



Non-digital interventions for adolescent mental health and psychosocial well-being

A review of the literature

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Key messages

- Non-digital interventions are important means of providing mental health services for young people, particularly in resource-constrained settings.
- Non-digital interventions allow face-to-face interactions and relationship building, with trained specialist and non-specialist actors including families, caregivers, teachers and communities.
- Using established platforms such as schools, primary healthcare systems and community institutions, these interventions are able to address the mental health needs of a wide range of young people and sometimes also include caregivers and families in programmes.
- Combining a diversity of approaches, activities and interactions, e.g. role plays, competitions, dramas, gardening, cartoons, photography, poetry, sewing, sports and yoga, these interventions can also address intersecting issues affecting adolescents, including reproductive health.
- Effectiveness of interventions designed to promote good mental health and psychosocial well-being (or to protect from poor mental health and psychosocial ill-being) is specific to the individual's gender, symptoms and context.
- Youth voice is central to all efforts to improve mental health; designing interventions without young people's input, or the input of their teachers or caregivers, will undermine impact, missing key elements that young people are looking for the service to deliver.

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Acronyms

CBT	community-based therapy
CBO	community-based organisation
CBT	cognitive behavioural therapy
CMD	common mental disorder
FBO	faith-based organisation
HICs	high-income countries
HCP	healthcare providers
IPT	interpersonal psychotherapy
LMICs	low- and middle-income countries
MHPSS	mental health and psychosocial support
NGO	non-governmental organisation
WHO	World Health Organization

1 Introduction

It has become increasingly recognised and accepted globally that mental health is intrinsic to physical well-being and good quality of life (Govindasamy et al., 2020). This has been demonstrated by progress and evolution in the design and development of preventive, promotive and curative interventions for improved mental wellness. Although technology-led online resources and interventions have seen marked increases in the past decade (Clarke et al., 2017), many non-digital means of delivering mental health support – through schools, families, faith-based organisations (FBOs) and non-governmental organisations (NGOs), traditional healers, communities, and primary care systems – continue to exist globally, with their presence particularly important in resource-poor settings.

Evidence-based psychological treatments, Patel et al. (2011a) argue, form the central approach of curative programmes, the majority of which are made available through primary care systems in many developed countries. In low- and middle-income countries (LMICs), however, such treatments remain inaccessible to those most in need, due to barriers such as resource constraints and cultural norms (Patel, 2007; Patel et al., 2011a; Rathod et al., 2017; Kutcher et al., 2017; Alloh et al., 2018). In LMICs, people face additional challenges of poverty, gender inequality, climate change, inadequate access to good physical health as well as literacy and housing, which can augment mental health difficulties (Weiss et al., 2012; Kutcher et al., 2016; Mathias et al., 2018). Additionally, Rathod et al. (2017) point out that mental health-seeking behaviours in LMICs – influenced by religious leanings and resource challenges, stigma, and lack of access to trained human resources – lead some people to seek help from traditional healers (Ngoma et al., 2003; Solera-Deuchar et al., 2020).

Adolescents and young people face an unequal risk of developing mental health complications

but remain one of the least accessible sub-populations to reach for support interventions. Challenges in meeting the mental health needs of adolescents in high-income countries (HICs) are well documented, with barriers to access including young people's choices to self-manage, stigma, lack of mental health awareness, and inadequate evidence on effective treatments and interventions (Hawke et al., 2019). While many of these barriers also apply in resource-constrained settings, adolescents in LMICs face a higher risk of mental ill-health due to adverse conditions, while also grappling with a shortage of trained medical professionals to address their mental health needs, leading to wide treatment gaps (Weiss et al., 2012; Kutcher et al., 2016). In addition to severe shortages of specialists like psychiatrists and psychiatric nurses, LMICs also have poorer resourcing of mental health support structures, with very little (if any) availability of these services in primary care settings and community networks (van Ginneken et al., 2013). For instance, in settings where health care is mostly provided by the private sector, these services incur huge direct and indirect costs to individuals and caregivers. These burdens lead to a large treatment gap, with many of the people who need mental health support excluded from accessing it (Patel, 2007; Patel et al., 2011a; Rathod et al., 2017). Urgent recognition and development of alternative delivery platforms, especially those involving non-specialists and lay workers, is crucial to ensure access and availability of these services (van Ginneken et al., 2013; Ryan et al., 2018; Verhey et al., 2020).

