

ODI Executive summary

Mental health and psychosocial well-being among adolescents in Viet Nam

Findings from a mixed-methods baseline study

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Cover: Painting featured at the UNiTE circle exhibition organized with the Vietnam Youth Union, Vietnam Women's Museum in Ha Noi, November 2011. Credit: Krista Seddon / Flickr. CC BY-NC-SA 2.0

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Executive summary

This mixed-methods study is part of a project funded by Fondation Botnar to address the mental health needs and psychosocial well-being of adolescents in two very different country contexts, Viet Nam and Tanzania.¹ The summary below outlines the content of the Viet Nam report, core findings and recommendations.

Study aims

This ODI Report is focused on identifying the key drivers of mental ill-health and psychosocial well-being among two subgroups of adolescents (those aged 11–15 years and those aged 16–19 years) in two cities (Vin City and Nha Trang) in Viet Nam.

A 2014 survey in Viet Nam found that approximately 3 million children (aged 12 or above) were in need of mental health services, with needs varying significantly across the 10 provinces surveyed. Viet Nam's mental health system is heavily focused on treating severe mental disorders (especially epilepsy and schizophrenia) in hospitals in urban areas, with few resources dedicated to more common mental health problems in any setting. Where mental health services do exist, uptake is low (especially among adolescents and children), partly due to lack of knowledge about those services, stigma surrounding mental ill-health, and lack of age- and gender-appropriate services.

Subsequent aims of the project are:

- To co-create (with adolescents, teachers and local authorities) and test a range of approaches (digital and non-digital) to support adolescents' mental health and well-being.
- To review and adapt potential approaches based on the monitoring, evaluation and learning (MEL) system, the baseline and endline studies, and ongoing feedback loops.
- To document the effectiveness of both digital and non-digital solutions in addressing adolescents' mental health problems.

Chapter 2: Methodology

We collected data from adolescents in eight public schools in urban and rural areas of two provinces, Khanh Hoa and Nghe An.

Primary data was collected in December 2020 and January 2021. The quantitative survey of 844 adolescents (in the 7th and 8th grades [middle school] and 10th and 11th grades [high school]) provided a baseline profile to better understand mental health status, literacy and service access, and to inform evaluation of the impact of the project's digital and non-digital interventions. We used purposive sampling to enrol adolescents, disaggregated by age (mid-adolescence [11–14 years] and older adolescence [15–19 years]), gender (male and female), mental health status and academic performance. Participants were recruited through enrolment lists with socio-demographic characteristics shared by the school teacher.

¹ The three-year programme of work consists of six phases: (1) inception; (2) mixed-methods baseline data collection; (3) co-creation/design of solutions; (4) implementation of solutions; (5) mixed-methods endline data collection; and (6) sharing, dissemination and research uptake. Starting in May 2020, the project will run for a total of approximately 36 months.

Primary qualitative data collection consisted of in-depth interviews (IDIs), focus group discussions (FGDs), family case studies (FCS, interviewing different generations of the same family) and key informant interviews (KIIs). Among those interviewed for the qualitative study were adolescents who participated in the survey, and who showed high levels of internalising issues such as depression or anxiety according to the Strengths and Difficulties Questionnaire (SDQ). A total of 92 qualitative research interactions were conducted across the two sites.

Chapter 3: Overview of mental health policy and services in Viet Nam

Although Viet Nam does not have a mental health law, there is a draft National Mental Health Strategy covering the period 2015–2020, with a vision to 2030. It includes consideration of service provision across all life stages (from infancy to older age).

The main government ministries responsible for mental health services are the Ministry of Health (MoH) and the Ministry of Labour, Invalids and Social Affairs (MoLISA). There are several pieces of legislation that protect the rights of mentally ill persons, including MoLISA's Scheme 1215 (2011–2020), providing community-based social assistance and functional rehabilitation for people with mental illness or mental disorders.

