YOUTH MENTAL HEALTH: NATIONAL AND GLOBAL PROGRESS

Patrick McGorry
Orygen, headspace & University of Melbourne
Mental illness is the #1 threat to young lives and futures.
THE RISING TIDE

Can we talk?
Seven year youth mental health report - 2012-2018

Psychological distress in young people up from 18.7% in 2012 to 24.2% in 2018

Depression and anxiety on the rise
MODERN HOPSCOTCH

Leunig

HARM
INSULT
HATE
OUTRAGE
ANGER
ANXIETY
STRESS
DEPRESSION

LEO LEUNIG
LONDON
The problem we are trying to solve

- Young people with mental ill-health are not able to access the quality, evidence-based services they need, when they need them.
- This drives poor outcomes including reliance on welfare, early mortality due to severe physical health issues, and death by suicide.
SOLUTION

• Build and deliver a comprehensive, evidence-based youth mental health service centred around young people’s needs that is scalable nationally and internationally

• Conduct integrated and top quality research guided by young people and spread this new knowledge throughout the new YMH system and beyond

• Create and nurture the fields of youth mental health and early intervention
Costs

Mental illness as a source of morbidity has a cost. Direct and indirect costs of mental ill-health are estimated to amount over 4% of GDP, more than that of cancer, diabetes and chronic respiratory disease combined.

Mental illness costs are expected to more than double by 2030.

Global cost of mental health conditions in 2010 and 2030. Costs shown in billions of 2010 $USD

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Mental health and cardiovascular diseases are the top drivers of lost output internationally.

Breakdown of NCD cost by disease type, based on EPIC model.
Global Burden of Disease:
#1 Health Issue for Young People
Psychiatry's Opportunity to Prevent the Rising Burden of Age-Related Disease

Terrie E. Moffitt, PhD¹,²; Avshalom Caspi, PhD¹,²

Author Affiliations

JAMA Psychiatry. Published online March 27, 2019. doi:10.1001/jamapsychiatry.2019.0037
Moffit & Caspi 2019

- “psychiatry is well situated to prevent disability among older people by doing something it does well: treat young people.

- Risk-prediction research shows that the same people who have poor mental and cognitive health while young tend to have age-related diseases years later.\textsuperscript{1,2} Moreover, the timing is right.

- Mental disorders peak in adolescence and young adulthood, whereas noninfectious diseases peak in midlife and neurodegenerative conditions peak in late life”
Age of Onset of Mental Disorders

Etiopathogenetic and Treatment Implications

- Brings together the available evidence regarding the age of onset of mental disorders and its significance
- Covers all the most important mental disorders
- Written by outstanding, well-known contributors and edited by leading experts

This book presents a thorough and critical review of current knowledge about the age of onset of mental disorders. The opening chapters offer information about the impact of the age of onset on the clinical picture, course, and outcome of physical illnesses, and about the neurobiological implications and correlates of different ages of onset. The impact and correlates of the ages of onset of all the most important mental disorders are then discussed in detail by internationally renowned scientists. The background to the book is the recognition that a better understanding of age of onset makes it possible to estimate the lifetime risk of disorders, helps to elucidate pathogenesis, and facilitates efficient, targeted clinical management. The book will be of value for clinicians, mental health professionals, mental health researchers, epidemiologists, and different stakeholders in the mental health field.
Real maturation

Actual development in the context of mental ill-health in young people
Vital to acknowledge the impact of illness on developmental trajectories
DIAGNOSIS .....  
CAN WE MAKE IT USEFUL?
Figure 1B. New transdiagnostic CHARMS paradigm in the context of clinical staging.
Figure 5: A staging approach to the classification and treatment of mental disorders

HC=primary health care. Adapted from McGorry et al\textsuperscript{73} and McGorry and van Os.\textsuperscript{74}
Moving From Static to Dynamic Models of the Onset of Mental Disorder
A Review

Barnaby Nelson, PhD; Patrick D. McGorry, MD, PhD; Marieke Wichers, PhD; Johanna T. W. Wigman, PhD; Jessica A. Hartmann, PhD

**IMPORTANCE** In recent years, there has been increased focus on subthreshold stages of mental disorders, with attempts to model and predict which individuals will progress to full-threshold disorder. Given this research attention and the clinical significance of the issue, this article analyzes the assumptions of the theoretical models in the field.

