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# The *Lancet Psychiatry* Commission on Youth Mental Health – Policy Brief

"The worsening global youth mental health crisis provides an unprecedented opportunity to societies and communities around the world to dramatically improve quality of life and life expectancy for their people and to improve social cohesion and economic productivity. These outcomes can be achieved through a combination of reversing harmful social and economic policies, investing strongly in prevention and mental health research, and giving top priority to the mental health of young people within innovative systems of integrated health and social care."

Patrick D McGorry

# Youth mental health matters

Mental ill health represents the principal threat to the health, wellbeing, and productivity of young people who are in transition from childhood to mature adulthood. Emerging adulthood, from puberty through to the mid-to-late twenties, is a vulnerable period for the onset of mental illnesses: up to 75% of mental illnesses have their onset before the age of 25 years.[1,2] Yet the majority of young people are unable to access good quality, evidence-based care[3,4] and the policy focus and funding for prevention are grossly inadequate. Mental illnesses are a major cause of premature death from physical illness and suicide and are the largest and most rapidly growing cause of disability and lost human potential and productivity across the lifespan. There is now substantial evidence showing that youth mental health has deteriorated since the early 2010s, with rising anxiety, depression, psychological distress, self-harm, and suicide (figure).[5-9] Since the COVID-19 pandemic, young people have experienced disproportionately poorer mental health outcomes.[10,11]

Megatrends, an interconnected set of socioeconomic and commercial forces, have over the past two decades seriously undermined young people's personal and economic security and hope for the future. The growing existential threats of climate change, unregulated and harmful social media, declining social cohesion, and socioeconomic precarity—as reflected in insecure employment, reduced access to affordable housing, rapidly growing intergenerational inequality, and polarisation of political views—have combined to create a bleak present and future for young people. It is no exaggeration to say young people and their mental health act as the early warning system for contemporary society; they are manifesting the warning signs and symptoms of a society and world that is in serious trouble.

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

For more on **youth mental health** see **The *Lancet Psychiatry* Commission 11:** 731–74

For the **Commission and related material** see www.thelancet.com/commissions/youth-mental-health