Viet Nam's healthcare system is based on four tiers (central, province, district and commune); psychiatrists only work at the first two levels. While most mental health services (focusing on epilepsy and schizophrenia) are provided in hospitals, follow-up usually occurs within the community. Mental health services are provided through six types of institution: (1) two national psychiatric hospitals (in Hanoi and Bien Hoa);

(2) provincial-level psychiatric hospitals; (3) outpatient facilities; (4) commune health stations; (5) day treatment facilities; and (6) community-based psychiatric inpatient units. Respondents most commonly mentioned the first two.

Chapter 4: Adolescents' mental health and psychosocial well-being status and knowledge

To establish the baseline of adolescents' mental health and psychosocial well-being status – including their mental health literacy, and the perceptions of adults and other community members about mental health – our key comparable metrics (collected through the survey) are the SDQ (a measure of emotional and behavioural difficulties) and the WHO-5 (a measure of subjective psychosocial well-being). We coded SDQ and WHO-5 scales on a range from 0% to 100%. In SDQ subscales (emotion, behaviour and prosocial), higher scores indicate a higher risk of mental health problems. On WHO-5, higher scores indicate greater psychosocial well-being.

To complement these continuous measures, we categorise the top quartile of the SDQ emotion distribution as consisting of students 'at risk' of mental health issues, and the top quartile of the WHO-5 distribution as consisting of students exhibiting relatively high psychosocial well-being. We also use the WHO-5 measure as a screening instrument for depression; following accepted standards, we designate individuals scoring 50% or less as being at risk of depression.

In the qualitative research, adolescents described symptoms or signs of mental distress as including 'overthinking' things, being stressed, having unresolved problems, being angry, being too emotional, thinking negatively, wanting to be alone, having too much energy and self-isolating. They

also cited physical symptoms such as being tired, having headaches and having a stomach ache. Some used derogatory terms to describe mental illness, such as ‘crazy’, ‘insane’ or ‘abnormal’.

In our survey, only 41% of respondents reported knowing about the causes of mental ill-health, while 45% said they recognise the signs. More than two-thirds (69%) said they know of strategies to help them be more resilient when facing difficulties, 64% said they know of strategies for dealing with stress and 72% said they understand how social media impacts well-being. Only 13% said they would not tell anyone if they had a mental illness, and only 16% said they would not seek help from a professional. Just over a quarter (26%) think that mental ill-health is not a real medical illness.

The survey identified 33% of respondents as being at risk of depression (WHO-5), with relatively equal proportions in middle school and high school.

Both the qualitative research and the survey suggest that girls are more likely to experience mental health distress than boys. The survey found that 28% of girls are at risk of mental ill-health (according to the SDQ emotion subscale), compared with 14% of boys, and 37% of girls are at risk of depression (WHO-5), compared with 30% of boys. In a multivariate analysis, we found that girls are 2.9 times more likely to be at risk of mental ill-health than boys, and 1.4 times more likely to be identified as at risk of depression, even after controlling for other factors.

Findings also suggest that mental health stressors increase with age. The SDQ emotion score was higher for high school respondents and older respondents (aged 14–15) compared with middle school and younger respondents.

Ethnicity and socioeconomic status (SES) also impact mental health. The qualitative research found that adolescents from minority backgrounds are more likely to be discriminated against and bullied, with consequences for mental health. The survey also shows that risk of mental ill-health was higher among respondents who had experienced hunger in the past 12 months.

Respondents in the qualitative study mentioned experiencing stress, depression/sadness, anxiety and anger. There were also accounts of suicide ideation and detailed planning of suicides, although some reported that their friends had dissuaded them from going through with it.

Most respondents in the qualitative research perceived that mental health problems have increased compared to 5 or 10 years ago, citing reasons such as growing use of social media and electronic devices, and rapid economic development, which has contributed to increasing pressures and stress.

There were also some positive views, with respondents noting that students are now more able to talk about their problems, and some schools are developing strategies to reduce academic pressures, which are a considerable source of anxiety for many adolescents (see Section 4.1).