Outside of the primary care system, families, caregivers, teachers and communities are recognised as crucial towards building positive relationships, ensuring mental health awareness and lower stigma as well as incorporating non-specialist contributions to mental health care in low-resource settings (Rathod et al., 2017).

These interventions are delivered at homes, schools, workplaces, refugee camps and other community-based locations. However, these methods often cause mental health disease burdens to spill over to the individual's family, friends or community, and require that caregivers receive support, training and economic opportunities (van der Ham et al., 2011; Iseselo et al., 2016).

Non-digital interventions offer an opportunity to use existing resources in the community, such as schools, primary health care and other institutions. One could argue that these institutions tend to be cost-effective, platforms as they are potentially able to provide youth mental health services (for example, screening) at scale, but supporting evidence on this remains inadequate, particularly in LMICs. Although interventions continue to evolve, there is still no standard classification on the resource-intensive nature of approaches; an informal categorisation of interventions into high resource intensity and low intensity has been suggested, although no such formal definitions exist (Rodgers et al., 2012). For instance, strategies that rely on one-to-one sessions with a professional, especially for longer periods, are considered resource intensive, while those using online platforms or group activities for psychological support (such as self-help, sports and other platforms, including community initiatives) are categorised as low-intensity interventions as they require little or no help from a health professional. This is particularly essential when considered alongside resource availability – a crucial determinant in LMIC contexts.

In establishing these new, low-resource platforms for service delivery, gaps are seen in the supportive evidence, such as inadequate data for caregiver support and training, and scalable contextual evidence on low resource-intensive measures for specific mental health disorders and population sub-groups of young people. As a step towards further understanding

these gaps, this review provides an overview of non-digital interventions that are focused on preventing mental health challenges, promoting positive mental well-being and aiding prevention, treatment and coping mechanisms for youth with diverse mental health disorders. The review addresses three questions:

1. What are the predominant non-digital approaches, activities, actors and target groups for addressing young people's mental health and well-being?
2. What are the advantages and challenges of using non-digital approaches to address the mental health and well-being of young people in our two study countries (Tanzania and Viet Nam)?
3. What are the opportunities to improve the design, implementation and uptake of these services and where are the gaps in the literature?

The review is embedded in a project spanning two and a half years to address the mental health needs of adolescents in schools, in the community and at institutional level in Tanzania and Viet Nam through the co-creation and application of digital technologies, funded by Fondation Botnar. The search strategy involved bibliographic database searches (Web of Science, PubMed, Scopus, Google Scholar), hand searching (relevant websites of international organisations, NGOs and think tanks) and snowballing (e.g. looking for sources identified in relevant articles/reports). The review also benefited from input and recommendations from various advisors. We included literature in the English language from 2005 onwards. The focus was on LMICs (especially Viet Nam, Tanzania, sub-Saharan Africa and South Asia) and mid (11–15 years) and older (16–19 years) adolescents; but if relevant, some global literature and literature on other age groups was included.

2 Non-digital interventions addressing adolescent mental health and psychosocial support

Over the past few decades, many innovative mental health interventions have been developed, using face-to-face methods and online/digital systems of service provision. Here, we focus on the non-digital approaches to addressing the mental health needs of young people and some adult target groups, focusing on interventions suitable for use in LMICs. These approaches can be better understood by exploring five key areas: (1) types of interventions; (2) types of platform for delivering interventions; (3) actors that support implementation; (4) target groups; and (5) key approaches and activities.

2.1 Types of intervention

According to the World Health Organization (WHO, 2002), the aims and objectives of mental health interventions can be classified into three primary categories (although they could be used as combinations).

- **Preventive programmes:** Preventive programmes can be understood as actions to keep a disease/disorder or condition at bay. However, since mental health challenges are enveloped by many uncontrollable environmental and genetic factors, it is difficult to comprehensively record onset, manifestation and symptomatic and asymptomatic disorders (WHO, 2002). Preventive programmes aim to address risk factors of mental ill-health, which are often indistinguishable from everyday stressors. These interventions can also be determined based on a ‘risk-benefit’ point of view (Gordon et al., 1987, cited in WHO, 2002: 8–9) where primary prevention involves (1) universal prevention for the general population (e.g. mental health awareness campaigns); or (2) selective prevention addressing specific target groups at higher risk of developing mental health complications (e.g. out-of-school youth, new mothers); or (3) indicated prevention targeting those at highest risk (e.g. youth with drug addiction, orphaned youth, people living with HIV). Secondary prevention includes those interventions aimed at lowering overall prevalence with specific targeted treatment measures and tertiary prevention measures focused on reduced disability and discomfort, and improved coping mechanisms.
- **Promotive programmes:** These interventions aim to improve well-being, capabilities and quality of life by focusing on the positive aspects of mental health rather than the negatives of mental ill-health. While there is much debate on a concrete definition of promotive interventions, they are often considered extensions of or complementary to preventive programmes. They aim to improve people’s capacities to take control of their own health and life, and highlight the value of good mental health as something to work towards improving.

