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STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SYSTEMS AND SERVICES

for children and adolescents in East Asia and Pacific Region

PAPUA NEW GUINEA

COUNTRY REPORT
2022

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COUNTRY REPORT
2022

Prepared for the UNICEF East Asia and Pacific Regional Office and UNICEF Papua New Guinea by:

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Contents

Acknowledgements 1

Abbreviations 3

Executive summary 4

Introduction 9

Project aims, objectives and approach 12

Aims and objectives 13

Overview of the approach 13

Country-level analysis 14

Regional conceptual framework for MHPSS for children and adolescents in East Asia and the Pacific 18

A regional framework for child and adolescent MHPSS 20

Mental Health and Psychosocial well-being: The situation for children and adolescents in Papua New Guinea 26

National policies, strategies and legislation 35

Current programmes and approaches to address child and adolescent mental health and psychosocial well-being 41

A priority package of mhpss actions for children and adolescents 52

Recommended sectoral roles and responsibilities 62

Health sector 66

Education sector 66

Social welfare sector 67

Justice sector 67

Non-government organizations 68

Private sector 68

Faith-based sector 68

UNICEF 69

Challenges and recommendations for strengthening the multisector mental health system **70**

Legislation, policies and strategies 71

National level 73

Administrative and implementation levels 73

The mental health and psychosocial support workforce and recommended MHPSS roles 79

Competencies, training and support 83

Key recommendations and conclusions **90**

Overarching recommendations 91

References **94**

Appendix A: Workshop agenda and interview guide **99**

Appendix B: Development of the regional MHPSS conceptual framework **113**

Appendix C: National data on mental health outcomes **114**

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Abbreviations

COVID-19	Coronavirus disease 2019
CSNU	Callan Services National Unit
DFCDR	Department for Community Development and Religion
EAPRO	UNICEF Regional Office for East Asia and the Pacific
MHPSS	Mental health and psychosocial support
NDOE	National Department of Education
NDOH	National Department of Health
NGO	Non-government organization
NOCFS	National Office of Child and Family Services
PDOEs	Provincial Divisions of Education
PNG	Papua New Guinea
PPP	Purchasing power parity
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

The mental health of children and adolescents (aged 0–18 years) is one of the most neglected health issues globally. Before the COVID-19 pandemic, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.[1] In East Asia and the Pacific, almost one in seven boys and one in nine girls aged 10–19 years have a mental disorder, with suicide the fourth-leading cause of death among youth aged 15–19 years in this region.[2] Additionally, many millions more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder but has significant impacts on their health, development and well-being. Poor mental health can have profound impacts on children's and adolescents' physical health, learning and participation, which then limits the opportunities to reach their full potential.

Despite this burden, there is a substantial unmet need for mental health and psychosocial support (MHPSS) for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of total health expenditure,[5] despite accounting for 7 per cent of the total burden of disease.[6] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescent is less than 0.5 per 100,000 population, and there are fewer than two outpatient facilities for child and adolescent mental health per 100,000 population.[5]

To address the mental health and psychosocial well-being of children and adolescents, there is a need for a holistic and tiered approach to MHPSS that includes actions to promote well-being; to prevent poor mental health by addressing risks and enhancing protective factors; and to ensure quality and accessible care for persons with mental health conditions. This requires mobilization of all sectors, including health, education, social welfare and justice, as well as engagement with communities, schools, parents, service providers, children and adolescents.

To support the urgent need to strengthen MHPSS systems and services for children and young people in the region, especially in the wake of the COVID-19 pandemic, which has had a profound impact on mental health, the United Nations Children's Fund (UNICEF) embarked on a research initiative to identify how MHPSS can be most effectively implemented. Supported by the regional Technical Advisory Group comprised of UNICEF, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization and the Global Social Service Workforce Alliance, this initiative included the development of a regional conceptual framework covering a tiered and multisectoral package of MHPSS services to meet the specific needs of children and adolescents; clarity on the role of allied sectors – health, education, social welfare and justice – in the delivery of this package; and the legislative, policy and institutional reforms and capacity-building steps required to ensure a multisector mental health system.

Central to this research initiative was the application of the conceptual framework in four countries in the region – Malaysia, Papua New Guinea, the Philippines and Thailand – to explore how MHPSS could be implemented across diverse contexts.

This report documents the application of the conceptual framework in Papua New Guinea (PNG) and provides **country-specific recommendations for strengthening the provision of MHPSS for children and adolescents**.

Data describing mental health outcomes and risks for children and adolescents aged 0–18 years in PNG are extremely limited. However, modelled estimates suggest that this age group experiences a high burden of poor mental health, with mental disorder and self-harm accounting for 10 per cent of the total disease burden of 10- to 19-year-olds and around one in seven of 15- to 19-year-olds living

with a mental disorder. Limited survey data and data from stakeholders interviewed for this study also suggest that risk factors for poor mental health, including exposure to violence, are common. Despite the substantial needs, children and adolescents in PNG experience considerable unmet requirement for services for mental health conditions and limited access to support to prevent poor mental health and programmes to promote psychosocial well-being.

There have been important efforts to address mental health and well-being in the country. The National Mental Health Policy and legislative frameworks provide a foundation, recognizing at least in part the needs of this age group and providing general protection and approaches to respond and to promote well-being. There is also some inclusion of mental health in education sector policies and a solid legislative framework for child protection that recognizes the importance of ensuring psychological well-being. To date, much of the response to mental health has been for clinical management of mental health conditions through the health sector. There are also examples of national and subnational programmes delivered by the Government, non-government organizations and United Nations agencies to provide support to children and adolescents at risk of poor mental health and to deliver education and counselling in school settings.

This analysis found important gaps in the current MHPSS response in PNG:

- Extremely limited availability, accessibility and visibility of community-based child- and adolescent-friendly, family-centred and multidisciplinary care for mental health conditions, with mental health services primarily provided in specialized tertiary hospitals.
- An absence of mechanisms within the health (and other) sector to holistically address the health and well-being of children and adolescents, with the primary focus on acute and severe mental disorders.
- No current national, standardized approach to the early identification and screening of children and adolescents at risk, in health or other settings (education, child protection, justice).
- Lack of clear referral pathways and mechanisms within and between sectors for children and adolescents with recognized mental health needs.
- Limited inclusion of MHPSS in child protection protocols (including procedures for mental health assessment, referral for care and support, delivery of targeted interventions or procedures to minimize further psychological harm).
- Lack of child-focused protocols within the justice sector to minimize psychological harm for children in conflict with the law or child victims or witnesses, and no protocols for mental health assessment, referral or mental health services.
- Lack of comprehensive whole-of-education approaches to mental health promotion.
- Limited coverage of national (and targeted) programmes to support nurturing and responsive care from parents or caregivers.
- No large-scale programmes to support healthy peer relationships and address peer victimization in schools, communities and online spaces.
- Limited national strategy for addressing mental health literacy, stigma and harmful norms.
- Limited data describing mental health outcomes and risks for children and adolescents aged 0–18 years.
- Limited funding and resources allocated to mental health, with a strong reliance on development partners for the sustainability of programmes and services.

There are also some critical cross-cutting challenges impacting on implementation of MHPSS. There is limited national-level commitment to and leadership on mental health and limited mechanisms to support multisectoral planning and coordination. While mental health and well-being are integrated to some degree in the sectoral plans of the education, social welfare and justice sectors, they generally focus narrowly on specific actions (such as provision of school counsellors) rather than encompassing a more holistic vision for mental health and well-being and clear articulation of the sector's role and response. At a subnational level, the lack of clear plans, guidance and structures to support implementation and multisector collaboration have contributed to limited coordination.

Across all sectors, extremely limited personnel with mental health training and skills is a major barrier to implementation of MHPSS. The constrained availability of services that are responsive to the needs of children and adolescents, particularly at the primary health care and community levels. Overreliance on tertiary and institutional-based care also contributes to high unmet needs and delays in access to services. Insufficient budget for MHPSS-related programmes and budgeting processes that do not support agenda-based and cross-sector budget planning are also challenges.

Overarching recommendations

In addition to specific recommendations to strengthen the multisector mental health system, this analysis led to many overarching recommendations to improve implementation of MHPSS for children and adolescents in PNG.

1. Increase national government commitment to and prioritization of child and adolescent mental health through strengthened advocacy. Existing initiatives with strong government support, such as INSPIRE (to end violence against children) could be used as a platform to raise awareness and advocate for child and adolescent mental health, drawing on the technical expertise and convening role of the WHO and UNICEF. UNICEF and the WHO could also facilitate opportunities for children, adolescents and families with lived experience of mental health needs to engage in advocacy efforts.
2. Technical partners, such as UNICEF and the WHO, should provide support to the National Department of Health (NDOH), the National Department of Education (NDOE), the Department for Community Development and Religion (DFCDR) and the Department of Justice to increase capacity in child and adolescent mental health to strengthen policy development and planning.
3. The Mental Health Act should be strengthened to articulate protections for children and adolescents, including addressing mandatory requirements for parental consent for adolescents and ensuring that the rights of children within the mental health system are protected.
4. The NDOH, in collaboration with the other allied sectors, should develop a multisector child and adolescent mental health strategy that articulates specific MHPSS actions for children and adolescents (as defined in the framework) and details a multisector plan (and coordination structure) for implementation. This should prioritize actions that can build on existing programmes or platforms in the short term (such as integration of mental health into primary health care, child protection, the Family Support Centres and the school health system).
5. At the national level, the Government should establish a multisector committee (or similar body) to drive action on child and adolescent mental health and be responsible for coordinating planning and implementation. This could be led by the Directorate for Social Change and Mental Health and linked to existing bodies, such as the National Office of Child and Family Services and initiatives such as INSPIRE.
6. At the subnational level, the Government, with support from UNICEF and the WHO, should provide capacity-building sessions for provincial, district and local government authorities to expand their awareness of mental health issues, develop local MHPSS implementation plans, allocate resources and better coordinate sectors.
7. The Government should include mental health services (including outpatient care) within the Free Primary Healthcare and Subsidized Specialized Service Policy. To support sufficient allocation of public resources for mental health, the Government, with support from development partners, should undertake budget analysis, including costing of a minimum-services package for child and adolescent mental health (informed by the regional framework of actions. That analysis should explore sources of budget and budgeting processes for MHPSS across sectors. Such information could be used to advocate with budget decision-makers within departments as well as the Budgets Division for increased investment in the mental health response.
8. The NDOH, with support from the WHO, should strengthen mental health delivery through primary and community-level health services, including early identification, screening, initial management, preventive interventions and mental health literacy. This should include integration of MHPSS through existing services – maternal and child health, nutrition, adolescent health, general health services – and supported by minimum standards of care and management protocols, referral

protocols and communication mechanisms. It also should include specialist care where needed and workforce training and support for non-specialist providers.

9. The DFCDR, with support from UNICEF, should strengthen programmes addressing family violence and supporting positive parenting. This could include increasing resources for programmes to prevent family violence; scale up positive parenting programmes (such as Parenting for Child Development); development of child-focused protocols for the management and support of families at risk, including integration of MHPSS as part of the immediate response to child protection; and integration of MHPSS into the Family Support Centres, including mental health training of providers and establishing referral links with mental health services.
10. The NDOE, with support from the WHO and UNICEF, should strengthen school-based responses to mental health and well-being, including developing a national whole-of-education mental health promotion strategy; strengthening curriculum-based mental health education; training and support for teachers to improve their mental health awareness, early identification and positive behavioural management; increasing the number and competencies of school counsellors; and developing policies to address the school environment and promote positive relationships (address peer victimization and violence, prohibit corporal punishment and support respectful teacher–student relationships).
11. The NDOH, in consultation with other sectors and technical partners, should strengthen national, standardized protocols for child and adolescent mental health across agencies, including:
    - early identification protocols and validated screening tools for this age and detailed guidance on use in different settings;
    - referral procedures across sectors;
    - non-specialist management;
    - case-management of children and adolescents in contact with the child protection and justice sectors;
    - greater protection for children in conflict with the law and child victims within the justice system; and
    - national quality service standards for child and adolescent mental health services across sectors.
12. The Government, with support from professional associations, training institutions and development partners, should strengthen the multisector mental health and psychosocial support workforce through:
    - further in-depth mapping to identify critical roles across sectors against the MHPSS priority actions and the required competencies and intersectoral training needs to support these roles;
    - development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for providers across sectors;
    - integration of child and adolescent development and mental health into pre-service training of health professionals, the social service workforce, justice sector officers, teachers and other school-based staff that aligns with roles and responsibilities with respect to MHPSS;
    - strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers through the WHO's mh-GAP), social service workers, the justice sector, teachers and education staff that is competency based and aligned with expected MHPSS roles;
    - training provided to relevant department staff from the health, education, social welfare and justice sectors to support the planning and development of the workforce, as well as support for broader MHPSS programmes; and
    - improved supervision and support for MHPSS providers across sectors, including establishing provider support networks and multidisciplinary teams, improved remuneration, job security and career pathways and attention to the mental health needs of providers.

13. The NDOH, in consultation with the NDOE, the DFCDR and the Department of Justice, as well as academic and development partners, should improve the collection, use and accessibility of data at the national and subnational levels, including data and mechanisms to identify mental health needs, support planning and implementation and track progress. This should include developing a minimum set of indicators for mental health that could be harmonized across sectors, integrating mental health (and risk factors) into existing systems (such as Primero) and strengthening data links and sharing across agencies, in conjunction with privacy laws to protect children and adolescents. Consideration should also be given to establishing a national suicide surveillance system. To inform policy and programmes and support rigorous evaluation of MHPSS programmes, the Government, development partners and donors should also increase investment in mental health research to understand the needs, barriers and preferences of children, adolescents and their families.
14. The Government, development partners and non-government organizations should increase opportunities for children and adolescents (and parents and caregivers) to participate in MHPSS policy and programming, including establishing formal roles for young people (such as representation on mental health committees and other bodies at the national and subnational level). They should also establish child- and adolescent-friendly mechanisms for providing feedback and complaints on MHPSS programmes and mental health services.
15. The Government, development partners and non-government organizations should develop national and community-based programmes to address mental health-related stigma and discrimination and improve mental health literacy (particularly targeting children, adolescents, parents and caregivers). This could also include supporting innovation and collaboration among MHPSS experts, advocates and people with lived experience by hosting conferences, summits and similar events to raise MHPSS awareness and support the development of effective, relevant and sustainable MHPSS for children and adolescents in PNG.

Introduction

The mental health of children and adolescents (aged 0–18 years) is one of the most neglected health issues globally. Before the COVID-19 pandemic, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.[1] In East Asia and the Pacific, almost one in seven boys and one in nine girls aged 10–19 years have a mental disorder, with suicide the fourth-leading cause of death among 15- to 19-year-olds.[2] Additionally, many millions of children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder but has significant impact on their health, development and well-being.

Papua New Guinea (PNG) has more than 3.7 million children and adolescents aged 0–18 years, making up approximately 41 per cent of the nation's population.[2] Children and adolescents in PNG experience a substantial burden of poor mental health. Modelled estimates from the 2019 Global Burden of Disease Study indicate that mental disorders and self-harm account for 10 per cent of the total burden of disease among 10- to 19-year-olds, with suicide a leading cause of death among 15- to 19-year-olds.[3] The COVID-19 pandemic has heightened the need for mental health and psychosocial support due to the significant impacts on education, social connectedness, family stressors, inequality and disruption of essential services.[4–6]

BOX 1. DEFINITIONS OF MENTAL HEALTH

Mental health and psychosocial well-being is a positive state in which children and adolescents are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn and have a positive sense of self and identity.

Mental health conditions is a broad term that encompasses the continuum from mild psychosocial distress to mental disorders and that may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, common mental health conditions include difficulties with behaviour, learning or socialization; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, psychosis, bipolar, eating conditions, substance use, attention deficit or hyperactivity, intellectual disability, autism and personality disorders.

Adapted from *The State of the World's Children 2021,* UNICEF, 2021.

Poor mental health can have profound impacts on children's and adolescents' health, learning, social well-being and participation, which then limit opportunities to reach their full potential. This age group encompasses a time of critical brain growth and development, when social, emotional and cognitive skills are formed and lay the foundation for adult mental health and well-being. In addition to mental disorders arising during this age, many risk factors for future poor mental health also typically have their onset in this developmental stage.[7,8] Poor mental health during the first two decades of life also has broad implications for communities and societies. The monetary value of lost human capital from mental disorders during childhood and adolescence in East Asia and the Pacific is estimated to be more than US$74 billion (PPP) – the highest of any region.[2]

Despite this burden, there is substantial unmet need for mental health and psychosocial support (MHPSS) for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of the total health expenditure,[9] despite accounting for 7 per cent of the total burden of disease.[10] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescent is less than 0.5 per 100,000 population,

and there are fewer than two outpatient facilities for child and adolescent mental health per 100,000 population.[9] There are also many gaps and missed opportunities to prevent poor mental health and promote well-being, with approaches often fragmented and small in scale. In addition to inadequate human and financial resources, lack of coordination between sectors and substantial stigma remain significant barriers to ensuring that children, adolescents and their families have access to quality services and support.[2,11]

BOX 2. DEFINITION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Mental health and psychosocial support (MHPSS) refers to any support, service or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders.

Originally defined by the Inter-agency Standing Committee Reference Group on mental health and psychosocial support in humanitarian settings, this composite term is now widely used and accepted by UNICEF, partners and practitioners in development contexts, humanitarian contexts and the humanitarian–peace nexus. It serves to unite as broad a group of actors as possible and underscores the need for diverse, complementary approaches to support children, adolescents and their families.

The focus of this project is primarily on actions required in non-humanitarian settings.

PNG has made important efforts to address mental health, with a strong focus on reducing the impact of risk factors, such as gender-based violence, domestic violence and early pregnancy. However, investments in MHPSS for children and adolescents are lacking. Challenges, such as a severe mental health workforce shortage, a lack of community-level understanding of mental health and cultural and geographical barriers, mean that access to services is still far from universal. Unmet need is prevalent. A greater understanding of how to effectively implement MHPSS for children and adolescents across multiple sectors is imperative to address these gaps.

To ensure mental health and psychosocial well-being of children and adolescents, a holistic and tiered approach to MHPSS is required. It must include actions to promote well-being; prevent poor mental health by addressing risks and enhancing protective factors; and ensure quality and accessible care for persons with mental health conditions. This requires mobilization of all sectors, including health, education, social welfare and justice, as well as engagement with communities, schools, parents, service providers, children and adolescents. This multisector approach is at the core of UNICEF's East Asia and Pacific Regional Conceptual Framework on Mental Health and Psychosocial Support and the guidance of the Global Multisectoral Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings.[12,13]

Project aims, objectives and approach

Aims and objectives

In response to the urgent need for strengthening MHPSS systems and services for children and adolescents in the East Asia and Pacific region, UNICEF embarked on a research project to identify how MHPSS can be most effectively implemented for those aged 0–18 years. This initiative included the development of a regional conceptual framework that defined:

- a tiered and multisector package of services required for child and adolescent mental health and well-being (package of priority actions);
- the systems, structures and resources needed to deliver these services;
- multisector roles and responsibilities – for health, social welfare, justice and education – and the role of other allied ministries, agencies, non-government organizations (NGOs), young people, youth organizations, communities and the private sector; and
- the legislative, policy and institutional reforms and capacity-building steps and reforms required to ensure a multisector mental health system.

While the importance of MHPSS in emergency settings was acknowledged, the project focused on implementation of MHPSS in non-emergency contexts.

The research applied the conceptual framework in four countries in the region – Malaysia, PNG, the Philippines and Thailand – to explore how MHPSS could be implemented across diverse contexts and in parallel and thus inform its finalization.

BOX 3. OVERVIEW OF THIS REPORT

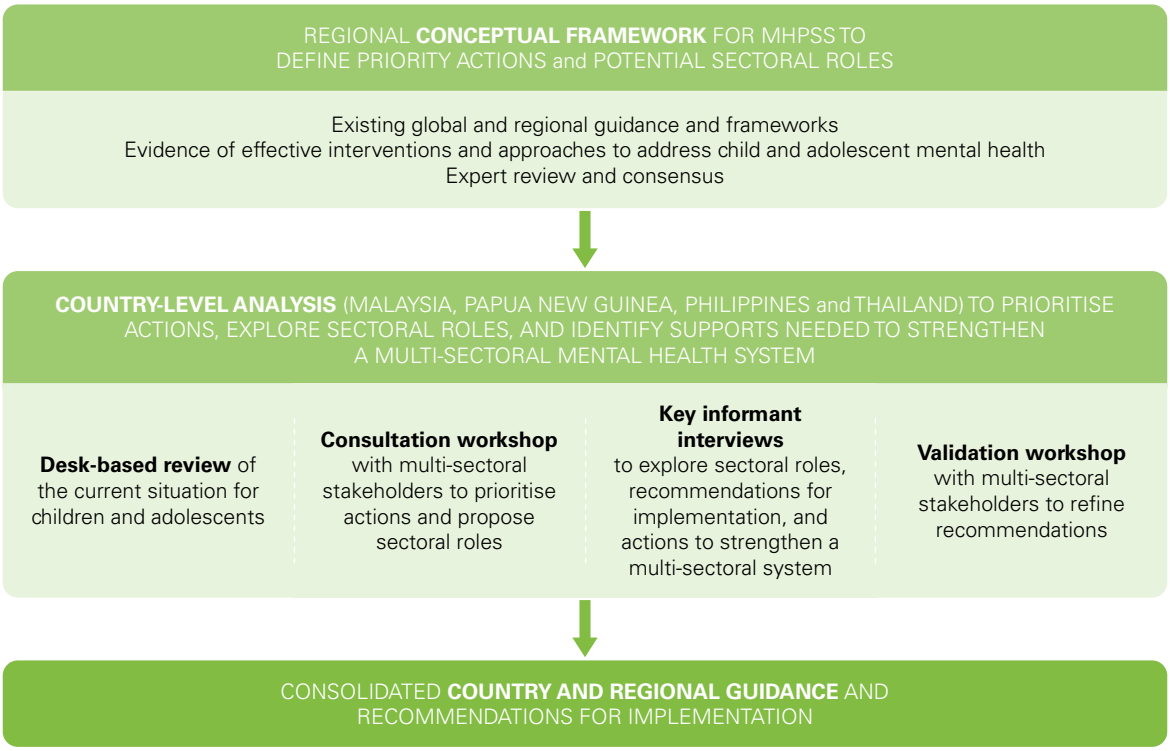
This report explains the overarching regional mental health and psychosocial conceptual framework and synthesizes the findings of a desk-based review, consultation and validation workshops and informant interviews to describe:

1. Mental health and psychosocial well-being of children and adolescents: the current situation (needs and policy and programming responses)
2. Priority package of mental health and psychosocial actions
3. Recommended sector-based roles
4. Challenges and recommendations for strengthening the multisector mental health system

Overview of the approach

The Burnet Institute, in partnership with the UNICEF East Asia and Pacific Regional Office (EAPRO), led the project. A regional Technical Advisory Group comprising UNICEF, the United Nations Educational, Scientific and Cultural Organization, the WHO, the Global Social Service Workforce Alliance and sectoral and child and adolescent health experts provided feedback and guidance on the conceptual framework, project approach and regional findings and recommendations. Figure 1 outlines the project.

FIGURE 1. OVERVIEW OF THE PROJECT APPROACH



Country-level analysis

The Burnet Institute, supported by the UNICEF PNG Country Office and the country Technical Advisory Group, also led the PNG analysis. The UNICEF EAPRO and the regional Technical Advisory Group provided oversight.

Objectives of the country-level analysis:

1. Synthesize existing data to describe the mental health needs of children and adolescents in PNG.
2. Synthesize policies, services and programmes (government and non-government) related to child and adolescent mental health to describe approaches, experiences and gaps.
3. Identify barriers and enablers to children and adolescents accessing MHPSS.
4. Define a tiered, multisector minimum services package for MHPSS.
5. Explore how the MHPSS regional framework and package of priority actions can be effectively implemented, including determining opportunities and challenges across allied sectors (health, education, social welfare and justice), with particular attention to the systems requirements (financial, human and governance) needed to support implementation.

This component included four main activities:

1. Desk-based review

Synthesis and secondary analysis of existing survey data

Priority indicators describing mental health outcomes and risks for children and adolescents aged 0–18 years were identified following a mapping of global and regional mental health indicators. For PNG, no national survey data were available for the selected indicators. Modelled estimates were taken from the 2019 Global Burden of Disease Study,[3] and data from subnational or other smaller studies were included where available.

Review and synthesis of available literature

To address the gaps and limitations of survey data, published literature was reviewed to describe:

- mental health needs of children and adolescents;
- risks and determinants of mental health and / or psychosocial well-being;
- barriers and enablers to accessing quality MHPSS; and
- evidence of interventions and approaches to address mental health and/ or psychosocial well-being.

Sources such as Medline, Embase, Emcare and PsychINFO were searched for articles published in English as of January 2010. The search strategy involved three main concepts: (i) mental health, (ii) children and adolescents and (iii) PNG. For mental health, search terms included mental health, psychology, psychosocial care, mental disease, suicidal behaviour, psychotherapy, anxiety management and several specific mental diagnoses and psychotherapy modalities. Regarding children and adolescents, search terms included child, adolescent and youth. And for PNG, search terms included Papua New Guinea, Port Moresby and several other PNG city and provincial terms, such as Lae, Morobe and Bougainville. This review covered all relevant studies including narrative reviews, systematic reviews, randomized controlled trials, quasi-experimental trials, observational studies and case series. Studies were reviewed if they were conducted in PNG, included children and/or adolescents aged 0–18 years and addressed one or more of the focus areas.

Search results were uploaded to Covidence, with 317 studies imported for screening and 93 duplicates removed. Of the 224 studies screened, 203 were excluded and 21 articles were included for full-text screening and extraction to the literature review as appropriate. Manual searching of reference lists from relevant articles was also conducted to identify additional peer-reviewed literature or grey literature.

Mapping and review of policies, strategies, plans and legislation

Information on government policies, plans, strategies and laws was taken from relevant government websites and United Nations agencies. Relevant government departments in each sector (health, education, social welfare and justice) were first identified, and websites were searched using similar search terms as the desk review to locate relevant documents relating to mental health. Documents were included if they were:

- produced by the government or described a government policy, plan, strategy or law;
- related to government intentions, actions or decision-making;
- national in scope;
- the most recent available; and
- addressing one or more tiers of the conceptual framework for MHPSS (care, prevention and promotion)

These were then mapped and reviewed to identify: sector; the extent to which they included specific actions for children and/or adolescents aged 0–18 years; conceptual framework tiers addressed; summary of actions in relation to children and adolescents; and targets and indicators (where relevant).

2. Country-level stakeholder consultation workshops

Two half-day online workshops were conducted, on 27 September and 1 October 2021, attended by government, non-government and United Nations agency representatives. The aim of the workshops was to present and reflect on the MHPSS regional conceptual framework, identify priority actions for MHPSS for children and adolescents in PNG and propose sectoral roles and responsibilities for implementation of the MHPSS package. To facilitate this, participants were invited to complete an online prioritization tool to provide feedback on each proposed MHPSS action and indicate a lead sector. The findings were presented and discussed during the second workshop.

3. Interviews with sector stakeholders

Informant interviews were conducted to deeply explore:

- perceptions and understandings of priority child and adolescent mental health needs;
- current programmes and approaches related to MHPSS;
- barriers and enablers impacting implementation;
- recommended sectoral roles and responsibilities; and
- challenges and considerations for strengthening a multisector mental health system.

Sector-specific question guides drew on the project's regional conceptual framework and were refined following review by the sectoral and mental health experts through the regional and country Technical Advisory Groups.

A total of 18 interviews were conducted with participants aged 18 years or older. These included interviews with stakeholders from the health (10), education (1), social welfare (5) and justice (1) sectors. One interview was also conducted with a youth representative. All interviews were conducted via Zoom due to the COVID-19 restrictions. Interviews were conducted in English, with some participants using sparse Tok Pisin. Interviews were facilitated by experienced Burnet researchers who had completed a three-day intensive training workshop covering the study objectives, study procedures and ethical considerations. Interviews were audio-recorded, transcribed verbatim and, where necessary, translated into English by bilingual researchers. Transcripts were analysed thematically using a Framework Method.

All participants provided voluntary informed consent. Ethics approval was obtained from the Alfred Ethics Committee (Australia), with a letter of support provided by the PNG Secretary for Health.

4. Validation workshop

Following the data analysis, a two-hour workshop was conducted with the country Technical Advisory Group (11 May 2022) and other sectoral stakeholders to present and reflect on the findings and refine the recommendations. Nine Technical Advisory Group members joined the workshop, including representatives from the education, health and social welfare sectors.

Limitations

Not all policy, strategy or legislation documents could be accessed online, with some gaps filled through the informant interviews. But some policies may not have been included. Additionally, the desk review was limited to national and high-level policies; specific details regarding protocols, guidelines, training programmes and standard operating procedures in relation to MHPSS were not included. Similarly, because the informant interviews were limited to 18 participants, some approaches, priorities and challenges at the subnational level may not have been explored in depth. This project also focused intentionally on supply-side priorities and challenges with respect to implementing MHPSS. Representatives from youth-focused organizations and networks were included in workshops and interviews to provide perspectives on demand-side barriers, enablers and service delivery preferences. But more research is needed to explore these issues in more depth with children, adolescents and their parents or caregivers (including those with lived experience). Finally, the COVID-19 pandemic impacted on the availability of some government stakeholders to participate in the workshops and interviews.