Chapter 5: Protective factors for mental health and drivers of mental ill-health

Adolescent respondents reported a range of factors that are protective of mental health. These include:

- having a positive perception of oneself (including physical appearance, personality and doing well at school)

- having positive family dynamics/good relationships with parents (in the survey, living with both parents was associated with higher subjective well-being (WHO-5))
- having close friends or other positive relationships outside the household
- having role models (this was positively associated with psychosocial well-being and a lesser risk of mental ill-health on the SDQ prosocial subscale)
- leisure activities (alone or with friends)
- having aspirations for the future (such as having a career, getting married, having children, and taking care of parents and grandparents).

In addition, the survey data found that adolescents with high psychosocial well-being have 11% higher self-efficacy than those with lower psychosocial well-being, whereas those at risk of mental ill-health had self-efficacy scores that were 7% lower than those classed as not at risk, and those at risk of depression had self-efficacy scores that were 10% lower than the rest.

Interestingly, girls were more likely to have a role model than boys. Respondents most commonly cited role models as the mother (52%), father (43%), grandmother (27%) and teacher (26%). The qualitative research indicates that a family member who had done well academically or who was financially successful was the most commonly mentioned role model.

Adolescent respondents also cited many factors as driving mental distress and ill-health, some of which appear to be the direct opposite of the protective factors. They include:

- negative self-perceptions, such as body image or physical appearance (among girls more than boys) was often linked to low self-esteem, self-worth and self-confidence
- unhappy or unstable family dynamics, which could make adolescents feel unloved, misunderstood, neglected or unsupported; some also reported being punished and/or scolded by parents, often due to poor academic achievement (see Section 5.2)
- parental separation or divorce, parental re-marriage or absence, parental death, or sudden accidents, injuries or chronic health problems among family members, as well as conflicts within the home (parents arguing, fathers ‘beating’ mothers); the survey found that 33% of respondents have witnessed physical violence against their mother, which was associated with higher risk of social and behavioural problems
- poverty/financial difficulties, leading to unmet basic needs (the survey found that adolescents who had gone hungry in the past 12 months had a statistically significant higher risk of mental ill-health on the SDQ emotion and behaviour subscales)
- conflict among peers and friends (whether due to jealousy, gossip, or perceived favouritism by teachers); bullying is also pervasive, and our survey found that being bullied is one of the best predictors of mental ill-health (it doubles the chances of being in the SDQ high-risk category or WHO-5 risk of depression, after controlling for other factors)
- schools, and the often extreme pressure (mostly from parents/family) on adolescents to perform well academically (which also leaves little time for leisure activities)
- experiencing violence or excessive discipline (most commonly from parents but also teachers, other adults, or peers); just under two-thirds of survey respondents (64%) reported experiencing physical or emotional violence or other maltreatment (e.g. being denied food) at home within the past year; experiencing physical violence more than doubles the chances of being identified with depression (after controlling for other factors)

- romantic relationships, particularly when they end, or are deemed socially unacceptable (such as homosexual relationships)
- technology, and addiction to mobile phones and social media (thus losing contact with the real world); the survey found that frequent internet use was among the best predictors of mental ill-health (it increases the likelihood of being high risk in mental ill-health (SDQ) by a factor of 1.7). The survey also found a higher risk of mental ill-health (SDQ emotion subscale) among respondents who had access to a smartphone, owned a mobile phone or had access to the internet whenever they needed.

Use of harmful substances (such as alcohol and cigarettes) was cited as both a driver of mental ill-health and a coping strategy. The survey found an association between consuming alcohol and high risk of mental ill-health, and that consumption of harmful substances was more common among respondents at risk of depression. Having ever smoked was associated with higher risk of mental ill-health, while consuming drugs was only associated with lower psychosocial well-being.

Chapter 6: Mental health-seeking behaviours, coping strategies and the influence of technology

Awareness and knowledge of services and support

Knowledge of what constitutes good mental health was high, at 74% (average); emotional literacy was also high (68%). Both were higher for those with high psychosocial well-being but lower for those at risk of depression.

For knowledge of sources of information about mental illness, the average score was 69%, indicating some level of confidence. However,

only 35% of respondents were confident about where to seek information. Knowledge of sources of information was also linked with mental health outcomes (lack of knowledge was among the best predictors of risk of depression). Knowledge was lower among respondents with high risk of mental ill-health on the SDQ emotion subscale, higher among respondents with high psychosocial well-being, and lower among respondents at risk of depression.