- **Curative programmes:** Focused on management of symptoms, diagnosis, and advice and treatment, these programmes are built on clinical and psychotherapy-based means to diagnose, manage and treat specific mental health disorders.

2.2 Types of platform for delivering interventions

Das et al. (2016) classify non-digital mental health interventions for youth based on the three predominant platforms which support their delivery – schools, communities, and individuals and their families (some interventions might use multiple platforms).

2.2.1 School-based programmes

Mental health interventions delivered via schools show promise in both HICs and LMICs, as educational attainment and school environments are inherently supportive of young people, helping them build social networks with peers and develop feelings of achievement, connection and purpose (Barry et al., 2013; Fazel et al., 2014; Liebenberg et al., 2015; Kutcher et al., 2016; Coleman et al., 2017). Fazel et al. (2014) further note that schools are considered important institutions within the community, bringing together community-based

actors such as nurses and counsellors to provide universal and specialist care to young people within the school set-up, as has been observed in many community-partnered school mental health programmes. These institutions are especially important in youth mental health across LMICs as school enrolment rates have been rising and children spend more time at schools compared to any other community institution. Schools offer a chance to provide and scale up effective programmes, spanning all the stages of the mental health care continuum: preventive, promotive and curative (WHO, 2002; Kutcher et al., 2016). Evidence shows that schools are most effective in offering safe spaces for after-school activities, establishing peer groups, building resilience and awareness, and supporting early diagnosis of mental health disorders. Barry et al. (2013) note that school-based mental health programmes are useful in conflict-affected areas and in reaching adolescents, but more systematic evaluations are required to effectively scale-up existing programmes and include more younger populations in LMICs.

2.2.2 Community-based programmes

For supporting out-of-school children and adolescents, Barry et al. (2013) argue that community-based programmes are particularly



Secondary school students completing a mental health survey, Dien Bien, Viet Nam. © Fiona Samuels, 2016

important to address the challenges of gender inequality observed in formal school-based systems in LMICs. As well as out-of-school children, the authors further argue that this platform allows for older adult participation and multi-component interventions addressing economic empowerment, training and life-skills focused opportunities (some examples include loans, skill-building, and physical health checks). This platform offers support to programmes that allow adolescents and their caregivers to participate jointly and also those that address intersectional issues such as HIV, gender equality, reproductive health, microfinance and other subjects. Community-based programmes are especially valuable in low-resource settings where primary systems requiring specialists are inadequately resourced (Rathod et al., 2017).

2.2.3 Individual/family-based programmes

Das et al. (2016) use examples from HICs in this category, which mostly focus on mental health clinical management and treatment for adolescents such as one-on-one psychotherapy programmes, pharmacological actions or hospital-based inpatient care (used either individually or sometimes, in combination). A few others include sports-based interventions, targeted interventions for specific mental disorders, and home-based mental health management. In LMICs, these interventions are far fewer, with a shift from hospital-based treatment to community-based care in resource-poor areas (Weinmann and Koesters, 2016). Another individualised approach involves printed mental health toolkits, books and self-help guides for young people, although information on uptake and effectiveness is unavailable (Ntulo, 2015; Abayneh et al., 2017). Family-based programmes are also encouraged in LMICs, although much remains unaddressed in terms of caregiver burdens and coping mechanisms.

2.3 Actors supporting implementation of different interventions

Adapting the overarching categorisation used by van Ginneken et al. (2013) in their systematic review, the evidence suggests that actors can be divided into specialist and non-specialist health

workers, other professionals with health roles, and others:

- **Specialist health workers:** Evidence suggests that specialists involved in providing mental health interventions for adolescents include psychiatrists, psychologists and psychiatric nurses.
- **Non-specialist health workers:** This includes doctors, nurses, midwives and any other professional health workers who might not have received training in mental health. These actors are also referred to interchangeably throughout the literature as lay health workers (Patel et al., 2011b; Ryan et al., 2018), community health workers or frontline health workers.
- **Other professionals with health roles:** This includes those outside of the formal health sector such as teachers, social workers, sports coaches, mindfulness meditation or yoga instructors, other school staff (such as counsellors, principals, coordinators), volunteers from NGOs or community-based organisations (CBOs), and mental health researchers and academics. Lay workers also sometimes fall into this category when they have had no training in health sciences.
- **Others:** Traditional healers, families, caregivers, peers, mentors, parents, doulas (non-medical, trained professionals who provide support to women during and immediately after childbirth).