Regional conceptual framework for MHPSS for children and adolescents in East Asia and the Pacific

The first phase of the project developed the Regional Conceptual Framework for Mental Health and Psychosocial Support for children and adolescents. It is based on a review and synthesis of the global and other regional frameworks for mental health and evidence for effective interventions; review and expert consensus provided by the regional Technical Advisory Group and external content experts; and review and feedback from the four country Technical Advisory Groups and PNG stakeholders during consultation workshops. See Appendix B for details.

An important foundation for this framework is the UNICEF Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings.[13] The Global Framework defines a range of interventions to promote psychosocial well-being and prevent or manage mental health conditions by providing guidance to support planning and implementation. While the inception of this research initiative predates the finalization of the Global Framework, the regional framework sought to include and harmonize its actions for MHPSS in East Asia and the Pacific with the global guidance. The purpose of the regional framework is to define the MHPSS that is high priority for the region and provide detailed guidance for its implementation. The guidance includes a description of sector roles and recommendations to strengthen a multisector mental health system.

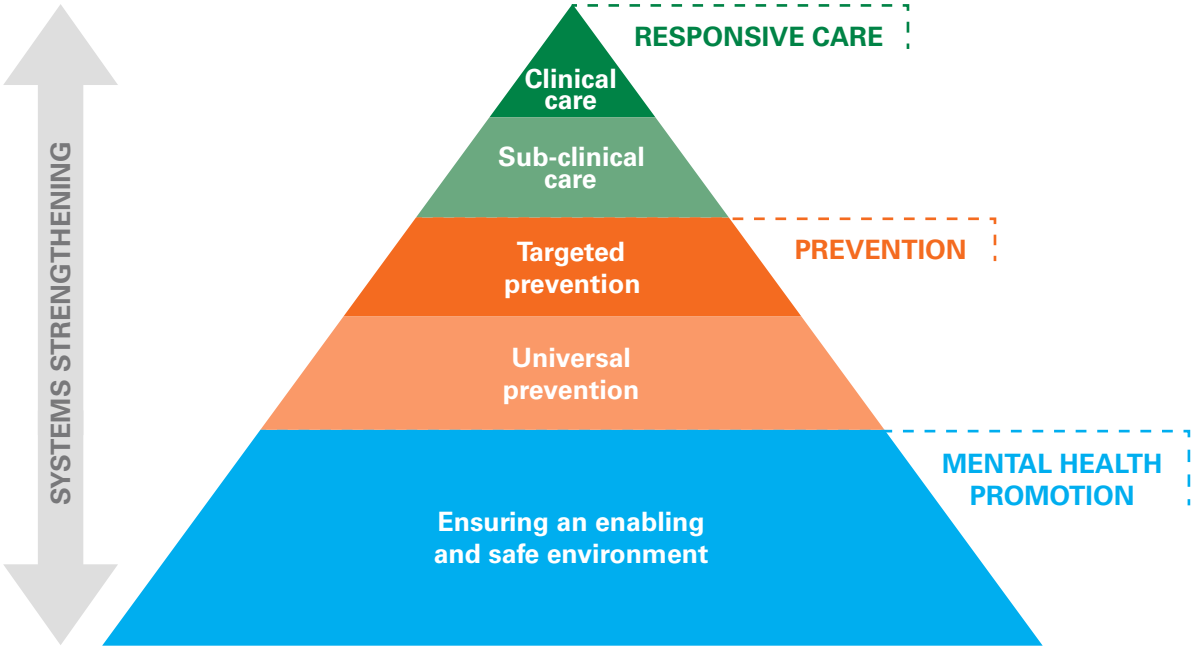
Guiding principles of the framework

Aligned with the Global Multisectoral Operational Framework, the regional framework takes a **socioecological approach** to addressing MHPSS, recognizing that the mental health and well-being of children and adolescents is profoundly influenced by individual attributes and experiences as well as relationships with family, peers, communities and the broader environment within which children grow, learn and socialize. The framework considers mental health and well-being across the **life course**, recognizing childhood and adolescence as a critical period of cognitive, social and emotional development, with implications that extend into adulthood and for the next generation. Responding to mental health needs and risks must adapt to the *developmental stages and needs* rather than follow rigid application of biological age. It also must consider the cumulative impacts of risks (or protective factors) across the life course. And it must acknowledge that there are significant gendered differences in risks, experiences, care-seeking behaviours and outcomes with respect to mental health. Children with disabilities also experience unique mental health needs and barriers in accessing MHPSS. Responses thus must take specific measures to ensure that MHPSS is **gender-responsive, accessible, inclusive and seeks the active participation** of children, adolescents and their families.

A regional framework for child and adolescent MHPSS

The regional framework defines three tiers of actions required to ensure the mental health and well-being of children and adolescents, with systems strengthening as a cross-cutting theme (*see Figure 2*).

FIGURE 2. TIERS OF MHPSS ACTIONS FOR CHILDREN AND ADOLESCENTS



Within each of the three tiers are **domains of action.**

Responsive care for children and adolescents with mental health conditions

This refers to care that is age-appropriate and developmentally appropriate, gender- and disability-inclusive and non-discriminatory. Actions include:

- ***Screening, assessment and early identification of mental health needs*** to determine the children and adolescents who are at risk of or have mental health conditions, with a focus on those who would most benefit from care. It also includes the ***referral pathways*** (between and within sectors) for those requiring specialized care or social support and protection, noting that screening in the absence of referral and accessible care can be stigmatizing.
- ***Management and treatment*** that is responsive to the needs of children and adolescents, including care that is developmentally appropriate, accessible, comprehensive and culturally appropriate, including for:
  - ***Clinical mental disorders,*** which refer to clinically diagnosable disorders generally made according to the classification system of the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) or the International Classification of Diseases.
  - ***Subclinical mental disorders and mental health conditions,*** when children and adolescents show signs or symptoms of a mental or psychological disorder but below the clinical threshold for mental disorder.

- ***Continuing care***. Mental health typically fluctuates for individuals over their life cycle. For those with identified needs, these conditions may increase and decrease over time and may be exacerbated by stressful life events. Continuing care (that ensures accessible care and support as required) is essential to ensuring the best outcomes for children and adolescents but also ensuring optimal outcomes across the life course.

Prevention of mental health conditions in the immediate social context

These actions aim to address risk factors for poor mental health and enhance protective factors. These can be universal (that is, applicable to all children and adolescents, such as limiting access to alcohol and other drugs) or targeted (focused on children and adolescents with high-risk behaviours or in high-risk settings, such as interventions to address harmful substance use). It includes four groups of interventions, coarsely mapped against the socioecological framework.

- ***Building individual assets of children and adolescents***, aimed at fostering individual assets (physical health, intellectual development, psychological and emotional development and social development). This includes a focus on social and emotional learning, building resilience and improving mental health literacy in children and adolescents.
- ***Strengthening positive peer support (including*** *online****),*** given that peer relationships are a critical protective factor for good mental health. This also includes addressing harmful peer relationships (online and offline), including bullying and victimization (cyberbullying).
- ***Psychosocial competence-building for parents and caregivers***, including positive parenting practices and improving parents' skills in responsive and nurturing caregiving. This includes a focus on preventing harmful parenting as well as addressing parental mental health.
- ***Safe and enabling learning environment*** that ensures a pro-social environment in a setting in which children and young people are connected, supported and not subject to harmful exposures (all forms of physical or mental violence, injury and abuse, discrimination and exclusion, neglect or negligent treatment, maltreatment or exploitation, including online sexual exploitation and abuse).

Ensuring a safe and enabling environment to promote mental health

Through policy, legislation and community engagement, these actions seek to address the structural determinants of mental health and well-being in relation to where children and adolescents live, grow and learn. The determinants of psychosocial well-being are broad, encompassing such factors as secure housing, the environment and climate change; poverty, nutrition, social justice and equality; and disasters, conflict, economic and fiscal contexts and political contexts. Following consultation with the regional Technical Advisory Group and expert advisers, this tier of the framework was narrowed to focus on actions in relation to:

- ***Community engagement and participation*** – the active involvement of people from communities, including young people and those with lived experience of poor mental health, in the process of planning, delivering, monitoring and evaluating policies and programmes and in mental health advocacy. The involvement of community members is essential to determine their own priorities in dealing with mental health conditions with respect to cultural context. Community engagement is also central to addressing harmful norms, attitudes and beliefs that contribute to poor mental health (such as discriminatory attitudes towards non-conforming gender identity or expression) that contribute to poor care-seeking behaviours (for example, harmful norms around masculinity that discourage seeking help) and that contribute to stigma and discrimination against children and adolescents with mental health problems.

- ***Policy and legislation*** that both *enables and protects* the rights of children and adolescents with mental health conditions, protects children and adolescents from harm and risks associated with poor mental health and provides a clear framework for the system and sectoral roles in responding to and supporting mental health, including sufficient allocation of public resources for MHPSS. Legislation should reflect the values and principles of human rights and the Convention on the Rights of the Child, with the best interests of children and adolescents as a primary consideration. This includes, but is not limited to, the right to equality and non-discrimination, dignity and respect, privacy and individual autonomy, information and participation.[14]

In addition to identifying what actions are required within each of these tiers, the framework also describes broad roles for allied sectors in implementing MHPSS for children and adolescents (*see Figure 3*). The specific roles and responsibilities of each sector were explored in-depth during the country-level analysis, although the regional framework proposes broad overarching roles.

The ***health sector*** has a central role in ensuring accessible and responsive mental health services for children and adolescents with mental health conditions. This includes the delivery of early identification, screening, referral and management by non-specialist providers (general practitioners, nurses, midwives, community health workers and volunteers and auxiliary health providers) as well as specialized care for severe or complex cases by child and adolescent psychiatrists, mental health nurses, neurodevelopment specialists, behavioural paediatricians, clinical psychologists, occupational therapists and speech therapists. The health sector also has an important role in targeted prevention for those at risk of poor mental health (such as the provision of preventive interventions for children and adolescents with comorbid health conditions, those identified to have risk behaviours, such as substance use, those in high-risk settings, supporting positive parenting and supporting parents with mental health conditions) and in mental health promotion (increasing mental health literacy and addressing harmful norms and stigma). The health sector may also have an overall leadership and advocacy role in MHPSS, given the role of the health service in mental health service provision.

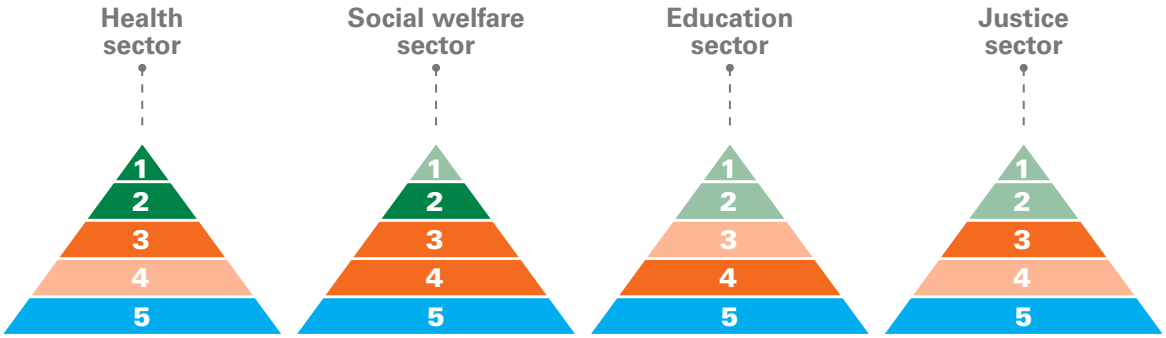
The ***social welfare sector*** has a significant role in the delivery of MHPSS. The social service workforce broadly encompasses government and non-government professionals, paraprofessionals and community volunteers who work within social welfare or community development but also may be employed by other sectors (including health, education and justice). Because of the particular focus on child protection and working with families at risk, this sector has a crucial role in the delivery of targeted preventive interventions to address risk factors among children, adolescents and their families, especially those with high-risk exposure to poor mental health (exposed to violence, neglect or exploitation). This also includes delivering and supporting programmes to improve responsive and nurturing caregiving, which may be universal or targeted to those at increased risk (such as parents with mental health conditions). This sector also has a role in early identification and screening in some settings, supporting a strong referral system and provision of responsive care for mental health conditions as part of a multidisciplinary team. There is also broader opportunity to ensure an enabling environment for good mental health through social welfare and social protection that addresses the social determinants of health. The social welfare sector may also have a role in community-based and national advocacy that can help tackle stigma and harmful norms.

The ***education sector*** is critical for implementing universal preventive interventions as well as ensuring that school and learning environments promote good mental health and well-being. The education sector arguably comprises the biggest mental health and psychosocial support workforce because teachers, school-based counsellors and psychologists and volunteers (such as peer counsellors) have the potential to reach large numbers of children and adolescents. In addition to the delivery of curriculum-based approaches to support social and emotional learning, there is also an opportunity for schools to shape attitudes and norms around mental health and positive relationships that makes an important contribution to building an enabling environment for good mental health. Teachers, school counsellors and school-based psychologists also are needed for early identification and assessment of mental health needs, referrals, behavioural management and targeted prevention. Schools have an important role in supporting children and adolescents with mental health needs, including through the opportunity for education generally and by providing alternative learning pathways. Schools may also provide an opportunity for screening, with careful consideration; screening alone, in the absence of accessible services and support, can be stigmatizing. Additionally, lack of age-,

culture- and language-appropriate tools, limited training in their application and lack of confidentiality may contribute to misdiagnosis and the pathologizing of normal behaviours and stigma.

The ***justice sector*** has a significant role in supporting children and adolescents who are at increased risk of poor mental health, including those who are in conflict with the law and those who are victims (or witnesses) of violence. This includes responding to mental health needs and risk factors (such as exposure to violence and substance misuse) for children in conflict with the law and preventing (or responding to) further harm and risks exacerbated by detention. In collaboration with the social welfare and health sectors, the police, public prosecutors, court psychologists, probation officers, detention centre workers, social service workers and judges could support the delivery of early identification and screening in some settings, referral and links with mental health services and targeted prevention and response in justice settings (including addressing the harmful use of substances and programmes to build individual assets and skills).

FIGURE 3. SUMMARY OF BROAD SECTORAL ROLES FOR MHPSS



Note: Darker shade indicates where a sector should have a leadership role or primary responsibility for implementation, by tier of action.

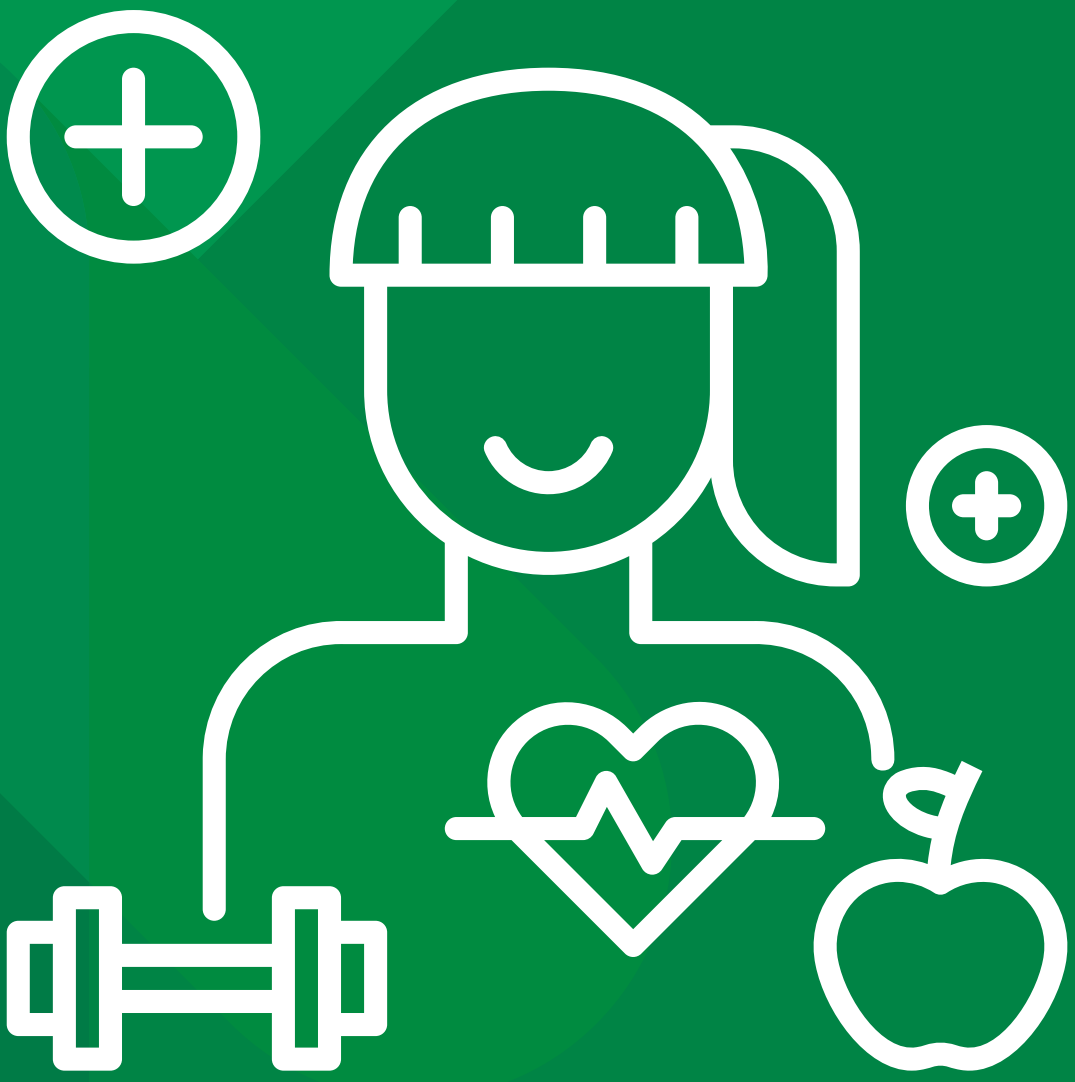
The regional framework also identifies eight pillars of **systems strengthening** required to enable effective and equitable implementation of these actions within and across the allied sectors (*see Figure 4*).

FIGURE 4. PILLARS OF SYSTEMS STRENGTHENING

Legislation and policy	*To promote an enabling environment, providing the legal and regulatory frameworks required to support implementation of MHPSS, and policies and plans to strengthen systems and services delivery
Leadership and governance	*To enable coordination within and across sectors, between levels of government, and with non-government and informal service providers, with clearly defined roles, responsibilities and accountability
Service delivery	*Modules of delivery to ensure services are equitable, inclusive, accessible to all, and age / developmentally appropriate. Includes identifying what actions can be integrated into existing platforms and what new models / platforms are required
Standards and oversight	*To support quality assurance and accountability
Workforce	*The multisectoral mental health workforce (across health, education, social welfare and justice), with defined roles, competencies, training and supervision
Budget and financial resources	*Adequate allocation and expenditure of resources and financing mechanisms to ensure equitable access and quality of services
Participation	*Engagement and participation of children adolescents, families and communities in planning, design, delivery and evaluation of MHPSS
Data, information and research	*Mechanisms for collection, analysis and dissemination of reliable and timely information to support planning, implementation and monitoring and evaluation

Mental Health and Psychosocial Well-being:

The situation for children and adolescents in Papua New Guinea



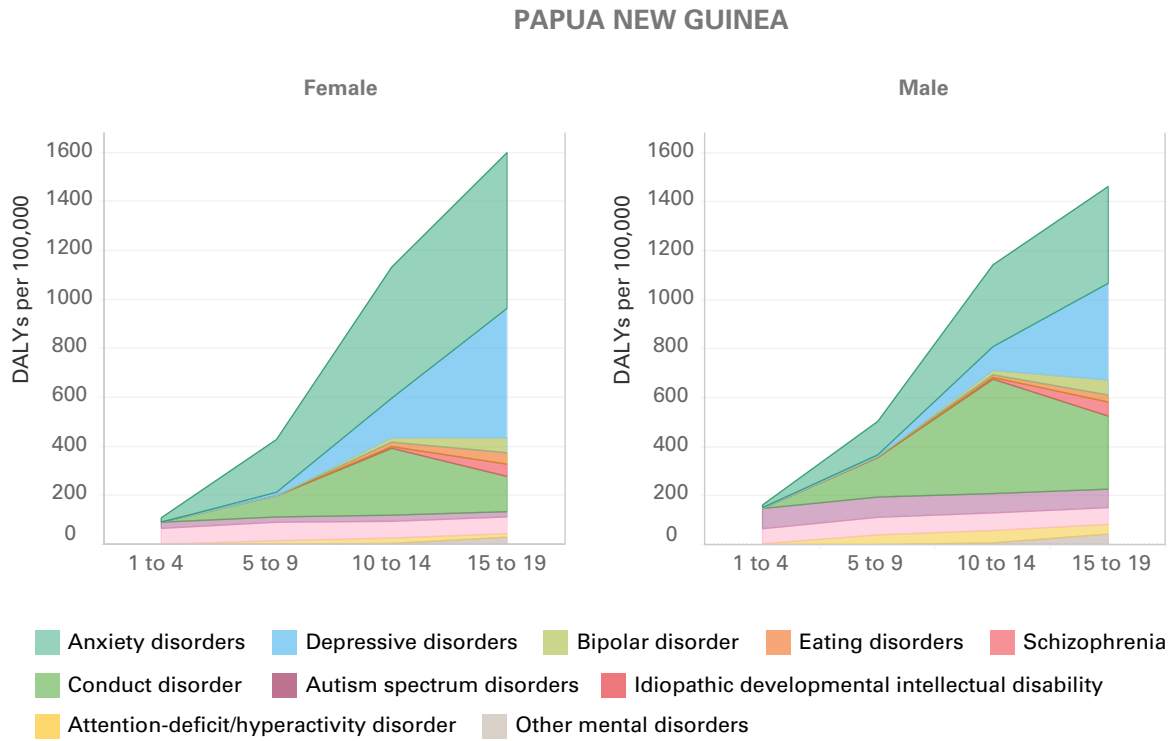
Mental health needs of children and adolescents

Mental health outcomes

Children and adolescents aged 0–18 years in PNG experience a substantial burden of poor mental health. Modelled estimates from the 2019 Global Burden of Disease Study indicate that mental disorders and self-harm account for 10 per cent of the total burden of disease among 10–19 year olds.[3] Among younger adolescents and children aged 5–14 years, mental disorders are the fifth-leading cause of poor health, with conduct disorder and anxiety disorder alone accounting for 4.5 per cent of the total burden of disease in this age group.[3] An estimated one in seven adolescents aged 10–19 years and one in fourteen children aged 5–9 years have a mental disorder (including developmental disorder).[3]

Figure 5 shows the burden of disease due to mental disorders across childhood and adolescence, reported as disability-adjusted life years (healthy years of life lost due to either disability (illness) or premature death). Several important observations can be made. First, the burden of disease due to mental disorder increases substantially during childhood and adolescence, with the greatest increases carrying into later childhood and early to mid-adolescence. Second, the specific causes of poor mental health vary substantially by age: for young children, developmental disorders predominate; for young adolescents, there is a sharp increase in conduct disorders, depression and anxiety; for older adolescents and young adults, there is a predominance of depression and anxiety, with the emergence of psychosis and eating disorders. Third, there are important differences in burden and pattern of mental disorder by gender. Girls have an overall larger burden of mental disorder that is mostly driven by excess depression and anxiety, with boys having an excess burden of conduct disorder.

FIGURE 5. MENTAL HEALTH DISORDERS ACROSS CHILDHOOD AND ADOLESCENCE IN PNG



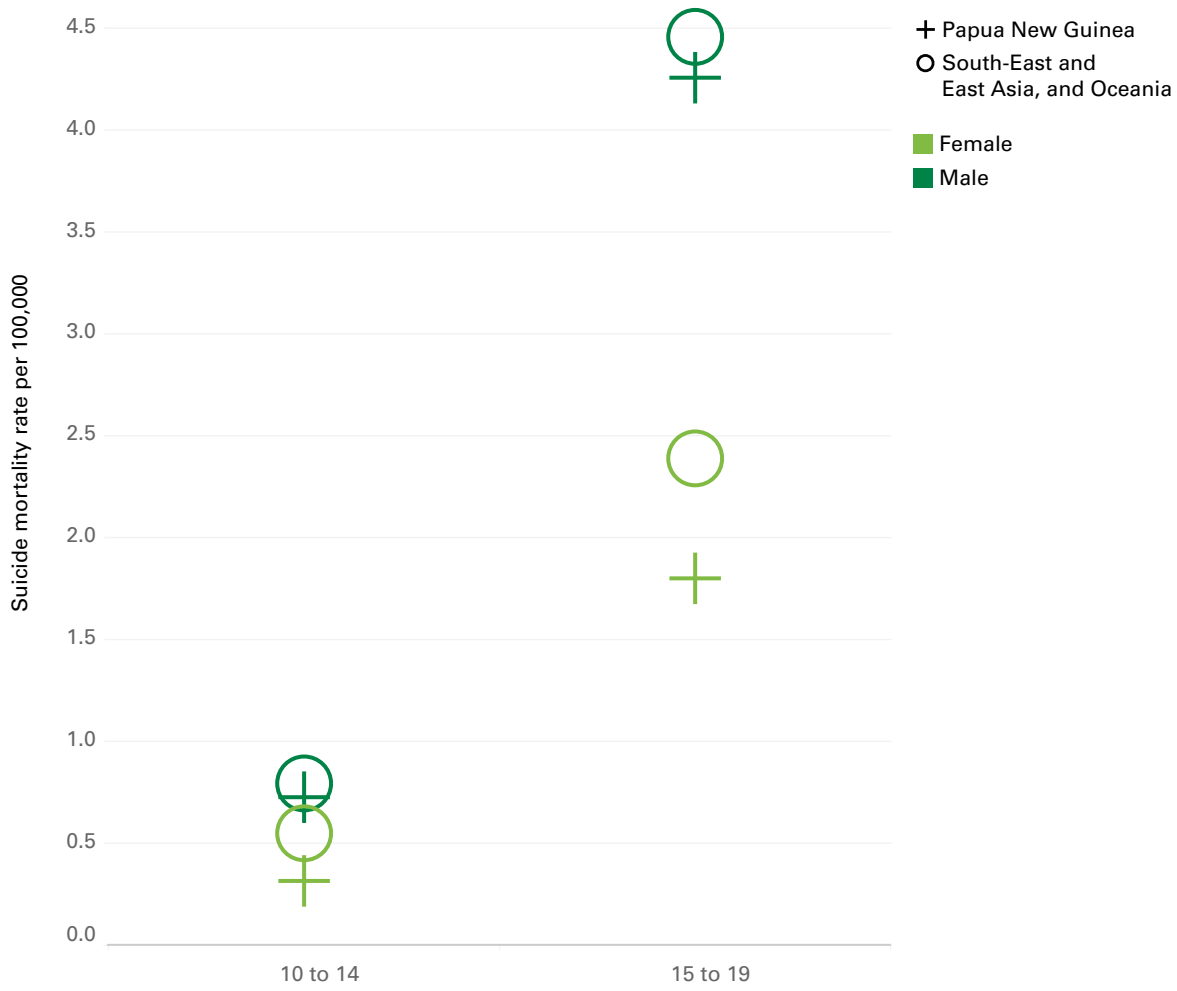
Note: The graph shows disease burden (in disability-adjusted life years, DALYs, with are the years of life lost to either cause-specific death or disability) due to mental disorders across childhood and adolescence.

Source: Institute for Health Metrics and Evaluation, *Evaluation IfHMa. Global Burden of Disease Data Tool,* IHME, Washington, D.C., 2019.

Other than modelled estimates (see Appendix C), the prevalence of mental disorders among children and adolescents in PNG is largely unknown because there is no systematic collection of mental health data.[15,16] Primary data from household or school-based surveys or smaller subnational studies are also lacking. In a 2010 regional survey conducted by UNICEF, self-reported general happiness and self-esteem among children and adolescents in PNG were relatively low when compared with other countries.[17] Slightly more than a quarter (28 per cent) of children and adolescents reported feeling happy most of the time, while 7 per cent reported they were never or almost never happy. The Global Burden of Disease Study's modelled estimates indicated that 2.5 per cent of adolescents aged 15–19 years had a depressive disorder and 5.3 per cent an anxiety disorder in 2019. Among younger adolescents (aged 10–14 years), conduct disorder (at 3.3 per cent) and anxiety disorder (at 4.5 per cent) were the most prevalent.[18]

Suicide is closely related to poor mental health. But there are no available data describing suicidal ideation or non-lethal self-harm among adolescents in PNG. There is no national system or register for recording suicide deaths, although, according to a study of suicides in the National Capital District, 42.4 per cent of suicides from 1999 to 2008 occurred among 15- to 24-year-olds. Modelled estimates from the 2019 Global Burden of Disease Study also indicted that the mortality rate due to self-harm in PNG for adolescents aged 10–14 years was 0.5 per 100,000 population and 3.1 per 100,000 population for those aged 15–19 years (*see Figure 6*). Boys had an excess risk of suicide when compared with girls.[18]

FIGURE 6. SUICIDE MORTALITY AMONG 10- TO 19-YEAR-OLDS



Source: Source: Institute for Health Metrics and Evaluation, *Evaluation IfHMa. Global Burden of Disease Data Tool,* IHME, Washington, D.C., 2019.