The qualitative research found that some adolescents are aware that psychiatric hospitals, psychological counselling offices in schools, school mailbox schemes and hotline numbers are sources of information about mental health; others cited school talks and television (TV) talk shows as sources. However, in contrast to the survey findings, the qualitative research found that most adolescents had not heard of the mental health services available to them (including school-based services), and did not know where to find information about mental health.

Experiences of accessing formal or informal services

More than three-quarters of survey respondents (79%) said they would find psychotherapy useful if experiencing a serious emotional crisis. More than two-thirds (68%) disagree with the statement that talking about problems with a psychologist was a poor way to get rid of emotional problems. Overall, there seem to be positive attitudes towards seeking professional help for mental health issues.

Most of the adolescent respondents in the qualitative research had not used formal mental health services (e.g. a psychiatric hospital or clinic). Most feel that they have not needed professional support, and even if they may have felt they did need it – in contrast to the survey findings – they

would probably not have sought it. Reasons for not doing so include fear of embarrassment, lack of awareness and information, lack of confidence, and fear of stigma and discrimination. Neither have they used mental health services at school (reasons included teachers and other school staff being unapproachable, and concerns about confidentiality – for example, of the mailbox scheme).

Coping strategies and behaviour

Adolescents reported using *positive coping strategies* such as distraction and calming themselves (through watching TV shows and films, playing video games, listening to music, going out with friends, spending time with friends and family, using the phone and internet, playing sports, studying, reading, taking a walk and drawing). Many relied on friends for comfort and counselling, even family members too; although boys and girls alike reported turning first to their mother to share problems, girls were more likely to talk to their mother, and boys to their father. Adolescents were also more likely to confide in a sibling or other family member of the same sex as them. Some adolescents reported that they talk to their teachers about problems, and had found them to be very understanding and helpful.

Our quantitative analysis (using the Kidcope scale) identified three main groups of coping mechanism: (1) problem-solving or active coping; (2) distraction or internal coping; and (3) emotion-focused coping. Overall, problem-solving or active coping mechanisms were more common among survey respondents, followed by distraction or internal coping. Emotion-focused coping mechanisms appeared to be relatively rare.

Use of coping mechanisms was a good predictor of respondent's mental ill-health. Emotion-

focused coping mechanisms were by far the highest predictor, increasing by 18 times the likelihood of being in the SDQ high-risk category (after controlling for other factors). Conversely, problem-solving reduced the risk by a factor of 0.3. Use of emotion-focused coping mechanisms more than triples the likelihood of being identified with depression, while use of distraction or internal coping mechanisms increases the likelihood by a factor of 2.5.

Negative coping strategies reported by adolescents included keeping problems to themselves, and not wanting to share with anyone for fear that people would not understand them. Some (girls more so than boys) coped by isolating themselves, staying in their room at home alone. Some also reported skipping meals (especially those who had been body-shamed by family or friends). Other adolescents reported sleep (or being unable to sleep – insomnia) as a negative coping mechanism.

Some adolescents (girls and boys) reported behaving in a violent way – for instance, hitting and breaking things as a response to depression or anger. While most adolescents in the qualitative research had not turned to harmful substances as a coping strategy, some did know of people who had used them.

Suicide ideation appeared to be common. Most adolescents in the qualitative research reported having friends or acquaintances who had had suicidal thoughts, with some (mostly older respondents of secondary school age) noting that they themselves had had such thoughts in the past. Self-harming was also mentioned by many adolescents and some key informants. Our survey found that as many as 28% of respondents had engaged in self-harm on occasion, while 2% did so frequently. There is a clear and statistically

significant association between mental ill-health (SDQ emotion subscale) and self-harming; 50% of respondents with high risk of mental ill-health have self-harmed, compared with only 25% among lower-risk respondents.