2.4 Target groups

Non-digital mental health and psychosocial support (MHPSS) interventions have primarily targeted the following groups.

2.4.1 Children, adolescents and youth

Universal preventive and promotive programmes target wide-ranging groups of young, aged 8–18 years. Targeted treatment programmes are also offered to children and young people who have been diagnosed with disorders such as anxiety, depression, and suicidal ideation. In some cases, the age groups defined as ‘youth’ vary by region and local categorisation such as school attendance or employment.

2.4.2 Parents, caregivers and families

Parents and caregivers (especially mothers) are important sources of MHPSS for young people, hence many of the interventions that target adolescents also provide training for parents and new mothers. In many instances, caregivers who provide MHPSS for young people face mental health burdens of their own which some interventions address through programmes such as support groups. Given that early diagnosis is important for mental ill-health, families play a larger role in these programmes, especially for younger children. Also of note is that parents and families can be considered stressors for children, using intrusive parenting and harsh punishment for the child's 'benefit' as observed in Viet Nam (Hang and Tam, 2013 as cited in Van Heel et al., 2019). Parents, therefore, must recognise and accept mental ill-health in young people, be aware of their own actions in contributing towards these psychosocial outcomes and also practice protective behaviours towards children and adolescents.

2.4.3 Health workers

In LMICs, community health workers or nurses and lay workers are crucial in providing mental health services in community clinics and primary care systems. They need to be regularly trained and up-skilled to support clinical and psychotherapy services.

2.4.4 Teachers and other school staff

With most MHPSS interventions delivered via school-based platforms, teachers are a crucial resource in improving awareness, detecting and referring young people with mental health issues to appropriate services, also acting as a link between schools and communities. Teachers and other school staff can facilitate after-school activities, peer support groups and one-on-one counselling and guidance for pupils. Liebenberg et al. (2015) highlight that school staff play an important role in facilitating and building resilience with young school-goers. Sports coaches and school coordinators also fulfil facilitating roles, for which they often receive training as a part of their roles in these mental health programmes.

However, the training is not standard and varies between programmes.

2.5 Some approaches and activities used in mental health and psychosocial support interventions for young people

Having reviewed a diverse set of programmes and interventions designed to support the MHPSS needs of young people, we can identify some central components that are used singularly or in combination, as outlined below.

2.5.1 Individual and group interpersonal psychotherapy (IPT)

Patel et al. (2011a) discuss individual psychotherapy as an important clinical treatment for many mental health disorders, which include behavioural modifications, adaptations and cognitive behavioural therapy (CBT) methods. These activities require trained specialists to conduct and facilitate therapy sessions. These are resource-intensive activities that require substantial human and financial resources, which means they are more difficult to administer in LMICs. These services are offered through outpatient, day care and inpatient services at primary care settings or private health facilities. IPT programmes can be adapted to suit contextual and resource requirements, such as provisioning in a group context, to be delivered by specialised and lay health workers as suggested by the WHO and Columbia University (2016) guide for Group-IPT for moderate to severe depression; IPT and antidepressants are considered to be first-line mental health treatment. The WHO and Columbia University guide is meant for use in primary care settings, in the community, within specialised mental health services as well as by trained and certified NGOs and CBOs.

The other first-line therapy for mental disorders is pharmacological drugs and interventions, which have not been investigated in this review.

2.5.2 Group counselling/support groups

Support groups are designed to be safe spaces where people of different ages can come together to discuss a variety of topics. These support groups

are also seen in cases such as same-sex only or girls' clubs (also referred to as youth clubs for either sex), where young people can discuss issues such as reproductive health, family planning and empowerment. In Viet Nam, Plan International has established facilitated group discussions to bring together out-of-school girls to discuss financial literacy and economic empowerment, while also using activities such as competitions and role plays (Marcus and Brodbeck, 2015).

