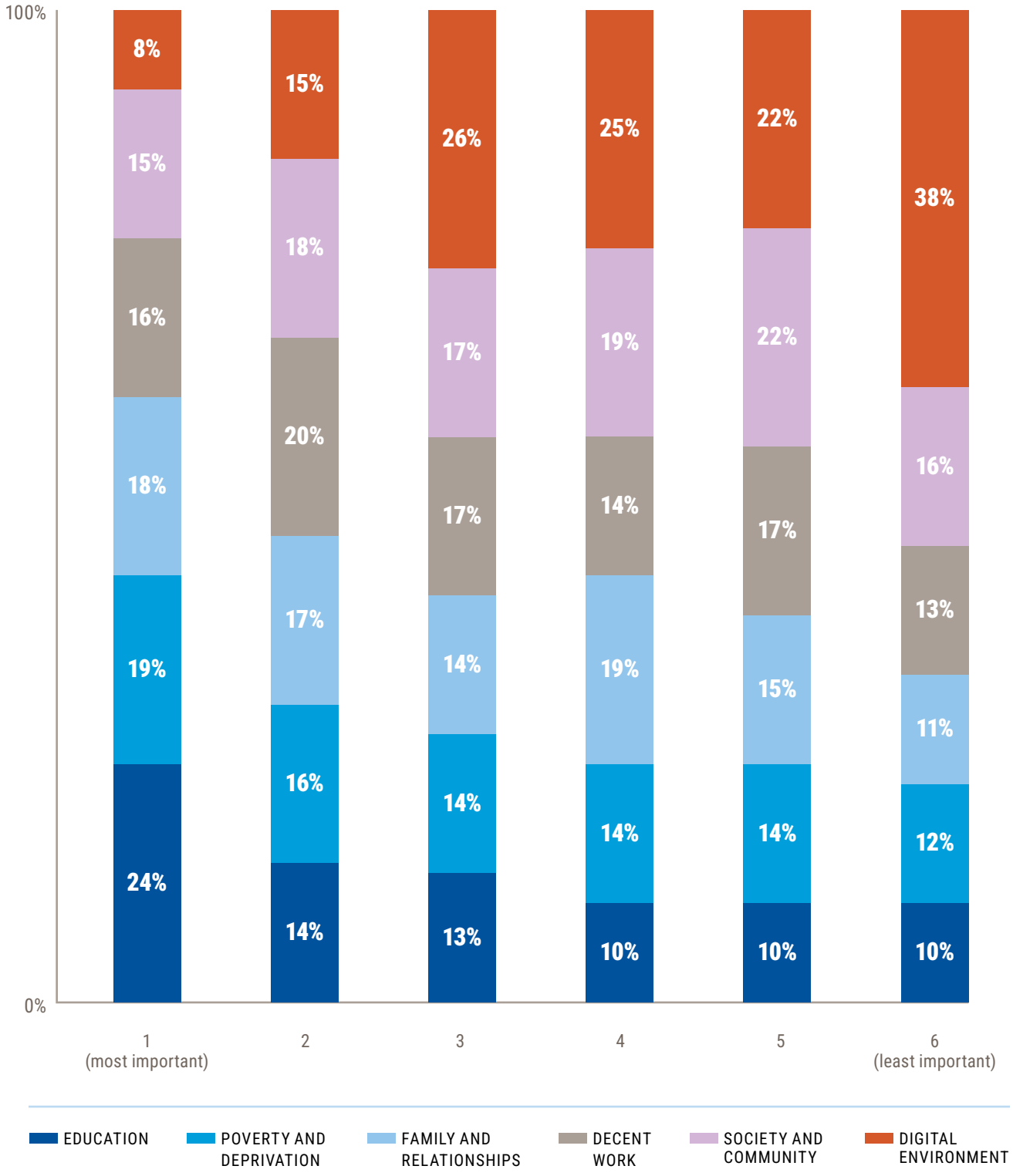
The young people also shared the following recommendations related to proactive mental health strategies and support across all six of the social determinants examined in this *Report:*

- Promote the positive nature of mental health treatments, programmes and medications in the same manner that other physical health issues are approached.
- Make mental health first-aid training free for young people.
- Ensure that mental health resources are publicly available for all young people.
- Make seeking professional help safe and anonymous.
- Recognize the importance of the cultural spectrum in the presentation of mental health issues and train medical practitioners in this area.
- Tailor the language used in key mental health texts so that it is culturally sensitive, recognizing that the internalized nature of mental health will be externalized in very different ways depending on culture.

The *Report* concludes with the observation that an inclusive approach to youth mental health and well-being is a fundamental aspect of social development that leaves no one behind.

FIGURE 33 YOUTH PRIORITIZATION OF SOCIAL DETERMINANTS

Which social determinants of mental health would you like to see government and service providers prioritise in your area? (Rate 1 to 6 with 1 being most important)



Note: Totals may not add due to rounding

Annexes

Cross-sectoral approaches are key to youth mental health. ©UN Photo/Shareef Sarhan

Annex I

Report of the expert group meeting

A virtual expert group meeting organized by the Division for Inclusive Social Development of the United Nations Department of Economic and Social Affairs (UN DESA) was held on 23 and 24 November 2020 to elicit inputs for the preparation of the next edition of the *World Youth Report*. This expert group meeting was attended by more than 60 experts from diverse fields and geographic areas, including young experts with experience of living with or overcoming mental health and well-being challenges. The experts included academics, researchers, and policy analysts with experience in mental health, youth development, or social sciences. A summary of that meeting is provided in the report below.

Background and context

The mandate for the *World Youth Report* stems from General Assembly resolution 58/133 and subsequent biennial resolutions, including the most recent General Assembly resolution (78/179). The *World Youth Report* is guided by the World Programme of Action for Youth and the 2030 Agenda for Sustainable Development.