To explore broader understandings of mental health needs during childhood and adolescence, stakeholders who participated in the interviews and workshops were also asked to describe their sense of such needs during this age. *Table 1* groups the most commonly cited mental health needs by stakeholders' sector. Stakeholders generally noted what related to their sector's focus. While health stakeholders prioritized mental disorders, the social welfare sector stakeholders, for example, more broadly described mental health in terms of impact on family life, relationships and job security. Young people had a more holistic understanding of mental health, reflecting a focus on well-being rather than the presence (or absence) of a mental disorder.

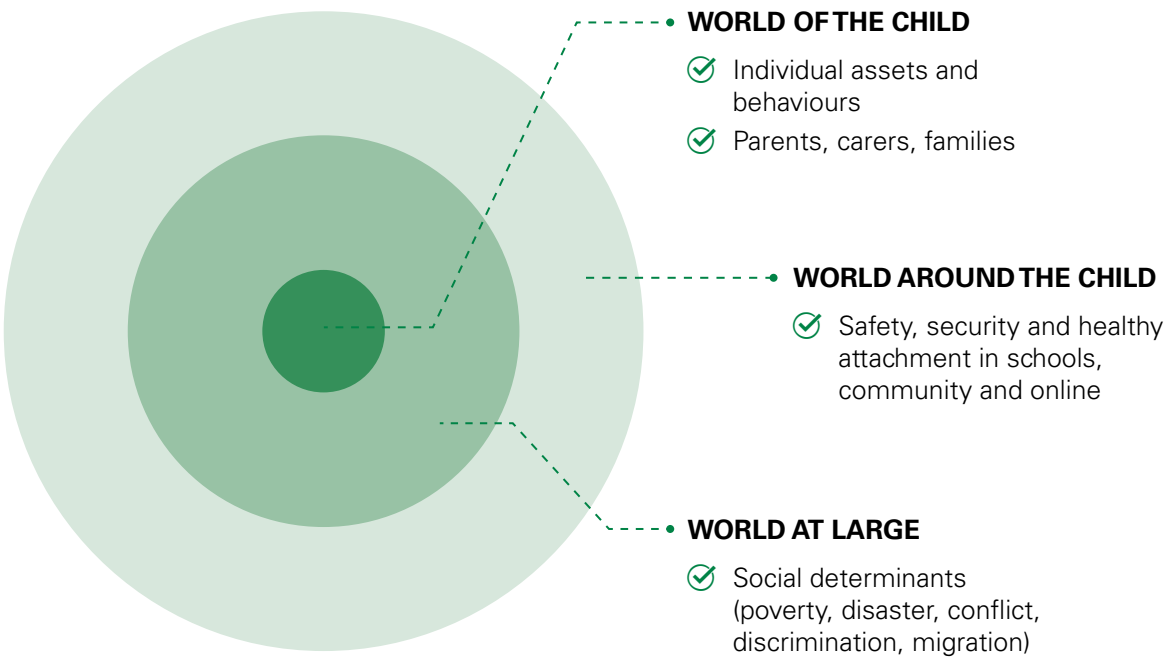
Table 1. Interviewed informants' sense of mental health needs of children and adolescents, by sector

Health	Psychosis; substance-use disorders; suicide, depression, anxiety, attention deficit and hyperactivity disorder; and the COVID-19 pandemic's impact on mental health
Education	Counselling and talk therapy in schools; improving help-seeking behaviours; the effects of family issues and poverty on education and child and adolescent mental health; alcohol and drug use; school dropouts; and the effects of COVID-19 on education
Social welfare	Mental health related to child protection; gender-based and domestic violence, child abuse, unstable and separated families; polygamy; tribal wars; substance use; bullying and gangs; the mental health of rural populations; and school dropouts as a result of the COVID-19 pandemic restrictions
Justice	Mental health conditions and behaviours linked to crime (substance use); and children and families in contact with the justice system
Young people	Substance use; a lack of understanding among the population of mental health, resulting in stigma; a lack of support, guidance and validation of mental health experience; and the effects of COVID-19 restrictions on routines and social events

Risks to and determinants of good mental health and psychosocial well-being

UNICEF's *The State of the World's Children 2021* report defines three spheres of influence that shape the mental health and well-being of children and adolescents: the "world of the child" (individual assets, parents, caregivers and families); the "world around the child" (safety, security and healthy attachment in school, communities and online); and the "world at large" (social determinants, including poverty, disaster, conflict, discrimination and migration) (*see Figure 7*).[2] Childhood and adolescence are times of rapid change in the social context, and roles and the timing and nature of exposure from the environment and immediate social context can powerfully shape mental health and well-being for children and adolescents across their lives. These risks and protective factors are cumulative across the life course and are often clustered – with children experiencing multiple adverse childhood situations (abuse, neglect, violence or dysfunction within families, peers or the community) having the highest risk of poor mental health.[2]

Figure 7. Spheres of influence on mental health and well-being



Source: Adapted from UNICEF, *The State of the World's Children 2021.*[2]

The world of the child

For young children, **healthy attachment with parents and other caregivers and nurturing, responsive care** are powerful determinants of mental health and well-being. Attachment is the emotional relationship between a child and their parents or caregivers that gives a child a sense of safety and protection and fosters the development of social and emotional skills. While attachment is crucial and evolving over the course of childhood and adolescence, it is one of the defining influences on mental health and well-being during infancy and early childhood.[2] The mental health of parents and caregivers also impacts on their capacity to provide responsive care and healthy attachment, including for adolescent parents.[19] Exposure to **violence, neglect and abuse** within families and households is also a risk factor for many mental health conditions.[20,21]

National data describing early stimulation, adequate supervision or exposure to family violence for this age group of 0–18 are limited. What is known: In a 2021 UNICEF and World Bank survey in PNG, 82.2 per cent of respondents believed physical punishment was appropriate and 40 per cent reported recently hitting their child.[22] Between 47 per cent and 74 per cent of cases presenting to the Family Support Centres for victims of domestic and family violence were children younger than 18.[23] Evidence from Haus Ruth, a domestic violence shelter in Port Moresby, indicated that of mothers who had presented as victims of abuse, 60 per cent of children had also been abused.[24]

Stakeholders also cited family violence and violent discipline as major contributors to poor mental health for children and adolescents.

> *I don't think we should make excuses for our customs and our traditions in terms of exerting physical violence on our children. A lot of people, you'll find the older generation still thinks disciplining kids by beating them up is healthy in terms of reinforcing good behaviour and doing away with some bad behaviour.* – Health representative

[Gender-based violence] contributes to mental health problems in this country more than, I think, anything else. When the father and mother have domestic violence in the family, children are traumatized. Those traumatized [children], you know, they grow up with it. In the later life, they cannot cope. The mental issue will be affecting them more. – Community development representative

A 2020 study of 162 children and youth aged 10–17 conducted in West Papuan communities in Kiunga found that 36.4 per cent of the children had experienced emotional abuse and 47 per cent had reported physical and/or sexual abuse.[25] The study assessed self-reported emotional and behavioural problems, such as somatic complaints, attention problems, aggressive behaviour, anxiety, depression, thinking problems and delinquent behaviour. Emotional and behavioural problems had a direct relationship with physical and/or sexual abuse and adverse parenting.[25]

The high rates of child sexual abuse were of particular concern among interviewed informants providing clinical and social services to survivors.

The child sexual abuse is alarming. It's increasing. I normally see one or two cases in a day. Now, it's five cases in a day. – Health representative

For older children and adolescents, **substance use and misuse** are important individual-level risk factors for poor mental health. Data describing substance use among adolescents and children are scarce. Among what is available, harmful use of alcohol has been reported to be the fourth-most common cause of morbidity in PNG, with 90 per cent of trauma admissions in hospitals related to alcohol use.[15] Adolescents are considered a particularly high risk for alcohol misuse and associated morbidity.[15]

Stakeholders also indicated that alcohol and substance use affect children as young as 7 years old and that substance use is commonly used to supress emotions.

A lot of young people tend to [get] involved in drugs and alcohol. That's a common approach that a lot of people take, like when they want to get over what they're going through. They turn to other areas like drinking. They try to get rid of what they're going through in their mind. – Youth representative

Children as young as 7–9 years are introduced to cannabis or marijuana, which is widely available in this country. This contributes towards these mental health issues for children. – Health representative

Children and adolescents with chronic illness and disability may also experience a higher burden of poor mental health. However, there are no data describing mental health outcomes or needs for children with disability.

The well-being and rights of children and adolescents with disabilities is a priority issue for NGOs and advocates.

There are many abuses that are happening to people with mental disability... No one, no one is helping them. No one is willingly to help them. No one is trying to help them. – NGO representative

Child marriage and early pregnancy are associated with poor mental health outcomes. In 2016, 27 per cent of women aged 20–24 years were married before the age of 18 and 17 per cent had commenced childbearing by the age of 18.[26] However, there are no studies describing mental health outcomes or needs among young married women or mothers.

Stakeholders cited adolescent mothers as a population at particular risk of poorer educational, social and health outcomes.

We went around to schools and found out that, especially girls in grades 7 and 8 and 6, they have not come back to school. One day they left because of COVID-19 and they became pregnant. And so, it affected…young girls when [COVID-19] happened. Many children are out of school. – Education representative

Children and adolescents living in alternative care, including residential care, are also at increased risk of poor mental health and exposure to risk factors, such as violence.[27] Accurate data on the number of children in alternative care are limited, and there are no studies available describing mental health needs of children in residential care. In 2020, the NGO Life PNG Care reported that they were providing care to 45 children (residential) and 450 non-residential children, many of whom were homeless or seeking accommodation due to violence or abuse.[28]

The world around the child

In addition to healthy parent and caregiver relationships, **peer relationships and attachment** also influence mental health and well-being, particularly during adolescence. **Exposure to bullying behaviour,[i] harassment and violence** are risk factors for poor mental health. While there are no national-level data describing loneliness or exposure to bullying, a study of West Papuan communities in 2020 found that more than half (55.6 per cent) of 10- to 17-year-olds had been exposed to peer violence, which was associated with behavioural problems and poor mental health.[25]

Stakeholders described encounters with adolescents who had experienced bullying and development mental health conditions as a result.

I've come across adolescents who have come to see me because they've developed anxiety or depression. And then when exploring it, I've discovered that bullying for some of them tends to go to the extent of like criminal activities. This is where the cult group in PNG also comes in. Sometimes in the secondary schools, they actually have a leader in the school. The leader will have a connection to someone who is out in the community who is much older.... So, somebody says, 'You do this.' Then they do it. And if not, that is when someone ends up beaten. There was one girl who just entered grade 9. In that school, the girls formed a group [with] core values. So, for this girl, one of the things they had to do was...go out drinking alcohol. For her, she did not do that, so they actually beat her up. So, she ended up developing depression and anxiety. And she had to come and see me. – Health representative

Sexual harassment, sexual violence and intimate partner violence are also important risk factors, most notably for adolescent girls. According to national survey data estimates for 2016, 42.8 per cent of married or cohabiting adolescent girls aged 15–19 years had experienced psychological, physical or sexual violence in their lifetime and around 3.4 per cent of adolescent girls aged 15–19 years had ever experienced sexual violence from a non-intimate partner.[26]

Stakeholders were acutely aware of the impacts of sexual violence on children.

We call them survivors. Survivors of sexual violence, physical violence and gender-based violence. These services are provided for all age groups, so we tend to see a lot of children and babies…even 3-month-old babies are sexually abused. These are the kinds of sexual abuses we're getting in the country. – Health representative

i. The term 'bullying' is used here because it is consistent with the survey measures referenced. However, there is an emerging approach to redefine bullying as 'unhealthy relationships or situations', with a focus on the behaviour itself, its determinants and impacts rather than on the child.

Safe and enabling learning environments profoundly influence mental health and well-being. Participation in early education and primary and secondary school are important protective factors. Available data indicated that almost one in two children (44 per cent) were not participating in organized early childhood education in 2018, and 430,000 children of primary and secondary school age were out of school.[29] Out-of-school children and adolescents were identified by stakeholders during workshops and interviews as being at particular risk of poor mental health due to poor access to school support networks, boredom and clustering of other risk factors (such as substance use, delinquency, crime and violence). Children with mental and/or physical health disorders or disability were also cited as experiencing excess risks for poor mental health in school settings, where resources to support them and their teachers are limited. Schools can also be a source of stress.

Stakeholders described the impacts of bullying in schools and the risks that school settings can pose as gateways to antisocial behaviour and pressure to engage in criminal activity. The COVID-19 pandemic has amplified school-related stress for families due to the increased pressures of remote learning coupled with social isolation, loss of peer support and the pressure of financing remote learning materials and internet data. Schools can also be a setting of violence, with corporal punishment and verbal abuse by teachers commonly reported.

The world at large

National data and published studies exploring the association of social determinants with child and adolescent mental health are limited. However, stakeholders cited several factors that are likely to influence mental health and well-being. These include poverty and economic instability (exacerbated by the COVID-19 pandemic), government inaction, limited funding, stigma and geographical barriers.

Refugees and communities exposed to conflict experience an excess burden of poor mental health in PNG. A 2018 study of 478 West Papuan refugee adults demonstrated how childhood adversities contributed to future mental health issues in this population. Childhood trauma increased the risk of any mental disorder and complex post-traumatic stress disorder in particular.[30] While published studies are lacking, stakeholders described the negative impact of tribal conflict and violence on mental health.

> *Tribal fighting is an example of where people pick up arms and go fighting over land. We're seeing a lot of children that have grown up in places where there's a lot of tribal conflicts and violence. [The children] have more or less adapted to some degree, but not in a very healthy manner. They become very vulnerable and aggressive and violent as young adults. There's a longitudinal study that's missing, where we really look at how we can tackle this with domestic information and address cultural factors. [Tribal wars] lead to a lot of domestic violence when they are adults themselves because violence has been normalized, which, as we know, is not correct and is pretty much pathological.* – Health representative

Stigma and discrimination are also important contributors to poor mental health in PNG. Deep-seated traditional beliefs about the causes of mental illness, based on supernatural agents and violations of social norms and taboos, exist.[15,31,32] Many of these beliefs lead to widespread and severe stigma and discrimination about mental health, which is a significant deterrent to help-seeking.[15]

Stakeholders shared their views on how the stigma around mental health causes barriers to treatment and care.

> *There's no proper avenue for the kids to stand up and express their feelings, express what is actually happening. They do not have that. They are not given that freedom to speak.* – NGO representative

> *Mental health is an issue where we're trying to break barriers. We want people to know that it's not a disease, it's not something where you're condemned. It is just like any other illness somebody gets.* – Health representative

One of the common barriers that I see is that [parents] stop the kids from being supported or reaching out to the suitable service providers for help.... We have this kind of status in the family; children are heard at a certain age. When the kid is a teenager or in their early twenties, then attention is given to [them]. But when the kid is at [an age], say, below 10, he or she is regarded as a kid. And parents do not listen to what the kid is telling them. – NGO representative

PNG has a rich history of **traditional healers and medicine**. According to traditional beliefs, sorcery and witchcraft are believed to be both the cause of mental or physical illness and the basis for traditional treatment.[16,32] Diagnosis and treatment are often sought from traditional healers instead of, with or in conjunction with a Western medicine trained health worker.[16] This can be another strong deterrent or complication to help-seeking.[15,32]

Stakeholders contemplated the challenges of cultural traditions and traditional medicines.

So, someone who has developed a psychological condition [would] be taken to the hospital [as] the last resort. The family would go and find a shaman and find the medicine man to look them over before they go to the hospital. And most times, when they bring people through, they're pretty much very, very unwell and very psychotic. [They] will be trying to find out who put a curse on this person...once they realize that they haven't resolved anything and the person's becoming more and more unwell, then, of course that's when they present to the emergency department. And usually with this very late presentation, that someone's completely psychotic. – Health representative

The place of traditional medicine is also quite important in how we view mental health in a holistic manner. So, there's always been conversation around trying to place it and what's appropriate for our traditional healers to make a difference. But of course, we know some of the practices are quite abhorrent at times. – Health representative

A more recent threat to mental health is the **COVID-19** pandemic.[4,33] The public health responses that limited social interactions and disrupted education and employment (along with the isolation, increased use of social media and increase in exposure to family violence and conflict) have had acute impacts on mental health. The economic uncertainties and projected socioeconomic inequalities will have more long-term implications.[5] These crises resulted in resources being diverted away from mental health services, and combined with greater need, resulted in services being more difficult to access. In a 2021 nationwide phone survey by UNICEF PNG and the World Bank, 35.1 per cent of households reported that their child was displaying increased negative behaviour. And 18.2 per cent reported that the child was crying more than usual, while others reported children being more withdrawn, quiet, defiant or aggressive than usual. Exacerbating this, 22.9 per cent of respondents reported that access to psychosocial support services had declined since the pandemic began.[22]

The COVID-19 pandemic and the associated restrictions and their affects were identified by stakeholders as a great challenge.

I think that COVID has caused a lot of our children…they've gone crazy. With the COVID, they are restricted from moving around. The children are hyperactive. They need to go out and use a lot of energy so that when they get back home, they can be able to fall asleep naturally. But when they are kept home with COVID and they are restricted, they just cannot sleep. – Health representative

COVID has driven fear into these children. – NGO representative

Responses to the mental health needs of children and adolescents

National policies, strategies and legislation

PNG is a federal constitutional monarchy. The tiers of government are illustrated in *Figure 8*. This report focuses mainly on national policies, strategies and legislation but acknowledges the importance and responsibilities of each tier of government.

FIGURE 8. PNG TIERS OF GOVERNMENT

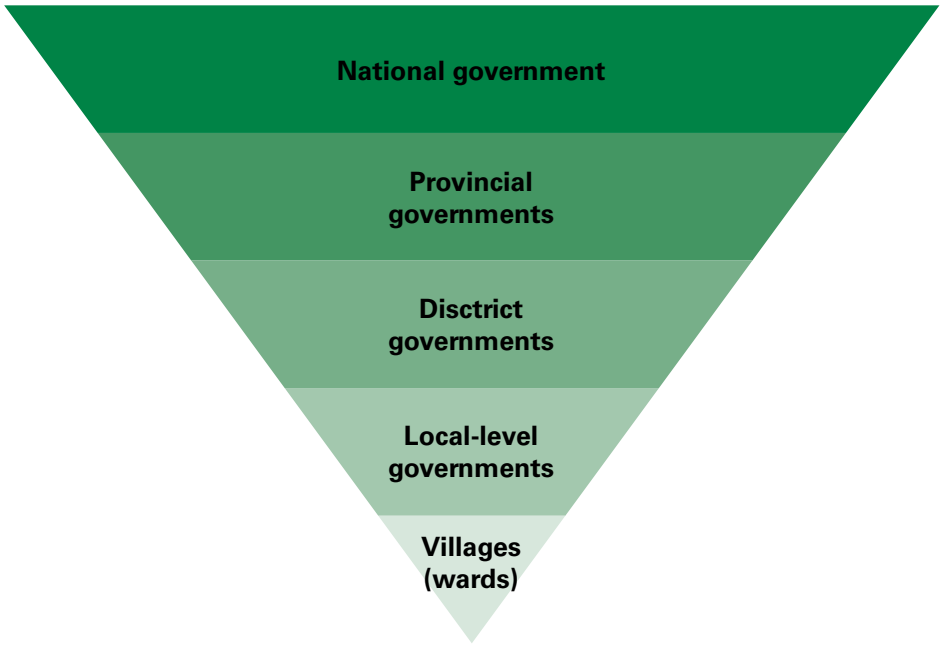


Table 2 describes the national policies and legislation relevant to MHPSS, with documents are summarized by sector.

Table 2. Summary of MHPSS-related legislation and policies

National mental health plan, policy and strategy	Overarching goal is to minimize the number of people who become ill and die from mental illnesses through programmes that provide protection and promotion of mental health and social well-being. Of 66 policy points in the document, only two items are specific to child and adolescent mental health: Section 4.7 on intersector collaboration and Section 5.2 on organization of services.	National Mental Health Policy 2011
Age of majority	18 years	Lukautim Pikinini (Child Protection) Act 2015
Age of consent to medical care	Public Health Act: 16 years Mental Health Act: 18 years	Public Health Act 1973 Mental Health Act 2015
Prohibition on physical restraint for those with acute mental illness	The Public Health Act stipulates that the Head of State may make regulations on the conditions and circumstances under which mechanical means of restraint or seclusion may be applied to patients.	Public Health Act 1973
Criminalization of suicide	A person who attempts to kill themselves is guilty of a misdemeanour. Penalty is imprisonment for a term not exceeding one year.	Criminal Code Act 1974
Mental health and education	Mental health is included as an issue in the National School Health Policy. The policy commitment to this is in statement 5 on counselling service. It contains provisions such as counselling services to be provided to all school children, referrals for any behavioural disorders or significant emotional stress and education of school children on mental health issues.	National School Health Policy 2015
Mental health and child protection	The Lukautim Pikinini Act's purpose is to protect and promote the rights and well-being of all children. It acknowledges the impacts of psychological harm on mental well-being. The PNG Development Strategic Plan outlines a youth goal of "[a] vibrant and productive youth population that has career opportunities, skills, good education, moral values and respect". But it does not explicitly refer to child and adolescent mental health.	Lukautim Pikinini (Child Protection) Act 2015 PNG Development Strategic Plan

Rights of children and adolescents	PNG ratified the United Nations Convention on the Rights of the Child in 1993. The Lukautim Pikinini (Child Protection) Act is based on the principles and provisions of the Convention, placing the best interests of the child as the paramount consideration and requiring that protective interventions prioritize community-based mechanisms over institutional alternatives.	Lukautim Pikinini (Child Protection) Act 2015
Age of sexual consent	16 years. Penalty for a perpetrator is imprisonment of up to 25 years. If a child is younger than 12 years, penalty for the perpetrator is imprisonment of up to life.	Criminal Code Act 1974
Age of consent for marriage	A male person is of marriageable age if he has attained the age of 18 years; and a female person is of marriageable age if she has attained the age of 16 years. A male person who has attained the age of 16 years but is younger than 18 or a female person who has attained the age of 14 but is younger than 16 years may apply to a judge or magistrate for an order authorizing their marriage to a particular person of marriageable age.	Marriage Act 1963
Prohibition of violence	If the person assaulted is a male child whose age does not exceed 14 years or is a female, the offender is liable to a penalty of a fine or to imprisonment.	Criminal Code Act 1974
Laws on corporal punishment	Article 278 of the Criminal Code provides for the use of force "by way of correction". It is lawful for a parent or a person in the place of a parent or for a schoolmaster or master to use, by way of correction towards a child, pupil or apprentice under their care such force as is reasonable under the circumstances.	Criminal Code Act 1974
Prohibition of recruitment to armed forces	The minimum age for voluntary recruitment is 16, with parental consent. It is not known how many persons younger than 18 are serving in the armed forces because a substantial proportion of the population does not know their date of birth.	Defence Act 1974

Minimum age of criminal responsibility	(1) A person younger than 7 years is not criminally responsible for any act or omission. (2) A person younger than 14 years is not criminally responsible for an act or omission unless it is proved that at the time of doing the act or making the omission, they had capacity to know that they ought not to do the act or make the omission.	Criminal Code Act 1974
Child labour	Minimum age for work is 16 years	Employment Act 1978
Same-sex consensual sex	Same-sex sexual activity is criminalized.	Criminal Code Act 1974

Health sector

The **National Mental Health Policy** was initiated in 2011 and a **Mental Health Secretariat** was launched to facilitate implementation.[15] Programme priorities include increasing staffing and training of psychiatric nurses, establishing psychiatric units in all provincial hospitals, establishing four regional referral and supervising units, upgrading the Laloki Psychiatric Hospital, improving intersector collaboration in forensic psychiatry, improving community knowledge and skills, expanding community mental health programmes and improving monitoring and reporting.[34] Of the 66 policy points in the National Mental Health Policy, however, there are only two items regarding child and adolescent mental health.[34]

PNG passed the **Mental Health Act** in 2015.[35] The law established a **Directorate for Social Change and Mental Health Services**, including a director, board, fund and a Mental Health Tribunal.[35] The law also addressed voluntary and involuntary patient admission, processes for treatment, discharge of patients, rights and freedoms of inpatients, protection of patients from abuse and neglect and the management of people with mental illness in the justice system.[35] However, there are no provisions regarding children or adolescents in the 24-page legislation.[35]

The **National Health Plan 2021–2030** was launched on 7 December 2021.[36] It is the governing policy document for the health sector, as mandated by the **National Health Administration Act 1997**. Mental health does not feature as a priority area in the National Health Plan. Only 2 of the 94 strategies have a mental health focus. Strategy 2.1.3 is to "collaborate with community-based organizations to provide health services such as disability, mental health and social change services". Strategy 4.2.2 is to "increase awareness on substance abuse and mental health, especially in youths and adolescents". As part of the National Health Plan, the Government commits to "building a workforce for the future". The numbers and projections provided in the document indicate that the health workforce must double in size by 2030 to meet the needs of the population. Numbers and projections for the mental health workforce are not provided. At the launch of the National Health Plan, Prime Minister the Hon. James Marape said Papua New Guineans across the length and breadth of the country should expect quality health care service delivery "within an hour's reach" of their home by 2030.

Education sector

The **Education Act 1983** (amended in 1995) outlines the national education system and the responsibilities of the national and provincial governments. The law makes no mention of mental health but does consider general health in section 91 on suspension of classes. Under the Education Act, the National Department of Education (NDOE) is responsible for national education policy and planning, developing curriculum, maintaining standards and facilitating teacher education and providing vocational training. The Provincial Divisions of Education (PDOEs) are responsible for the administration of elementary, primary, secondary and vocational education. Local-level government responsibilities include the establishment and operation of elementary schools.[37]

Mental health is emphasized in the **National School Health Policy 2015**, as 1 of 12 main policy statements. Policy statement 5 on counselling service includes provisions for all school children, referrals for any behavioural disorders or significant emotional stress and education of school children on mental health issues.[38] It is unclear how far this policy has been implemented.

The **National Education Plan 2015–2019** centred on equity and access, with a clear aim of providing everyone in the country, regardless of their ability, gender or socioeconomic background, an opportunity to be educated.[39] Provinces were responsible for implementing the National Education Plan's strategies, using the framework and reporting progress. Acquiring skills for a "happy and healthy life" was a theme throughout the document. There were two MHPSS strategies: strategy 18 involved providing specialized training for teachers on guidance, counselling and behaviour management and strategy 47 involved strengthening and supporting behaviour management systems by establishing school-based counsellors in each school.[39] The deadline provided in the document for these strategies was 2019. It is unclear to what extent they were implemented, with stakeholders indicating that little progress has been made.

The **National Education Plan 2020–2029**[40] has a similar overarching goal, with new major outcomes, minor outcomes and activities. Focus area 7 on leadership and partnership states that approximately 1,200 school-based counsellors have been trained but acknowledges that not all schools have counsellors. Activity 7.5.2 is "to train school-based counsellors". The Guidance and Counselling Division of the NDOE is responsible for this activity. This training is ongoing and is supported by UNICEF, ChildFund, Save the Children, World Vision and other NGOs. Issues remain with funding ongoing in-service training and employing trained counsellors in schools.

A 2009 PNG Department of Education guide for teachers, ***Behaviour Management Policy: A Guide for Schools,*** indicates a commitment to child protection. There are extensive sections explaining that corporal punishment is unacceptable and detailed guidelines on how to prevent and respond to bullying. However, it is unclear how well these guidelines are monitored or enforced.[41]

In October 2020, the NDOE launched the country's **COVID-19 Education Emergency Response and Recovery Plan** to help sustain learning and inclusion during and after the COVID-19 pandemic. The Response and Recovery Plan was developed by the NDOE with support from Education Cluster members, including Save the Children, UNICEF, CARE International, ChildFund, the Government of Australia, UNESCO and World Vision International. Its budget is 76,297,224 PNG kina (US$22,440,360). A rapid assessment of the COVID-19 situation in the national education system found that the majority of schools were facing significant barriers to delivering remote learning, including limited access for students in the home to basic learning materials, electricity and technology, such as radio, phones, television or internet.[37] Students faced other critical challenges during the crisis, including access to information on COVID-19, lack of supervision by caregivers, safety and protection issues and access to water and sanitation.[37]

The Response and Recovery Plan details actions and sustainable initiatives to address challenges that the education system has faced since the school closures in March 2020 that disrupted the education of almost 2.4 million students across the country due to COVID-19. Across all phases of the plan, there are several strategies to ensure that the most marginalized children, including children with disabilities, struggling learners, displaced children, children in the most rural hard-to-reach and poorest communities and girls tasked with caring for family members, are re-engaged via the plan.[37]

Social welfare sector

The **Lukautim Pikinini (Child Welfare) Act 2015** is the national child protection law. Its objective is to protect and promote the rights and well-being of all children and to protect children from all forms of violence, abuse, neglect, exploitation and discrimination, with a clear focus on services for prevention and family strengthening. The law legislates the responsibility of parents to fulfil the basic rights of children, including equal access to school, and removes previously legislated discrimination against children born outside of marriage.

The **National Child Protection Policy 2017–2027** provides the overall framework for the formulation and enforcement of the Lukautim Pikinini Act. It also provides direction and guidance for a coordinated approach to promoting and protecting the rights and well-being of all children in PNG.[42] The document acknowledges the vulnerabilities of children with physical and mental disabilities as well as other at-risk groups in the population (such as children exposed to violence, street children and children in contact with the law) and makes policy recommendations to ensure their safety. It also includes the need to provide psychological first aid for children engaged in the child protection system.