Support groups are also crucial for caregivers of young people suffering from mental ill-health. Evidence suggests that these groups offer a common space for caregivers (mothers, parents, other family members) to discuss their experiences, learn from others and also combat stigmatisation. Describing support group approaches, Pegon and Calvot (2017) outline three interventions: in Lebanon, where an NGO supported the formation of a monthly support group for mothers of autistic children to discuss their challenges; in Togo, where a faith-based organisation brought women suffering from mental health disorders together; and in South Sudan, when civil society organisations (CSOs) hosted families with young children and patients once a fortnight. Two of these three support groups were facilitated by psychiatrists and all groups showed acceptance of these interventions. In Lebanon, participating mothers expressed an interest to expand the support groups to include more members. Community-based support groups are also used in HICs to bring young people and their carers together for different activities.

2.5.3 Peer networks

Peer groups (occasionally also referred to as support groups) are also important for young people, both within and outside schools, to build self-confidence, resilience and empowerment (Zimmerman, 2010). They use a diverse set of activities to encourage participation such as training programmes, role plays, problem-solving activities, quizzes and competitions. Peers are important in school as role models and mentors, as discussed by Coleman et al. (2017), who also note the significance of peer-support systems in anti-bullying initiatives. Using examples from HICs such as the United Kingdom (UK), these authors note that peer-based activities often involve

different methods, including: one-on-one support, where students are matched with other peers (older or same age) based on requirements; group peer-based learning or support, where an older pupil engages younger peers, or a professional facilitates peer group discussion; or the training given to peer supporters who pass along public health messages to the wider school network (these peer supporters also act as champions and role models in schools). In Viet Nam, a teacher-facilitated training activity from Plan International's programme set up a school-based girls' club to give girls a safe space to interact and discuss issues such as child marriage and reproductive health, using more participatory, engaging approaches such as quizzes, games, competitions and role plays. School-based peer sessions facilitated by teachers in Uganda for specific cohorts, such as orphaned children with AIDS, have also demonstrated positive results in terms of depression and anxiety among the students, and some include a life skills component (Kumakech et al., 2009; Ssewamala et al., 2009).

After-school peer networks are also a widely used approach and usually include a large variety of activities to encourage young people to bond, build social connections and participate in life skills activities such as cooking, photography, sewing, gardening and sports, and yoga. These networks have been shown to be effective in building promotive, positive understanding of mental health, building empowerment and confidence.

In many countries, there are peer networks for women and men from disadvantaged communities to come together, outside of school settings. In India, Mathias et al. (2018) describe the Nae Disha (New Pathways) intervention for young women (aged 12–24) in urban slums that involves peer-facilitated groups that met weekly for 15 weeks, which were seen to improve resilience and self-efficacy and reduce anxiety. In Tanzania, Mwilike et al. (2018) document that the peer network component of a reproductive health intervention was most successful in bringing together pregnant young girls who felt more at ease to discuss this information in a peer group, having confidence in reaching out to group members over their own partners in cases of financial and health emergencies. Kaaya et al. (2013) also note the benefits of a school peer group approach for resilience-building among adolescents with HIV.

2.5.4 Mentorship

Mentors and role models offer young people the opportunity to build positive, protective attributes that support good mental health. Examples of mentorship programmes include the use of positive youth development-based frameworks in sports to help young people develop new skills, address anxiety and build self-confidence (Ho et al., 2017). There are also specific groups, such as for students with attention deficit hyperactivity disorder (ADHD) who meet with mentors on a regular basis, pursuing projects and activities to improve social and emotional well-being (mentors and mentees are chosen from different schools) (Haft et al., 2019).

2.5.5 Mental health literacy programmes and psychoeducation

These approaches are effective prevention pathways that help raise awareness for mental health and also assist in early diagnosis. While there are many different methods of improving psychoeducation across schools, families and communities, some of the most effective involve giving parents, carers and teachers training on mental health, screening and early diagnosis of symptoms and disorders among students and young people. In Tanzania, Kutcher et al. (2016) discussed the benefits of a teacher training programme using the African Guide, which was built on the premise that improving mental health awareness among teachers meant better health outcomes for children. They suggest that training teachers to be more aware has positive spillover effects in the community as well as in establishing more referral systems with community clinics. Pedersen et al. (2019) suggest that improving caregiver psychoeducation is one of the most promising approaches to improving youth mental health, as the two (youth and caregiver) share a symbiotic relationship, especially in building positive approaches towards mental well-being. Training community-based healthcare providers also improves mental health literacy, awareness and lowers stigma, encouraging positive behaviour towards addressing challenges from mental ill-health (Kutcher et al., 2017).