The upcoming *World Youth Report* will focus on the mental health and well-being of young people and will take a holistic, multisectoral approach in identifying elements required for mainstreaming mental health considerations in broader policymaking processes.

In recent years, the mental health and well-being of young people has garnered significant attention within the United Nations system – not only among youth civil society actors and official youth delegates engaging in United Nations processes, but also among the Member States themselves. In General Assembly resolution 74/121, youth mental health and well-being is identified as an area for further action, with specific reference made to addressing the social determinants of health. Mental health is included in the 2030 Agenda for Sustainable Development, mainly under Sustainable Development Goal 3 (good health and well-being), and is also mentioned within the context of several other Sustainable Development Goals, including Goal 4 (quality education), Goal 8 (decent work and economic growth), and Goal 10 (reduced inequalities).

The expert group meeting participants agreed that mental health and well-being, like physical health, were affected by a multitude of variables ranging from healthcare access to social, economic, and environmental factors – broadly termed "social determinants" in the health literature. At this meeting, the focus was on promoting better mental health and well-being through inclusive social policies, an approach grounded in understanding the social determinants of mental health and the experiences of youth.

To promote a better understanding of this dynamic, the organizers decided to focus on six policy spheres of influence relating to key social determinants of youth mental health and well-being – namely, education, employment, families and relationships, poverty and deprivation, technology and the online environment, and society and community. The six social determinants and policy spheres are interlinked and can have a compounding effect on youth mental health. The issues of climate change and external shocks were also discussed during the meeting.

Education

Providing quality education and ensuring access to key resources such as educational materials, school lunches, support services, and the Internet contribute to a positive learning environment, with a strong positive impact on mental health and well-being. Conversely, entrenched inequalities and a lack of funding for schools can lead to diminished educational gains and a poor school environment, particularly for vulnerable and marginalized youth. Low resource access is compounded by a general lack of mental health awareness, education and training in schools for both students and staff. This is especially striking in countries with a significant rural-urban divide;

many rural schools have fewer educational resources and less mental health support than do (the generally wealthier) urban school systems.

Quality education is more than the availability of adequate resources. Schools should be places where young people can grow and develop in all respects – not only academically, but also in terms of mental health and well-being. Educational institutions need to promote and facilitate open dialogue about mental health, addressing issues such as stigmatization, discrimination, and bullying, and teachers need to be equipped with the knowledge and tools they need to create and sustain a more inclusive school environment. Students with mental health issues often disengage from school activities and face barriers to future opportunities because of stigma and bullying that have not been addressed. Promoting or providing mental health services and literacy courses for students is a potentially impactful direction, but efforts in this area need to be localized to suit cultural, religious, and social expectations surrounding mental health and well-being. Existing cultural, religious, and social norms can sometimes contribute to negative mental health outcomes for young people and possibly create barriers to effective access to mental health services and literacy for marginalized groups. Ethnic, gender, religious, and other identities need to be considered within this context.

Many young people experience feelings of depression and anxiety, particularly when faced with an uncertain future. Students in secondary education who are unable to pursue tertiary or other post-secondary studies often have weaker employment prospects, and those with higher degrees may have crippling student loan debt.

The COVID-19 pandemic compelled most of the world's students to shift to online schooling, placing students in unfamiliar learning environments, exacerbating educational inequalities, and disrupting normal socialization processes – all of which had an impact on youth mental health and well-being.

Employment

The workplace environment and culture can have a tremendous impact on young people who are able to secure employment. Those who work in positive environments that promote discussion on mental health issues and offer employee benefits tend to have better mental health outcomes than those who do not. In certain work environments, young people may experience burnout or stresses relating to performance, job security, or work-life balance, which can have a serious impact on their mental health. In both developed and developing countries, there is a relatively poor understanding of mental health in the workplace, with employers believing that those dealing with mental health issues are incompetent or cannot perform. Systemic change in management and leadership and mental health training for managers, supervisors and staff are needed to address the stigma surrounding mental health challenges in the workplace.

Hazardous work conditions, unfair labour practices, and discrimination in the workplace all have negative effects on the mental health of young people. Because decent jobs are often scarce, low-income or marginalized young people often become trapped in jobs with poor working conditions, which can be detrimental to their well-being. Young people are often exploited through unfair labour practices, leading to feelings of negativity, depression and anxiety. Access to high-quality, decent employment, the recognition and enforcement of established labour and human rights, and adequate pay and job benefits can help provide young people entering the job market with hope and a sense of security. Young people who are able to secure decent work typically experience less workplace discrimination and stigma.

Families and relationships

Family relationships strongly influence youth mental health and well-being. An enabling environment supportive of youth is often linked to positive mental health outcomes, while an unsupportive or toxic environment can activate or exacerbate mental health issues. It is important that both formal and informal groups be established to provide activities and forums for young people who lack adequate family support, with interaction facilitated through community-based extracurricular activities or youth-led mental health awareness initiatives.

Creating open environments and safe spaces for personal expression within communities can foster a sense of belonging and purpose for youth with mental health disorders. Safe environments may offer more opportunities to strengthen mental health awareness and

promote dialogue on how to address mental health and well-being in community and family settings, especially for marginalized and vulnerable groups such as LGBT youth, Indigenous youth, young girls, and youth in foster care. Efforts should also be made to address the needs of young people who do not live in traditional families or community settings, including young migrants, asylum-seekers, and displaced persons – many of whom lack access to mental health support services offered by government agencies or within communities.

Because the relationship young people have with their families often plays a strong role in shaping their personality and mental health, increased attention needs to be given to how socioeconomic determinants and inequalities impact family dynamics and development. Many young people develop mental health issues because of socioeconomic pressures placed on their families or communities owing to gaps in social protection systems, cycles of poverty, or disruptions in long-term employment. Especially vulnerable within this context are groups that are neglected or ignored because of underlying stigma, racism, gender inequality or marginalization. Some hardships contribute to intergenerational trauma and inequalities that can impact parenting style, family dynamics, and living conditions.