The **National Office of Child and Family Services** is responsible for protecting the rights of children and welfare issues of families through the provision of services by implementing the Lukautim Pikinini Act and the National Child Protection Policy as well as the relevant international conventions and other national legislation and policies. The Office sits within the **Department for Community Development and Religion** (DFCDR) and works in partnership with development partners, other government agencies and external stakeholders.[43]

Other overarching national development government policies include the **PNG Development Strategic Plan 2010–2030** and **Vision 2050 for PNG to "be a Smart, Wise, Fair, Healthy and Happy Society by 2050"**. Although health strategies are included in the former, mental health is not designated as a strategic area. The latter document does not refer to mental health at all.

The purpose of the **National Youth Policy 2020–2030** is to, first, address issues regarding the psychophysical, intellectual, cultural and spiritual development of young people in different stages of their life and, second, to attend to the issues arising from the prolonged period of transition from a dependent stable condition in a family to finding employment and

setting up an independent household. Under section 3.4 on health, sports and culture, one of the strategies refers to promoting healthy lifestyles, including mental health care.[44] There are no other references to mental health in the document.

The social, emotional and physical costs of domestic and gender-based violence in PNG are widely recognized, as are the national economic costs. The **Papua New Guinea National Strategy to Prevent and Respond to Gender-Based Violence 2016–2025** is the Government's road map to achieving zero-tolerance on the violence through policies, legislative reforms and programmes.[45] Many programmes and services have been established to respond to the endemic problem and also respond indirectly to the mental health needs of child and adolescent survivors.

Justice sector

The **Lukautim Pikinini Act** legislates the powers of child protection officers and volunteers and institutes procedures for reporting and the investigation of child abuse, removal of a child, approach to a child in immediate danger or after abandonment, family court proceedings, organizing temporary or permanent custody, licensing and inspection of child-care centres and child-friendly practices in prisons and police custody.[46] It criminalizes child labour, child marriage, harmful customary practices and the sale of children. There are also mandatory reporting obligations on professionals who engage with children and adolescents, with civil penalties for failure to report abuses.[46] Alongside the passing of the law, the Government committed to the recruitment, training and deployment of 300 new child protection officers and volunteers.[47] It was not possible to determine whether this commitment had been fulfilled. In 2013, the Parliament passed the **Family Protection Act** (amended in 2021), which explicitly defines domestic violence as a criminal offence.[23]

The **Juvenile Justice Act 2014 i**ncludes a focus on diversion for juvenile offenders and on supporting the role of the family unit to support rehabilitation and reintegration. There are some protections with respect to minimizing psychological harm during arrest or justice processes and an option to provide counselling as part of diversion, but there are no requirements to provide mental health assessment or services.

The **Criminal Code Act 1974** establishes crimes, misdemeanours and offences and the penalties they incur. The law does not mention mental health but has provisions to protect children from rape, sexual offences, violence, corporal punishment and infanticide and removes criminal responsibility for children younger than 7 years.

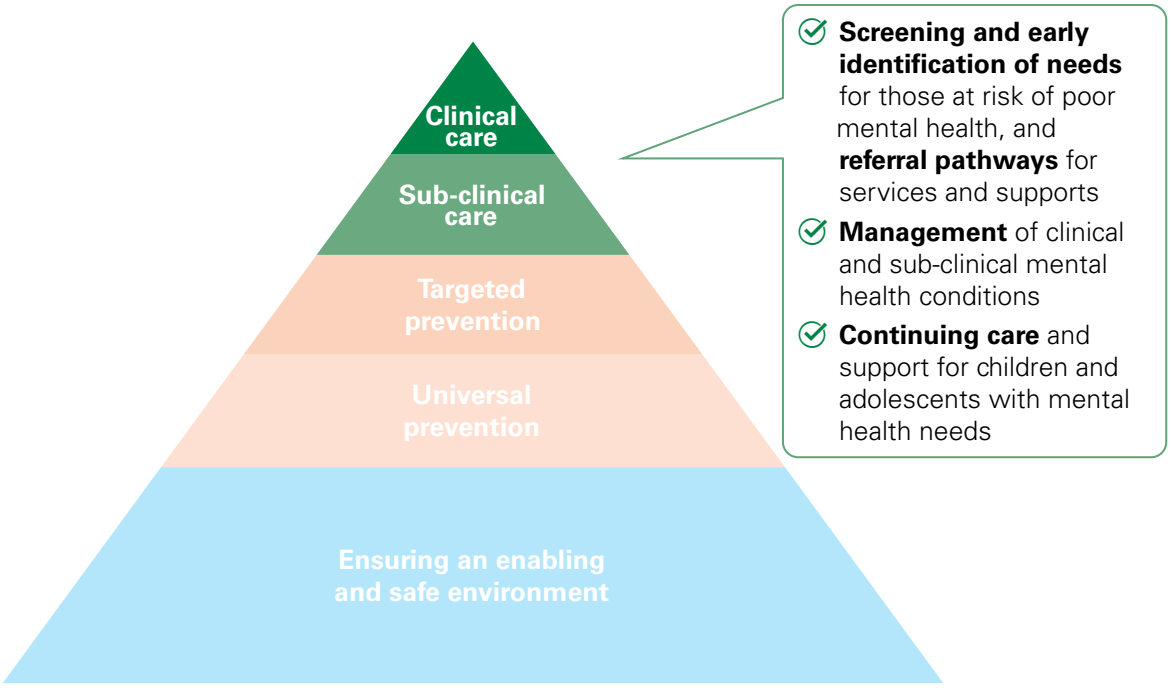
Stakeholders shared information about the **Protocol for Child Victims and Witnesses**, which UNICEF and the Royal Papua New Guinea Constabulary are drafting to provide police officers with a protocol for reporting and referring children who come in contact with the law. The Protocol articulates the statutory and non-statutory responsibilities of the Constabulary and other partner agencies. MHPSS is being considered in the drafting to ensure that quality assistance is provided to children in conflict with the law or child victims and witnesses.

Current programmes and approaches to address child and adolescent mental health and psychosocial well-being

In rural areas, where 70 per cent of households have no water supply and 69 per cent have no electricity, mental health care is provided by generalist health care workers in public and private facilities.[16] These facilities include health centres, health subcentres and rural aid posts. Rural aid posts are limited, however.[48] The generalist health care staff provide a range of services, including assessing and referring mental health presentations.[48] Most have had minimal exposure to mental health in their training, so care provision is spotty.[15,31,32]

For severe mental disorders, specialist care is provided in tertiary and secondary hospitals. The National Department of Health (NDOH) oversees the Port Moresby General Hospital acute inpatient psychiatric unit and Laloki Psychiatric Hospital for complex or long-term cases. Sixteen other provincial hospitals admit psychiatric patients as part of their general medical unit provision. Some of these units have mental health nurses available, but almost none have a permanent medical psychiatry staff.[15] Thirteen provincial hospitals provide specialized outpatient mental health services with mental health nurses, but capacity is limited.[15]

FIGURE 9. RESPONSIVE CARE FOR CHILDREN AND ADOLESCENTS WITH MENTAL HEALTH CONDITIONS



Specialist mental health services for children and adolescents are limited. The Port Moresby General Hospital and the Laloki Psychiatric Hospital are frequently congested. Bed occupancy at Laloki Psychiatric Hospital at times exceeds 150 per cent, with several patients sleeping on the floor.[49] Forensic and non-forensic patients are also mixed in the hospital,[15] representing a potential risk to vulnerable patients, particularly children and adolescents.

> *Because Papua New Guinea is a developing country, we do not really have a lot of facilities or centres that assist people that are currently experiencing mental health issues.* – Youth representative

Screening and early identification of mental health needs

National mechanisms for screening and early identification of mental health needs are not well established. There are limited age-appropriate and validated screening tools for common mental disorders or risk factors and limited tools to support early identification (including in non-health settings). Limited numbers of trained mental health providers in general and limited number of providers (including non-health) trained in the use of screening and other tools are also challenges. Low mental health literacy contributes to low care-seeking behaviour by parents, caregivers, children and adolescents. Stakeholders within the health sector described the emphasis on specialist, clinical care for severe disorders contributing to limited focus on other services, such as screening and prevention.

> *We don't have child counsellors; we don't have case managers or trauma counsellors or social workers…we need to integrate that or establish or develop that within the health structure. So that the social work gets prominence in terms of reaching out to the community and to the other [sectors for] multisectoral support. Because right now we are focused on the clinical services.* – Health representative

Within the **health sector**, some public hospitals, including the Laloki Psychiatric Hospital, have teams that conduct outreach programmes throughout the provinces. Outreach teams provide some screening, health promotion and limited treatment in the communities they visit. However, these programmes face significant funding and logistical challenges. Health centres, health subcentres and rural aid posts throughout the provinces also have varying ability to screen for mental health needs. It is unclear if rural health care workers use validated tools to screen for mental health conditions.

Within **child protection,** the Family Support Centres provide dedicated safe spaces for women and children experiencing violence to seek treatment, counselling and legal advice.[23] These centres are generally able to screen for mental health needs and refer cases needing psychiatric care to a hospital. There are currently no formal approaches or mechanisms to support early identification or screening through schools or through the justice sector for children and adolescents in conflict with the law or those who are victims or witnesses.

The **DisAbility Coalition** is a not-for-profit organization that advocates for and supports people living with a disability. The DisAbility Coalition operates a screening programme in mainstream schools to identify children with intellectual and learning disabilities. Officers from the DisAbility Coalition then help the school to devise an individual education plan for these students. This is developed with support from a medical officer and schoolteachers and includes the parents.

The Australian Government provides funding through the Callan Services National Unit to help children and adults living with disabilities, including providing training and qualifications in special education for teachers.

It was not possible to find any other screening or early identification programmes operating in the health, education, social welfare or justice sectors.

> *Nothing. Nothing at all [in terms of early identification of mental health issues in children]. So, for our patients, we only get the referrals from the hospital or from other health services outside. I believe there's more to be done.* – Health representative

> *We adults better start listening, having that, you know, time for our children will help us to identify at that early age, for us to help them.* – NGO representative

> *I am just speaking as the former teacher – like I didn't know what to do, where to send the kids.* – NGO representative

Referral pathways

Similar to screening and early identification, referral pathways for responsive care are poorly established. Within the **health sector**, generalist health care staff can refer children and adolescents with mental health conditions to provincial hospitals or, for severe disorders, to psychiatric hospitals in Port Moresby. In rural and remote areas, if a child or adolescent is assessed as needing mental health care, rural health care workers can use their mobile phone (if they have a network and data) to seek help from psychiatric staff in Port Moresby. Rural health care workers will try to treat children and adolescents at the district level, but if the required treatment is beyond what can be provided, transfer to Port Moresby is necessary.

In **school settings**, challenges exist for teachers referring children with mental health needs to appropriate services because of misperceptions that mental health is an issue for the family to deal with.[39] As part of the National Education Plan 2015–2019, school-based counsellors are supposed to be available in every school (strategy 47),[39] but stakeholders reported that this has not been achieved.

Within the **justice sector**, there are no clear mechanisms for referral to mental health services. Stakeholders revealed that the only process in place for a juvenile in the justice system to access psychiatric care is via a court order. This process was described as complex and time-consuming. The Constabulary is developing protocols for providing protection services and child-friendly spaces and referring children who come in contact with the law.[42]

Referral systems for child and adolescent health were cited by stakeholders as a priority for improving access to care.

> *According to my understanding, there are no referral pathways and if there is, then only the hospital...there is no awareness and there is no clarification. The community as a whole wouldn't know where to get help from.* – NGO representative

> *There's no proper referral pathway to us. You have to find out for yourself how to get to the clinic.* – Health representative

> *In terms of the referral pathway, I would be very, very sceptical as to what happens when the children and the adolescents are picked up [due to having a mental illness]. Where do they go in the provinces? If they're in Moresby, of course, they would have access to the hospital. But then also it depends on the parents and the remoteness of the place and whether they actually access these services at all.* – Health representative

> *There is nobody in the school who has this knowledge about who can help the children, to refer them.… Teachers wouldn't have that knowledge about who is there, who can help. They might send them to the hospital. But they don't have units for mental health information. So, where do they go? They go to a welfare office? Child protection officer? But it depends. We don't have resources to support them there. And so, the teacher is lost. The teacher only calls the parents or sends [the children] home so that the parents can help them.* – Education representative

Management of mental health conditions and continuing care

Clinical management of mental health conditions is largely provided through the **health sector**. Scarce mental health funding, human resources, infrastructure, stigma, taboos and other barriers to access inhibit the clinical management of mental health conditions. Child-, adolescent- and family-friendly services providing confidential care (particularly in rural areas) are extremely limited.

> *There is not a friendly mental health service for the person to access.... That is one of our greatest needs. We don't have this service, where you don't want anybody else, your school mates, your family to know that you are experiencing mental health issues. You just want to go and get the professional help. You look right, left, centre, and there is no recovery centre, there is no rehabilitation place, there is no friendly mental health service around….* – Health representative

Between 18 and 21 district government hospitals offer psychiatric admission,[15,50] although some of these facilities are run by non-medical health workers.[50] According to the 2014 WHO *Mental Health Atlas,* there was a total of 110 inpatient beds for psychiatric patients in the country that year.[51] It is unknown how much inpatient psychiatric care is utilized by children and adolescents. For specialist outpatient management, as of 2013, Port Moresby General Hospital had a weekly clinic for children with complex psychiatric presentations, managed by the country's only psychiatrist with child and adolescent psychiatry training.[50] Thirteen of the 21 provincial government hospitals offer outpatient clinics run by trained mental health nurses.[15] It is unclear if these cater to child and adolescent patients. The PNG National Health Policy 2010 reports that there are child and adolescent mental health services available,[34] but further details on these programmes are lacking.

Otherwise, mental health care is delivered as outpatient care in rural communities by general health care workers, including community health workers, health extension officers and nursing officers.[16] Care is delivered out of health centres, health subcentres or rural aid posts.[52] Most of these health care workers are funded by provincial governments, although some are funded by churches, mining companies and NGOs.[52] The **faith-based sector** has contributed significant resources and made considerable progress towards improving MHPSS and responsive care. Stakeholders discussed various health care and social welfare services provided by churches and NGOs. Access to mental health training is limited for these staff, and there is no evidence of any child and adolescent mental health training among them.[15,16]

Within the **child protection** sector, the Family Support Centres provide some responsive care for children who have been exposed to violence, including psychological first aid. In 2016, around half (47–64 per cent) of all cases of violence presenting to Family Support Centres were children.23 The first Family Support Centre was established at Lae Hospital in 2013. By 2015, there were 15 centres in 13 provinces, based at hospitals. Organizations such as UNICEF and Soroptimists International have been critical partners and supporters of these facilities. The services for domestic and family violence victim-survivors vary but can include psychological support and links for legal support and social protection, as well as medical first aid and other health care. Family Support Centres staff are not required to be registered as health professionals, and the training they undergo is unregulated.

Management of mental health in **school settings** varies. The PNG National Education System has seen considerable growth in the past 40 years. There are 66,789 teachers, 2,328,062 students in 9,400 elementary schools, 4,056 primary schools, 299 secondary and high schools, 148 vocational schools, 22 Flexible Open Distance Education Centres and 22 Inclusive Education Resource Centres.[53] The tertiary subsector consists of 16 colleges and six universities. In 2020, there were approximately 75,600 students in at least 1,128 early childhood education centres across the country.[37] Mental health training among teachers is low, and there are few accessible guidelines or policies available to support MHPSS implementation in schools. Stakeholders described how many teachers perceive mental health as a family issue. Because of this, they are reluctant to interfere with children who appear to have poor mental health, out of fear of being chastised. Although part of the **National Education Plan 2015–2019** was to establish school-based counsellors in every school, stakeholders indicated that little progress has been made on this goal.

> *The education department needs to have teachers who are trained in counselling. Or we [should] have counsellors within the schools so that they can be able to identify children who need help. And that is where they can manage them or refer them to a psychiatrist or mental health establishment.* – Health representative

> *The common approach that the teachers [have] is like, oh no it's the parents' [responsibility]. And if, say, they speak to a parent, they were seen as like, minding their business because it was a family problem. So, most of the children that come from broken home families are the main ones that are mainly affected with mental health. And that affects their learning.* – NGO representative

> *Most [teachers] do not have an idea about what psychosocial support is. Because they were never trained at teachers' college. So that's what we are lacking in PNG.* – Education representative

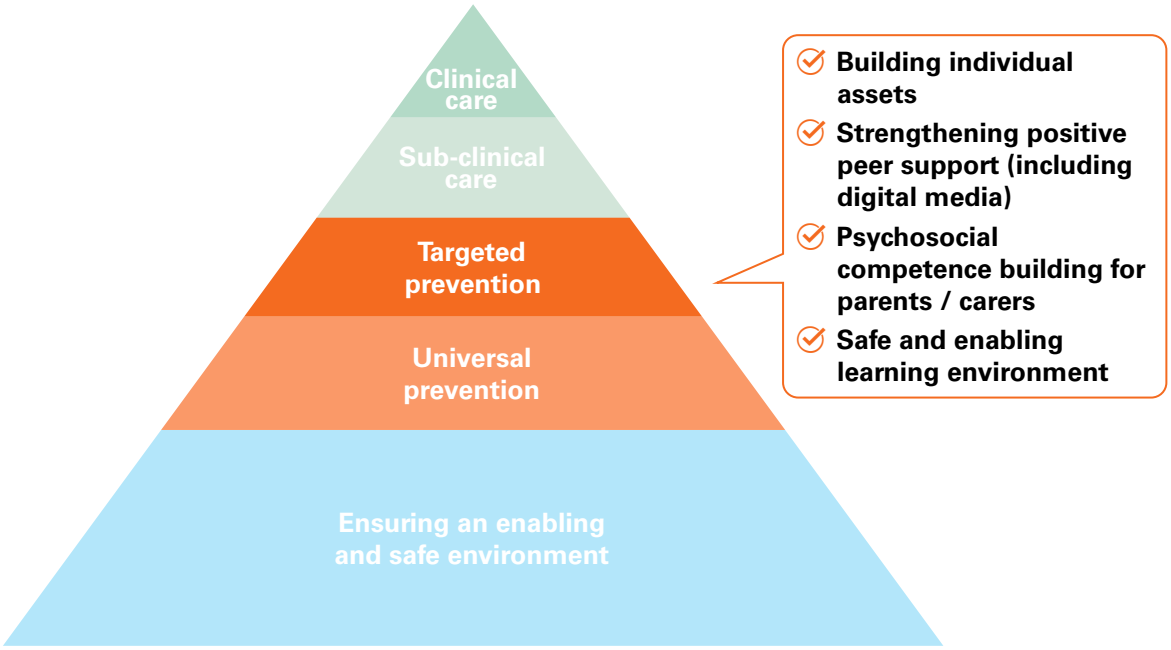
Phase 3 of the COVID-19 Education Emergency Response and Recovery Plan prioritizes student and teacher safety and well-being. This includes provision of mental health and psychosocial support to students and their families. Outcome 3.1 is to ensure that students and teachers receive timely psychosocial support from guidance officers and school inspectors to manage stress, anxiety, gender-based violence and gender inequalities. Activities associated with this outcome were allocated slightly more than 3 million kina in the 2020 budget.[37] Five target provinces (National Capital District, Madang, Morobe, Sandaun and Western) were chosen for initial activities. Psychosocial support and well-being training has been conducted with more than 90 inspectors, guidance officers, school-based counsellors and volunteers across the districts. These participants conducted training at the school level for teachers that ended in April 2022. Evaluation of the training programme, including an end line survey, was conducted in May 2022.

There are no child and adolescent mental health services provided within the **justice sector**. PNG Correctional Services statistics for 2017 indicated that 49 per cent of all juvenile inmates are detained at pre-trial stage, often with adults and rarely with adequate access to legal or medical support or independent and transparent oversight of their treatment.[42] The Constabulary is working with UNICEF to establish child-friendly spaces in police facilities, provide protection services for children who come into contact with the law and develop and maintain protocols and guidelines for sectors in managing children who come into contact with the law. Children who are identified as having a severe mental health disorder, behavioural problem or suicidal ideation are referred to specialist health care.

There are also some aspects of responsive care provided by **United Nations agencies and NGOs**. For example, ChildFund operates a 24/7 helpline (1-Tok Kaunselin Helpim Lain (715–08000)) for anyone experiencing sexual and gender-based violence.[6] The helpline is the only national telephone counselling support service. It is toll free and is staffed with counsellors. Funding for the helpline has come from ChildFund, the Consultative Implementation and Monitoring Council, the New Zealand Aid Programme, St John of God Ambulance, UNICEF and UN Women.[54] In 2020, UNICEF and ChildFund delivered case management and psychosocial support services to more than 500 children affected by the COVID-19 crisis via the helpline.[6] UNICEF has supported the provision of mental health services for children and young people affected by disaster. During natural disaster periods in Southern Highlands and Hela provinces, UNICEF delivered psychosocial support activities to more than 5,000 children through 26 child-friendly spaces.[55] Headstret, a private counselling agency, was recently established in Port Moresby to primarily provide counselling services to the private sector. In addition, the owner provides advocacy and mental health awareness services as a not-for-profit endeavour. The Facebook page Mental Health Awareness for the People of Papua New Guinea has almost 4,000 followers and is an avenue for sharing simple mental health awareness and educational messages.

While not specific to children and adolescents, the International Committee of the Red Cross has been providing a joint MHPSS and health programme to help Papua New Guineans affected by armed conflict and tribal conflict. The programme has facilitated more than 10 cycles of support group sessions for more than 340 participants and trained a total of 33 facilitators in support group techniques.[56] The group sessions provide emotional and psychosocial support to women who are living with high levels of stress. They cover violence, sexual violence and tribal conflict and its consequences and assist women in identifying stressors and signs of stress. The knowledge gained in these sessions can help the women learn how to better support themselves and others in dealing with adversity and promoting positive coping.[56]

FIGURE 10. PREVENTION OF MENTAL HEALTH CONDITIONS IN THE IMMEDIATE SOCIAL CONTEXT



Actions to prevent poor mental health by addressing risk factors and enhancing protective factors are critical. For children and adolescents, this requires a focus on factors related to where they live, grow, learn and socialize, with parents and caregivers, peers and learning environments a high priority. Interventions to improve mental health literacy and prevent mental health disorders in children and adolescents are limited. According to the 2014 WHO *Mental Health Atlas*, there were no functioning national mental health promotion or prevention programmes in PNG and no suicide prevention strategy.[51]

Building individual assets

The NDOE provides a syllabus for core subjects to be taught in all schools. A health syllabus is part of the curriculum for lower-primary school classrooms and a personal development syllabus is part of the curriculum for upper-primary, lower-secondary and upper-secondary school classrooms.[57] Mental health is considered broadly in these documents, but they do not include content or learning outcomes directly relevant to MHPSS. Christian values education is also taught in schools and provides the opportunity for teachers to discuss mental health and well-being with their students. But stakeholders involved in this study believed that the mental health content is not taught in practice.

There have been some initiatives to support social and emotional learning in response to the COVID-19 pandemic. To help children and families cope with the stresses of the pandemic, the storybook *My Hero is You* was translated into Tok Pisin for families. A radio version of the storybook was also broadcast. UNICEF provided training for teachers and social workers in schools to deliver messages on mental health to students.[6] ChildFund and the Young Women's Christian Association trained youth leaders and teachers to implement and deliver sessions on healthy relationships, alcohol and gender-based violence to adolescents.[47] A search for external evaluations of the impact of these programmes came up empty.

As part of the Education Emergency Response and Recovery Plan, officers from the NDOE have worked with researchers from Griffith University in Australia to develop and trial emotion identification tools in schools. The tools display a set of faces with different emotions so students can choose the face that aligns with how they feel. Learning to identify and express feelings in a positive way helps children to develop the skills they need to manage them effectively. The goal of deploying this tool is to help teachers screen student well-being and provide counselling as necessary to children who need support. The trial has not been evaluated yet.

A 2013 WHO report described a programme by the NDOH and an NGO called the Foundation for People and Community Development. As part of the programme, the Youth and Mental Health Project was developed to help young people prevent mental health issues through empowerment and self-employment.[47] No information on whether this project is ongoing could be found. And there is little evidence of school-based programmes to improve mental health literacy or provide mental health support.

The National Child Protection Policy includes priority interventions to provide children and adolescents with life skills to "manage protection risks", although there is no other detail about what these interventions include or the extent to which they are being implemented.[42]

Strengthening positive peer support

There are no national programmes to address healthy peer relationships or increase peer support with respect to mental health. However, there is a long-standing history of peer education and youth groups to support other health needs (such as HIV and sexual and reproductive health), which may serve as a model for increasing peer support for mental health. Recent initiatives include programmes delivered by the University of PNG with support from the United Nations Population Fund and Marie Stopes International, focused on sexual and reproductive health. The NDOE are collaborating with ChildFund to revive the peer education programme and roll it out across the country. Stakeholders revealed that 34 participants had been recruited to be trained in peer education, and it is hoped that this will expand further.

Young people listen to young people. So, we want peer education to be a programme revived in our schools in our country…the way to go is to train young people who can talk to young people. And we are trying that out in school systems so that we can capture that population within the school. – Education representative

Stakeholders also described examples of churches and faith-based organizations providing activities to support positive peer engagement through social and sporting events and youth programmes. In the Eastern Highlands, church groups have organized large conventions for youth to gather and talk about their spiritual work. A convention involves activities for children and adolescents and presentations from mentors. Organizers recently tried to arrange for a mental health nurse or counsellor to attend and lead discussions on youth mental health and well-being. This was raised as a priority for the young people in attendance.

Psychosocial competence-building for parents and caregivers

Although there is no nationwide programme to support positive parenting and caregiving, the National Child Protection Policy outlines a strategic priority focused on supporting parents, caregivers and families (priority 5.1).[42] Associated activities include establishing national parenting resource centres for parenting education, resources and helplines and identifying and strengthening existing community-based child protection mechanisms, such as community learning and development centres to support families in their parenting role. It also defines a role for the NDOH to integrate parenting support and programmes into antenatal care and immunization programmes.

There are examples of parenting programmes that have been developed and piloted in PNG. For instance, the Parenting for Child Development is a group programme that was created to support positive parenting and reduce child maltreatment and violence against children. The Menzies School of Health Research supported its development and piloting of the programme, which found that parents could identify messages and themes from the programme and were able to link these convincingly to comments about their own family situations.[58] Findings of the quantitative analysis suggested that the programme is a promising vehicle for the education of parents on child development, particularly children's social-emotional and behavioural development and in parenting, with the potential to lead to changes in parenting practices of significance for child and family well-being.[58] Further evaluation conducted by UNICEF in 2021 demonstrated that the programme achieved most of its objectives by improving parents' knowledge and skills, which had led to the reduction of violence, abuse and neglect of children.[59] The programme is entirely dependent on UNICEF financing. Thus, collaboration and integration with government agencies and their programmes will be important for the sustainability of Parenting for Child Development.

NGOs have conducted several activities to support mental health prevention for children and young people in recent years. In 2020, UNICEF worked directly with caregivers in 6,500 vulnerable families to provide tips on self-care and parental support. Social media was used to deliver good parenting tips, reaching 39,000 parents in 2020.[6]

Safe and enabling learning environments

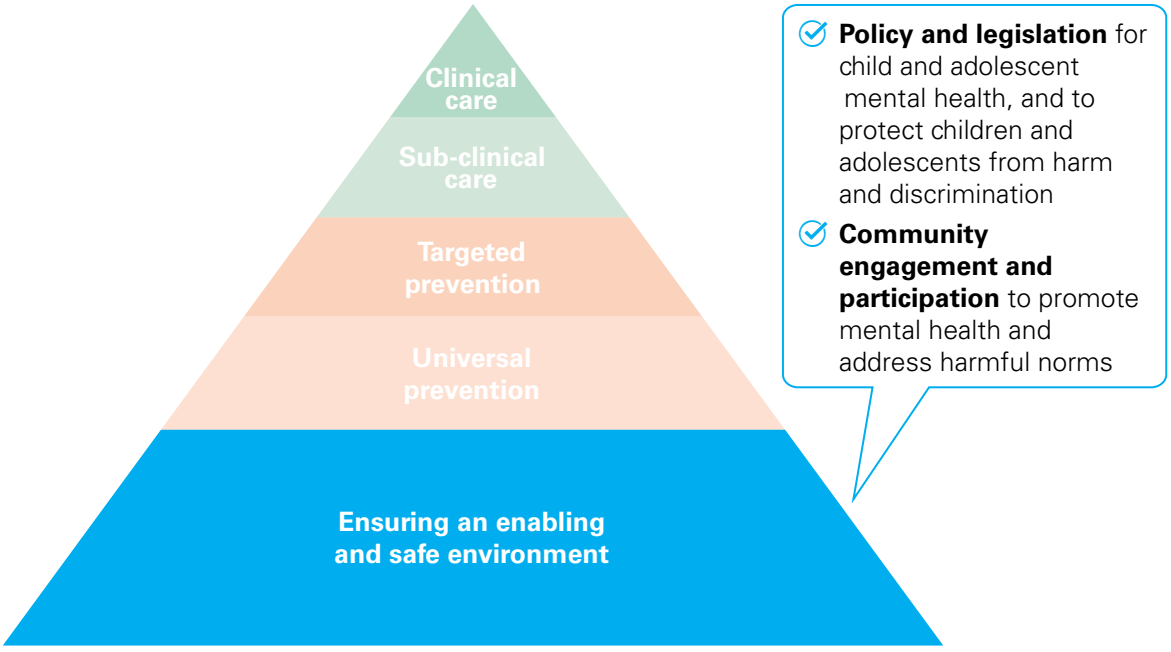
Mental health is included in the National School Health Policy. The commitment to MHPSS is found in policy statement 5 on counselling service. Included are counselling services to be provided to all school children, referrals for any behavioural disorders or significant emotional stress and education of school children about mental health issues. As previously described, mental health is also included in the health curriculum to be delivered in schools. The NDOE has provided a guide for schools to address corporal punishment and prevent and respond to bullying behaviour.[41] However, as noted by stakeholders, implementation of the mental health components of the School Health Policy is limited due to lack of resources, training and other support for teachers and education-based staff. There is no whole-of-education policy or examples of programmes to supporting mental health and well-being in schools that provide a comprehensive approach to ensuring inclusive, respectful and non-violent learning environments.

