Centring the youth mental health discourse on low- and middle-income countries

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The Lancet Commission on Youth Mental Health heralds a new field of research and practice with a focus on 12–25-year-olds. Commissioners assert the global relevance of the field whilst acknowledging that much of its underpinning evidence comes from high-income countries (HICs). This is problematic because 90% of children and adolescents live in low- and middle-income countries (LMICs) that are underrepresented academically yet bear the highest mental health burden. Extrapolating findings from HICs to LMICs ignores critical diversity in young people's socioeconomic and cultural contexts that gives rise to variations in determinants of development, expectations of normative behaviour and sanctions for not conforming.

Whilst priority youth mental health problems have been identified in HICs, the picture in LMICs is less clear. According to the Global Burden of Disease (GBD) 2019 study, depression and anxiety are leading causes of disability adjusted life years, but due to limited data there is more uncertainty associated with burden estimates for other mental disorders such as conduct, bipolar, schizophrenia and eating disorders.[1] Compared to HICs, among adolescents in LMICs rates of suicide attempts are two- to three-fold higher and perinatal mental disorders are more prevalent due to higher rates of early pregnancy and childbearing.[2] Other important mental health problems and idioms of distress are not captured in the GBD such as *chhopne*, a conversion disorder in Nepal that closes down schools, in Gaza psychological crises and fatigue among conflict-exposed youth, and *cen,* the haunting of Acholi youth in Uganda by spirits of people who died in the civil war.

In LMICs youth are more exposed to social determinants of poor mental health such as unemployment, food insecurity and childhood adversity. The effects of these are compounded by black swan events and global mega trends such as the COVID-19 pandemic and climate change. In sub-Saharan Africa, poverty and the HIV/AIDS epidemic exacerbates youth mental ill health through personal and parental illness, death of family members, lower school attendance, stigma and bullying.[3] In some Latin American settings, intersecting effects of poverty, norms of violence, political unrest and conflict manifest as mental health symptoms among young people.[4]

Context affects opportunities and preferences for intervention. Imposing models of care from HICs on LMICs ignores their shortcomings and disregards local knowledge and systems. Youth mental health service provision in LMICs is weak and inequitably distributed. Staff are few and not trained in ways that are youth-friendly and encompass integrated care models. Youth may be deterred from seeking care due to inaccessibility, low quality, high cost, and stigma. In many settings youth do not seek care because they interpret their mental health problem as a response to adversity and unmet basic needs.[5] Interventions that tackle the deep social issues that prevent youth from flourishing are therefore needed alongside clinical services. Coping strategies and behaviours vary with context including interpersonal support and self-soothing, and negative coping mechanisms such as substance use and self-harm. Making society mental health friendly through wider promotion programmes could benefit informal networks and peer populations that influence youth.

In LMICs, the lack of resources has led to creativity and innovation in youth mental health, generating learning that is equally relevant for HICs. In settings with weak health systems for mental health care, locating programmes in schools, sexual and reproductive health services has improved acceptability and accessibility. Poverty reduction, education, art and sports initiatives have been combined with psychosocial support to address otherwise intractable social determinants.[6] At-risk groups have been targeted in antenatal and HIV clinics, refugee camps and informal settlements. Task-sharing models have been implemented where mental health workers supervise trained nurses, peers, teachers and clergy providing psychosocial support, using tools to promote fidelity.[7] Proactive community case detection strategies have been

developed to address high levels of under-detection of youth mental health problems.[8] Whilst digital interventions show promise, equitable access to these technologies remains a challenge in LMICs.

Despite emerging evidence for LMIC youth mental health interventions, few have been scaled and sustained. This reflects a lack of community and government buy-in and a paucity of youth mental health researchers in these settings, compounded by inequitable funding and academic partnerships between LMICs and HICs. Leadership of youth mental health initiatives in LMICs must be rooted in the realities of these settings and led by scholars, advocates and communities who understand and live in them. Programmes involving south-south and triangular cooperation such as the African Mental Health Research Initiative (AMARI) can help to support leadership in youth mental health research.[9] Initiatives that build capacity of youth in LMICs as researchers will ensure that research agendas reflect the needs of this population. Evidence driven, people-centred methodologies are needed that improve participation of youth with lived experience, clinicians and system leaders in intervention design and implementation.[10] Co-production and co-creation are potential ways to achieve this but require training and support to enable meaningful contributions.

In sum, LMICs must be prioritised in the youth mental health discourse. Research to characterise the mental health burden and understand key contextual factors is urgently needed to inform interventions and service planning in these settings. Broader recognition of LMIC innovations and initiatives that engage youth and re-centre leadership to LMICs are essential for transformational change.

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References

1. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry* 2022; **9**(2): 137-50.
2. Uddin R, Burton NW, Maple M, Khan SR, Khan A. Suicidal ideation, suicide planning, and suicide attempts among adolescents in 59 low-income and middle-income countries: a population-based study. *Lancet Child Adolesc Health* 2019; **3**(4): 223-33.
3. Dessauvagie AS, Jörns-Presentati A, Napp AK, et al. The prevalence of mental health problems in sub-Saharan adolescents living with HIV: a systematic review. *Global Mental Health* 2020; **7**: e29.
4. Vahedi L, Seff I, Meinhart M, Roa AH, Villaveces A, Stark L. The association between youth violence and mental health outcomes in Colombia: A cross sectional analysis. *Child Abuse & Neglect* 2024; **150**: 106336.
5. Roberts T, Miguel Esponda G, Torre C, Pillai P, Cohen A, Burgess RA. Reconceptualising the treatment gap for common mental disorders: a fork in the road for global mental health? *The British Journal of Psychiatry* 2022; **221**(3): 553-7.
6. Zimmerman A, Garman E, Avendano-Pabon M, et al. The impact of cash transfers on mental health in children and young people in low-income and middle-

income countries: a systematic review and meta-analysis. *BMJ Global Health* 2021; **6**(4): e004661.
7. Ndetei DM, Mutiso V, Osborn T. Moving away from the scarcity fallacy: three strategies to reduce the mental health treatment gap in LMICs. *World Psychiatry* 2023; **22**(1): 163-4.
8. van den Broek M, Hegazi L, Ghazal N, et al. Accuracy of a Proactive Case Detection Tool for Internalizing and Externalizing Problems Among Children and Adolescents. *Journal of Adolescent Health* 2023; **72**(1, Supplement): S88-S95.
9. Chibanda D, Abas M, Musesengwa R, et al. Mental health research capacity building in sub-Saharan Africa: the African Mental Health Research Initiative. *Global Mental Health* 2020; **7**: e8.
10. Lamahewa K, Griffin S, Seward N, et al. Protocol for intervention development to improve adolescent perinatal mental health in Kenya and Mozambique: The INSPIRE project. *SSM - Mental Health* 2023; **3**: 100200.