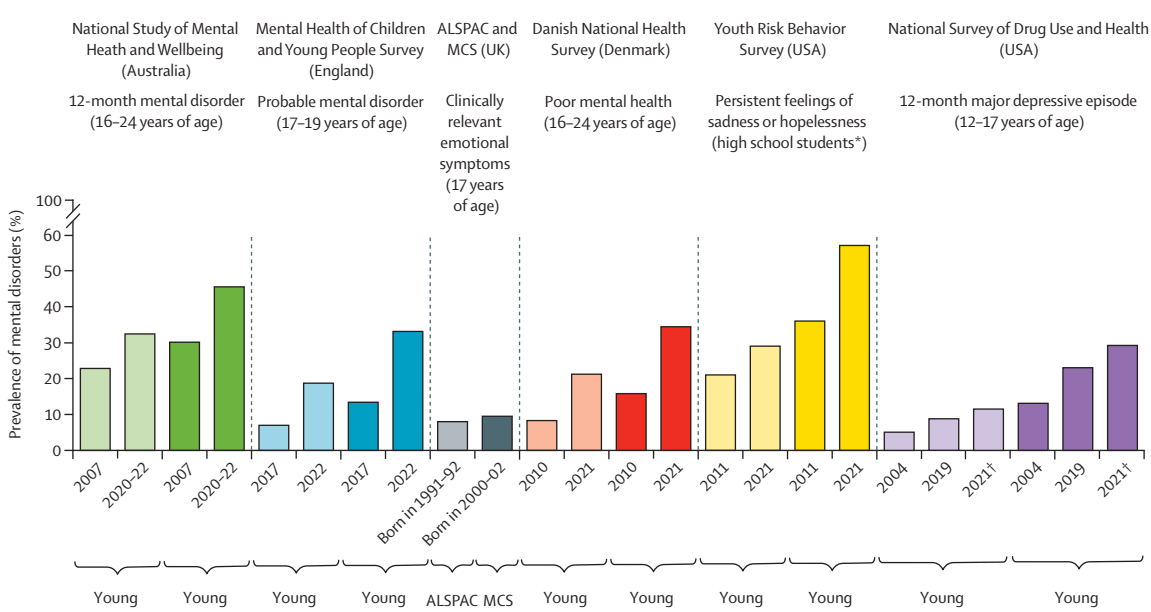


***Figure 1:*** **Youth mental health trends by country and sex**
Measures used were the National Study of Mental Health and Wellbeing: WHO's Composite International Diagnostic Interview, version 3.0; Mental Health of Children and Young People Survey: Strengths and Difficulties Questionnaire;[60] ALSPAC and MCS: Strengths and Difficulties Questionnaire (emotional subscale; trends by sex unavailable); the Danish National Health Survey: 12-Item Short Form Health Survey, version 2; the Youth Risk Behavior Survey ("during the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"); the National Survey on Drug Use and Health (measures the nine symptoms associated with major depressive episode as defined in DSM-5); and survey questions adapted from the depression section of the National Comorbidity Survey Replication Adolescent Supplement. ALSPAC=Avon Longitudinal Study of Parents and Children. MCS=Millennium Cohort Study. *Students in grades 9–12, aged 14–18 years. †2021 estimates not comparable with estimates from 2019 and earlier, as 2021 estimates are based on multimode data collection and estimates from 2019 and earlier are based on in-person data collection alone.

## Outmoded thinking and policy inertia

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

## Solutions are at hand or within reach

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

First, government policies must be forensically analysed to diagnose which policy settings are contributing to the youth mental health crisis. This will extend well beyond the usual suspects among the social determinants of mental health to encompass new megatrends that have surfaced over the past two decades. These include climate change, the rise of smartphones, social media, and the increased time spent on digital devices, the impacts of new technologies (most notably in AI), geopolitical insecurity, and the serious socioeconomic consequences of unrestrained neoliberal economic policies, which

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

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

have worsened inequality, especially intergenerational inequality, in so many nations. It will be important to ensure that this analysis is genuine since there is a risk that softer targets such as reduced individual resilience and social media will distract from more fundamental economic forces and be therefore preferred as culprits by political leaders, vested interests, and even the mental health community, who might feel political economy is outside their comfort zone (panel). The field will have been encouraged by the stance taken recently by Vikram Patel in a *Lancet* editorial.[21] The urgency to adopt a much more assertive stance in relation to these harmful megatrends derives not only from the manifest public health crisis, but also from socioeconomic and human rights considerations.

Second, youth mental ill health, youth mental health (with a strong emphasis on indicated prevention and high-quality early intervention) must become the top priority in mental health for reform and investment. Patching up a residual and reactive system constrained to palliating chronic mental illness, which has been the dominant approach for over a century and a consequence of funding neglect is not acceptable. Naturally, such a pre-emptive focus must be complemented by ensuring that the substantial cohort of people who do need longer-term care can be guaranteed sustained optimal care to build on and maintain the gains of early intervention and to support those who take longer to recover or may not do so. A new proactive and stigma-free system of youth mental health care is needed that is developmentally, culturally, and epidemiologically appropriate. Its content and expertise must be holistic, designed so that the care is proportional to the stage and complexity of illness, and sociocultural context. Integrated models of enhanced primary youth mental health care, which maximise access, acceptability, and outcomes, and are already shown to be cost-effective for mild to moderate levels of need for which they were designed,[16] lie at the heart of this reform, covering age 12–25 years (table).[22] However, these portals and focal points of care must be complemented by other elements, notably upstream by preventive efforts and detection strategies, and downstream by a specialised backup system for more complex and typically recurrent or persistent conditions and comorbid health and social issues, by digital mental health platforms that empower young people as partners in their health care journey while genuinely promoting responsive, measurement-based care, and by sophisticated mental health programmes in educational settings and workplaces.

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

Potential interventions according to the authors are shown. Adapted from McGorry et al[23] with permission.

***Table:*** **Implementation of integrated youth mental health care according to level of resource**

In low-resource and middle-resource settings, and quite different cultural settings, where most of the young people in the world are now growing up, youth mental health reform might need to adopt a variety of strategies fit for their specific cultures and circumstance. The Global Framework for Youth Mental Health,[24] developed in partnership with stakeholders from various countries and settings, outlines areas where investment can be directed depending on the cultural, resourcing, and workforce contexts of different countries and regions. In a fully fledged model of youth mental care, which will require higher levels of resources, vertical integration of services—across the broad spectrum from self-care through various primary care options and on to secondary and tertiary levels—is essential to eliminate fragmentation and effectively meet the needs of young people experiencing severe, complex, and persistent mental illness in a proactive and proportional way.

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