The National Child Protection Policy also outlines priorities to ensure that children and adolescents are connected, supported and not subject to harmful experiences. These include introducing a Child-Friendly School programme aimed at preventing children's exposure to crime and violence and promoting positive values; supporting the Safe School campaign to help children address different aspects of sexual, emotional and physical violence, including bullying among peers, violence in relationships, school fights and online bullying; establishing child-friendly counselling services for children in all schools; and providing training to staff members and teachers on the prevention and protection of children from violence in schools.[42]

Targeted interventions for children and adolescents at high risk

There are limited examples in the published literature or from the stakeholder interviews concerning programmes and interventions to address specific risk factors or exposures. A major focus of the existing policies is on actions to **prevent and respond to child abuse, violence, exploitation and neglect** because these children and adolescents are at excess risk of poor mental health. The National Child Protection Policy[42] defines a system that should provide targeted interventions to families and children vulnerable to violence and abuse and tertiary or specialized support for those who are victims of serious abuse or neglect, in addition to universal interventions (such as the parenting programmes described previously). These actions include supporting early detection of violence or other risks, referral for services and case management. The policy also outlines the need for a child-friendly helpline to report violence and seek support and for improving the capacity of responsive Family Support Centres and Police Sexual Violence Units to address and prevent violence and abuse. The national policy also prioritizes establishing diversion programmes and vocational skills training for children in conflict with the law.

FIGURE 11. ENSURING A SAFE AND ENABLING ENVIRONMENT TO PROMOTE GOOD MENTAL HEALTH



PNG has policies and legislation for MHPSS as well as legislation to protect children from harm (described previously), which are required to support safe environments for well-being. However, child and adolescent mental health has received relatively limited national attention, and to date, there have been few national programmes or campaigns to improve mental health awareness or address stigma.

There are examples of initiatives to address broader determinants, most notably to prevent family and gender-based violence. The joint WHO–UNICEF initiative INSPIRE includes a technical package of seven strategies to end violence against children, including by addressing norms and values, creating safe environments and implementation and enforcement of legislation to protect children. PNG became the 33rd country to join the partnership in 2021. Other examples include UN Women activities to advocate for legislative and constitutional reforms to ensure women's fair access to governance, including providing political leadership training and mentorship to young women aspiring for political posts. UN Women also creates public awareness of the causes and consequences of gender-based violence and provides technical support to the Government to amend, develop and pass national plans and policies on violence against women, gender equality and women's empowerment. The **Spotlight Initiative** is a United Nations programme funded by the European Union that aims to eliminate all forms of violence against women and girls. The Spotlight Initiative engages in a range of activities, including advocating to government, providing technical assistance to promote laws and policies that prevent violence and discrimination and promoting gender-equitable social norms and behaviours by mobilizing communities and providing education. Stakeholders noted that these initiatives were important opportunities to support child and adolescent mental health and well-being and potential entry points to explicitly integrate MHPSS into programmes focused on prevention of violence that already have government support.

A priority package of MHPSS actions for children and adolescents

The package of priority MHPSS actions were defined during the development of the regional conceptual framework in the initial phase of this project. As described previously, these actions were assembled after a review of existing frameworks, guidance, evidence and expert consensus and then reviewed, refined and prioritized during consultation workshops, an online prioritization tool and through informant interviews. *Table 3* describes the package of MHPSS actions.

Table 3. Package of priority MHPSS actions for children and adolescents

Accessible and responsive services for mental health conditions	
Screening and early identification of needs	
DOMAIN	**ACTION**
Early identification of mental health conditions and risks	Train and sensitize providers engaged in child and adolescent health, development and welfare to identify, support and refer children and adolescents with mental health needs (for example, nutrition actors, teachers, school-based counsellors, social welfare workers, justice-sector workers)
	Train and sensitize front-line and community-based health workers to identify, support and refer children and adolescents with mental health needs
Screening children and adolescents at higher risk for poor mental health	Strengthen screening of children and adolescents with high-risk behaviours (such as substance use) in clinical, school, child protection and justice settings
	Strengthen screening of children and adolescents with high-risk exposure (such as family violence, sexual violence, family separation) clinical, school, child protection and justice settings
	Strengthen screening of pregnant and post-partum adolescent girls through antenatal and postnatal services
Strong referral pathways	Establish referral criteria and mechanisms both within the health system and from other sectors or settings (schools, social welfare, child protection, justice)
	Strengthen self-referral through helplines, hotlines and online
	Integrate mental health responses into primary health care and physical health services
Management of clinical and sub-clinical mental health conditions	
DOMAIN	**ACTION**
Accessible and inclusive mental health services	Establish child-, adolescent- and family-friendly services that are inclusive
	Deliver community-based and mobile services, including for underserved children and adolescents (and their families)
Responsive care for sub-clinical conditions	Establish child and adolescent specialist support, case management and therapy provided by multidisciplinary team
	Establish specialized services and support to families of children with complex behaviours and needs in social welfare, child protection and justice settings
Responsive care for mental disorders	Establish specialist clinical child and adolescent mental health treatment and care (including hospital-based care)
	Provide child and adolescent mental health residential rehabilitation services

Continuing care	
DOMAIN	**ACTION**
Continuing care for those with mental health conditions	Provide person-centred care that includes social support, peer support and mental health professionals to support recovery and rehabilitation
	Ensure ongoing participation in education for those with mental health conditions
	Provide education and support for parents of children and adolescents with mental health conditions
Prevention of mental health conditions in the immediate social context	
Build individual assets of children and adolescents	
DOMAIN	**ACTION**
Social and emotional learning, resilience, and problem-solving skills	Implement universal interventions and approaches in early education, schools and out-of-school settings that focus on social and emotional learning; positive behaviours; social connectedness; effective problem-solving; help-seeking behaviour; digital literacy; mental health literacy; and common risk factors for poor mental health
Targeted interventions for children and adolescents at risk	Deliver selective, intensive programmes in clinical, school, community, residential care and justice settings for children and adolescents with high-risk behaviours (such as substance use) or exposure (including as part of emergency response in humanitarian or disaster settings); it can be packaged with counselling and referral to services for screening and further care
	Provide guidance and support to schools on effective interventions following a crisis (including suicide in the community)
Build psychosocial competence of parents and carers	
DOMAIN	**ACTION**
Safe, stable parenting and attachment	Implement programmes to raise awareness about nurturing and responsive care, positive parenting, non-violent discipline and social and emotional learning and the mental health of children and adolescents
	Implement parenting programmes focused on building skills in nurturing and responsive care, positive parenting practices and non-violent discipline across childhood and adolescence, including targeted support for parents and caregivers of children with disabilities or who are at high risk of poor mental health
	Identify and address mental health needs of parents, guardians and caregivers
Strengthen positive peer support, including online	
DOMAIN	**ACTION**
Positive peer relationships	Establish and support peer-to-peer groups and youth clubs in school and community settings
	Develop or strengthen online social networks that promote mental health literacy among children and adolescents

Address peer-victimisation	Implement programmes to promote online and digital civility and digital literacy among children, adolescents, parents and teachers, and integrate education on digital civility and literacy into the school curricula
	Implement school policies and curricula that promote healthy and respectful peer relationships and address peer-to-peer violence and harassment
Ensure safe and enabling learning environments	
DOMAIN	**ACTION**
Optimal school environment for mental health and well-being	Implement a whole-of-education approach to mental health promotion (early education, primary and secondary school levels). In addition to curriculum-based and other approaches to support social and emotional learning and positive peer relationships and include strategies and policies to ensure a safe, respectful and inclusive environment with a focus on well-being; positive approach to behaviour management; promotion of positive teacher–student relationships; participation and partnerships with students, parents, community and service providers
	Promote teacher–parent communication on the safety and well-being of children and adolescents
Teacher and education staff capacity to support student mental health	Provide training and resources to teachers, school counsellors and other education-based workers to build mental health literacy and skills to support mental health and social and emotional learning of children and adolescents
	Implement programmes to support mental health and well-being of teachers and education-based workers

Mental health promotion: Ensuring an enabling and safe environment	
Community engagement and participation	
DOMAIN	**ACTION**
Community-based mental health promotion	Implement campaigns to raise awareness about mental health; address mental health-related stigma, discrimination and abuse; and promote help-seeking behaviour
	Train community-based workers, volunteers, young people, religious and community leaders and educators to raise awareness about mental health, promote mental health literacy and address harmful social and gender norms
	Build up the capacity of adolescents and provide opportunities for them to participate in the planning, design and evaluation of MHPSS policies and programmes (including adolescents with lived experience of mental health)
Supportive mental health-related policies and legislation at the national and subnational levels	
DOMAIN	**ACTION**
Policies, strategies and plans for child and adolescent mental health	Adopt a national mental health strategy and policy that details the multitiered and multisector vision and plan for mental health; and develop and adopt a multisector implementation plan with specific goals, actions and performance indicators for child and adolescent mental health
	Adopt a multisector national suicide-prevention plan and integrate prevention of suicide and self-harm across child and adolescent health, development and welfare programmes
	Integrate mental health into child and adolescent health, nutrition and maternal and child health policies and plans
	Integrate mental health into the education sector policies and plans
	Integrate mental health into early childhood development, child protection, social welfare and social protection policies and plans
	Integrate mental health of children and adolescents into juvenile justice and justice health policies and plans
Legislation and actions required for effective mental health services	Adopt a policy that defines high-quality mental health care for children and adolescents (minimum standards of care) that includes relevant sectors and government, non-government and private providers
	Adopt legislation and develop implementation guidance that ensure children's and adolescents' right to access mental health services in accordance with their evolving capacities and in a manner that protects confidentiality; this must include removing mandatory requirements for parental consent for adolescents
	Assess and address the barriers for children and adolescents in accessing mental health care, particularly for marginalized groups
	Adopt legislation that mandates access to mental health care for children and adolescents who are deprived of liberty, in conflict with the law or in out-of-home placements

	Address legislation that denies access to mental health care for migrant, displaced or other marginalized children and adolescents
	Assess and address legislation permitting corporal punishment (or the use of force) 'by way of correction'
	Remove legislation that criminalizes suicide or attempted suicide
Legislation to protect children and adolescents within the mental health system	Prohibit physical restraint of children and adolescents with acute mental conditions in homes, schools, health care or any other settings that provide services or care
	Adopt protections (legislation, regulation, monitoring and complaints mechanisms) to ensure that deprivation of liberty, including detention for mental health purposes, is a last resort, for the shortest appropriate period and subject to periodic review
Policies, programmes and legislation to protect children and adolescents from harm and discrimination	Prohibit all forms of violence (physical, sexual, emotional) against children and adolescents in all settings, including homes, schools, online and in places of alternative care and detention
	Prevent family separation by addressing drivers or causes of alternative care (such as abuse, neglect, poverty) as well as policies that support deinstitutionalization and reintegration of children in residential care
	Prohibit early marriage of adolescents who are younger than 18 years
	Prevent and eliminate child labour (defined as work that deprives children of their childhood, their potential and their dignity and is harmful to physical health or mental development)
	Prohibit the association and recruitment of children and adolescents with armed forces or groups
	Legislate a minimum age for the purchase of substances (alcohol and other drugs), and introduce alternatives to criminalization of possession and use of substances by adolescents younger than 18 years
	Adopt legislation that restricts access to lethal means (firearms, poisons, drugs)
	Ensure effective implementation of legislation defining a minimum age of criminal responsibility (currently at age 14 years)
	Adopt legislation to protect children and adolescents from discrimination on the basis of gender identity or sexual orientation and decriminalize consensual sexual acts
	Adopt legislation to prohibit discrimination on the basis of gender, race, ethnicity, religion, disability, nationality, political affiliation or geographic location
	Implement social protection programmes (social insurance, social protection schemes and other means) with a focus on families and caregivers of children and adolescents

All actions proposed in the regional framework were considered by stakeholders as a high priority for inclusion in an MHPSS package. However, not all were considered feasible in the short term. While progress has been made in some areas (such as programmes responding to family violence and the development of programmes to support mental health in schools), stakeholders across sectors noted significant challenges impacting on implementation, particularly at scale.

Responsive care for children and adolescents with mental health conditions

Stakeholders gave the highest priority to actions related to responsive care. Within the short term, there is a critical need to **integrate mental health into primary-level care and community-based services** to improve access to care. Stakeholders recommended:

- Training and support to primary-level non-specialist health providers and Community Health Workers to provide first-line mental health care (including implementation of the WHO mh-GAP).
- Establishing psychiatric units in all provinces to provide inpatient and outpatient mental health services and receive referrals.
- Integrating MHPSS into Family Support Centres and other services for children who have been exposed to violence or abuse.
- Strengthening case management to include MHPSS delivered by social workers and others engaged in child protection or welfare.
- Establishing guidance counsellors in schools to provide psychological first aid, case management and counselling.
- Ensuring that child-friendly primary-level care and community-based services are available throughout the country, including in rural and remote areas.

Integrating MHPSS into the management of children who are victims of violence or abuse is a high priority. There are no child-centred protocols or processes to manage child-victims to ensure access to MHPSS and/or prevent further psychological harm, although these are currently being developed.

Stakeholders also recommended that the focus of current mental health services needs to shift from highly specialized institutional care to community-based recovery and rehabilitation that is multidisciplinary and person-centred. They also recommended considering establishing community centres, like Family Support Centres, that could provide children with safe spaces and services for their mental health. Additionally, stakeholders also prioritized establishing child- and adolescent-friendly rehabilitation facilities, noting that once adolescents are discharged from care back to the community, there is no support and poor access to services.

The next high priority they recommended is to establish a system **for early identification and screening**. Actions must include development and/or validation of screening tools and development of guidelines and training for health workers, school-based staff and child protection workers to support early identification. Integrating mental health screening or protocols to support early identification of mental health needs or risks into physical health services, Family Support Centres, schools and justice settings are also a high priority.

Screening in the absence of available and accessible services is likely to be stigmatizing, so stakeholders emphasized that this must be developed in the context of accessible care and a functioning referral system.

To support access to care, stakeholders recommended establishing **referral mechanisms** for MHPSS. This should include developing clear referral criteria, protocols and pathways within the health sector as well as clear protocols to manage children and adolescents who are identified in other settings (such as social welfare, justice and schools). This is particularly critical within the justice setting, where there are no formal or informal processes to support early identification, mental health assessments or referral for care for children in conflict with the law.

Prevention of mental health conditions in the immediate social context

Stakeholders' third high priority are actions related to prevention. Among them, they placed greatest importance on programmes to address **family violence, conflict and separation and support positive parenting**. Scaling-up evidence-based parenting programmes (such as the Parenting for Child Development) that have been delivered by UNICEF and NGOs was cited as a significant action, with a longer-term goal of establishing a national positive parenting programme. Family Support Centres, school-based parent groups, church-led groups and health services (such as antenatal care) are considered as potential entry points for delivering parenting programmes that focus on increasing mental health awareness as well as skills in nurturing, responsive care and non-violent discipline. Tailored programmes for parents of children with disabilities were also cited as important. More broadly, stakeholders placed high priority on expanding programmes to prevent and respond to family violence and conflict, noting that this is one of the main contributors to poor mental health. Such actions could include strengthening Family Support Centres to provide targeted interventions to children and families at risk, including through integration of MHPSS into responses to violence, development of protocols and job aids for Family Support Centres staff specific to addressing mental health risk factors (as well as responsive care) and accreditation and standardized training of Family Support Centres staff that includes mental health.

In addition, **school-based actions** (from early childhood education through to secondary education and higher) were also considered central to preventing poor mental health and enhancing protective factors. High priority actions include developing the Health and Personal Development syllabus to incorporate a national standard curriculum on mental health, with emphasis on mental health literacy, skills and supporting social and emotional learning; improving mental health training and support for teachers; addressing peer victimization and bullying; and establishing guidance counsellors in all schools. Other platforms for reaching children and adolescents with mental health education and supporting positive peer networks include integrating mental health programmes through sporting groups, church groups and other youth groups (such as Scouts).

Ensuring a safe and enabling environment to promote mental health

Among actions related to ensuring a safe and enabling environment, stakeholders gave high priority to programmes that **address stigma and discrimination and lack of mental health awareness,** noting that stigma and misconceptions about mental health are significant barriers to seeking services and support. This includes programmes delivered through existing channels (churches, community organizations, schools, sports events, NGOs and media) to address misconceptions and taboos, increase awareness of mental health, its determinants and available services and to promote care-seeking behaviour. Employing a range of methods, including community-based drama, sporting events (including competitions), mass media campaigns and 'mental health days' were proposed by stakeholders as approaches that are feasible in the PNG setting, likely to achieve positive outcomes and/or have been trialled at the grass-roots level. Creating safe and healthy spaces and events where young people can gather and discuss mental, social and emotional health should be a priority to help promote healthy lifestyles and well-being.

Strengthening legal protections and programmes to protect children and adolescents from harm were cited as another high priority. These include greater protection from family violence (including corporal punishment) and protection from harm within justice settings and also within mental health care. Developing a national multisector mental health strategy that includes specific actions for children and adolescents was included as an important goal in the short to medium term, as well as integrating mental health into other sectoral policies.

BOX 4. ACTIONS GIVEN THE HIGHEST PRIORITY FOR IMPLEMENTATION IN THE NEXT TWO YEARS

- **Integrating mental health into primary health care and community-based services**
- Establishing early **identification and screening** in health and non-health settings
- Establishing **referral mechanisms** within the health sector and between sectors
- E establishing **inpatient and outpatient mental health units** in hospitals

- Developing and implementing **parenting programmes** that focus on nurturing, responsive care and non-violent discipline
- Integrating MHPSS into **family violence** programmes, such as Family Support Centres
- Developing **school-based programmes** to deliver mental health education and mental health literacy, address violence and bullying and provide support (such as counselling)

- **Integrating mental health into other sectoral policies** and plans (education, social welfare and child protection, justice)
- **Increasing protection** against violence, harm and discrimination
- Implementing programmes to address **stigma, discrimination and harmful norms**

Recommended sectoral roles and responsibilities

Table 4 gives an overview of the recommended roles of the health, education, social welfare and justice sectors in implementing the priority package of MHPSS actions.

Stakeholders cited the health sector as the best positioned sector for an overarching leadership role with respect to setting national policy, planning and oversight of MHPSS. Across the sectors, they also described important roles for the education and social welfare (community development) sectors in terms of prevention and promotion of mental health and a greater potential role for the justice sector in supporting early identification, referral and targeted interventions to address risk factors.

Table 4. Sectoral roles in implementing MHPSS actions

Accessible and responsive services for mental health conditions			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Screening for those at risk	Early identification of those with mental health conditions or risks	Screening for children and adolescents with high-risk exposure	Screening for high-risk behaviours and exposure
Referral systems and mechanisms Self-referral hotlines	Referral links and mechanisms	Referral links and mechanisms Self-referral hotlines	Referral links and mechanisms
Multidisciplinary case management and support	Ongoing education participation for those with mental health conditions	Multidisciplinary case management Targeted education and support for parents of children with mental health conditions and complex behaviours	Specialized services and supports (including in detention settings)
Community-based, online and outreach services	School-based child- and adolescent-friendly counselling and case management	Community-based, online and outreach services	
Establishing specialized and clinical services			
Establishing residential services		Supporting residential mental health services	

Prevention of mental health conditions in the immediate social context			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
Support to mental health approaches in education, including teacher well-being	**School and education-based programmes and approaches** – mental health promotion – social and emotional learning – positive peer relationships – violence and bullying – substance use – teacher–parent communication – teacher and staff well-being	Support to mental health approaches in education	Support to mental health approaches in education
	Establishing youth and peer support groups	Establishing youth and peer support groups	
Digital literacy, **online networks for mental health**	**Digital literacy and civility education**	**Digital literacy, online networks for mental health**	
Intensive interventions to address risk factors Support to schools following a crisis (such as a suicide in a community)	Intensive interventions to address risk factors **School-based interventions following a crisis in the community (such as suicide)**	**Intensive interventions to address risk factors**	Intensive interventions to address risk factors
Identify and address mental health needs of parents and caregivers	Raise awareness about positive parenting Supporting **parenting programmes** to build skills in nurturing and responsive care and non-violent discipline	**Parenting programmes** to build up skills in nurturing and responsive care and non-violent discipline	

Mental health promotion: ensuring an enabling and safe environment			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
National, multisector mental health plans and strategies, including suicide prevention	**Integrating mental health into education policies and curricula**	**Integrating mental health into early childhood development, child protection, ending violence, social welfare and social protection policies and plans**	**Integrate mental health of children and adolescents into juvenile justice and justice health policy and plans**
Integration of mental health into maternal and child health, adolescent health, nutrition and HIV policies and strategies			
Policy and standards for high-quality mental health care		Identifying barriers in access to mental health services for marginalized groups	
Legislation mandating access to mental health care, including removing mandatory parental consent requirements			**Legislation mandating access to mental health care for children and adolescents deprived of liberty and in out-of-home placements**
Protection for children and adolescents in the mental health system		Support to legislation and policies to protect children and adolescents from violence and harm	**Legislation and policies to prohibit violence, harm and discrimination** – decriminalize suicide – end all forms of violence – end child marriage – end discrimination – control substance use – restrict access to lethal means – end child labour – end recruitment to armed forces – minimum age criminal responsibility

Mental health promotion: ensuring an enabling and safe environment			
HEALTH	**EDUCATION**	**SOCIAL WELFARE**	**JUSTICE**
		Social protection programmes for families	
Training and community-based programmes to address stigma and discrimination		**Training and community-based programmes to address stigma and discrimination**	
	Capacity-building for adolescents to support participation, including those with lived experience of mental health needs, in the planning and design of MHPSS	Capacity-building for adolescents to support participation, including those with lived experience of mental health needs, in the planning and design of MHPSS	

Note: Actions in **bold** indicate where a sector is recommended to have a leading role or primary responsibility for implementation.

See Figure 3 for a summary of the broad sectoral roles.

Health sector

The health sector, specifically the NDOH, was recommended to have an overall leadership role with respect to technical guidance and policy for MHPSS, including responsibility for coordination and oversight across all three tiers. The recent establishment of the independent Directorate of Social Change and Mental Health was cited as an important reform in the health sector, which will help to ensure that mental health services are expanded and improved. The Directorate, established under Mental Health Act 2015, has its own budget and is informed by board members representing all sectors. Dedicated support from the NDOH will be necessary until the Directorate is adequately resourced and defined. The NDOH and the Directorate should collaborate to ensure that all mental health reforms are equitable and sustainable.

The NDOH and the Directorate were cited as having primary responsibility for the implementation of actions related to responsive care. While this reflects the sector's role and mandate with respect to the delivery of clinical services, stakeholders also emphasized that the health sector should have a much greater role in prevention and promotion, including strengthening collaboration with schools, communities and families to support preventive actions and address community-based norms and stigma. The National Child Protection Policy also defines a role for the NDOH to integrate parenting programmes into antenatal care and childhood immunization services.

Education sector

The education sector, specifically the NDOE, was recommended to have the leading role in coordination and implementation of preventive actions needed to optimize learning environments, build individual assets and support healthy peer relationships. The education sector was considered as having responsibility for developing and implementing mental health promotion activities and addressing the impacts of the school culture, environment and teaching approaches on mental health. The education sector was also recommended to lead efforts to strengthen the national curriculum on social and emotional learning, promotion of positive and respectful peer relationships, addressing

risks (bullying and substance use) and improving mental health literacy. In addition to strengthening the curricula, the education sector was identified as having responsibility for training and upskilling teaching and school staff on mental health awareness and first aid.

Significantly, the education sector was recommended to take a greater role in early identification and screening of children and adolescents with mental health conditions. This will require improved training and support for teachers and school-based counsellors and greater links with health services. Stakeholders stressed that teachers have the most contact with young people and therefore are in a unique position to identify children and adolescents with mental health conditions (or those at risk) and be the first link between families and other mental health services. Schools and other education settings were also cited as having a significant role in providing initial care and support for mental health conditions, including counselling and classroom-based behaviour modification interventions.

Social welfare sector

Through the DFCDR and the NOCFS, the social welfare sector was recommended to take a leading role in planning, coordinating, developing and monitoring actions related to child welfare and family and parenting support. This sector was seen as an important link between families and the health, education and justice sectors. This not only included a link for service delivery but also for strengthening the identification and monitoring of children most at risk. Stakeholders recommended that this sector take a role in providing support to at-risk children and families, including financially insecure families, single-parent families and families who have migrated to settlements. The social welfare sector was cited as having primary responsibility for implementing parenting programmes and community-based actions to improve mental health literacy, work with the health sector to train front-line community responders and address stigma and discrimination. Additionally, early identification and screening of children and adolescents with high-risk behaviours or exposure (including in community, education, alternative care and justice settings), supporting a strong and efficient referral system and being part of a multidisciplinary team to provide acute and continuing care were included as important roles for the social welfare sector.

Justice sector

The justice sector, through contact with children and adolescents who are at increased risk of poor mental health, has an important role in supporting early identification, screening and referral for mental health services. Although this sector lacks MHPSS systems, policies and training, stakeholders noted an urgent need to improve the mental health support and care available to children interacting with the justice system. The justice sector will require engagement with other sectors, agencies and stakeholders to take on these roles and provide mental health services to children and adolescents. Support will also be needed from the health sector to train police, juvenile detention officers, judicial and court officers and other justice sector workers to increasingly provide front-line care.

Of immediate importance for the justice sector is creating a pathway for children who are victims of violence or those in conflict with the law to access responsive mental health services without requiring a court order and protocols to minimize psychological harm during judicial procedures. Stakeholders also cited a need for the justice sector to take on a role in screening, referral and continuing care. This includes follow-up and support to families who have been in conflict with the law or have had contact with the justice system.

The justice sector was also identified as having a central role in improving and enforcing legislation to protect children and adolescents from harm, especially the Lukautim Pikinini Act. In addition to existing legislation prohibiting all forms of violence against children, the stakeholders noted an increasing role needed in terms of addressing drug production, use and trade.

In addition to sectors having responsibility for implementing different MHPSS actions within each tier, there are **several critical areas of convergence** where effective implementation of specific actions require strong collaboration across sectors. These include actions to:

- improve early identification, screening and referral to multidisciplinary care;
- ensure continuing care and support for children, adolescents and their families experiencing mental health conditions or at increased risk of them;
- implement targeted, intensive interventions for children and adolescents at increased risk of poor mental health (particularly in relation to high-risk exposure, such as violence and when in conflict with the law);
- implement school-based approaches to prevent poor mental health and promote well-being; and
- support positive parenting and provide services and support to parents and caregivers of children with mental health needs or for their own mental health needs.

Non-government organizations

Not-for-profit NGOs were seen as having a potentially important role in the implementation of MHPSS. While their engagement in mental health is limited, many organizations are involved in areas that relate in some way to mental health and well-being (physical health, sexual and reproductive health, child welfare, child development) that can provide a platform to integrate more specific MHPSS actions. Stakeholders emphasized the importance of NGO activities being community-led. Meaningful community engagement, leadership, cultural safety and the unique tailoring of international NGO programmes are all necessary to ensure the success and sustainability of MHPSS actions. In particular, strong partnerships with communities and greater understanding of community needs would facilitate delivery of action around mental health literacy, addressing stigma, community-based service delivery (identification, referral and first aid) and programmes to support parents and families. Stakeholders noted some past NGO programme failures due to lack of community engagement.

The greater flexibility of the NGO sector to respond to community needs and adopt new models of delivery, without the bureaucratic constraints of the government sector, was a noted advantage. Additionally, the NGO sector was seen to have an important role in resourcing MHPSS activities and advocating for additional funding from the Government. Around 20–30 per cent of health system financing in 2021 came from donors and development partners.[36] The NGO sector was also noted for their broad support for and important role in mental health advocacy.

Private sector

The private sector (health and education) was cited as having a small but important role in filling service-delivery gaps. In general, private mental health services are extremely limited. The sector was noted for its additional resources, however, and seen as having a potential role in providing financial support or other resources to support MHPSS initiatives through the training of public sector staff or corporate social responsibility programmes.

Faith-based sector

The faith-based sector was included as significantly important and essential towards improving MHPSS, with religious leaders already having a role in providing counselling and guidance to young people. Church networks are important in communities, collectively providing up to half of the country's health services.[60] Churches co-manage many primary and secondary education facilities, run two of the country's six universities and are responsible for training many of the country's teachers and health workers. They have deep roots in diverse communities and can draw upon considerable social capital to influence change processes at various levels.[60] Due to their strong presence throughout the country (including in geographically isolated areas) and links with families, communities and other sectors, the faith-based sector has the potential to support delivery of MHPSS actions through church-run health services and community-based programmes to enhance peer support, promote mental health literacy and address stigma and harmful norms.