**OBSERVATIONS** Psychiatric research into predicting the onset of mental disorder has shown an overreliance on one-off sampling of cross-sectional data (ie, a snapshot of clinical state and other risk markers) and may benefit from taking dynamic changes into account in predictive modeling. Cross-disciplinary approaches to complex system structures and changes, such as dynamical systems theory, network theory, instability mechanisms, chaos theory, and catastrophe theory, offer potent models that can be applied to the emergence (or decline) of psychopathology, including psychosis prediction, as well as to transdiagnostic emergence of symptoms.

**CONCLUSIONS AND RELEVANCE** Psychiatric research may benefit from approaching psychopathology as a system rather than as a category, identifying dynamics of system change (eg, abrupt vs gradual psychosis onset), and determining the factors to which these systems are most sensitive (eg, interpersonal dynamics and neurochemical change) and the individual variability in system architecture and change. These goals can be advanced by testing hypotheses that emerge from cross-disciplinary models of complex systems. Future studies require repeated longitudinal assessment of relevant variables through either (or a combination of) micro-level (momentary and day-to-day) and macro-level (month and year) assessments. Ecological momentary assessment is a data collection technique appropriate for micro-level assessment. Relevant statistical approaches are joint modeling and time series analysis, including metric based and model-based methods that draw on the mathematical principles of dynamical systems. This next generation of prediction studies may more accurately model the dynamic nature of psychopathology and system change as well as have treatment implications, such as introducing a means of identifying critical periods of risk for mental state deterioration.

**Author Affiliations:** Orygen, The National Centre of Excellence in Youth Mental Health, The University of Melbourne, Melbourne, Australia (Nelson, McGorry, Wichers).
**NEW RESEARCH**

*Cumulative Prevalence of Psychiatric Disorders by Young Adulthood: A Prospective Cohort Analysis From the Great Smoky Mountains Study*

William Copeland, Ph.D., Lilly Shanahan, Ph.D., E. Jane Costello, Ph.D., Adrian Angold, M.R.C.Psych.

**Objective:** No longitudinal studies beginning in childhood have estimated the cumulative prevalence of psychiatric illness from childhood into young adulthood. The objective of this study was to estimate the cumulative prevalence of psychiatric disorders by young adulthood and to assess how inclusion of not otherwise specified diagnoses affects cumulative prevalence estimates. **Method:** The prospective, population-based Great Smoky Mountains Study assessed 1,420 participants up to nine times from 9 through 21 years of age from 11 counties in the southeastern United States. Common psychiatric disorders were assessed in childhood and adolescence (ages 9 to 16 years) with the Child and Adolescent Psychiatric Assessment and in young adulthood (ages 19 and 21 years) with the Young Adult Psychiatric Assessment. Cumulative prevalence estimates were derived from multiple imputed datasets. **Results:** By 21 years of age, 61.1% of participants had met criteria for a well-specified psychiatric disorder. An additional 4% met criteria for a not otherwise specified disorder only, increasing the total cumulative prevalence for any disorder to 65.5%. Male subjects had higher rates of substance and disruptive behavior disorders compared with female subjects; therefore, they were more likely to meet criteria for a well-specified disorder (67.8% vs 56.7%) or any disorder (89.1% vs 77.8%). Children with a not otherwise specified disorder only were at increased risk for a well-specified young adult disorder compared with children with no disorder in childhood. **Conclusions:** Only a small percentage of young people meet criteria for a DSM disorder at any given time, but most do by young adulthood. As with other medical illness, psychiatric illness is a nearly universal experience. J. Am. Acad. Child Adolesc. Psychiatry, 2011,50(3):252–261. **Key Words:** epidemiology, prevalence, not otherwise specified disorders, psychiatric disorders

*Figure 1.* Percent with serious psychological distress in the last month by age group, 2008–2017.
46% increase in MH
13% in Physical Health
Burden of psychiatric disorder in young adulthood and life outcomes at age 30
Sheree J. Gibb, David M. Fergusson and L. John Horwood

Background
Psychiatric disorders are common during young adulthood and comorbidity is frequent. Individual psychiatric disorders have been shown to be associated with negative economic and educational outcomes, but few studies have addressed the relationship between the total extent of psychiatric disorder and life outcomes.

Aims
To examine whether the extent of common psychiatric disorder between ages 18 and 25 is associated with negative economic and educational outcomes at age 30, before and after controlling for confounding factors.