2.5.6 Talking therapies

Talking therapies can be understood as interventions built on dialogue between a trained specialist and an individual or group. They are used for multiple common mental disorders, although their use with communities struck by adversity, with victims of torture or mass violence, and those in humanitarian settings is well known (Ryan et al., 2018). Talking therapies were recognised by WHO as a scalable intervention when delivered by lay health workers, as one of the approaches most accessible in these contexts, and it has since been advocated for uptake in challenging contexts. Talking therapies are also part of trauma narratives used in IPT with young people affected by AIDS – one component of the Sauti Ya Vijana programme in Tanzania (Dow et al., 2016).

2.5.7 Life-skills training

Life-skills training for young people and families is used in positive, promotive approaches to youth mental health, and includes training on financial literacy, skill-building through vocational training, microfinance options and other opportunities. While these form a component of some mental health interventions, they are crucial to others that focus on building young people's economic capital. Examples include the Better Future Initiative in Tanzania, which aimed to unite caregivers and young children under a holistic model of care, providing schooling (for children), physical health checks, support groups and vocational training and entrepreneurship for adult carers and families (Kail et al., 2020). Ssewamala et al. (2009) discuss the focus on building money-management skills as a means of building self-confidence and resilience in young people so that they can manage their assets and plan for the future, further encouraged by the monthly mentorship component in the Ugandan intervention.

Table A1 provides some examples of prominent programmes in LMICs which have demonstrated the use of some of these pathways. This list is by no means exhaustive. Notably, interventions from refugee/displacement contexts have not been included, largely because this review is with non-displaced populations.

3 Advantages and challenges of using non-digital approaches

Schools, community and family-based interventions feature as some of the most prominent non-digital pathways for reaching young people and their caregivers. Among these, the greatest focus has been on the contributions made by school-based platforms.

Utilising approaches that are not reliant on digitisation and technology has shown some advantages over digital approaches, especially in resource-constrained settings like LMICs. However, they also face some key implementation challenges.

3.1 Advantages

3.1.1 Promotes relationship-building and face-to-face interaction

Kumakech et al. (2009) describe the importance of a ‘big hug’ in their youth mental health approach as a way to engender trust and build physical connections with peers. Face-to-face interactions within mental health interventions are particularly emphasised in psychosocial support and therapeutic interventions, which constitute first-line therapy for addressing common mental health disorders (CMDs). In cultural adaptations of psychotherapy, the roles of language, context, and the therapist delivering the intervention have been identified as key elements, which once again highlight the need for face-to-face interactions in these systems (Chowdhary et al., 2014). Several peer network and support group interventions, as well as approaches that include counselling, IPTs and CBT-based approaches and talking therapies, underline the importance of interaction, both with facilitators (specialists and non-specialists) as well

as with peers in group settings. Social relationships have been shown to help build self-confidence, self-efficacy, motivation and resilience – positive, protective attributes for good mental well-being as well as necessary for providing treatment, alongside pharmacological prescription in many circumstances. The importance of these social interactions and the negative effects of social deprivation have been highlighted due to the Covid-19 pandemic, with concerns about possible long-term mental health consequences for young adults and adolescents who are isolated (Orben et al., 2020).

Peer-based group activities, within and outside schools, allow young people to bond with one another in ways that allow them to embrace their collective journeys and struggles. Facilitated group activities allow the possibility of an empathetic knowledge exchange. For instance, in Viet Nam, the Because I am a Girl programme runs a teacher-facilitated girls’ club for lower secondary students aged 11–15 to discuss child marriage, sexual health and other challenges in a participatory, creative manner, using games, competitions and story-telling (Marcus and Brodbeck, 2015). In settings characterised by political violence, conflict or among groups of people living with HIV, such group activities with peers offer hope and, in some cases, youths also report lower scores of mental distress (Tol et al., 2008). For instance, the role of youth clubs, particularly girls’ clubs or women’s groups, is seen as important for girls who are out of school, although peer support is also vital for sub-groups such as orphaned children as well as those in conflict zones and those living with AIDS or HIV.

In programmes built on peer group-based support and in others where it is only a small component, the emphasis on positive benefits of relationship-building, acceptance, and lowered anxiety and depression is well documented. This interaction is also valued among caregivers of mentally troubled adolescents. One example is the case of autistic youth in Lebanon, where mothers felt less alone in support groups and expressed an interest in expanding these to more members (Pegon and Calvot, 2017). In Tanzania, Iseselo et al. (2016) document that little has been done to monitor the psychosocial burdens that families experience from caring for relatives with mental ill-health, which manifests through increased stigmatisation from extended family and community as well as a loss of economic opportunities. They further note that one of the coping mechanisms repeatedly requested by families is social support groups of any nature, for patients and caregivers to feel more connected and accomplished. Thuy and Berry (2013) also recommend a similar intervention for mothers of children with moderate-to-severe mental disability in the mountainous regions of Viet Nam who are severely socially disadvantaged. The study reports that improving social contact opportunities for these women to enable them to develop friendships or connections with others facing similar situations to build trust and closeness would be very helpful.