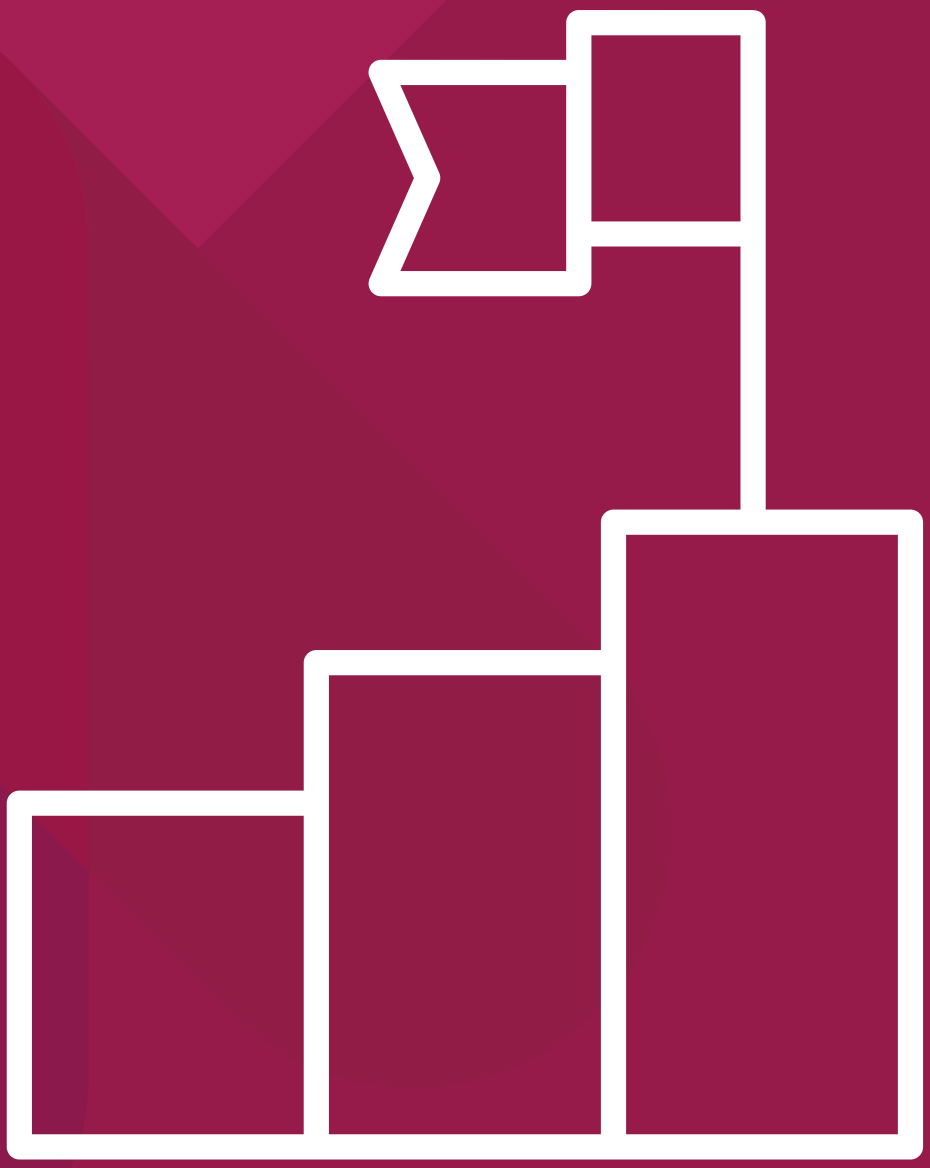
UNICEF

UNICEF was noted for its critical role in resourcing MHPSS activities, advocating for evidence-based policy action and galvanizing support across the sectors. Supporting mental health research and developing new programmes and models of delivery, facilitated by strong links with national, regional and global academics, technical experts and professionals, was also seen as an important role for UNICEF and other United Nations agencies. Stakeholders highlighted the potential for UNICEF to provide funding to support new initiatives and pilot projects and other innovations to test new ways of implementing MHPSS for children and adolescents.

UNICEF was also cited as having an important role and comparative advantage in:

- leading advocacy efforts;
- convening, including capacity to facilitate links between sectors (such as health, social welfare, child protection and education) and support cross-sector dialogue, planning and resource allocation;
- integrating MHPSS into existing UNICEF programmes and platforms (including primary health care, education, parenting and child protection);
- supporting and delivering programmes to address mental health-related stigma and improve mental health literacy through national advocacy and community-based programming; and
- integrating MHPSS into emergency settings.

Challenges and recommendations for strengthening the multisector mental health system



Legislation, policies and strategies

PNG has a legislative and policy foundation for supporting MHPSS and ensuring good mental health and the well-being of children and adolescents. The **National Mental Health Policy 2011** broadly outlines actions to improve access to mental health services, including at the community level and to improve community awareness. Many of these actions are relevant to child and adolescent mental health, but the policy does not provide a comprehensive plan for this age group that identifies and responds to their specific needs. Although the importance of multisector collaboration is recognized, the policy does not articulate a multisectoral vision for mental health, define the specific roles of non-health sectors or describe the mechanisms needed to enable cross-sector collaboration and accountability.

The National Child Protection Policy calls for a whole-of-government approach and implementation strategy for child protection that could serve as an example for mental health or an entry point for integrating MHPSS across sectors through child protection.

Importantly, the **Mental Health Act 2015** defines the rights and protections of individuals with mental health conditions, including those within the mental health system, including protection in relation to the least restrictive assessment and treatment possible, involuntary treatment, physical restraint and deprivation of liberty for mental health reasons, appeal and complaints. However, there are no specific considerations or protections for children and adolescents. Such protection could include:

- right to least restrictive assessment and treatment possible, including specific consideration on the use of physical restraint, involuntary seclusion and deprivation of liberty for children younger than 18 years;
- right of children and adolescents to make decisions about mental health care and recovery to the fullest extent possible, with consideration of the best interests of the child or adolescent;
- appointment of a personal representative, other than a family member, if necessary;
- right to have contact with family or other support persons; and
- right to recreational activities, education and other support that respond to individual needs.

Mandatory requirements for parent or guardian consent is a significant barrier impacting on adolescents' access to mental health services. The Public Health Act sets the minimum age for providing medical consent at 16 years, although it is 18 years within the Mental Health Act. Amending this legislation to remove mandatory requirements for parental consent for adolescents and developing implementation guidance that ensures children's and adolescents' right to access mental health services in accordance with their evolving capacities would be important for improving access to services. Stakeholders also noted a need to strengthen legal protection for individuals living with developmental or intellectual disability.

Mental health has been integrated to some extent into **sectoral policies and plans of education and social welfare**. Within the education sector, the National School Health Policy includes mental health, with a focus on the provision of counselling services, referrals for behavioural disorders or significant emotional stress and education on mental health issues. The National Education Plan also includes a commitment to providing school-based counsellors and supporting behaviour management. A comprehensive plan for a whole-of-education approach to mental health promotion is lacking, and there are gaps in plans with respect to addressing bullying and promoting positive peer relationships, providing a standard national curriculum to support social and emotional learning and reaching more marginalized children and adolescents with complex needs (in formal education and other learning environments).

The Lukautim Pikinini Act and Child Protection Policy address some of the determinants of mental health (violence, abuse, neglect and exploitation) and recognize the importance of protecting children from psychological harm. However, they do not include specific reference to children's right to receive mental health services as part of child protection. While there are some provisions included in the law for child-friendly practices in prisons in relation to children of incarcerated women, these protections

are not clearly defined for children in conflict with the law or child victims and witnesses. Similarly, the Juvenile Justice Act includes some protection for children in conflict with the law to minimize psychological harm but does not address mental health. There is no requirement for mental health assessment or right to access mental health care.

Legislative reforms are also needed **to improve protection from harm and discrimination**. This includes prohibiting all forms of violence (including corporal punishment) in homes, schools, alternative care and residential facilities; increasing protection against early and forced marriage; decriminalizing attempted suicide; and addressing criminalization and discrimination against adolescents with diverse sexual orientation and/or gender identity or expression.

Across sectors, stakeholders noted that in addition to addressing these gaps, there are needs for strategies, plans and frameworks that more clearly define the roles and responsibilities of agencies, particularly at an implementation level. Limited dissemination of policies, plans and legislation at the local level is a significant barrier to implementation, with many stakeholders not aware of relevant policies and guidance.

KEY RECOMMENDATIONS – LEGISLATION AND POLICY:

- Ensure 'mental health in all policies' with more explicit recognition and actions to address mental health in non-health sector policies and as part of the COVID-19 pandemic response.
- Expand the National Mental Health Policy or develop a child and adolescent mental health policy to provide clearer and more comprehensive guidance on actions to promote, prevent and respond to mental health of this age group.
- Strengthen the Mental Health Act to include specific protections and considerations for children and adolescents, including removal of mandatory requirements for parental consent to access services.
- Develop multisector implementation plans and guidance, with clear roles, responsibilities and accountability at all levels (including performance indicators related to multisector coordination).
- Develop policies and strategies to reach out-of-school children and adolescents and other marginalized groups.
- Improve dissemination of MHPSS-related policies and plans across sectors and to administrative and implementation agencies.
- Develop multisectoral mental health plans at the subnational level to support coordination and implementation.
- Strengthen legal protections against all forms of harm and discrimination, including prohibiting use of corporal punishment in homes, schools and alternative care, decriminalizing suicide and addressing criminalization and discrimination on the basis of sexual orientation.

Leadership, coordination and governance

National level

Stakeholders noted the lack of clear national leadership for child and adolescent mental health as one of the barriers impacting the implementation of MHPSS. Limited coordination and collaboration across sectors were included as barriers, with most sectors described as working in silos without a shared vision or goal for mental health. Subsequently, policy and plans are fragmented, and there are significant gaps in implementation. The Chief Psychiatrist was cited as having a significant role in advocacy and building engagement across sectors, but there is critical need to establish a national structure to support multisector coordination and planning.

To address this, stakeholders first emphasized the need for high-level political support and commitment to mental health, with mental health elevated as a national priority and a multisectoral vision for mental health articulated. Second, they recommended that a national mental health committee (or similar structure) be established to support multisector policy, planning, coordination and accountability. The Directorate for Social Change and Mental Health was singled out by stakeholders as a body that could have a leading role in establishing a national multisector committee (or taskforce) to drive action on child and adolescent mental health and be responsible for coordinating planning and implementation. The NOCFS was recommended to also take a leadership role.

Similar bodies already exist for other national priorities, such as the NOCFS, the National Narcotics Bureau and the Gender Equity and Social Inclusion initiative. Within such a committee, the NDOH, specifically the Directorate for Social Change and Mental Health, was cited as having an overall leadership role, noting that the NDOH needs to expand its role beyond provision of clinical mental health services to also provide leadership around mental health prevention and promotion. The NOCFS, the NDOE, the DFCDR, the Youth Commission, the Department of Justice and the Attorney General were also included as having leadership roles in MHPSS policy and planning. The justice sector, in particular, was described as having limited engagement in mental health, with articulation of the sector's role and participation in national dialogue around mental health needed. Additionally, stakeholders identified a critical role for UNICEF and the WHO in supporting national coordination through their convening roles and technical expertise in child and adolescent mental health.

In addition to establishing a national mental health committee, stakeholders also suggested that a memorandum of understanding (MOU) or other formal agreement between sectors may improve coordination around some aspects of MHPSS. For example, an MOU between the NDOH and the NDOE may facilitate better collaboration and coordination of school-based MHPSS initiatives.

Administrative and implementation levels

Stakeholders also mentioned the need to improve coordination and governance at the administrative and implementation levels. This includes addressing the disconnect between national policy and strategies and the authorities responsible for planning and implementation at the local level. It also includes building up mental health capacity among local authorities to support planning as well as coordination across sectors in MHPSS implementation. At the subnational level, the provincial health authorities were referenced as having a leadership role, with responsibility for planning and implementation of national policies and supporting district and local governments. Provincial and district authorities within the NDOE and the NOCFS also have roles in planning, coordination and implementation at the local level. Establishing multisector coordinating bodies or committees at the provincial level would be important for improving implementation of MHPSS. NGOs, church organizations and United Nations agencies (particularly UNICEF and the WHO) also have current and potential roles in implementation of MHPSS-related programmes.

Therefore, stakeholders recommended that communication and coordination mechanisms must include non-government actors. Importantly, they added, these mechanisms need to engage communities and community leadership structures to ensure that implementation strategies are embedded in local contexts.

KEY RECOMMENDATIONS – LEADERSHIP AND GOVERNANCE:

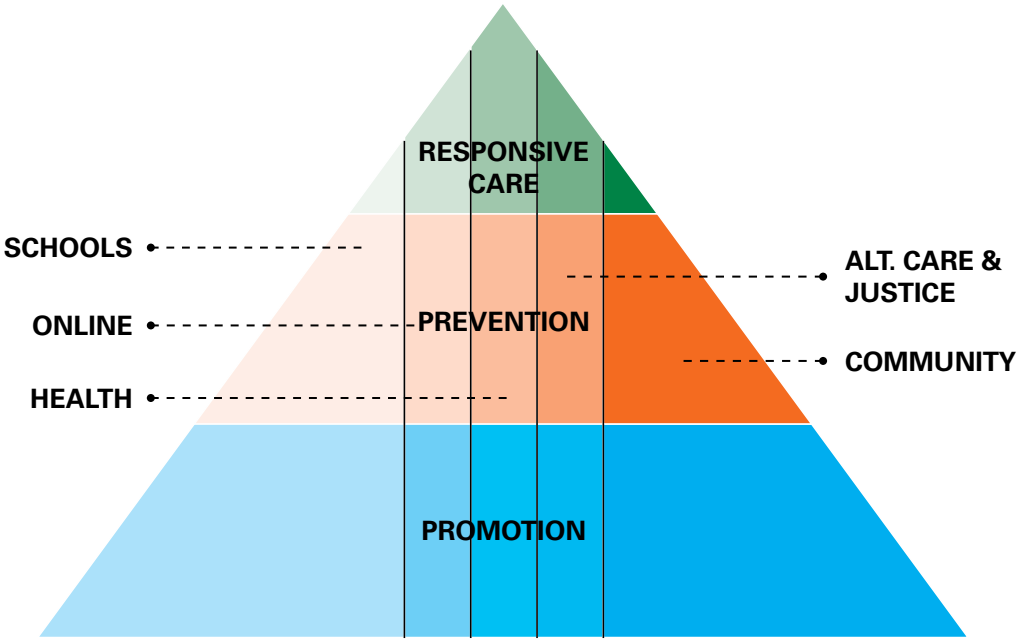
- Establish high-level political support and commitment for mental health through advocacy.
- Establish a national multisector coordinating body with representation from all allied sectors and with authority and resources to drive action.
- Build up the capacity of provincial health authorities and district and local government authorities in MHPSS to support local planning, coordination and resource allocation.
- Establish local multisector committees to support coordination and implementation of the priority MHPSS package.
- Develop subnational implementation plans for MHPSS that articulate sectoral roles and responsibilities and are aligned with national goals and strategies for mental health.

Service delivery

Multiple platforms exist to support the delivery of MHPSS actions (*see Figure 12*). Within responsive care, **health facilities** (primary, secondary and tertiary level) are an important setting to deliver screening and specialized care. However, the lack of mental health services, particularly outside of Port Moresby, was noted as a major barrier. A high priority for PNG is to integrate mental health services into primary and community-based care and to address the overreliance on highly specialized, often stigmatizing, institutional-based care that is largely inaccessible to children and adolescents and limited to severe mental health disorders (like psychosis). Early identification and screening, provision of initial care for non-complicated cases and strengthened referral mechanisms could be integrated into existing primary and community-based services, including through general outpatient clinics and maternal and child health services (such as vaccination programmes). Additionally, stakeholders recommended that district and provincial hospitals be strengthened through improved staff training to manage more complicated cases through inpatient and outpatient care and to reduce the overreliance and inaccessibility of tertiary-level institutional care.

Church-based health services were singled out as having a significant role in supporting greater access to screening, referral and care. Stakeholders considered churches essential to ensuring access to health care in the rural and geographically isolated areas of the country. Health facilities were also cited as having a role in supporting prevention and promotion, for example, through the promotion and delivery of parenting programmes through antenatal and postnatal care. In addition to integrating mental health into primary and community health services, establishing child and adolescent-focused services was also identified as a priority. This includes developing national standards and protocols for child and adolescent mental health and national standards for adolescent-friendly health services to improve accessibility and acceptability.

FIGURE 12. PLATFORMS FOR DELIVERY OF MHPSS



Note: The figure illustrates how existing platforms cut across the three tiers of MHPSS actions.

Community-based delivery was also identified as a critical platform for implementing actions to address mental health literacy, shift community norms, tackle stigma and deliver preventive actions (including parenting programmes and targeted interventions to children, adolescents and families at risk). In particular, health sector stakeholders cited the need for community-based rehabilitation models to support recovery and continuing care outside of institutional settings. Through social welfare, the Family Support Centres were considered as a potentially important platform for delivering MHPSS to children and families at risk of poor mental health, such as those exposed to family violence. Stakeholders noted that existing programmes addressing gender-based and family violence were important entry points to also deliver MHPSS actions for children and adolescents, from early identification, screening, referral and care through to parenting programmes, targeted interventions for children at risk and improving mental health literacy. NGOs and faith-based organizations were emphasized as important partners in supporting implementation of community-level action, with opportunities to integrate mental health into existing child- and family-focused programmes (such as increasing awareness, addressing stigma and violence and supporting positive parenting, early identification and referral). Churches in particular could have an important role in addressing stigma, myths and misconceptions about mental health.

Schools and other learning environments are also a critical platform for reaching large numbers of children and adolescents with MHPSS. All stakeholders nominated school-based delivery as essential to the effective implementation of MHPSS, with a focus on school-based programmes to build individual assets and support social and emotional learning, promote positive peer relationships, address bullying and create safe learning environments. Schools were also described as having a greater potential role in responsive care. Existing programmes (school counsellor and behavioural management) could be strengthened to improve coverage and greater integration of MHPSS, including supporting teachers and counsellors in early identification and establishing referral pathways and protocols for mental health care.

The potential of **phone, online and digital platforms** has received increasing recognition, particularly in the context of the COVID-19 pandemic. There are some examples of existing hotlines and helplines that provide phone counselling, such as the ChildFund service, and stakeholders noted that there are online forums available, although there was little information available about their focus, coverage or uptake. In addition to providing hotlines for self-referral and counselling, stakeholders recommended that digital technology, such as SMS, could be used to increase mental health awareness and support

care-seeking by providing health promotion messages. Access to technology in rural and remote areas and access to phones and internet access by young people were stressed as barriers to expanding the use of these platforms.

Justice settings are an underutilized platform for delivering MHPSS to children, adolescents and families at risk. Early identification, screening, referral and provision of services (including targeted prevention) were all noted to be services that should be provided in justice settings, in collaboration with the health and social welfare sectors. Integrating MHPSS through Family and Sexual Violence Units within the police services would be an important entry point for reaching children and families at increased risk of poor mental health.

All stakeholders referenced significant barriers impacting equitable access to MHPSS. Rural and remote communities were recognized as having limited access to facilities, services and skilled providers, with both government and NGO services concentrated in more urban settings. Children and adolescents not engaged in formal education were cited as an underserved group because most national policies and programmes focus on school-based delivery. Further research is needed to understand the barriers and service-delivery preferences as well as improved coordination with community-based organizations to better serve marginalized groups.

KEY RECOMMENDATIONS – SERVICE DELIVERY:

- Integrate mental health services into primary and community care, including through existing programmes (maternal and child health, nutrition, adolescent health and general health care).
- Strengthen the capacity of district and provincial hospitals to receive referrals and provide child and adolescent mental health care.
- Develop models and standards of child and adolescent-centred mental health care.
- Integrate MHPSS into Family Support Centres and other government and NGO-programmes addressing family violence.
- Strengthen the delivery of MHPSS in schools (school counsellors to support early identification, referral and care, curriculum-based education and programmes to address bullying and peer support).
- Integrate MHPSS into justice settings, including early identification and screening, referral, provision of care and targeted prevention.
- Explore, through further consultation and research, the potential to provide phone-based or online MHPSS (awareness, peer support, early identification, referral and counselling).
- Identify barriers and service-delivery preferences for marginalized and underserved communities, particularly strategies needed to reach out-of-school children and adolescents.

Standards and oversight

Stakeholders cited the limited available national standards, protocols and guidelines for MHPSS as barriers to its effective implementation. The NDOH was referenced as having primary responsibility for developing standards in relation to responsive care, with engagement with community development and justice sectors in relation to guidelines and protocols for supporting children at risk. There is less clarity around oversight responsibility in relation to other tiers (prevention and promotion), although many stakeholders noted that the NDOH should take on greater responsibility for oversight and guidance around these actions.

Stakeholders also noted that there are few standards, guidelines or protocols for child and adolescent mental health. They positioned the following as high priorities for enabling effective implementation:

- national guidelines on early identification and screening, in health and non-health settings (including by non-specialist health providers and in education, child protection and justice settings);
- development and/or validation of screening tools for common mental health conditions in children and adolescents;
- referral protocols for children and adolescents within the health system (when, where and how to refer) and referral between sectors (particularly from schools and child protection and justice settings to health services);
- national child and adolescent mental health service standards and management protocols, including protocols for community-based management;
- improvement of counselling guidelines for children and adolescents;
- strengthened school-based protocols for behavioural management and psychological first aid;
- standardization of protocols across sectors for case management and support of children within the child protection system (for example, children who are exposed to violence); (These should cover the roles and responsibilities of agencies, protocols for early mental health screening and assessment, provision of MHPSS as part of the immediate response and child-focused protocols that minimize further psychological harm during investigation and other police procedures.)
- review of the clinical guidelines for Family Support Centres to ensure MHPSS are included, with a focus on children and adolescents; and
- standardized protocols within the justice sector to ensure universal access to mental health assessment, referral and care for children in conflict with the law and protocols to minimize harmful impacts of judicial processes on mental health. This should also include protocols for preparation for release and follow up, with links to other agencies.

Although the NDOH was cited as having primary responsibility for the development of many of the standards, stakeholders acknowledged roles for the Division of Guidance and Counselling within the NDOE to develop and/or strengthen school-based guidelines and protocols and the NOCFS with respect to child protection protocols.

Additionally, they recommended greater regulation of Family Support Centres and their staff to improve the quality of care.

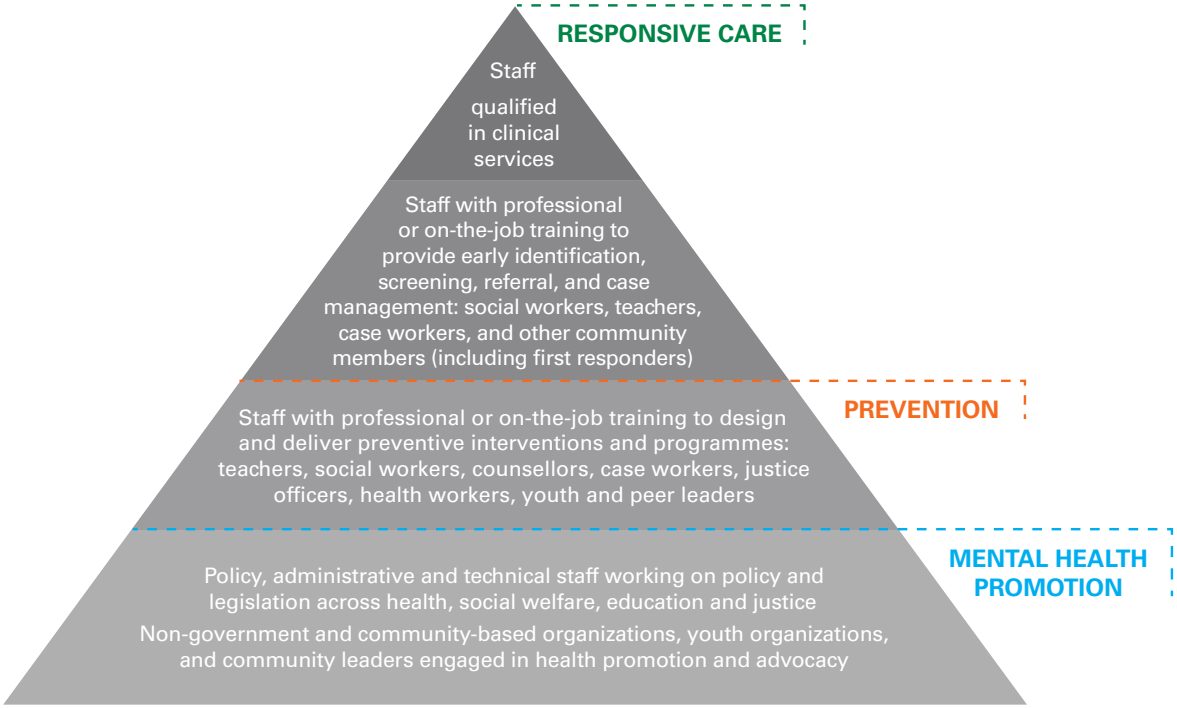
KEY RECOMMENDATIONS – STANDARDS AND OVERSIGHT:

- Develop national standards and protocols for child and adolescent mental health within the health system, including screening, referral, management and follow-up, with attention to child and adolescent-centred care and support.
- Develop national standards and protocols to support early identification, screening and referral in non-health settings.
- Develop standard operating procedures across agencies to support coordinated and child-focused care of children and adolescents who are exposed to violence and/or engaged in child protection, including provision of MHPSS as part of the immediate response.
- Develop protocols and procedures within justice settings to minimize psychological harm and to ensure timely access to mental health assessment and other services.

Multisector mental health and psychosocial support workforce

The multisector mental health and psychosocial support workforce is challenging to define because it is diverse and dynamic, incorporating specialist providers whose primary roles relate to mental health and providers and volunteers who may be required to deliver some aspect of MHPSS but for whom this is not a primary responsibility. The three tiers of MHPSS action (responsive care, prevention and mental health promotion) are coarsely mapped against the corresponding multisector mental health workforce in *Figure 13*.

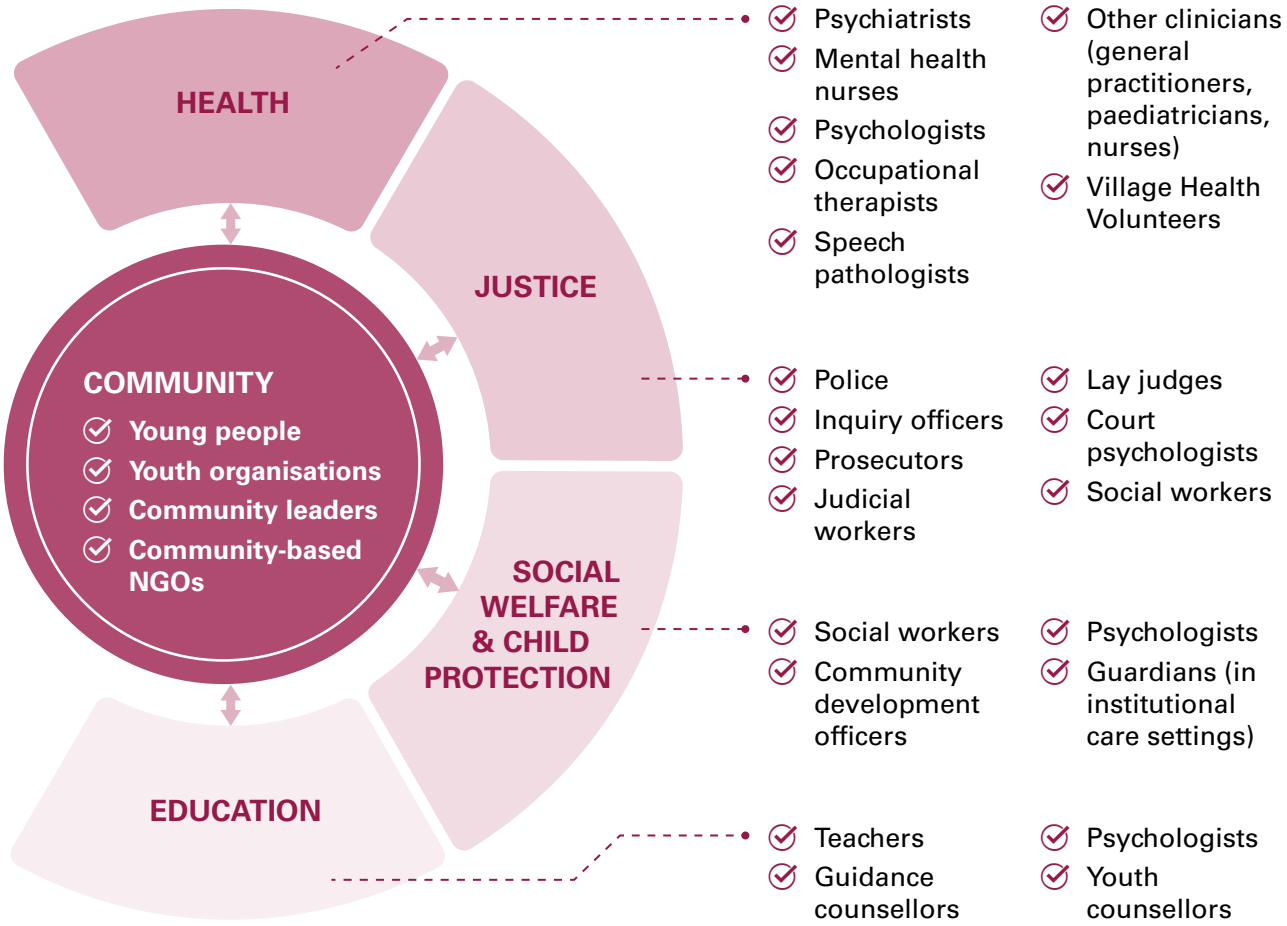
FIGURE 13. TIERS OF WORKFORCE REQUIRED TO ENSURE MHPSS



The current workforce

The broad mental health and psychosocial support workforce includes public, private and non-government actors across the health, education, social welfare (child protection), justice and community sectors (*see Figure 14*).