Method
Participants were 987 individuals from the Christchurch Health and Development Study, a longitudinal study of a birth cohort of individuals born in Christchurch, New Zealand, in 1977 and followed to age 30. Linear and logistic regression models were used to examine the associations between psychiatric disorder from age 18 to 25 and workforce participation, income and living standards, and educational achievement at age 30, before and after adjustment for confounding factors.

Results
There were significant associations between the extent of psychiatric disorder reported between ages 18 and 25 and all of the outcome measures (all P<0.05). After adjustment for confounding factors, the associations between psychiatric disorder and workforce participation, income and living standards remained significant (all P<0.05), but the associations between psychiatric disorder and educational achievement were not significant (all P>0.10).

Conclusions
After due allowance had been made for a range of confounding factors, psychiatric disorder between ages 18 and 25 was associated with reduced workforce participation, lower income and lower economic living standards at age 30.

Declaration of interest
None.
“EXISTING SYSTEMS AND STRUCTURES FOCUS ALMOST EXCLUSIVELY ON CHILDREN OR ON ADULTS, MEANING FEW INVESTMENTS AND INTERVENTIONS ARE DIRECTED SPECIFICALLY TO YOUNG PEOPLE.”

MELINDA GATES
Young people don’t seek or get professional help!!

Only 13% of young men and 31% of young women access professional mental health care.

Young men aged 16-24 have the lowest professional help-seeking of any age group.
Figure 1: Number of child and adolescent mental health services per 100,000 young people in European Union countries

Figure 2: Number of inpatient beds per 100,000 young people in European Union countries
Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study
Swaran P. Singh, Molly Paul, Tamzin Ford, Tamí Kramer, Tim Weaver, Susan McLaren, Kimberly Hovesh, Zoebla Islam, Ruth Belling and Sarah White

Background
Many adolescents with mental health problems experience transition care from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS).

Aims
As part of the TRACK study we evaluated the process, outcomes and user and carer experience of transition from CAMHS to AMHS.

Method
We identified a cohort of service users crossing the CAMHS/AMHS boundary over 1 year across six mental health trusts in England. We tracked their journey to determine predictors of optimal transition and conducted qualitative interviews with a subsample of users, their carers and clinicians on how transition was experienced.

Results
Of 104 individuals who crossed the transition boundary in 1 year, 90 were actual transfers (i.e., they made a transition to AMHS), and 14 were potential referrals (i.e., were either not referred to AMHS or not accepted by AMHS). Individuals with a history of severe mental illness, being on medication or having been admitted were more likely to make a transition than those with neurodevelopmental disorders, organic or neuropsychiatric disorders and emerging personality disorder. Optimal transition, defined as adequate transition planning, good information transfer across teams, joint working between teams and continuity of care following transition, was experienced by less than 5% of those who made a transition. Following transition, most service users stayed engaged with AMHS and reported improvement in their mental health.

Conclusions
For the vast majority of service users, transition from CAMHS to AMHS is poorly planned, poorly executed and poorly experienced. The transition process accentuates pre-existing barriers between CAMHS and AMHS.

Declaration of interest
None.
The research leading to these results has received funding from the European Community’s Seventh Framework Programme (FP7/2007–2013) under grant agreement n° 602442.
From early intervention in psychosis to youth mental health reform: a review of the evolution and transformation of mental health services for young people.

Ashok Malla, Srividya Iyer, Patrick McGorry, Mary Cannon, Helen Coughlan, Swaran Singh, Peter Jones & Ridha Joober
A New Architecture and Culture of Care

Integrated Youth Mental Health through Enhanced Primary Care

A Global Paradigm
Adolescent mental health

Cultures for mental health care of young people: an Australian blueprint for reform

Patrick D McGorry, Sherilyn D Goldstone, Alexandra G Parker, Debra J Rickwood, Ian B Hickie

Mental ill-health is now the most important health issue facing young people worldwide. It is the leading cause of disability in people aged between 10 and 24 years, contributing 45% of the overall burden of disease in this age-group. Despite their manifest need, young people have the lowest rates of access to mental health care, largely as a result of poor awareness and help-seeking, structural and cultural flaws within the existing care systems, and the failure of
Creating headspace for integrated youth mental health care

International momentum in global mental health reform is building, responding to overwhelming evidence of unmet need in high, middle and low income countries alike, and powerful economic arguments that mental health care represents the best value for money. Yet adequate investment remains an elusive goal, with the treatment gap as wide as ever. We have long argued that new paradigms that dispel stigma, open up early access, safeguard hope, and build expertise and quality based on the best available evidence, must be embraced and scaled up in real world settings. The growing success of prototypical evidence-based early psychosis models in many parts of the world has paved the way for a more definitive reform paradigm, one which links transdiagnostic early decision-making, with social and vocational outcomes as the key targets.