Family-focused social policy interventions could have a long-lasting impact on youth mental health and well-being, as new norms, support systems, and ideas could be introduced into the home environment, easing hardships for young people. Parenting education and family life education programmes could provide support for existing and new families as they navigate raising children; such support would likely be particularly beneficial for single-parent families and young people who are also parents. Community-based policies and programmes could focus on educating families about mental health disorders and promote awareness about gender inequality and sexual/gender identities. Schools and online platforms could host informational events and offer resources for families on how to create an enabling environment for children and youth.

The COVID-19 pandemic put a huge strain on unemployment services and the traditional social protection systems upon which many families relied. Revamping social and public services delivery to address inequalities and poverty could provide more effective support mechanisms for families that are in need or vulnerable to socioeconomic shocks. Many of the expert group meeting participants noted the transformative impact that universal basic income could have on families that were nearing or below the poverty line and unable to afford the basic commodities and services needed to support young people's development.

Poverty and deprivation

Young people experiencing poverty face challenges on multiple levels. They often lack access to basic services and have limited social, economic, educational and occupational mobility. They tend to be marginalized in policy considerations. It is important to address pervasive socioeconomic inequalities both within and between countries, as poverty and marginalization can contribute to negative mental health outcomes for young people and affect their access to mental health services and support.

As there is no universal definition or system of measurement for poverty, applying a relative definition and conception of poverty is likely the best approach within the present context. Additional research and data are needed to better understand how poverty and income/wealth inequality are connected to mental health; those most vulnerable and marginalized are often neglected in existing data, leaving a critical gap in the feedback needed for mental health studies and interventions.

Technology and the online environment

Online environments play a significant role in both youth mental health outcomes and mental health services delivery. Young people with Internet access may face online harassment, discrimination and stigmatization in social media and other online forums, but many youth are also able to find support groups and access to personalized mental health services through social impact platforms and government websites. In terms of contributing to mental health outcomes, digital technologies present both risks and opportunities; this suggests that the intentional regulation and design of online environments could yield strong results, though only young people who have access to the Internet and know how to use it would be affected. The lack of Internet access and the pervasive

digital divide have been found to be harmful for many young people unable to find support within their communities, as they are unable to learn about mental health issues online and have no access to the services they need. Just as the digital divide perpetuates pre-existing inequalities in education and employment, digital inequalities contribute to diminished mental health outcomes and represent lost opportunities for young people.

During the recent global health crisis, quarantines kept young people at home for extended periods, with some forced to endure unstable or toxic family environments. Where Internet access was available, youth were able to seek supportive communities online through virtual groups and mental health services, though increased digital engagement also exposed them to intensified mental health risks and threats.

As conditions surrounding the COVID-19 pandemic led to increased dependence on digital technologies and Internet access, more discussions arose around the need for increased regulation of the online environment to improve mental health outcomes. Young people, in partnership with private and public sector actors, could have a strong impact in terms of guiding policy design and offering recommendations that promote sensitivity to mental health disorders. Guiding policy in ways that magnify the positive aspects of the online environment could promote more opportunities for young people.

Society and community

Social, cultural, gender, and religious norms help shape the lens through which young people view their self-identity and well-being and have a significant impact on the way a community or society approaches mental health. In more conservative traditions, there exists a culture of silence around mental health issues; discussing certain aspects of mental health (including risk factors such as non-normative sexuality identity) is considered taboo. These belief systems can have serious repercussions, with young people marginalized or ostracized from their families or communities because of their identities or denied access to essential resources, services, or opportunities because of discriminatory practices. It is worth noting that many young people possess intersectional identities based on ethnicity, socioeconomic status, gender, education, religion, and sexuality. Both within and between individuals, some of these identities may conform to established norms, while others are in conflict with societal expectations – a dichotomy that may be especially pronounced in rural or traditional settings. Cultural or normative barriers within communities make it difficult to apply a uniform or generalized approach to mental health services delivery or awareness initiatives.

Climate change and external shocks

External shocks such as armed conflicts, forced displacement, disease, or natural disasters can transform a community or society. Such ordeals drastically alter the lived experiences of young people and contribute to personal, family, group and intergenerational trauma. Mental health and well-being indicators should be given increased consideration in humanitarian and rebuilding efforts in post-conflict areas and refugee camps; this is especially important for the most vulnerable groups, including women and young girls. Climate change and the consequent natural disasters contribute to negative mental health outcomes through the disruptions caused to daily lives and services, the pressures linked to rebuilding lives and security, and the post-traumatic stress and trauma internalized by individuals and communities.

Climate change and the COVID-19 pandemic have emerged as more recent determinants of youth mental health and well-being, with both producing feelings of despair, anxiety, and uncertainty about the future. Negative mental health outcomes derive from immediate impacts often linked to other social determinants but also from a deeper existential dread – longer-term concerns and uncertainties relating to future economic crises, widening inequalities, and the effects of climate change. In mental health literature and services, promoting mental health resilience and adaptive capacities can help support those youth who are most vulnerable to external shocks.

Faced with these evolving risks and threats, many young people have mobilized through youth-led groups and organizations to address issues of concern within their communities and countries. This has contributed to positive mental health outcomes and a greater sense of belonging but has also led to burnout and anxiety when youth agency is not recognized or leveraged by Governments or when promises made to young people

Gender inequality limits youth well-being and opportunities for growth. ©UN Photo/Manuel Elías

are not kept. Ensuring that youth are involved in the design of inclusive policies and supporting youth-led initiatives and movements can produce better health outcomes for young people.