Technology use

Most adolescent respondents (in both cities, and as confirmed by the survey and qualitative research) have a smartphone, and if they do not own one themselves, they can use a parent's phone. Our survey found that 71% of respondents had their own mobile phone and 67% had access to a smartphone daily; only 7% did not have access at all. Adolescents reported the most common reasons for using a phone as studying, playing games and communicating with friends.

Fewer adolescents had access to a computer, and even fewer reported owning one. According to the survey, only 38% of adolescents live in a household without a computer, rising to 56% among children from the poorest households; only 12% of respondents indicated that they never have access to a computer when they want it. Adolescents cited the most commonly used platforms or applications as Facebook and Messenger, followed by YouTube and TikTok (in Vinh City) and Zalo, gaming apps and YouTube (in Nha Trang).

Respondents reported some positive aspects of technology use, including: relieving stress and loneliness; allowing people to 'connect', especially those who find it easier to text/write rather than speak; and finding information and services online (with reliable and up-to-date information that can be accessed quickly). Our survey found that more than 70% of respondents had looked for mental health information in the previous 30 days. Those with more access to technology appeared to have more emotional literacy and to be more

knowledgeable about sources of information on mental illness.

The negative aspects or challenges of technology use (according to adolescents in the qualitative research), include distracting students from their school work, and risk of addiction and losing touch with the real world, causing difficulties in managing daily life. Respondents also raised some concerns about the effectiveness of the internet for addressing mental ill-health, noting that information on websites is often not checked or verified (and may even be dangerous), is often too generic to be useful, and may lack a personal/emotional connection (one of the benefits of in-person services). There is also a risk of children/adolescents seeing distressing and/or age-inappropriate images.

Overall impact of coping factors and technology access on mental health outcomes

The relationships we identify are suggestive only, and highlight several areas on which the intervention might usefully focus to support adolescent mental health. Overall, our multivariate analysis is able to explain around 30% of variation in the SDQ and WHO-5 scores. When controlling for a range of factors, we distil only a small number that appear to exert an independent influence on the SDQ emotion subscale. Emotion-focused coping mechanisms are by far the highest predictor, increasing by 18 times the likelihood of being in the SDQ high-risk category; being a girl triples the likelihood, being bullied doubles the likelihood, while frequent access to the internet increases the likelihood by a factor of 1.7. Conversely, being from the wealthiest socioeconomic group halves the likelihood, having someone to rely on also reduces it by nearly half, and using problem-solving or active coping mechanisms reduces the likelihood.

When analysing risk of depression, we found that all three coping mechanisms are the highest predictors. Distraction or internal coping increases the likelihood of being identified with depression by a factor of 3.5, while emotion-focused coping increases it by a factor of 2.5. Using problem-solving or active coping mechanisms reduces the likelihood of depression by 0.1 (90% less likely). Experiencing physical violence from parents also increases the likelihood of depression by a factor of 2.2. Being bullied or being a girl increases the likelihood of depression by a factor of 1.4. Conversely, having good knowledge of sources of information about mental health reduces the likelihood of depression by a factor of 0.7, and having someone to rely on reduces the likelihood by a factor of 0.6.

A range of other variables do not appear statistically significant for depression or high risk of mental ill-health, but remain significant for other outcomes. For example, living with both parents remains significant and positively associated with psychosocial well-being (WHO-5), and school level remains significantly associated with psychosocial well-being (lower well-being for high school students) and significant also for SDQ (emotion subscale) (lower score for high school students). Emotional violence remains statistically significant and positively correlated with SDQ (emotion subscale) and negatively associated with psychosocial well-being. Witnessing intimate partner violence increases the SDQ score (prosocial and behaviour subscales). Harmful behaviour remains statistically significant for SDQ (emotion subscale) (increasing risk).

Chapter 7: Recommendations

Many of the recommendations listed here include suggestions of how, and therefore also who, could take this up, and often this relates to those working in the education sector and especially schools

and teachers. Other sets of recommendations are specific to certain stakeholders (such as mental health service providers, local authorities). More generally, many of these recommendations could be considered by government and development partners including donors and non-governmental organisations (NGOs).

Individual level

Recommendations at this level could be implemented by, for example, schools and teachers or extracurricular activities.