- A single, visible trusted location, a “one stop shop” or “integrated practice unit” with providers organized as a dedicated team of clinical and non-clinical (e.g., peer worker) personnel providing the full spectrum of care around the young person and his/her family.
- Elimination of discontinuities at peak periods of need for care during developmental transitions, in particular dismantling the anachronistic and developmentally inappropriate “hard border” at age 18.
- Seamless linkages with services for younger children and adults.
From Australian communities to Prime Ministers: Sustained universal support for headspace
OPPORTUNITIES
Costs

- Mental illness as a source of morbidity has a cost. Direct and indirect costs of mental ill-health are estimated to amount over 4% of GDP, more than that of cancer, diabetes and chronic respiratory disease combined.
- Mental illness costs are expected to more than double by 2030.

Global cost of mental health conditions in 2010 and 2030. Costs shown in billions of 2010 $USD

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Mental health and cardiovascular diseases are the top drivers of lost output internationally.

Breakdown of NCD cost by disease type, based on EPIC model5
Beyond brand
Inside youth mental health
Integrated (one-stop shop) youth health care: best available evidence and future directions

Sarah E Hetrick¹, Alan P Bailey¹, Kirsten E Smith³, Ashok Malla², Steve Mathias⁴, Swaran P Singh⁵, Aileen O’Reilly⁶, Swapna K Verma⁷, Laelia Benoit⁸, Theresa M Fleming⁹, Marie Rose Moro⁶, Debra J Rickwood³⁰, Joseph Duffy⁶, Trissel Eriksen¹¹, Robert Illback¹², Caroline A Fisher¹³, Patrick D McGorry¹

Mental health problems represent the largest burden of disease in young people.¹ Fifteen per cent of mental disorders first emerge by the age of 14 years, and 75% by the age of 24 years.⁷ Left untreated, these mental health problems have high rates of recurrence and cause negative outcomes for the individual, including reduced economic productivity, as well as societal costs.³⁴ A range of risk behaviours coexist with mental health difficulties, including tobacco, drug and alcohol use; sexual risk taking; injury-related risk behaviour; violence; reduced levels of physical activity; and poor nutrition.⁷ Health behaviours laid down during adolescence and young adulthood tend to continue long term.³⁵

Despite this, access to mental health services for young people has been poor.¹⁰⁻¹³ Identified barriers to help-seeking for young people include internal factors, such as concerns about confidentiality, lack of knowledge about mental health disorders and available services and perceived attitudes of clinicians; and external barriers, including lack of access and financial costs.²⁹ Historically, mental health services have not been developmentally sensitive or youth-oriented. Many services restrict access depending on age, diagnosis or comorbidities. Further, poor engagement of young people in child and adult psychiatric services has been endemic, and challenges in transitioning young people between and across these services has often been poorly dealt with.¹⁴⁻¹⁶ Together, these processes have caused a “crisis in care”, where most young people with mental health difficulties do not get the care they need, resulting in high rates of distress, functional impairment and suicidality.¹⁷⁻¹⁹

Summary

- Although mental health problems represent the largest burden of disease in young people, access to mental health care has been poor for this group. Integrated youth health care services have been proposed as an innovative solution.
- Integrated care brings together physical health, mental health and social care services, ideally in one location, so that a young person receives holistic care in a coordinated way. It can be implemented in a range of ways.
- A review of the available literature identified a range of studies reporting the results of evaluation research into integrated care services.
- The best available data indicate that many young people who may not otherwise have sought help are accessing these mental health services, and there are promising outcomes for most in terms of symptomatic and functional recovery.
- Where evaluated, young people report having benefited from and being highly satisfied with these services.
- Some young people, such as those with more severe presenting symptoms and those who received fewer treatment sessions, have failed to benefit, indicating a need for further integration with more specialist care.
- Efforts are underway to articulate the standards and core features to which integrated care services should adhere, as well as to further evaluate outcomes. This will guide the ongoing development of best practice models of service delivery.
Developing a Global Model for Youth Mental Health

Craig Hodges: Global Project Lead, Youth Mental Health
Global Survey YMH

Also contributed to the survey
US outlying Islands
Mauritius
Maldives
Barbados
Palestinian Territories
American Samoa.
Hong Kong which was a part of the consultations is represented under the magnifying glass.
Youth Mental Health Programs
headspace - Australia
since headspace started

2 million
Over the past 11 years almost 2 million young people have accessed headspace services through headspace centres, 111 service and phone counselling services at headspace (as of 30 June 2017).