Key messages and additional observations

- With the uncertain and diminished employment opportunities linked to the economic impact of the COVID-19 pandemic exacerbating pre-existing inequalities, many young people have had difficulty finding decent work and are increasingly turning to the gig economy, intensifying feelings of anxiety and depression.
- Associations between poverty, deprivation, and mental health need to be further explored in research and policy spaces, with clear links established between pre-existing and emerging inequalities.
- Access to quality education and resources has a strong impact on mental health and well-being. Quality education entails promoting or providing mental health literacy, services, and training within educational institutions to reduce stigma around mental health disorders starting at a young age.
- Online environments play a significant role in both mental health outcomes and the delivery of mental health services for young people. Engagement with online platforms, including social media, can lead to both positive and negative mental health outcomes.
- As the relationship young people have with their families plays an important role in shaping their personality and mental health, more attention needs to be given to how socioeconomic determinants and inequalities impact family dynamics and development and the lived experience of young people.
- Social, cultural, gender, and religious norms help shape the lens through which young people view their self-identity and well-being and have a significant impact on the way a community or society approaches mental health.
- Climate change events and the COVID-19 pandemic have emerged as strong determinants of youth mental health and well-being in recent years, engendering feelings of despair, anxiety, and uncertainty about the future.
- New approaches to mental health should underpin the establishment of a new social contract for young people.

Annex II

Methodology – youth consultations

A key element of the *Report* is first-hand information on the experiences of young people relating to their mental health and well-being, shared through stakeholder engagement and youth consultations. The consultations were conducted with young people from diverse backgrounds and different geographic areas, including through youth-led and youth-focused organizations, to gather data on the topic of youth mental health and well-being.

Data were collected using quantitative and qualitative methods, including an online questionnaire, facilitated consultations with young people, and individual interviews across United Nations regional groupings with vulnerable and marginalized youth and young people who had experienced mental health conditions. The consultations were carried out using digital platforms (Zoom, WhatsApp and email), and additional follow-ups were conducted with individuals prior to publication.

The role and impact of inclusive social policies is demonstrated throughout the *Report*. A number of interviews and real-life examples from the qualitative data are woven through the publication, creating a narrative which brings the policy environment to life.

Dissemination partners

The youth consultations were facilitated with the support of dissemination partners to ensure the capture of diverse mental health experiences from across the world. Networks and resources were shared by the United Nations Major Group for Children and Youth (MGCY), World Health Organization, United Nations Children's Fund, UN Women, United Nations Secretary-General's Envoy on Youth, International Labour Organization, United Nations Educational, Scientific and Cultural Organization, United Nations Inter-Agency Network on Youth Development (IANYD), Numbers and People Synergy (NAPS), relevant youth constituencies, and relevant focal points in the IANYD Youth Caucus.

Methodology

Young people from diverse backgrounds and different geographic areas shared their experiences on the topic of mental health and well-being via three mechanisms – a perception survey, facilitated consultations, and individual interviews.

The youth consultations were undertaken by NAPS with the support of MGCY, the Commonwealth Secretariat Youth Division, and UN DESA. The consultation plan was guided by feedback from young people, youth leaders, and experts at the *World Youth Report* expert group meeting.

Particular attention was given to ensuring privacy protection and avoiding retraumatization in the collection of quantitative and qualitative data for the *Report*.

Perception survey

The online perception survey was distributed through the dissemination partners to their networks via an electronic link that was shared directly with young people and youth-led organizations or through the networks of youth organizations, service providers, and sporting organizations. This was supported by a social media strategy that directly targeted both young people and organizations working with young people. Participants gave informed implied consent by opting in to the questionnaire and confirmed that their participation was voluntary, confidential and non-identifiable. The survey was purposely designed as a high-level questionnaire to accommodate local differences in laws, concepts and taboos. The full questionnaire can be found below.

The online questionnaire for the perception survey was designed by NAPS. The questions, based on the social determinants of youth mental health and well-being, were collated from relevant mental health surveys already utilized in the field across six countries. The questions were further tested with young people and youth experts prior to launch. Questions were not mandatory and could be skipped at any point. The online questionnaire was available in six languages: Arabic, Chinese, English, French, Russian and Spanish.

A total of 2,949 people voluntarily responded to the questionnaire. The data were screened to include only individuals between the ages of 15 and 29 , though <15 and >30 years of age were included as survey options. Given the anonymous nature of the questionnaire, several steps were taken to screen for suspicious response patterns (for example, always selecting the first option for each question or not answering any questions after demographic characteristics). Around 13 per cent of the original responses were excluded as they did not answer the questions or were from respondents outside the targeted age bracket. The post-screening data used in the current research are based on a final sample size of 2,578 respondents.

The majority of respondents (71 per cent) were female, and 1 per cent identified their gender as "other". Most were heterosexual (69 per cent), with bisexual respondents being the next largest group (12 per cent), and gay, lesbian and other individuals together accounting for 6 per cent. Respondents in the 20-24 age range constituted the largest group (42 per cent), followed by those aged 25-29 years (30 per cent) and 15-19 years (28 per cent). Respondents further identified themselves as migrants (5 per cent), persons with a disability (9 per cent), carers (24 per cent), or Indigenous/First Nations people (32 per cent).

Responses were received from 137 countries. The region with the most responses was Latin America and the Caribbean (accounting for 28 per cent of the total), followed by Eastern Europe (17 per cent), South-eastern Asia (12 per cent), and sub-Saharan Africa (11 per cent).

Targeted focus groups

Eight focus groups comprising 148 young people from around the world were run virtually between January and February 2021 on specific topics of interest, with a view to investigating the complexities of the interaction between the various social determinants, creating additional space for commentary by marginalized groups of youth, and capturing policy recommendations for inclusive social policies from young people themselves.

Young people opted in to the focus groups via an email invitation sent through dissemination partner networks and social media channels. The focus groups were limited to individuals between the ages of 16 and 29 who gave informed consent for information to be collated and included in the *Report*. The groups were moderated by NAPS. Attendees included young people who identified with marginalized groups and/or who showed specific interest in the issues relating to youth mental health that had been identified by the expert group meeting.