- Raise awareness among adolescents of the drivers and symptoms of mental ill-health.
- Give adolescents information on mental health services available to them, including face-to-face and online services.
- Raise awareness of stigma and discrimination around mental ill-health, as this prevents adolescents accessing support and services.
- Build adolescents' life-skills, to help them develop self-confidence, self-esteem and agency.
- Hold informed discussions around puberty, body image and romantic relationships (contributors to adolescent mental distress).
- Build peer support and social bonds among adolescents to provide opportunities for friendship and connectedness (protective factors).
- Train peer counsellors to act in a leadership/mentorship role.

Household and family level

- Encourage more dialogue and communication between parents and children by: providing classes on parenting skills; engaging parents in school-related platforms (e.g. parent and teacher associations); encouraging more parent and child joint activities (e.g. sports,

entertainment); using role models (examples of families where parents have been supportive, for instance by allowing their children leisure time) to highlight positive impacts on children.

- Raise awareness among parents (and other family members) of the drivers and symptoms of mental ill-health, including discussing the norms that drive mental ill-health among adolescents and providing information about the services available.

School, school environment, teachers and headteachers

- Build teachers' capacity to provide mental health support to students, and help them to recognise the most common mental health disorders; they should be able to recognise and counteract stigma and discrimination, and know to which services they can refer students.
- Assign specific teachers and/or professional counsellors to address student mental health issues, giving appropriate consideration to issues of gender and age.
- Review and improve existing school-based approaches to address students' mental distress (e.g. mailboxes, counselling units), improving how they are run, and addressing concerns around confidentiality and potential backlash.
- Provide more school-based counselling services/units (staffed by experts), learning lessons from schools that have had better experiences and outcomes with such services than others.
- Advocate with provincial-level educational authorities to earmark more resources for school-based mental health support.
- Review workload (including homework and school hours) and academic pressures on students – one of the key drivers of mental distress – ensuring that non-academic subjects (e.g. sports) are given sufficient time in the curriculum.

Community level

- Raise awareness of the drivers of mental ill-health among adolescents and adults – for instance, through local associations, advocacy campaigns, media (TV and radio), etc.
- Identify, raise awareness amongst and build capacity of community-based associations or organisations to support adolescent mental health, such as youth unions or women's unions.

Mental health service providers

- Raise awareness among service providers of the drivers of mental ill-health (including gendered norms), and build their capacity to better recognise mental ill-health symptoms (including the most common disorders) and to provide age- and gender-appropriate targeted services.
- Advocate to increase the number and capacity of social workers and/or community-based mental health providers, to extend services beyond urban areas and make them more accessible to rural people.
- Inform mental health service providers of other services to which they might refer adolescents – including targeted services (e.g. telephone hotlines) but also activities/groups that promote adolescent well-being (e.g. youth or sports clubs).
- Link mental health service providers to schools and other community-based organisations (CBOs, e.g. youth unions), not only to allow easier referral but also so that they can give talks, provide materials, etc. to raise awareness about mental health (and support services) within schools.

Local authorities

- Improve coordination among those providing mental health services for adolescents – ministries (MoLISA, the Ministry of Education

and MoH), NGOs and CBOs, and within and between provinces.

- Raise awareness among local authority staff of the prevalence and drivers of mental ill-health among adolescents, shifting attention away from severe disorders towards the most common disorders.
- Advocate for more resources for mental health, not just staffing (including psychologists and counsellors) but also resources for mental health hospitals and services beyond the cities.

Radio, TV, (smart)phones and computers

- Increase the use of technology to promote messages on mental health, including through TV and radio.

- Promote digital approaches to addressing mental ill-health, as the anonymity they afford could enable adolescents to access information and resources more readily.
- Monitor online material and websites to ensure that they are providing accurate information and that adolescents are not exposed to dangerous materials or at risk of online abuse.
- Adults (parents and teachers) need to engage with adolescents so that they do not become addicted to being online, playing games, etc.
- Ensure blended (digital and face-to-face) approaches to supporting mental health and psychosocial well-being. While digital can be more confidential, face-to-face approaches also have value, so a combination of the two would be optimal.