355,000
Over 355,000 young people have accessed headspace centres and youth热线 as of 30 June 2017.

100+2
headspace has 100+2 centres and 2 national call centres across Australia (as of 1 September 2017).

1 in 4
One in four young people are doing it tough.

1/3
School support.

1,149
School support.

7,429
With 7,429occasions of service, headspace School Support works with 1,418 schools in the 2016/17 school year.

220
Since it started in August 2010 to 30 June 2017 the headspace Digital Work and Study Service has helped 1,935 young people with their work and study challenges.

headspace
Headspace, the National Youth Mental Health Foundation, provides early intervention mental health services to 12-25 year olds.

state overview

demographics

2% Indigenous, 9% Culturally and Linguistically Diverse, 6% Aboriginal & Torres Strait Islander.

gender

60% female, 38% male, 2% gender diverse, non-binary.

age

12-14: 31%, 15-17: 32%, 18-20: 24%, 21-23: 12%, 24-25: 8%.

New clients: 64%.

presenting issue

13.7% situational (family, school, bullying, stress).

27.8% mental health (depression).

27.4% signs of anxiety.

6.1% substance misuse.

5.1% other mental health (eating, bipolar).

10% other mental health (eating, bipolar).

2.8% alcohol or other drugs.

2.8% sexual & reproductive health.

1.7% physical health.

1.6% vocational assistance.

1.8% other.

headspace.org.au

The headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health.
Youth Mental Health Programs

headspace - Denmark
Youth Mental Health Programs

Foundry – BC Canada
Youth Mental Health Programs
@ ease - Netherlands
YOUTH MENTAL HEALTH REFORM WORLDWIDE

THE NETHERLANDS

- Centres established
- Centres planned for 2018
Youth Mental Health Programs
headspace Israel
ISRAEL

- centre established
- centre planned for 2018
Youth Mental Health Programs
Maison des Adolescents - France
Youth Mental Health Programs
Jigsaw - Ireland
YOUTH MENTAL HEALTH REFORM WORLDWIDE

USA

Santa Clara, California

centres planned for 2018
Waves for Change
Cape Town - South Africa

- Works with young people exposed to adverse childhood events
- Lack access to consistent caring adult
- Connects young people to surf therapy
- Uses simple listening, problem-solving techniques along with some guided CBT principles
- Measures impact of program on young people
IN BRIEF

Mental health is a major health issue for young people globally. 75 per cent of mental health issues have their onset before the age of 25, which has profound impacts on young people’s development and capacity to participate and contribute economically and socially. Despite the acute need, service responses are often non-existent or limited and poorly co-ordinated even in most high-income settings. Youth mental health systems need to take a systematic, evidence-based approach, centred around early intervention. It is important to address the symptomatic, developmental and functional impacts of mental health in the stage of life between adolescence and early adulthood.

FOUR THINGS TO REMEMBER:

1. 87 per cent of the global population is impacted by mental ill-health either through their own experience or that of a family member or someone close to them.

2. Poverty, childhood trauma and violence significantly increase the risk of young people experiencing mental ill-health.

3. Accessing support and appropriate treatment early significantly improves a young person’s recovery and capacity to lead a fulfilling and meaningful life.

4. From an economic perspective, adolescence and young adulthood is a key period during the life course when mental capital is formed.
## WEF ORYGEN PROJECT 2020

### KEY PRINCIPLES

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<td>No referral required</td>
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<td>Mapping of referral pathways</td>
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<td>Holistic care including functional recovery</td>
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<td>Guidelines for youth practice with consideration of developmental stage</td>
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<td>Evidence informed, individually tailored interventions</td>
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<td>Consultation with youth about service environment</td>
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<td>Utilising technology</td>
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### Awareness, engagement and integration

- Stakeholder mapping and engagement
- Develop relationships with stakeholders
- Education of community
- Education of referrers
- Integration across services and systems
- Anti-stigma measures
- Advocacy
- Cross sector partnerships
### Early intervention

- Development and use of screening tools
- Active community partnerships
- High-risk group awareness
- Community outreach
- Training
- Community setting
- Community education
- Crisis intervention for suicide risk
# Youth partnership and engagement

- Youth empowerment
- Youth advisory group
- Shared decision making
- Workforce training
- Co-design
- Peer workers
# Family engagement and support

- Psychoeducation
- Family therapy
- Family support
- Self-care
- Family peer workers
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<td>Evaluation informing improvement</td>
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<td>Utilise technology</td>
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<td>Map needs before developing program</td>
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Prevention

- Health promotion
- Anti-stigma measures
- Suicide prevention
- High-risk group focus
- Addressing social determinants

**LOCAL CONTEXTUAL FACTORS**

These could include culture, funding, political will, popular will, existing infrastructure and availability and skill level of workforce among many possible others.