Focus group discussions and consultations took place exclusively through online platforms (Zoom and WhatsApp) due to limitations associated with the COVID-19 pandemic and were held in English owing to time constraints. All focus group interactions were moderated, recorded and transcribed by NAPS. The data were collated into thematic areas relating to the selected social determinants and analysed in conjunction with the research undertaken by the research team.

Interviews with young people

In February 2021, interviews were conducted with nine young people from various parts of the world to collect information on experiences relating to mental health and well-being. The interview subjects were vulnerable and marginalized youth and young people who had experienced mental health conditions. Data from the interviews are embedded throughout the Report to highlight youth voice, localized experiences, and the interplay of social determinants.

Young people were approached to participate in the interview process by a trusted person such as a worker in a youth service or civil society organization or a youth leader in their youth organization. Participants were recruited through existing MGCY networks and the Commonwealth Secretariat or selected from among the youth experts attending the expert group meeting.

Information and data collection for each of the interviews was carried out in a private setting chosen by the young person and through a secure online platform. Consent was discussed and obtained before the interviews took place, and the interviews were recorded and sent to the research team for analysis with the participants' permission. The interview participants had the opportunity to edit and review their respective interview responses before they were added to the final *Report*.

Annex table II-1.

Focus groups

COUNTRIES	NUMBER OF YOUTH	AGE RANGE (YEARS)	FOCUS GROUP TOPICS
United Kingdom, Kingdom of the Netherlands, Kenya	11	16-29	Structural barriers in education (secondary school) for youth mental health (1 of 2)
Barbados	1	21	Family influence on youth mental health
North Macedonia	1	21	Positive experience of acceptance for youth mental health (LGBT youth)
Canada	26	17-29	Inequity and youth mental health
Oman, Philippines, Singapore, Georgia, Malaysia, Australia, Ghana, North Macedonia	10	16-29	The digital environment and youth mental health
Oman, Bangladesh, Nigeria, Kenya, North Macedonia, Ghana, United States of America, Barbados	11	21-28	Employment, unemployment, decent work and youth mental health
Barbados, Jamaica, United Kingdom, North Macedonia, Philippines, Sudan	6	21-27	Structural barriers in education for youth mental health (2 of 2)
India, Republic of Korea, United Kingdom, United States of America, Canada, Philippines, Japan, Nigeria, Indonesia, Pakistan, Kenya, Ireland, Sweden, Afghanistan, Romania, Ghana, Fiji, China **(Not all countries were recorded.)**	82	18-29	Climate change and youth mental health
TOTAL NUMBER OF YOUTH	**148**		

The interviews incorporated the top-level themes that emerged from the perception survey (questionnaire) to give voice to personal youth experiences relating to mental health and well-being.

The interview process was staged as follows:

- Interview focus areas were finalized after initial analysis of the questionnaire findings and in consultation with the expert group meeting participants.
- Dissemination partners contacted youth in the specified focus areas, and young people were nominated for inclusion in the interview process.

- Selected young people were contacted to be involved in the interview process.
- Consent and participant information was provided by interviewees.
- A local contact was identified by each interviewee for access to post-interview follow-up and ongoing mental health support.
- Qualitative interviews were conducted with young people using Zoom, WhatsApp and email platforms. Interviews were recorded for accuracy and transcribed.
- Participants reviewed and approved their respective case studies prior to publication.

Interview responses have been mainstreamed in the *Report*. Although grammar, mechanics and formatting issues have been addressed, the text is substantively unedited, representing the experiences of youth in their own words. The resulting themes are not influenced by the aims and objectives of the research team beyond the thematic direction set by the wording of the questions.

Nine young people from around the world were interviewed to highlight the diversity of youth experiences with mental health challenges (see **annex table II-2**). The living situations of these youth varied widely; low-, medium- and high-income countries were represented in this group, and some of the young people resided in conflict or post-conflict settings.

Data storage

The perception survey (questionnaire) captured basic demographic information, including age group, sex, gender/sexuality, disability status, caring responsibilities, Indigenous and migrant status, cultural background, location (rural/regional/metropolitan), general mental health information, level and type of education and experience, employment experience, poverty- and deprivation-related information, digital environment experience, family and relationship information, and experiences relating to society and mental health.

Data were generated in Microsoft Forms, held by UN DESA, and exported as a CSV file for analysis and secure storage by NAPS. Respondents provided consent for their information to be held and analysed by UN DESA and NAPS and were encouraged to seek professional assistance if the survey created any concerns.

Limitations

As with all research, this study had some limitations. While every effort was made to ensure that youth in all Member States were aware of and able to participate in the survey, the sample was self-selecting and may be skewed. The questionnaire was provided in six languages: Arabic, Chinese, English, French, Russian and Spanish. It should be noted that the questionnaire was promoted and administered during the COVID-19 pandemic, which created additional barriers to reaching youth across the world.

The survey was administered online using Microsoft Forms. The questionnaire did not aim to be representative of all young people, but rather to elicit a high enough response rate to provide a broad understanding of the diverse mental health experiences among young people across the world.

World Youth Report perception survey (questionnaire)

The full survey questionnaire is provided below.

The United Nations Department of Economic and Social Affairs (UN DESA) is currently preparing the next edition of the *World Youth Report,* which will focus on the topic of youth mental health and well-being. In compiling this *Report*, a key objective is to capture experiences of young people across the world through this survey and through consultations with young people just like you.

The survey, run by UN DESA and Numbers and People Synergy (NAPS), is being conducted for research purposes. Individual responses will be combined to give us a broad picture of the views of young people across the world. The survey is aimed at young people aged 15-29 years.

Talking about mental health is really important, but we know it can also be difficult. In this survey, you will (to a limited extent) be asked to provide information relating to your own mental health and that of your family and friends. Specific questions about mental health and

Annex table II-2.