FIGURE 14. MULTISECTOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT WORKFORCE



All stakeholders emphasized severe workforce shortages as a major challenge impacting the implementation of MHPSS policies and programmes. Limited numbers of professionals trained in mental health and/or trained to deliver components of MHPSS contribute to the extremely constrained availability of mental health services, low coverage of school counselling and other school-based programmes and limited integration of mental health into child protection and Family Support Centre services.

The mental health and psychosocial support workforce and recommended MHPSS roles

Some priority MHPSS actions are already integrated into workforce roles, although providers' capacity to carry out these roles is hampered by the challenges previously noted. *Table 5* outlines recommended roles by sector.

Within the **health sector**, specialist clinicians (psychiatrists and mental health nurses) have primary responsibility for the delivery of responsive care. The extremely limited number of specialists, however, particularly those with additional training and expertise in child and adolescent mental health, is a significant bottleneck, with many of these specialist providers concentrated in urban areas and in tertiary hospital settings. A 2013 review found the country had only 12 psychiatrists, 1 psychologist and between 43 and 74 psychiatric nurses.[15] A 2015 publication by the Head of Psychiatry at the University of PNG reported there were seven psychiatrists in the country. Five were based in Port Moresby and two in the second-largest city, Lae. The remaining 20 provinces had no psychiatrist.[49]

The WHO estimated in 2021 that there is only one psychiatrist per 1 million people in PNG, with no data available regarding child psychiatrists, mental health nurses, psychologists, occupational therapists or speech pathologists.[61]

> *There are only about eight psychiatrists at the moment who are actually in the system. So, eight psychiatrists and maybe 200 mental health nurses. But the mental health nurses don't get to provide mental health activities in the health care system. They are assigned to do other general activities or different sections of the health system in the hospitals. So, the health work force is a big issue in the country.* – Health representative

To address these constraints, stakeholders recommended that in addition to increasing the number of trained specialists, other non-specialist providers should be trained and supported to deliver mental health care, particularly outside the urban areas, including primary-level nurses and doctors, community health workers and church-based health providers. They added that there needs to be consideration of the heavy workloads of health providers and therefore careful consideration of what roles could be integrated and what support is required.

Establishing collaborative care models and reliable communication mechanisms may also support the delivery of MHPSS at the primary care levels by linking non-specialist providers with psychiatrists and mental health nurses. The stakeholders added that a previous radio system for enabling rural clinicians to contact psychiatrists was effective but is no longer operational due to lack of funding. In addition to responsive care, they recommended that health-based providers deliver some aspects of prevention and promotion, such as supporting positive parenting and supporting school-based programmes (such as mental health education, screening and enabling referrals).

The **education sector** arguably comprises the biggest mental health and psychosocial support workforce. Teachers and school counsellors should have a significant role in the delivery of MHPSS, particularly actions to support social and emotional learning (such as curriculum-based mental health education), promote positive peer relationships, provide early identification and referral for those with mental health conditions and deliver behavioural management and counselling for non-complicated cases. Although there are supportive policies in place, stakeholders noted that implementation is challenging due to limited financial resources, low prioritization of mental health and lack of trained counsellors in schools.

> *Nearly all of our schools don't have school counsellors. The entire system…our teaching service commission has not created positions for school counsellors. I believe nobody sees the importance of having counsellors in our schools, in our PNG system. That is why when children have mental health issues, there is nobody in the school to help them.* – Education representative

> *We tried to create school counsellor positions across the country. It will cost the teaching service commission a lot of money, so…. I don't know when, maybe the end of this generation we will realize that counsellors were so important in our schools.* – Education representative

The National Child Protection Policy points out that the child protection workforce is insufficient to meet the demands of the Child Protection Act. The policy outlines the need to establish a senior child protection officer in each province and one child protection officer (minimum) at each district and local government level, with an additional cadre of five community child protection volunteers per local government. There is limited professionalization of the **social service** workforce. There is no law on social work, no standard definition or scope of practice and limited data concerning social service workforce numbers, distribution or current roles. Social service workers and child protection officers primarily work under the NOCFS, although they may also have a role within the justice sector (juvenile justice and Family and Sexual Violence Units) and are also employed by NGOs.

Expected roles include case management of children at risk, although it is not clear to what extent these include provision of mental health services. Given their focus on children and families at risk, roles for the social service workforce could also include screening and referral, provision of care and support as part of a multidisciplinary team, targeted prevention to address risk factors and support positive parenting and mental health literacy.

Within the **justice sector**, stakeholders noted that front-line officers (police, judicial officers) are frequently called upon to provide social welfare service or deal with acute mental health and behavioural concerns but lack expertise to effectively provide this help. Low awareness of child and adolescent development and mental health was noted, with limited numbers of justice sector workers having had access to training in mental health to support children who come into conflict or contact with the justice sector. Providing early identification, screening and referral were cited as MHPSS roles that could be integrated into this workforce, in addition to creating new cadres of psychologists or social workers employed through the justice system to support children in conflict with the law or child victims.

At the **community level**, youth organizations, community-based organizations and faith-based organizations and churches were recognized as an underutilized workforce with potential to support early identification and psychological first aid, support to preventive programmes (in the community as well as through links with schools) and deliver community-based programmes to promote mental health literacy and address stigma and discrimination.

Table 5. Overview of MHPSS roles, by sector

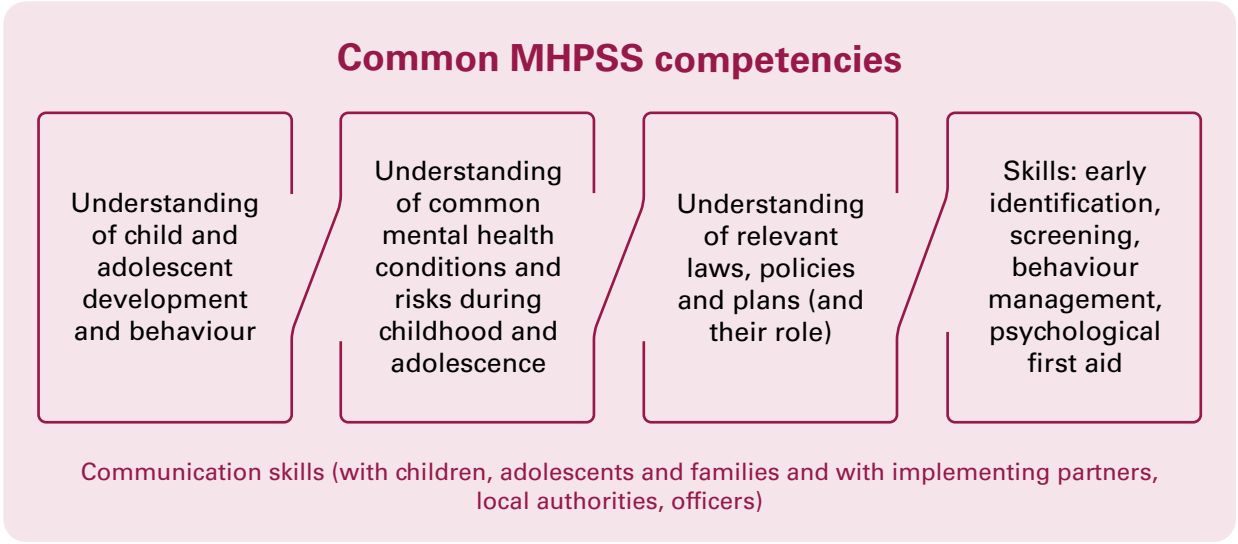
Sector	Provider	Responsive care	Prevention	Promotion
Health	Specialist mental health clinicians	Screening, diagnosis and management as part of a multidisciplinary team	Targeted interventions to address risks (such as harmful substance use) Support to school-based approaches	
	Other clinicians	Screening, diagnosis and management as part of a team and supported by specialists as needed	Supporting positive parenting and targeted interventions to identify and supporting children and families at risk Support to school-based approaches	Support mental health literacy
	Community Health Workers	Community-based early identification and screening, referral and supporting community-based care	Supporting universal prevention actions (promotion of positive parenting)	Mental health literacy, addressing stigma and discrimination
Education	Teachers	Early identification, screening and referral Behaviour modification for uncomplicated cases Support continuity of care and ongoing education	Supporting social and emotional learning, skills and resilience, promoting positive peer relationship (curriculum-based and participation in whole-of-school approaches)	Supporting mental health literacy and anti-stigma through greater engagement with families and school communities

Sector	Provider	Responsive care	Prevention	Promotion
	School counsellors	Screening and referral, provision of counselling and initial management of mental health conditions	Supporting school-based interventions to increase mental health literacy and social and emotional skills	Supporting mental health literacy and anti-stigma through greater engagement with families and school communities
Social welfare and child protection	Social workers and child protection officers	Early identification, screening and referral of children and adolescents at increased risk Case management as part of a multidisciplinary team (facility, residential and community-based)	Parenting programmes (universal) and supporting families in need (targeted) Other targeted interventions to address risks	Mental health literacy and programmes to address stigma and discrimination Social protection programmes for children and families
Justice	Police, judges and other front-line justice workers	Early identification and referral for screening, diagnosis and management	Targeted interventions and follow-up of children, adolescents and families at risk (including meaningful skills training for young offenders)	
Community	Youth leaders, community leaders, church leaders	Early identification and mental health first aid	Promoting positive peer relationships, positive parenting and support to community-based interventions	Mental health literacy and programmes to address stigma and discrimination

Competencies, training and support

Stakeholders identified common competencies required of a multisector mental health and psychosocial support workforce (*see Figure 15*). They emphasized improving understanding of child and adolescent mental health and related behaviours as well as specific skills in relation to screening, managing difficult behaviours and dealing with crises (including psychological first aid).

FIGURE 15. COMMON CROSS-SECTOR MHPSS COMPETENCIES



The primary training programme for **psychiatrists** is a Masters in Psychiatry programme at the University of PNG. The programme has had significant challenges, and only 13 people have graduated in more than 20 years.[50] The situation for nurses is better. Since 2002, 200 mental health nurses have been trained in a post-bachelor's degree course at the University of PNG, and an average of 10 new mental health nurses are trained annually.[15] Unfortunately, due to the high demand for nurses across the health system, the majority of them likely are not working in mental health roles.[15,52] Most working mental health specialist staff are based in the regional centres of Port Moresby and Lae, leaving many districts with no specialist psychiatric staff.[15]

> *When mental health nurses are returned to the province [after their training], they get diverted because the hospital doesn't have a specific objective for the mental health nurse specialist.... For example, I've been trained as a mental health nurse specialist. When I was sent back to my hospital, I didn't have this specific objective or a job description. There is no specific job description for mental health nurse specialists who have graduated with a bachelor's [degree].* – Health representative

> *We've always had funding challenges to get nurses and community health care workers to train.* – Health representative

As part of the Psychiatry Service Plan, the NDOH is trying to determine how to attract more junior doctors to the psychiatry specialty. Several issues have been identified as contributing to the small number of graduating psychiatrists: (i) There are no psychiatry training positions available in PNG. (ii) A psychiatry training programme is not included in the residency programme (in the 'blue book'). And (iii), junior doctors are not interested in psychiatry. One strategy identified in the Psychiatry Service Plan to alleviate this problem is to ask the provincial health authorities to identify medical students and encourage them to undertake specialist training. Additionally, health sector stakeholders suggested that doctors could be supported to undertake specialist training and placements in other countries, with a requirement to undertake practice in PNG upon return, although there is no funding to support such a programme.

In addition to supporting specialist training, the stakeholders recommended that mental health training be provided to non-specialist clinicians. This includes strengthening pre-service training of all nurses and doctors as well as scaling up the implementation of the WHO mh-GAP training programme (currently being piloted in Hela Province and Bougainville). This includes providing training opportunities for church and faith-based health providers. Other recent initiatives included mental health training provided by professional associations. In 2016, the Royal Australian and New Zealand College of Psychiatrists Faculty of Child and Adolescent Psychiatry delivered a child and adolescent mental health training programme for two medical officers and six nursing staff in PNG. Between 24 and 30 hours of training were delivered to prepare the participants to assess, diagnose and manage common child mental health issues. Formal participant feedback rated most aspects of the programme as good or excellent.[62] Feedback included the need to further adapt the training to be more culturally relevant and sensitive.[63]

There is no standardized training in mental health for Community Health Workers. The stakeholders acknowledged them as having a significant role in mental health care, prevention and promotion and recommended that a specific mental health training programme be developed for this cadre, with completion of training certified. Overarching responsibility for Community Health Worker training lies with the NDOH, with a standardised curriculum delivered through several Community Health Worker schools, and graduates registered and licenced to practice. The Community Health Worker training manual is reviewed every three years, which is an opportunity then to integrate mental health into the training of all providers at this level of care.

While general training and education in mental health is limited and needs to be strengthened, stakeholders also recognized a need for specific training in child and adolescent mental health for psychiatrists, mental health nurses, counsellors and non-specialist providers. This was in recognition of the unique needs of children and adolescents, as well as improved knowledge and skills in the management of child and adolescent mental health (including child trauma counselling).

Stakeholders also recommended integrating mental health into pre-service and in-service training and education for all teachers and educators, social workers, police and justice officials, with emphasis on improving the understanding of child and adolescent mental health and skills to recognize and manage mental health conditions. For the **education sector**, limited teacher training in mental health and well-being was described as contributing to a lack of recognition and understanding of mental health conditions and behavioural problems. In addition to integrating mental health into teacher training, education sector stakeholders also recommended improving training guidelines for counsellors. Updating content and technical knowledge, focusing on competencies and skills and including referral and follow-up procedures were high priorities.

Within the **social welfare sector,** a bachelor's degree in social work is offered through the University of PNG, although it is unclear to what extent, if any, mental health is integrated into this programme. Child protection officers may or may not have relevant qualifications or be university graduates, and others may have received one-off or a short training provided through an NGO or faith-based organizations. There appears to be no standardized training programme for social workers and child protection officers working with children and adolescents, nor provision of mental-health training. Similarly, there is no standardized training (including in mental health) for staff providing services through the Family Support Centres. Stakeholders thought that increasing the total number of trained social workers, child protection officers and Family Support Centre staff should be a priority, as

well as improving the quality and integration of mental health training for this workforce to support implementation of MHPSS.

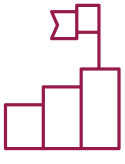
As for other workers, priorities cited encompassed understanding of child and adolescent mental health needs, training in early identification and screening, case-management and delivery of child-centred care (including counselling). The National Child Protection Policy requires the establishment of national competency standards for Child Protection Officers, a review of in-service training and consideration of establishing certificate, diploma and degree-level training. These initiatives provide opportunities to also ensure that MHPSS and mental health are included in the core training of this workforce.

For the **justice sector**, particular priority was given to training that improved understanding of the multidirectional links between mental health, behaviour and conflict with the law. In addition to pre-service training, stakeholders highlighted the need for continuing training and support to maintain quality, motivations and awareness of new policies and plans.

There were also recommendations for actions to improve support and supervision of the mental health workforce. These included establishing multidisciplinary teams; improving salaries, other remuneration and other incentives to attract and retain mental health providers; ensuring opportunities for ongoing training; and providing support (including psychological support) to front-line workers, particularly those working in child protection, counsellors and teachers. Additionally, non-health stakeholders recommended that human resources divisions create specific roles and jobs for mental health workers, such as counsellors in schools, with clear MHPSS roles in job descriptions and adequate funding to support their position. The National Child Protection Policy also recommends developing standards, guidelines and tools to support the child protection workforce, a code of conduct for workers engaged in child protection and clear career pathways.

KEY RECOMMENDATIONS – MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT WORKFORCE:

- Establish a multisector taskforce or working group for the development, planning and support of the mental health workforce. This could include subcommittees within sectors to support workforce development.
- Undertake further detailed mapping of the multisector mental health workforce and existing mental health competencies to identify gaps (numbers, skills and distribution).
- Integrate pre-service mental health training for health, education, social welfare and justice sector providers, coordinated by the NDOH in collaboration with the NDOE.
- Strengthen job aids, tools and protocols to support MHPSS roles (screening, referral, behaviour management and mental health first aid).
- More explicitly integrate MHPSS actions into the defined roles and performance indicators of cadres (teachers, counsellors, social workers and justice officers).
- Establish mechanisms for support supervision of the mental health workforce through multidisciplinary teams, support networks and services and support to address the mental health of providers.



Budget and financing

Despite the little data concerning national expenditure on mental health, stakeholders across sectors noted that limited financial resources are a major constraint to implementing MHPSS. No recent data on mental health expenditure as part of total government health expenditure are available; nor is there data on MHPSS-related expenditure through non-health sectors. Stakeholders noted that the new Directorate of Social Change and Mental Health will have funding and resources to support MHPSS, but this is still being established. The health sector received 2.8 billion kina in the 2022 national budget, the highest to the health sector since independence,[64] but there appears to be no budget allocation for mental health at the national or provincial levels. And there is lack of clarity about sources of funding. Most stakeholders described smaller programmes or initiatives relying on NGOs, development partners (United Nations agencies and other donors) or sponsorship from local leaders.

The Free Primary Healthcare and Subsidized Specialized Service Policy does not reference mental health services, although several related medicines are included in the national list of essential medicines.

The National Child Protection Policy outlines roles and responsibilities to be carried out by organizations and agencies involved in child protection service delivery (section 6).[42] Within this, the Department of Treasury is responsible for establishing and implementing a child-sensitive budget process. The policy also recommends a whole-of-government budget to support implementation, establish a Pikinini Trust Fund to support financing of child and family services and engage with development partners to support alignment of funding with the national strategy. These approaches provide an opportunity to integrate MHPSS and serve as a potential model for responding to mental health issues.

KEY RECOMMENDATIONS – BUDGET AND FINANCIAL RESOURCES:

- More explicitly include mental health services (including outpatient services) within free primary health care.
- Include a national mental health goal in social and economic plans and/or as a primary programme within the NDOH, with a specific budget line.
- Define a detailed minimum-services package for child and adolescent mental health (based on the tiered framework of actions) that address responsive care, prevention and promotion that can be costed, with a budget responsibility across allied sectors clearly defined.
- Establish a national cross-sector planning body and cross-sector budgeting committees for MHPSS to support coordinated budget requests and processes.
- Increase support for subnational and local government units to improve resource allocation for implementation of MHPSS.

Participation

Mental health-related stigma, discrimination and lack of mental health literacy are major barriers to seeking support and services. Stakeholders reported that psychiatry has negative connotations, and mental health stigma remains a significant challenge in society. It was described as contributing to a lack of care-seeking by parents, with a preference for keeping mental health conditions and symptoms secret and addressed within the family or by means of traditional medicine. Misunderstandings and misconceptions about mental health and behaviour are also common, with teachers and parents reportedly dismissing signs of poor mental health as simply bad behaviour. Limited mental health literacy among children, adolescents and their parents and caregivers also contribute to delays in seeking care and a lack of awareness of available support and services. International studies have reported high rates of stigma relating to major depressive disorders, and this has contributed to low rates of help-seeking and undertreatment.[65]

Engaging communities and strengthening the participation of children, adolescents and families is central to ensuring that policies, programmes and services respond to needs and address barriers. Stakeholders had several recommendations to support participation. At a policy and planning level, supporting opportunities for youth, including those with lived experience of mental health conditions, to engage in setting high-level priorities and designing policies and programmes are critical. Stakeholders highlighted positive examples of community consultation conducted by the NDOH, via a technical working group. Stakeholders also suggested increasing the scope and prevalence of conferences to specifically engage young people and provide them with a platform to share their experience and provide input on mental health planning. The Inspire Conference was described as a great example of engaging and listening to young people.

At an implementation level, young people were emphasized as important implementation partners. Specifically, providing opportunities for training and capacity-building for youth leaders, counsellors and advocates could help strengthen peer-led early identification, referral and support in community and school settings. As one stakeholder said: "Young people listen to young people." Additionally, youth and peer groups are an underutilized resource for supporting community engagement in mental health and delivering mental health literacy and anti-stigma and discrimination programmes. Many stakeholders added that there is urgency for more formal mechanisms for linking government agencies directly with communities to identify needs and support the implementation of community-based actions.

KEY RECOMMENDATIONS – PARTICIPATION:

- Build up capacity and increase opportunities for young people and youth organizations to participate in MHPSS policy and planning.
- Strengthen engagement between government agencies, communities and youth groups to ensure that MHPSS approaches meet local needs and support implementation.
- Invest in conference-like events in which youth can be involved in idea-sharing and consulted on mental health planning.

Data, health information and research

The prevalence of mental illness in PNG is largely unknown because there is no systematic collection of mental health data.[15,16] Unlike many other countries in the Asia–Pacific region, there have been no recent systematic surveys of young people, making it difficult to understand the mental health profile of PNG's youth. In 2021, four mental health indicators were added to the **National Health Information System** – psychosis, depression, epilepsy and bipolar disorder. Prior to the recent additions, there were no mental health diagnosis data recorded in the health system. It is unclear if these new additions will be age-disaggregated. Other challenges described by stakeholders included inconsistent data entry across the country and software failings. Because of the issues that exist with the information system, there are significant gaps in data on child and adolescent mental health incidence, prevalence, treatment, length of hospital stay and outpatient follow-up. Most estimates of mental health issues in children and adolescents come from the Global Burden of Disease Study findings, whose reliability is also limited in the PNG setting.[52]

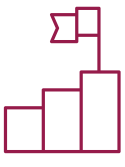
Stakeholders cited several data and information needs. At the national level, timely and reliable statistics (disaggregated by location, age and sex) related to the prevalence of common mental health conditions and risks is needed to inform policies and support prioritization, implementation plans and budgeting. These include estimates of common mental disorders (depression, anxiety, developmental disorders and psychosis), suicide rates, psychological distress and behavioural problems, risk factors (substance use, bullying, violence and adolescent pregnancy) and population and service delivery data (such as the number of families requiring social welfare). Considerable resources will be required to improve and expand the National Health Information System to ensure basic national health data and information.

Stakeholders highlighted a need to collect data on mental health indicators in other sectors outside of health and to improve the sharing of data within and between sectors to support planning and implementation. For example, the better sharing of data collected through the education, social welfare and justice sectors could improve the identification, planning and follow-up of children and families at risk. In 2021, the Government launched Primero, an online and offline information management system to support the social welfare sector in the management of data related to child protection and violence against children and women. The system, developed in collaboration with UNICEF, the Department of Community Development and the Office of Child and Family Services, aims to strengthen administrative data to better understand the prevalence of violence and populations most impacted to support planning, budgeting and advocacy. It is also intended to support child protection officers, social workers and other providers to improve the case management of children and families affected by violence and increase accountability.[66]

Further primary research is also needed to better understand children's and adolescents' mental health needs and preferences in PNG. Research exploring barriers, enablers, knowledge, attitudes, beliefs, risks and determinants would provide evidence to guide and support government and NGO programmes. Stakeholders said that evaluation of past and ongoing mental health interventions should be a research priority.

KEY RECOMMENDATIONS – DATA, INFORMATION AND RESEARCH

- Prioritize improvement and expansion of the National Health Information System to ensure basic health data and information collection.
- Integrate child and adolescent mental health indicators into information systems of education, social welfare and justice.
- Improve mechanisms for timely analysis, reporting and sharing of data within and across sectors to support implementation of MHPSS and continuity of care for those at risk.
- Invest in research to understand the needs, preferences, barriers, enablers, risks and determinants of child and adolescent mental health



Key recommendations and conclusions

Children and adolescents aged 0–18 years in PNG experience a high burden of poor mental health and unmet needs for services and support to respond to their mental health conditions, to prevent poor mental health and to ensure safe and enabling environments for psychosocial well-being.

National policy and legislative frameworks are broadly supportive, recognizing at least in part the specific needs and considerations for this age group as well as a national multisector approach to mental health care, prevention and promotion. While a large focus of the current response has been on the clinical management of mental health conditions through the health sector, there are also many examples of national and subnational programmes delivered through the education, social welfare and justice settings to improve early identification and assessment, multidisciplinary management and programmes in schools, child protection and justice settings to address risk factors.

This analysis has detected important gaps in the MHPSS response. These include the accessibility and availability of child- and adolescent-friendly and multidisciplinary care for mental health conditions (particularly outside the specialized tertiary and institutional settings); comprehensive and coordinated whole-of-education approaches to mental health promotion; a national (and targeted) approach to support nurturing and responsive care provided by parents and caregivers; and coordinated programmes to support healthy peer relationships and address peer victimization. There are also important gaps in relation to programmes reaching marginalized, out-of-school and migrant children and adolescents.

There are also some critical cross-cutting challenges impacting on the implementation of MHPSS. Although mental health and well-being are integrated to some degree in the sectoral plans of education, social welfare and justice, they generally focus narrowly on specific actions (such as mental health screening or provision of counselling) rather than encompassing a more holistic vision for mental health and well-being and articulation of the sector's role and response. At the subnational level, the lack of clear plans, guidance and structures to support implementation and multisector collaboration have contributed to limited coordination across sectors.

Across all sectors, insufficient numbers and inappropriate distribution of skilled personnel were cited as a major barrier to implementation, contributing to heavy workloads, long delays in access to care and inconsistent delivery of interventions (such as screening). Limited availability of services that are responsive to the needs of children and adolescents, particularly at the community-level, and overreliance on tertiary and institutional-based care also contribute to the high unmet needs and delays in access to services in the health and social welfare sectors and the time-consuming referral from other sectors, such as education. Administratively, complex and unclear referral protocols, particularly for referrals arising outside the health sector, also contribute to delays in access to services and support, as does the lack of standardized protocols across agencies for supporting children at high risk.

Insufficient budget for MHPSS-related programmes and budgeting processes that do not support agenda-based and cross-sectoral budget planning are also significant challenges.

Overarching recommendations

In addition to specific recommendations to strengthen the multisector mental health system, this analysis led to many overarching recommendations to improve implementation of MHPSS for children and adolescents in PNG.

1. Increase national government commitment to and prioritization of child and adolescent mental health through strengthened advocacy. Existing initiatives with strong government support, such as INSPIRE (to end violence against children) could be used as a platform to raise awareness and advocate for child and adolescent mental health, drawing on the technical expertise and convening role of the WHO and UNICEF. UNICEF and the WHO could also facilitate opportunities for children, adolescents and families with lived experience of mental health needs to engage in advocacy efforts.
2. Technical partners, such as UNICEF and the WHO, should provide support to the NDOH, the NDOE, the DFCDR and the Department of Justice to increase capacity in child and adolescent mental health to strengthen policy development and planning.

3. The Mental Health Act should be strengthened to articulate protections for children and adolescents, including addressing mandatory requirements for parental consent for adolescents and ensuring that the rights of children within the mental health system are protected.
4. The NDOH, in collaboration with the other allied sectors, should develop a multisector child and adolescent mental health strategy that articulates specific MHPSS actions for children and adolescents (as defined in the framework) and details a multisector plan (and coordination structure) for implementation. This should prioritize actions that can build on existing programmes or platforms in the short term (such as integration of mental health into primary health care, child protection, the Family Support Centres and the school health system).
5. At the national level, the Government should establish a multisector committee (or similar body) to drive action on child and adolescent mental health and be responsible for coordinating planning and implementation. This could be led by the Directorate for Social Change and Mental Health and linked to existing bodies, such as the NOCFS and initiatives such as INSPIRE.
6. At the subnational level, the Government, with support from UNICEF and the WHO, should provide capacity-building sessions for provincial, district and local government authorities to expand their awareness of mental health issues, develop local MHPSS implementation plans, allocate resources and better coordinate sectors.
7. The Government should include mental health services (including outpatient care) within the Free Primary Healthcare and Subsidized Specialized Service Policy. To support sufficient allocation of public resources for mental health, the Government, with support from development partners, should undertake budget analysis, including costing of a minimum-services package for child and adolescent mental health (informed by the regional framework of actions. That analysis should explore sources of budget and budgeting processes for MHPSS across sectors. Such information could be used to advocate with budget decision-makers within departments as well as the Budgets Division for increased investment in the mental health response.
8. The NDOH, with support from the WHO, should strengthen mental health delivery through primary and community-level health services, including early identification, screening, initial management, preventive interventions and mental health literacy. This should include integration of MHPSS through existing services – maternal and child health, nutrition, adolescent health, general health services – and supported by minimum standards of care and management protocols, referral protocols and communication mechanisms. It also should include specialist care where needed and workforce training and support for non-specialist providers.
9. The DFCDR, with support from UNICEF, should strengthen programmes addressing family violence and supporting positive parenting. This could include increasing resources for programmes to prevent family violence; scale up positive parenting programmes (such as Parenting for Child Development); development of child-focused protocols for the management and support of families at risk, including integration of MHPSS as part of the immediate response to child protection; and integration of MHPSS into the Family Support Centres, including mental health training of providers and establishing referral links with mental health services.
10. The NDOE, with support from the WHO and UNICEF, should strengthen school-based responses to mental health and well-being, including developing a national whole-of-education mental health promotion strategy; strengthening curriculum-based mental health education; training and support for teachers to improve their mental health awareness, early identification and positive behavioural management; increasing the number and competencies of school counsellors; and developing policies to address the school environment and promote positive relationships (address peer victimization and violence, prohibit corporal punishment and support respectful teacher–student relationships).
11. The NDOH, in consultation with other sectors and technical partners, should strengthen national, standardized protocols for child and adolescent mental health across agencies, including:
    - early identification protocols and validated screening tools for this age and detailed guidance on use in different settings;
    - referral procedures across sectors;
    - non-specialist management;

- case-management of children and adolescents in contact with the child protection and justice sectors;
- greater protection for children in conflict with the law and child victims within the justice system; and
- national quality service standards for child and adolescent mental health services across sectors.