**KEY PRINCIPLES**

- Rapid, easy and affordable access
- Youth specific care
- Awareness, engagement and integration
- Early intervention
- Youth partnership
- Family engagement and support
- Continuous improvement
- Prevention

**LOCALLY OPERATIONALISED YOUTH MENTAL HEALTH MODEL**

(consistent with principles, ambitious and innovative within the resources available)

**YOUTH FACING AGENCIES** ↔ **PRIMARY CARE** ↔ **SPECIALIST CARE**
**Marketing Strategy for International Success**

- **Standardization Strategy**
  - Anywhere the company operates, it offers identical food products such as the McFlurry, McNuggets, McCafe, Happy Meal, and Filet-O-Fish. The plan provides the company with a strong image.

- **Adaptation Strategy**
  - This strategy can be compared to localization. With this strategy, McDonald's adapts to the needs of the consumers as required by the cultures of specific countries.

**USA**
- McDonald's does many new product trials and innovation in its home country, where it has the biggest audience. The company's advertising is typically skewed to children, where McDonald's produces about 250 ads annually.

**Japan**
- McDonald's in Japan added menu items to cater to Japanese preferences. The company introduced Green Tea Ice Cream, Rice Burgers, Seaweed Shaker Shrimp Burgers, Shrimp Nuggets and Teriyaki Burgers.

**China**
- For China, instead of meat from chicken breasts, McDonald's uses meat from chicken thighs in its chicken burgers because it's the locals' preference.
  - The Grilled Chicken Burger is a meal offered during Chinese New Year, which is served with curry fries and a Chinese horoscope with the 12 animal signs.

**Germany**
- Because Germans love to eat meat, its burgers combine Nürnberger sausages with beef. And it's a known fact that Germans love their beer with food. So, McDonald's outlets in Germany also serve beer.

**India**
- McDonald's in India offers Masala Grilled Veggie Burgers, McAloo Tikki, the McVeggie and the Maharaja Mac which is the local version of the standard Big Mac.
  - The McVeggie features products. It is a tandoori chicken sandwich with onion and cucumber pickles, onion and mint raita, and chutney.

**Switzerland**
- The McRaclette is only served in McDonald's outlets in Switzerland. It is a sandwich with raclette cheese, unique raclette sauce, onions and gherkin pickles.

**Morocco**
- McDonald's offers a special menu for Ramadan. They call it Fatar (end of fasting) and the meal consists of a Big Mac, milk, dates and traditional Moroccan soup.

**Indonesia**
- The majority of the population in Indonesia is Muslim, therefore, McDonald's is adapted to the eating needs of the population by replacing pork with halal.
  - Since Indonesians prefer rice over bread, they serve rice as well, together with some spicy meals that locals prefer.
Everyone, everywhere should have someone to turn to in support of their mental health.
UNITED GLOBAL EVENT @ UN GA
Lancet Psychiatry Commission in Youth Mental Health

Building the momentum and blueprint for reform in youth mental health

Mental disorders have been well characterised as “the chronic diseases of the young” and continue to disproportionately affect young people worldwide. They are a major contributor to the overall burden of disease between 10 and 24 years of age, making them the leading cause of disability and premature death for this age group. Societies across the globe are heavily weakened by mental disorders. Projections suggest that by 2030, among the non-communicable diseases, mental illness will pose the greatest threat to worldwide economic growth. This threat to economic growth is a direct result of the timing in the lifecycle of mental disorders; 75% emerge by 24 years of age, with the major syndromes, which so often persist and disable across adulthood, emerging during the transition from puberty to the mid-20s. This critical developmental period is especially important for completing education, securing employment, and growing social relationships. Consequently, the long-term effects on fulfillment of human potential and productivity are enormous, through poor economic and vocational outcomes. This erosion of so-called mental wealth demands an urgent response to mental disorders in young people at an individual, societal, and global level.