As they can support relationship-building, these personal interactions are vital in conflict zones and communities suffering from violence. For instance, in Uganda, community-based volunteers who are chosen from within their communities work with children who have been abducted by soldiers, developing supportive relationships with them, scoping their mental states and providing emotional support. These children are thought to have difficult relationships with their communities when they return home, and because volunteers from within the community help the initiative, it helps them reintegrate (Lorschiedter, 2007). The same system of local volunteers supporting children affected by political violence in a school mental health programme in Indonesia led to improvements in feelings of hope and in PTSD scores (Tol et al., 2008).

3.1.2 Uses creative and innovative activities and approaches

It is striking to see the diversity of approaches, activities and interactions that are facilitated by these non-digital programmes. Some examples include role plays, quizzes, competitions, dramas, gardening, cartoons, photography, poetry, sewing, sports, yoga and meditation, walking, journaling, and several other participatory methods (PAHO, 2015; Hagell, 2016; Rodecker, 2018; Lam et al., 2019). Keenly tied in with face-to-face interactions and peer networks, these approaches allow young people to come together to share, learn and solve problems, build social capital and other developmental assets (see Table A1 for examples). For instance, several community interventions comprehensively address mental health and HIV, sexual health and mental health, recognising the importance of each interconnected issue and working to support caregivers and children in pursuit of better mental health and reproductive decision-making (Van Tam et al., 2012; Chibanda et al., 2015; Sikkema et al., 2015; Maman et al., 2016).

School-based platforms offer the chance to identify motivated teachers and students who could be mentors and ‘youth champions’ who can motivate, promote, assist and offer support to others (Coleman et al., 2017). These peer champions are particularly important for preventive health messaging in school settings. This finding corresponds with other evidence which suggests that young people often prefer school-based preventive health care, which is fundamental to ensuring good mental health (Mason Jones et al., 2019, cited in Das et al., 2016). Similarly, in Tanzania, Kutcher et al. (2016) are quick to point out that school-based mental health literacy training for teachers offers benefits to teachers and students, by improving their attitudes to adolescent mental health and early diagnosis of CMDs; it has also led to improved awareness in the community through lowered stigma and improved teachers’ mental health-seeking behaviours for themselves, their friends and families. The study suggests that this improvement in awareness also led to the establishment of community clinics in the region, which supported referral services. Improvements in mental health attitudes and care seeking were

also found in a training programme offered to community-based healthcare providers in community clinics in Tanzania, for detection and treatment of adolescent depression (Kutcher et al., 2017).

Daly et al. (2015) describe two models of support provided to parents or families-economic support through cash transfers or subsidies to support children or psychosocial services and training. The authors note that the services-based model is more widely used, with economic support through job-seeking and vocational skill-building for caregivers included within these trainings, while cash transfers which have a long-standing history of use to support anti-poverty and positive parenting in HICs, are now being used in LMICs to incentivise uptake of school or health services and influence child-rearing practices. These programs are thought to build relationships between adolescents and their caregivers and/or families, and also improve the likelihood of accessing mental health through social services or conditional income transfers. Vocational support and economic opportunities are also documented as part of the Tanzanian Better Future International (BFI) Family Care Model as well as the Tabaco City programme, which offered loans for setting up businesses and buying livestock through family support groups (Cohen et al., 2011; Kail et al., 2020).

Non-digital approaches to adolescent MHPSS also host the innovative ability to bring together parents, caregivers and other family members such as siblings. Young adults benefit from better resilience and positive mental health when they have good relationships with their parents and families. There has been increasing empirical evidence to suggest that the death of a parent deeply impacts orphaned children and young people in terms of their mental health and psychosocial functioning (Ssewamala et al., 2009; Jordan et al., 2011, in UNICEF, 2015). Non-digital approaches provide the opportunity to have combined group sessions where families and caregivers can be present with their youth or they can also choose to have training on their own. Van Heel et al. (2019) note that parenting is considered a crucial determinant of problematic adolescent behaviour, making positive parenting training an important

requirement. Using community-based or family-based platforms, non-digital approaches can bring together a variety of stakeholders, including parents, caregivers and other adults in the community (UNFPA, 2010; UNICEF, 2015; PAHO, 2016; WHO, 2017). Das et al. (2016) and Marcus et al. (2019) report lower levels of depression among adolescents who have benefited from parental or caregiver training, also documenting that programmes can help address not just issues of mental health but other related issues such as sexual and reproductive health. Barry et al. (2013) also show that in conflict settings, parental or caregiver involvement is an important driver of mental well-being.