Interviews by location

LOCATION	GENDER	AGE	SOCIAL DETERMINANT FOCUS
SIERRA LEONE	Male	22	Humanitarian crisis experience; child labour experience
UNITED STATES OF AMERICA	Female	23	LGBT; high socioeconomic background
CANADA	Female	24	Person with disability
AUSTRALIA	Male	19	Indigenous; out-of-home-care experience
NAMIBIA	Male	29	Justice system experience
CHINA	Female	26	Child of parent with mental illness
INDIA	Female	29	Descent-based discrimination; learning disability
TRINIDAD	Female	24	Experience of racism
UNITED KINGDOM	Female	19	Low socioeconomic background; religious discrimination
TOTAL NUMBER INTERVIEWED	9		

social issues (such as access to services, poverty, and knowledge about mental health conditions) may be sensitive. If, for any reason, you find this survey experience upsetting, you may skip questions or stop at any time.

The survey is voluntary. If you participate, your personal information will be collected and handled by UN DESA and NAPS. No personal information will be provided to any outside organization.

Your personal information will be handled openly, transparently, and in accordance with best international practice. If you have any questions about how we are protecting your privacy in relation to this survey, please contact NAPS at https://www.numbersandpeople.com/contact-naps.

By continuing to the survey, you consent to your data being collected and used as outlined and acknowledge the following:

- The research may not be of direct benefit to me.
- My participation is completely voluntary.
- I have the right to withdraw from the study at any time without any implications for me.
- The risks, including any possible inconvenience, discomfort or harm as a consequence of my participation in the research project, are my responsibility.

If you feel like you need to talk to someone about any of the issues raised in this survey, please make sure to seek out appropriate support from your local health facility, a community group that specializes in mental health, or (if available) a national helpline.

1. Please select the age range you fit into:

- ☐ <15
- ☐ 15-19
- ☐ 20-24
- ☐ 25-29
- ☐ >29

2. In what country do you currently live?

_____

3. Are you a migrant or refugee?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

4. What sex do you identify as?

- ☐ Male
- ☐ Female
- ☐ Prefer not to answer
- ☐ Other (please specify)

5. What sexuality do you identify as?

- ☐ Heterosexual (straight)
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Prefer not to answer
- ☐ Don't know
- ☐ Other (please specify)

6. Do you have a disability (physical, mental, intellectual, psychosocial, sensory and/or other impairment)?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

7. Do you have daily unpaid carer responsibilities (parent, guardian, carer)?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

8. Do you identify as an Indigenous or First Nations person in the country where you reside?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

9. Where do you live?

- ☐ Urban setting (city, big town)
- ☐ Semi-urban setting (small town)
- ☐ Rural setting (farm, rural community)
- ☐ Don't know
- ☐ Prefer not to answer

10. Have you ever seen a doctor, nurse, or counsellor about your emotional or mental health?

- ☐ Yes
- ☐ No
- ☐ Don't know

11. If yes, in the last 12 months, how often have you seen a doctor, nurse, or counsellor about your emotional or mental health?

- ☐ Never
- ☐ 1-10 times
- ☐ 11 or more times
- ☐ Don't know

12. How would you rate the following:

	POOR	GOOD	FAIR	VERY GOOD	EXCELLENT	DON'T KNOW
Your general well-being (emotional, physical, spiritual)	☐	☐	☐	☐	☐	☐
Your general mental health	☐	☐	☐	☐	☐	☐
Your relationships with friends	☐	☐	☐	☐	☐	☐
Your relationship with family	☐	☐	☐	☐	☐	☐
Your ability to cope with life	☐	☐	☐	☐	☐	☐

13. Thinking about your day-to-day life over the last month, how much of the time have you felt any of the following:

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS	DON'T KNOW
You were relaxed and free of tension.	☐	☐	☐	☐	☐	☐
You generally enjoyed things.	☐	☐	☐	☐	☐	☐
Calm and peaceful	☐	☐	☐	☐	☐	☐
You expected an interesting day.	☐	☐	☐	☐	☐	☐
You woke up fresh and rested.	☐	☐	☐	☐	☐	☐
Happy, satisfied, or pleased.	☐	☐	☐	☐	☐	☐
Daily life was interesting.	☐	☐	☐	☐	☐	☐
Your future was hopeful or promising.	☐	☐	☐	☐	☐	☐

14. Do any of your family members have difficulty managing their emotions, suffer from mental health disorders, or use alcohol or drugs?

- ☐ Yes
- ☐ No
- ☐ Not applicable / No family members
- ☐ Don't know

15. Are you currently enrolled in / attending an educational institution (school, university, or technical and vocational education and training)?

- ☐ Yes
- ☐ No

16. **Have you attended an educational institution (school, university, or technical and vocational education and training) in the last 12 months?**

☐ Yes

☐ No

17. **Is your mental health a major reason you have not engaged in studying over the last 12 months?**

☐ Yes

☐ No

18. **Thinking about your experiences as a student at this educational institution, please rate the items below.**

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE	DON'T KNOW
I feel close to others at this school.	☐	☐	☐	☐	☐	☐
I feel safe at this school.	☐	☐	☐	☐	☐	☐
I feel like school is a nice place to be.	☐	☐	☐	☐	☐	☐
I feel I can talk to teachers about problems at school.	☐	☐	☐	☐	☐	☐
I think teachers care about me.	☐	☐	☐	☐	☐	☐
I enjoy coming to my school.	☐	☐	☐	☐	☐	☐

19. During the last 7 days, how often have you engaged in each of the following behaviours at your educational institution?