12. The Government, with support from professional associations, training institutions and development partners, should strengthen the multisector mental health and psychosocial support workforce through:
    - further in-depth mapping to identify critical roles across sectors against the MHPSS priority actions and the required competencies and intersectoral training needs to support these roles;
    - development of job descriptions for identified roles and/or integration of MHPSS roles into the defined scope of practice and performance indicators for providers across sectors;
    - integration of child and adolescent development and mental health into pre-service training of health professionals, the social service workforce, justice sector officers, teachers and other school-based staff that aligns with roles and responsibilities with respect to MHPSS;
    - strengthened in-service training in mental health (including continuous education) for health providers (including non-specialists and community-based workers through the WHO's mh-GAP), social service workers, the justice sector, teachers and education staff that is competency based and aligned with expected MHPSS roles;
    - training provided to relevant department staff from the health, education, social welfare and justice sectors to support the planning and development of the workforce, as well as support for broader MHPSS programmes; and
    - improved supervision and support for MHPSS providers across sectors, including establishing provider support networks and multidisciplinary teams, improved remuneration, job security and career pathways and attention to the mental health needs of providers.

13. The NDOH, in consultation with the NDOE, the DFCDR and the Department of Justice, as well as academic and development partners, should improve the collection, use and accessibility of data at the national and subnational levels, including data and mechanisms to identify mental health needs, support planning and implementation and track progress. This should include developing a minimum set of indicators for mental health that could be harmonized across sectors, integrating mental health (and risk factors) into existing systems (such as Primero) and strengthening data links and sharing across agencies, in conjunction with privacy laws to protect children and adolescents. Consideration should also be given to establishing a national suicide surveillance system. To inform policy and programmes and support rigorous evaluation of MHPSS programmes, the Government, development partners and donors should also increase investment in mental health research to understand the needs, barriers and preferences of children, adolescents and their families.
14. The Government, development partners and non-government organizations should increase opportunities for children and adolescents (and parents and caregivers) to participate in MHPSS policy and programming, including establishing formal roles for young people (such as representation on mental health committees and other bodies at the national and subnational level). They should also establish child- and adolescent-friendly mechanisms for providing feedback and complaints on MHPSS programmes and mental health services.
15. The Government, development partners and non-government organizations should develop national and community-based programmes to address mental health-related stigma and discrimination and improve mental health literacy (particularly targeting children, adolescents, parents and caregivers). This could also include supporting innovation and collaboration among MHPSS experts, advocates and people with lived experience by hosting conferences, summits and similar events to raise MHPSS awareness and support the development of effective, relevant and sustainable MHPSS for children and adolescents in PNG.

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Appendix A:

Workshop agenda and interview guide

COUNTRY-LEVEL CONSULTATION WORKSHOP ON THE MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES IN EAST ASIA AND THE PACIFIC REGION

Programme

Day one

Time	Activity	Facilitator
Session A: Introduction		
9:00–9:15	Welcome remarks and introductions	UNICEF, Country Technical Advisory Group chair
9:15–9:30	Overview and objectives of the project and workshop	Burnet
Session B: Overview the conceptual framework for MHPSS		
9:30–10:15	The conceptual framework for MHPSS *Presentation of the framework* *Questions and discussion*	Burnet to provide overview Country partner, UNICEF to help facilitate discussion
Session C: Prioritizing actions and sectoral roles		
10:15–10:30	Introduction to the proposed actions of the conceptual framework *Presentation of the actions against each tier* *Introduction to potential sectoral roles*	Burnet to provide overview
10:30–10:45	Overview of the prioritization tool and tasks *Introduction to the online tool and tasks to be completed before the next meeting*	Burnet to provide overview
10:45–11:00	Questions and next steps	UNICEF, Country Technical Advisory Group

Participants to complete the online tool in preparation for the second workshop

Day two

Time	Activity	Facilitator
Session A: Introduction and recap		
9:00–9:15	Welcome and recap	UNICEF, Country Technical Advisory Group chair
Session B: Defining a minimum-services package for MHPSS		
9:15–9:30	Presentation of the key findings from the online tool *Outline of the actions prioritized for the minimum-services package*	Burnet
9:30–10:30	Discussion and agreement on the minimum-services package *Break out rooms by sector to discuss:* • *Agreement on actions included* • *Any actions missing or need modification* • *Agreement on timeframe* *Each group feedback*	Country partner, UNICEF, Country Technical Advisory Group chair
10:30–10:45	Break	
Session C: Identifying sectoral roles		
10:45–11:00	Presentation of the findings from the online tool *Recommendations for sectoral roles for key actions*	Burnet
11:00–12:00	Discussion and agreement on sectoral roles *Break-out rooms by sector to discuss:* • *Agreement on lead sector* • *Recommended roles for other supporting sectors* *Each group feedback*	Country partner, UNICEF, Country Technical Advisory Group chair
12:00–12:15	Questions and next steps	UNICEF, Country Technical Advisory Group

Example of the online prioritization tool

MHPSS Prioritisation Tool

Thank you for participating in this online consultation.

In brief, this prioritisation tool seeks your feedback on a series of actions to strengthen mental health and psychosocial support services (MHPSS) for children and adolescents in your country. We will collate all responses and discuss these at our workshop to define a key package of actions (a minimum-services package). You can find more information on the aim of the project and the framework of actions here:
https://www.dropbox.com/sh/vp3odcso41p7r20/AADXuS7HzXWqlzuy1ykVSAV1a?dl=

This tool will present you with a series of actions in three groups: actions to ensure an enabling and safe environment for mental health promotion; actions for prevention of mental health problems in the immediate social context ; and actions to ensure accessible and responsive services for mental health problems.

For each action, please indicate what priority you believe it is for your country. For actions that are rated as high and medium priority, we will then ask some brief questions about sectoral roles and timing of implementation. We will also ask for any additional actions that should be included.

Your responses will be anonymous and confidential. You can save and return to this tool at any time, but please complete it by the end of today so that your responses can be included in the key findings presented at the next workshop.

** If possible, please complete this form in one sitting. You can also save and return to it but clicking the button 'save and return' at the bottom of the page. It will ask for your email address- this will only be used to send you a link and will not be saved with your responses.

For any further info or clarification please contact A/Professor Peter Azzopardi on Peter.azzopardi@burnet.edu.au

Page 1 of 72

Demographics

Which country do you work in?
* must provide value

- ○ Malaysia
- ○ Papua New Guinea
- ○ Philippines
- ○ Thailand

reset

What sector do you mainly work in?
* must provide value

- ○ Health
- ○ Education
- ○ Social Welfare
- ○ Justice
- ○ Other (specify)

reset

What organisation do you represent?
* must provide value

- ○ Government
- ○ Non-government and civil society organisations
- ○ UN agency
- ○ Private sector
- ○ Professional associations (such as psychiatry, social work)
- ○ Youth-focused organisations
- ○ Other (please specify)

reset

Next Page >>

Domain	Subdomain	Recommendation
Accessible and responsive services for mental health problems (clinical and sub clinical disorders)	Screening and early identification of needs	Screening for those at risk of poor mental health

Specific action required

Routine mental health screening of children and adolescents with high-risk behaviours (e.g. harmful use of alcohol and other substances, sexual risk behaviours)

Priority for including this action in minimum package for MHPSS in your country:
* must provide value

- (●) High
- ( ) Medium
- ( ) Low

reset

Who should be the lead sector?

- ( ) Health
- ( ) Education
- ( ) Social Welfare
- ( ) Justice
- ( ) Other

reset

What other sectors should play a role in this action?

- [ ] Health
- [ ] Education
- [ ] Social Welfare
- [ ] Justice
- [ ] Other

Is this action already being implemented?

- ( ) Yes
- ( ) No

reset

What is your suggested timeline for implementation?

- ( ) Next 2 years
- ( ) 2-5 years
- ( ) 5 years plus

reset

Any challenges or considerations in implementing this action?

Expand

<< Previous Page Next Page >>

Implementing the mental health and psychosocial support services in East Asia and the Pacific

Key informant interview

**Note that sector-specific question guides were also developed and are available on request*

Interviewer ID:		Date (dd/mm/yy):	
Start time:		End time:	
Participant ID:		Sector / organization:	
Current designation / role of participant:			
How is this role related to MHPSS?			
Has the participant had a previous role related to MHPSS? Please describe			
Age of participant		Gender of participant:	
Consent obtained?	YES / NO		

Thank you very much for agreeing to participate in this interview.

Today we will be asking for your views and opinions about how to improve mental health and psychosocial support services (MHPSS) for children and adolescents. This includes your thoughts about the mental health needs of children and adolescents, what role your sector currently plays in delivery of support services and the challenges and opportunities to improve the delivery of MHPSS.

The session today will take approximately 60–90 minutes.

Participating in this project is voluntary. You do not have to answer any question that I ask you, and we can stop the interview at any time. If you don't want to answer a question or would like to stop the interview you do not have to give a reason. If you wish to withdraw from the project after our discussion, please contact the study team and the information that you shared will be destroyed.

With your permission I will be taking notes and recording today's interview using the video recording function, or an audio-recorder, to make sure we gather all your ideas. Everything you say will remain confidential. Your responses will not be shared with your manager or employer and they will not affect your role or employment.

What we learn from this interview will be compiled with the responses from other interviews. A summary of the findings will be shared with government representatives and United Nations agencies in this country and in East Asia and the Pacific region. They will also be used to develop recommendations to improve the delivery of mental health support services in your country and the region. No personal information identifying you or your organization or employer will be included in any reports or other documents.

Please confirm the participant's consent to continue the interview and consent to have the interview recorded.

Question guide:

Theme	Questions
Mental health needs of children and adolescents	**I would like to start by asking what you think the main mental health needs or problems are of children and adolescents in [YOUR COUNTRY]?** • Children (younger than 10 years) • Adolescents (10–18 years) • Are there particular groups of children or adolescents who have worse mental health than others, or are at increased risk? Why? **What do you think are the main factors that contribute to poor mental health or well-being of children and adolescents?** • Individual-level • Family-level • Peer • Community • Society **What factors promote good mental health and well-being?** **What impact do you think COVID-19 has had on the mental health and well-being of children and adolescents?**
MHPSS policies and national plans	**I would like to ask you about what is currently being done by your sector or organization to address mental health and well-being of children and adolescents.** **Are you aware of any government policies, plans or initiatives that relate to mental health of children and adolescents?** • Can you briefly describe these – what sectors do they relate to, what plans or actions do they include for child or adolescent mental health? • To what extent do you think these sectoral plans or policies are being implemented? **What national standards, guidelines, or other tools currently exist to support the delivery of mental health services or programmes?** *If the participant identifies specific policies, please ask them if they would be happy to be contacted by the research team at a later date to help us access these documents for the desk review.*

Theme	Questions
Current role in providing MHPSS	**I would like to ask you about the different mental health and psychosocial support services that are provided by your sector or organization. I will refer to this as 'MHPSS', which broadly includes services, support and programmes to respond to children and adolescents with mental health problems, to prevent mental health problems (addressing risk factors) and to promote good mental health.** **Could you talk me through what specific MHPSS for children and adolescents your sector or organization currently provides? We are interested in understanding what services or programmes are provided, who they are for and how they are delivered** **Which groups of children and adolescents are these MHPSS for? Are any programmes targeted and, if so, to who?** **To what extent are these initiated or led by the government** • Which ministries? • By non-government organizations? • By private sector? • Where they are led by non-government or private sector agencies, what role has the Government had? **Were there any MHPSS that had been implemented your sector or organization previously but are no longer provided? Why?** **Are there any new MHPSS that are being planned or developed?** *Additional prompts:* **Services** • What MHPSS does your sector or organization provide for children or adolescents who have mental health problems (**responsive care)**? • What MHPSS does your sector or organization provide that address specific risk factors to prevent mental health problems (**prevention**) • What MHPSS does your sector or organization provide to promote good mental health and well-being **(enabling environment)** – For example, programmes to address harmful norms or attitudes towards mental health, stigma or discrimination related to mental health, to protect children and adolescents from harm (violence, exploitation, abuse, neglect etc) **Delivery** • Through what mechanisms, systems or platforms are these MHPSS provided: – community-based – facility-based (health, education, residential care, other) – Online or digital – *[explore what services are provided through which platforms]*

Theme	Questions

	• Who provides MHPSS within your sector or organization and what roles do they have in supporting MHPSS?
	  – Who (professional, paraprofessional, volunteer) and what role or tasks do they have in delivering MHPSS?
	  – What training and other supports do they receive with respect to mental health of children and adolescents?
	  » pre-service or in-service
	  » accredited (diploma, degree, etc.) or informal
	  » who provides this training
	• Who is responsible for supervision of these MHPSS roles?
	• Are these MHPSS workers supported by a professional association?
	• How are these roles licenced, accredited or regulated? Is there specific regulation with respect to MHPSS roles?
	
	Linkages
	• Is there any current engagement between your sector or organization and communities to address norms and attitudes related to mental health, stigma, care-seeking behaviour or other factors that influence mental health?
	• What links are there with other supports provided in other sectors (health, social welfare, education, justice)?
	  – What linkages exist with NGOs? The private sector?
	  – How are these linkages coordinated?
	  – For children and adolescents who are identified as having mental health problems, how are referrals coordinated to
	  » health services
	  » social welfare
	  » or other community-based supports
	  » Are there regulations, guidelines to support these referral systems?
	• To what extent have adolescents, children and parents and caregivers been involved in designing, delivering or evaluating mental health supports or services in your sector or organization? Is there a process for children, adolescents and parents and caregivers to provide feedback?

Barriers and enablers providing current MHPSS	**I would like to ask now about what has been working well and what some of the challenges have been delivering MHPSS for children and adolescents** • What do you think is currently being done well to address the mental health of children and adolescents by your sector or organization? • What could be improved or strengthened? • What are the gaps (what specific areas of mental health and well-being aren't being addressed)?

Theme	Questions
	• What are the main challenges currently impacting on the delivery of MHPSS through your sector or organization? For example: – Lack of understanding or prioritization of mental health – Community and parent attitudes and norms and social taboos – Funding and other resources for MHPSS – Existence of nationally mandat ed programmes that include MHPSS – Mental health worker training and education – Links and coordination with other sectors (social welfare, education, health services, NGOs, etc.) – Information sharing within your sector or organization and across sectors and organizations
What role *should* the social welfare sector have in implementing MHPSS and minimum-services package	**I would like to ask you about what roles and responsibilities your sector or organization *should* have in MHPSS for children and adolescents** • Broadly speaking, what do you think the role of your sector or organization should be in implementing MHPSS? How is this different to the current roles we have already discussed? • Reflecting on the different 'tiers' of MHPSS what role should your sector or organization have in: – Responsive care for children and adolescents with mental health problems – Prevention of mental health problems – Creating an enabling environment to promote good mental health *You can refer to figure A1 and table A1 in the conceptual framework* **I would like to ask you now about the specific MHPSS actions or services that your sector or organization should have responsibility for. This minimum-services package for MHPSS has been proposed by stakeholders across different sectors in [YOUR COUNTRY]** • Are there any actions that you think are missing? • What actions do you think your sector/organization should have primary responsibility for and why? • Which of these would be feasible for your sector/organization to deliver and why? • How could they be delivered? – What mechanisms currently exist to support implementation of these MHPSS actions? (what existing programmes or services could MHPSS be integrated with, what existing workforce could deliver MHPSS actions) – Do new delivery mechanisms or systems need to be developed? • What actions do you think your sector or organization could contribute to (if not primary responsibility) and how (linkages with other sectors, etc.)?

Theme	Questions
Challenges and considerations for implementation of a minimum-services package and strengthening a multisector mental health system	**I would like to ask you about how the MHPSS actions proposed in the minimum-services package could be effectively implemented. In particular I would like to ask about what frameworks, structures, resources or supports your sector or organization would need to strengthen implementation** **Legislation and policy** • What additional policies are needed to support the delivery of MHPSS? • What legislation or regulation changes are needed? • *[consider: sector-specific policies to enable delivery of MHPSS, multisectoral mental health policies that clearly define sectoral roles]* **Governance and leadership** • What government or non-government agencies should have primary responsibility for implementation of MHPSS? – Planning – Implementation – Monitoring • What role in leadership or governance do you think your sector or organization should have, why? • How could coordination be improved within your sector or organization (planning, implementation, monitoring)? • How could coordination with other sectors (health, education, justice, social welfare) and with NGOs and private sector be improved? • What role should other sectors have in implementation of MHPSS? • What role should UNICEF have in supporting MHPSS? • What role should the private sector have in supporting or delivering MHPSS • What role should NGOs have in supporting or delivering MHPSS **Services** • How could MHPSS be integrated with existing services or programmes for children and adolescents? • What new services or programmes might be needed? • Are there systems or structure changes needed within this sector or organization to take on these roles and implementation of MHPSS? • What tools, resources or supports would be needed? • Is there an opportunity for online or digital delivery of MHPSS? • What actions are needed to ensure that children, adolescents and parents and caregivers have access to these services and support? What actions are needed to reach the most underserved children and adolescents?

Theme	Questions
	Standards and oversight • What national standards, guidelines, or other tools currently exist to support the delivery of MHPSS? How could these be improved? What additional guidance is needed? [Consider: new procedures, SOPs, programmes, referral mechanisms, etc.] • What further actions are needed with respect to accreditation or certification of workers who are engaged in delivering MHPSS? • How should quality of MHPSS be monitored and assessed? By whom? **Resources** *Financial* • How are current (or planned) MHPSS delivered by your sector/ organization currently funded? – If government organization: » Are national policies or programmes that relate to MHPSS costed? » What is the source of the budget (through a specific programme, specific budget line, etc.) » To what extent does the budget include contributions from user fees, sponsor contributions, in-kind contributions, private sector or local business support? » Are MHPSS funded through national or district and local government? » How are the staff who deliver MHPSS funded? » How is infrastructure for MHPSS funded? – If non-government, private sector or United Nations » Are MHPSS plans or programmes costed? » What is the source of budget for these » To what extent does it include user fees, private sector support, government funding, other? • What additional financial resources would be required to support MHPSS? Where should these come from? *Workforce* • What additional human resources are required for MHPSS? • What 'types' of MHPSS providers are needed in your sector/ organization? With what competencies? • Can MHPSS be integrated into existing roles and/or are new roles needed? • What additional training is needed? For whom? Who should provide this? • What supportive supervision is needed? • What job aids or other resources are needed? • What requirement or role might there be for professional associations for MHPSS workers in your sector or organization? • How could linkages with other MHPSS providers (health workers, teachers, social workers) be improved to support delivery of MHPSS?

Theme	Questions
	Participation • What role should children, adolescents and parents and caregivers have in designing or developing MHPSS policy, programmes and services? • What role should they and the community have in monitoring and evaluating MHPSS? What mechanisms are needed to enable feedback? • What mechanisms are there or could be developed to support the participation and engagement of young people? **Data and information** • What data or information do you think is needed to support the implementation of MHPSS? – For design and delivery of services or support programmes – For monitoring and quality assurance – For evaluating outcomes and impact – For financing MHPSS • Are there existing systems (routine data collection, population or household surveys, etc) that do, or could, include mental health? How? • What systems are needed (or could be strengthened) to improve reporting, use and communication of mental health data? How is or could this information be shared (within your sector or organization, across different sectors, with NGOs and the private sector)? • What do you think are some important knowledge and evidence gaps with respect to child and adolescent mental health? For example, what further research would help support MHPSS?
Any other issues?	Any other comments or suggestions you would like to raise that we have not yet covered today? I will go over a summary of what we have discussed, if you would like to add or change anything you have said please let me know.

Technical advisory group findings workshop implementing mental health and psychosocial support services (mhpss) for children and adolescents in papua new guinea 11 may 2021

PROGRAMME

Objectives

1. To present findings of the PNG MHPSS project
2. Co-develop final recommendations for implementation of MHPSS in PNG

Time	Activity	Facilitator	Notes
Session A: Introduction			
9:45–10:00	Guests arrive		
10:00–10:10	Welcome remarks and introductions	UNICEF Country Technical Advisory Group Chair Burnet Country Director	
10:10–10:25	Overview of the project, framework and objectives of this workshop	Burnet	Recap the project aims, methods and purpose of the workshop, emphasizing that this is a participatory workshop to develop and refine recommendations
Session B: Matching actions to needs			
10:25–10:50	Presentation of findings: • Methods • Mental health needs in PNG • Current response • Overview of priority actions • Recommended sectoral roles • Overview of findings on challenges and considerations for systems strengthening *Questions and reflections*	Burnet	20–minute presentation of findings, followed by 20 minutes for general questions and feedback (noting there will be time to explore areas in more detail during the rest of the workshop)
10:50–11:00	BREAK		

Time	Activity	Facilitator	Notes
Session C: Deep dive on priority actions and implementation			
11:00–11.30	**Group discussion:** • What is needed to increase political support for mental health? • What national and subnational leadership and coordination structures are needed to support policy, planning, multisector collaboration and implementation of MHPSS? • What high priority actions could be feasibly integrated into existing health services, education settings and child protection? And what is needed to enable this?	Burnet, UNICEF, Technical Advisory Group	
Session D: Wrap up and next steps			
11:45–11:55	Questions, reflections, feedback Next steps	Burnet	
11:55 –12:00	Close workshop	UNICEF / Technical Advisory Group Chair	

Appendix B:

Development of the regional MHPSS conceptual framework

The approach to develop the regional conceptual framework was consultative and iterative and included the following.

Synthesis of the available evidence

An important foundation to this work is the framing of mental health and well-being in UNICEF's *The State of the World's Children 2021* report.[2] A core recommendation of that report is to consider the 'spheres of influence' that shape mental health and well-being from an early age, with spheres including 'the world of the child' (mothers, fathers and caregivers), 'the world around the child' (schools and communities) and 'the world at large' (the social determinants). In a related commentary co-authored by UNICEF, opportunities to intervene were broadly mapped against these spheres of influence:[67] Mental health promotion largely targets the social determinants of health that impacts on the world of the child, with preventive and treatment services more targeted towards the world of and around the child.

The following additional documents and resources were reviewed in drafting the conceptual framework: UNICEF reports focusing on MHPSS;[68–71] WHO guidelines related to mental health;[14,72–75] the Lancet Commissions on Global Mental Health and Sustainable Development and on Adolescent Health and Wellbeing;[76,77] United Nations guidance on social and emotional learning;[78,79] and available country-level operational guidance on implementation of MHPSS from both high-income settings[80–82] and available guidance from focal countries for this project (Thailand and the Philippines).[83–87] The draft framework considered the context of the region and in particular the experience and capacity of allied sectors to implement MHPSS.

Review by the regional Technical Advisory Group

The regional Technical Advisory Group was assembled specifically for this project by UNICEF, with experts in child and adolescent mental health and well-being, UNICEF regional focal points related to child and adolescent mental health, as well as UNICEF representatives from each of the four countries where the research was to be undertaken. The conceptual framework was first presented during a virtual meeting, then circulated for written feedback in April 2021. All members of the Technical Advisory Group provided feedback and subsequently endorsed the conceptual framework.

Additional review by content experts

Written input was sought from content experts in social and emotional learning, interventions to address the social determinants of mental health and the role and responsibilities of the social welfare sector in mental health. Input was also sought from programming and implementing partners in each focal country, as well as the technical lead for MHPSS at UNICEF headquarters, with consideration of the forthcoming Minimum Services Package for MHPSS (in development) in refining the conceptual framework and actions.

Finally, extensive feedback was sought from country-level stakeholders during a two-day online workshop in each focal country.

Each online workshop (in Thailand, the Philippines, Papua New Guinea and Malaysia) was organized with stakeholders and implementation partners across health, education, social welfare and youth advocacy, representing government, non-government, the private sector and United Nations agencies. Feedback was gathered through facilitated discussion and an online prioritization tool completed by individuals. The feedback from across all countries was collated to inform a cross-cutting regional framework, in addition to identifying specific priorities within each country.

Appendix C:

National data on mental health outcomes

Mental health outcomes

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of depressive disorders	Female	5–9	0.05	0.05	0.05	GBD	2019
	Male	5–9	0.04	0.04	0.04		
	Both	5–9	0.05	0.05	0.05		
	Female	10–14	0.90	0.90	0.90		
	Male	10–14	0.57	0.57	0.57		
	Both	10–14	0.73	0.73	0.73		
	Female	15–19	2.83	2.83	2.83		
	Male	15–19	2.15	2.15	2.15		
	Both	15–19	2.47	2.47	2.47		
Prevalence of bipolar disorder	Female	10–14	0.08	0.08	0.08	GBD	2019
	Male	10–14	0.08	0.08	0.08		
	Both	10–14	0.08	0.08	0.08		
	Female	15–19	0.27	0.27	0.27		
	Male	15–19	0.28	0.28	0.28		
	Both	15–19	0.27	0.27	0.27		
Prevalence of anxiety disorders	Female	1–4	0.19	0.19	0.19	GBD	2019
	Male	1–4	0.12	0.12	0.12		
	Both	1–4	0.16	0.16	0.16		
	Female	5–9	2.24	2.24	2.24		
	Male	5–9	1.43	1.43	1.43		
	Both	5–9	1.82	1.82	1.82		
	Female	10–14	5.52	5.52	5.52		
	Male	10–14	3.54	3.54	3.54		
	Both	10–14	4.49	4.49	4.49		
	Female	15–19	6.54	6.54	6.54		
	Male	15–19	4.11	4.11	4.11		
	Both	15–19	5.27	5.27	5.27		

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of conduct disorder	Female	5–9	0.72	0.72	0.72	GBD	2019
	Male	5–9	1.43	1.43	1.43		
	Both	5–9	1.09	1.09	1.09		
	Female	10–14	2.34	2.34	2.34		
	Male	10–14	4.08	4.08	4.08		
	Both	10–14	3.25	3.25	3.25		
	Female	15–19	1.22	1.22	1.22		
	Male	15–19	2.57	2.57	2.57		
	Both	15–19	1.93	1.93	1.93		
Prevalence of idiopathic developmental intellectual disability	Female	1–4	1.67	1.67	1.67	GBD	2019
	Male	1–4	1.70	1.70	1.70		
	Both	1–4	1.69	1.69	1.69		
	Female	5–9	1.84	1.84	1.84		
	Male	5–9	1.88	1.88	1.88		
	Both	5–9	1.86	1.86	1.86		
	Female	10–14	1.76	1.76	1.76		
	Male	10–14	1.81	1.81	1.81		
	Both	10–14	1.78	1.78	1.78		
	Female	15–19	1.65	1.65	1.65		
	Male	15–19	1.68	1.68	1.68		
	Both	15–19	1.67	1.67	1.67		
Prevalence of schizophrenia	Female	10–14	0.01	0.01	0.01	GBD	2019
	Male	10–14	0.01	0.01	0.01		
	Both	10–14	0.01	0.01	0.01		
	Female	15–19	0.08	0.08	0.08		
	Male	15–19	0.09	0.09	0.09		
	Both	15–19	0.08	0.08	0.08		
Prevalence of autism spectrum disorders	Female	1–4	0.17	0.17	0.17	GBD	2019
	Male	1–4	0.58	0.58	0.58		
	Both	1–4	0.38	0.38	0.38		
	Female	5–9	0.16	0.16	0.16		
	Male	5–9	0.56	0.56	0.56		
	Both	5–9	0.36	0.36	0.36		
	Female	10–14	0.15	0.15	0.15		
	Male	10–14	0.53	0.53	0.53		
	Both	10–14	0.35	0.35	0.35		
	Female	15–19	0.14	0.14	0.14		
	Male	15–19	0.50	0.50	0.50		
	Both	15–19	0.33	0.33	0.33		

Indicator	Sex	Age group	Estimate	Upper CI	Lower CI	Data source	Year
Prevalence of attention-deficit and hyperactivity disorder	Female	1–4	0.15	0.15	0.15	GBD	2019
	Male	1–4	0.41	0.41	0.41		
	Both	1–4	0.28	0.28	0.28		
	Female	5–9	1.26	1.26	1.26		
	Male	5–9	3.40	3.40	3.40		
	Both	5–9	2.37	2.37	2.37		
	Female	10–14	1.67	1.67	1.67		
	Male	10–14	4.51	4.51	4.51		
	Both	10–14	3.15	3.15	3.15		
	Female	15–19	1.29	1.29	1.29		
	Male	15–19	3.36	3.36	3.36		
	Both	15–19	2.38	2.38	2.38		
Mortality rate due to self-harm (deaths per 100,000 population)	Female	10–14	0.32	0.54	0.16	GBD	2019
	Male	10–14	0.73	2.18	0.30		
	Both	10–14	0.53	1.30	0.28		
	Female	15–19	1.80	3.11	0.94		
	Male	15–19	4.26	12.83	1.88		
	Both	15–19	3.10	7.53	1.67		

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