	0 TIMES	1-5 TIMES	5-10 TIMES	10 OR MORE TIMES	DON'T KNOW
I teased students to make them angry.	☐	☐	☐	☐	☐
I got angry very easily with someone.	☐	☐	☐	☐	☐
I said things about students to make other students laugh (making fun of them, for example).	☐	☐	☐	☐	☐
I encouraged other students to fight.	☐	☐	☐	☐	☐
I pushed or shoved other students.	☐	☐	☐	☐	☐
I swore at or used insulting language against someone.	☐	☐	☐	☐	☐
I called other students bad names.	☐	☐	☐	☐	☐
I threatened to hurt or hit someone.	☐	☐	☐	☐	☐

20. During the last 12 months, did you feel that anyone at school held negative opinions about you or treated you unfairly because of your past or current emotional or mental health issues?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ Don't know

21. If yes, how much did these negative opinions or unfair treatment affect the following:

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS	DON'T KNOW
Family relationships	☐	☐	☐	☐	☐	☐
Relationships with friends	☐	☐	☐	☐	☐	☐
Your romantic life	☐	☐	☐	☐	☐	☐
Your work life	☐	☐	☐	☐	☐	☐
Your financial situation	☐	☐	☐	☐	☐	☐
Your housing situation	☐	☐	☐	☐	☐	☐
Your physical health care	☐	☐	☐	☐	☐	☐
Your engagement with your studies	☐	☐	☐	☐	☐	☐

22. Were you in paid employment in the last 2 years?

- ☐ Yes
- ☐ No

23. During the last 4 weeks you were employed, did you feel that you were under any stress, strain, or pressure at work?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ Don't know

24. In the last 12 months, how frequently did you feel the following:

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS	DON'T KNOW
You had enough work.	☐	☐	☐	☐	☐	☐
Your job security was good.	☐	☐	☐	☐	☐	☐
Your wage was fair.	☐	☐	☐	☐	☐	☐
You were exposed to hostility in the workplace.	☐	☐	☐	☐	☐	☐

25. In the last 12 months, was there a time when you wanted to talk to someone about a mental health or emotional issue you had but did not know where to turn?

- ☐ Yes
- ☐ No
- ☐ Don't know

26. In the last 12 months, did any of the following reasons keep you from getting the help you felt you needed? (Select all that apply.)

- ☐ I wanted to work out the problem on my own or with help from family or friends.
- ☐ I wasn't sure if I needed help.
- ☐ I wasn't sure where to get help.
- ☐ I thought that the problem would get better by itself.
- ☐ I asked for help at school/work but didn't get it.
- ☐ There was a problem getting to a service that could help me.
- ☐ I thought it might cost too much or my family couldn't afford it.
- ☐ I couldn't get an appointment when I needed it.
- ☐ I was worried about what other people might think.
- ☐ I was worried about stigma.
- ☐ I was worried about making the trauma worse.
- ☐ Talking about my issue would put me at legal, cultural or physical risk.
- ☐ I didn't want to talk about it with a stranger.
- ☐ None of these reasons / other
- ☐ Don't know

27. Some young people go to school, work or to bed hungry because there is not enough food at home. How often does this happen to you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ Don't know

28. Which statement describes your current living situation?

- ☐ I have somewhere to live, and accommodation is NOT a problem for me.
- ☐ I have somewhere to live, but accommodation is an issue for me (for example, I struggle to pay rent or have a conflict with household members).
- ☐ I am in short-term (less than 12 weeks) or unstable accommodation (I am currently couch surfing or in emergency accommodation).
- ☐ I am homeless / sleeping rough.
- ☐ Other (please specify)

29. In the last 12 months, have you done any of the following things to help manage any emotional or behavioural issues you may have or to avoid having issues? (Check all that are relevant.)

- ☐ Did more exercise or took up a sport
- ☐ Improved your diet
- ☐ Meditated or did relaxation therapy
- ☐ Did more of the things you enjoy
- ☐ Smoked cigarettes or used alcohol or drugs
- ☐ Stopped smoking, drinking alcohol or using drugs
- ☐ Sought support from friends
- ☐ Sought support through social networking (online chat rooms, Facebook, or other Internet groups)
- ☐ Joined a social group of some kind
- ☐ Sought information in books or magazines or on TV
- ☐ None of these

30. How I feel about myself depends on what others think of me online.

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Don't know

31. In the last 12 months, how often were you cyberbullied? Cyberbullying is when people use mobile phones or the Internet to send nasty or threatening emails or messages, post mean or nasty comments or pictures on websites such as Facebook, or have someone pretend to be them online to hurt other people over and over by, for example, using hate speech because of someone's ethnic background, religion or culture. It is not bullying when two people of about the same strength or power argue or fight or tease each other in a friendly way.

- ☐ Never
- ☐ Once or twice in the last 12 months
- ☐ Every few months
- ☐ Every few weeks
- ☐ About once a week
- ☐ Most days
- ☐ Every day
- ☐ Don't know

32. In the last 12 months, have you used any of the following Internet-based services to get help or information about an emotional or behavioural issue? (Select all that are relevant.)

- ☐ Information about mental health issues
- ☐ An online assessment tool (filling out a questionnaire on the Internet to find out if you needed help, for example)
- ☐ A chat room or support group
- ☐ Online personal support or counselling
- ☐ Online self-help
- ☐ Information about services in the community
- ☐ None of the above
- ☐ Don't know

33. Are there people you are in regular contact with that are detrimental to your well-being because they are a source of discomfort and stress?

- ☐ Yes
- ☐ No
- ☐ Don't know

34. How often do you talk about your problems or feelings with at least one of your parents/ guardians/carers?

- ☐ Never
- ☐ Once or twice in the last 12 months
- ☐ Every few months
- ☐ Every few weeks
- ☐ About once a week
- ☐ Most days
- ☐ Every day
- ☐ Don't know

35. In the last 12 months, how often did you feel that you belonged to a community (including a social group, your neighbourhood, your city or your school, for example)?

- ☐ Never
- ☐ Once or twice in the last 12 months
- ☐ Every few months
- ☐ Every few weeks
- ☐ About once a week
- ☐ Most days
- ☐ Every day
- ☐ Don't know

36. In the last 12 months, how often did you feel confident enough to think about or express your own ideas and opinions?

- ☐ Never
- ☐ Once or twice in the last 12 months
- ☐ Every few months
- ☐ Every few weeks
- ☐ About once a week
- ☐ Most days
- ☐ Every day
- ☐ Don't know

37. I am able to stand up for myself and what I believe in.

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Don't know

38. How often do you feel safe in your local area?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Don't know

39. What would stop you from speaking to someone about your own or someone else's mental health? (Select all that apply.)

- ☐ Embarrassment
- ☐ Fear of being judged
- ☐ Not being taken seriously
- ☐ Fear of being a "burden" to others
- ☐ Mental health stigma
- ☐ Fear of not having confidentiality and privacy
- ☐ Fear of possible negative consequences
- ☐ Lack of trust in other people
- ☐ Lack of understanding about mental health (both other people's and my own)
- ☐ Not knowing who to talk to
- ☐ Not knowing how to talk about mental health
- ☐ Lack of confidence / shyness
- ☐ Shame
- ☐ Don't know

40. Which social determinants of mental health would you like to see the Government and service providers prioritize in your area? (Rate from 1 to 6, with 1 being the most important)

- ☐ Education
- ☐ Decent work
- ☐ Poverty and deprivation
- ☐ Digital environment
- ☐ Family and relationships
- ☐ Society and community

41. What are your greatest concerns in connection to COVID-19? (Select up to 3 options.)

- ☐ My mental health
- ☐ My family members getting ill with COVID-19
- ☐ Disruptions to my school or career path
- ☐ Me getting ill with COVID-19
- ☐ Earning enough money to pay my bills
- ☐ My job security
- ☐ Me getting treatment for other physical health problems
- ☐ Being able to get the substances I use
- ☐ My housing security
- ☐ Food and water security

Annex III

Methodology – literature review

Search strategy

A systematic search of peer-reviewed literature was conducted between 9 and 11 November 2020 using the MEDLINE, PubMed and PsycINFO electronic databases. Searches were carried out using free-text keywords and controlled terms relating to the following concepts: (a) risk and protective factors or structural and social determinants of mental health (with specific terms relevant to each domain); (b) mental health problems; and (c) youth.

Database filters were applied to identify reviews, including umbrella reviews, systematic reviews, and meta-analyses. This enabled the research team to focus on high-quality reviews. For topics for which there was an insufficient number of high-quality reviews meeting the inclusion criteria, the team widened the search to include narrative reviews, high-quality primary studies (such as longitudinal studies and randomized controlled trials) where available, and grey literature for those topics that were identified using hand-searched reference lists of included articles and Google Scholar keyword searches.

Inclusion and exclusion criteria

The literature review included peer-reviewed journal articles published in English between 1 January 2010 and November 2020. No restrictions were applied to contextual factors such as geography or country income level.

Participants

Study participants were between 10 and 25 years of age. Studies that covered a wider range of ages were included if results could be meaningfully extracted for this age range. For (reviews of) observational studies, the research team included studies of general and clinical populations. For (reviews of) interventions, studies were excluded if they were conducted in clinical settings and thus considered to be treatment interventions. Where a review of interventions included both general and clinical populations, the team included it if less than half of the included studies were conducted with a clinical population.

Study content (exposures/interventions)

Articles were included if they addressed any of the key factors listed in the domains above as exposures in observational studies or if they reported on interventions that aimed to address any of the above factors and also included a mental health measure in adolescence.

Outcomes

Studies were included if they examined the onset or presence of mental illness (diagnosed by a mental health professional or identified through the assessment of symptoms on a validated scale) as an outcome. The following classes of mental disorders were included: anxiety disorders, depressive disorders, obsessive-compulsive and related disorders, eating and feeding disorders, schizophrenia spectrum and other psychotic disorders, trauma and stressor-related disorders, bipolar and related disorders, and disruptive, impulse-control and conduct disorders, in addition to suicide and self-harm. Other classes of mental disorders, including substance-related and addictive disorders, neurodevelopmental disorders, and personality disorders, were excluded as these were likely to be linked to different determinants. The research team did not include studies that examined emotional well-being or similar constructs in recognition of the evidence that, while related to mental illness, well-being is often conceptualized as a distinct construct with varying definitions.

Types of studies included in the literature review

- *Observational studies.* Studies were reviews of observational studies, prospective (longitudinal or cohort) studies, or cross-sectional studies of nationally representative samples that aimed to assess associations between the exposures listed above and mental health outcomes.
- *Intervention studies.* Studies were reviews of intervention studies, randomized controlled trials, quasi-experimental studies, or pre-post studies that aimed to assess the impact of intervening on the factors listed above. To be included, interventions (programmes, policies or initiatives) must have been delivered primarily to youth in the general community or designed to directly benefit youth in the general community (through youth policy or delivery to parents, for example). The interventions must have been oriented towards primary prevention; treatments for individuals with a mental illness or within a clinical setting were excluded. The intervention studies had to include mental health outcome measures for youth. Studies conducted in all settings (online, in educational institutions, in the workplace, within the community, through health services, or in family contexts) were included, provided the intervention targeted the factors of interest.
- *Evidence summaries.* Evidence summaries were primarily based on systematic reviews that were identified during the systematic search. Where no systematic review was available for a topic or where notable gaps in the evidence base were identified (such as the dearth of evidence from low- and middle-income countries), evidence summaries were based on narrative reviews, high-quality primary studies (such as prospective cohort studies or randomized controlled trials), or grey literature, identified through hand-searching reference lists and Google Scholar searches. The team also included studies (where available) that endeavoured to examine mechanisms or moderators of association. Evidence summaries covered the key findings of the reviews or primary studies (including any evidence on gender or age-group differences) and examined the consistency of the findings and their generalizability across diverse contexts such as country income levels (high, middle and low income), subpopulations (such as Indigenous, religious, or ethnic minority populations), and settings (schools, workplaces, health services, or the general community). Evidence summaries were also used to highlight data gaps to guide future research.

Research can be strengthened by adding mental health measures to gender equality interventions. ©UN photo/Mark Garten

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