3.1.3 Offers training opportunities for actors delivering interventions

Each mental health intervention implemented at the community, school or family level is implemented or facilitated by trained actors, or experts and specialists in mental health. These training opportunities ensure that standards are maintained and all discussions between young people are facilitated and monitored. Access to trained facilitators also ensures that follow-up and impact evaluations have an additional input to complement self-report questionnaires, which are often the only source of impact data available on completion of the programme. Facilitators are also able to take note of the number of attendees for different interventions and the challenges that participants face or benefits they gain from programmes. Several types of actors involved in facilitation can play important roles in the lives of young people, such as sports coaches and teachers, who are often role models for youth, encouraging their participation and achievements.

The benefits of training and refresher training, as well as the practice of facilitation, are a crucial component of these approaches as they improve the quality of mental health care provided. In semi-structured curriculum-based programmes that used a positive youth development (PYD) framework or a problem-solving approach to adolescent mental health, participants were allowed to develop their own solutions, benefiting from facilitation in the process of doing so (Kumakech et al., 2009; Ho et al., 2017).

3.1.4 Uses established institutional platforms (schools and community institutions)

Schools provide a ready, sustainable platform for mental health interventions targeting youth in their early childhood and adolescence, also noting that these approaches are often helpful in equipping teachers to promote, prevent and diagnose early mental health disorders (Kutcher et al., 2016).

Across HICs and LMICs, these institutions have been able to implement their own mental health programmes for young people while also offering their infrastructure for use by NGOs, CSOs and pilot interventions outside of school hours. The Stepping Stones intervention in Tanzania and the Mindfulness Meditation programme in Viet Nam are examples of where school settings were used (in the evenings or during school holidays) to provide mental health activities for adults and young people (Le and Trieu, 2015; Holden et al., 2019). In the Photovoice project in Canada, schools

offered spaces for the establishment of gardens where young people and older adults gathered after-school (Lam et al., 2019). All three examples offered school spaces to young people or adults (including caregivers) independent of enrolment. Peer networks are also easily established in school settings, which encourages student participation and discussion, alongside easy facilitation aspects from trained teachers and school staff. Several modes of peer-based interventions, including support groups, have facilitated discussions on related issues such as reproductive health, sexual health and HIV and AIDS, and these have shown promise in Viet Nam and Tanzania, with same-sex groups allowing discussion of ‘controversial’ subjects (Marcus and Brodbeck, 2015; Marcus et al., 2019). Barry et al. (2013) review a variety of school-based platforms in LMICs where sessions on life skills (including problem-solving, decision-making and financial planning) are taught by teachers. These interventions have



Secondary school students completing mental a health survey, Dien Bien, Viet Nam. © Fiona Samuels, 2016

resulted in an increase in self-esteem, self-appreciation, interpersonal skills and resilience scores as well as lowered anxiety, hopelessness and depressive symptoms among young people. In some cases, the relationship between students and teachers improved as well. These findings are also echoed by Das et al. (2016).

Barry et al. (2013) review a variety of community-based interventions for youth mental health, which are provided exclusively or in combination by trained facilitators, specialist and non-specialist health workers. Largely, all these interventions can be seen to have positive implications on mental health, with strong evidence indicating that they lower anxiety and improve mental well-being. Das et al. (2016) also point to similar findings in their reviews. Community-based institutions and primary health care systems and clinics function as universal points of access when they are well-funded. For instance, in a small district of Kerala in southern India, Ashwasam, a ‘mental

health for all’ campaign, was instituted by the authorities for community screening by frontline health workers to identify people suffering from mental health disorders; they were subsequently referred to the primary health care centres (Lang, 2019). In Tanzania, Kutcher et al. (2017) also suggest that training healthcare providers in community clinics to diagnose and treat adolescent depression has shown positive results in terms of increased detection and reduced stigma. A similar result is shown by Patel et al. (2011b) in the use of lay health counsellors for depressive and anxiety disorders in India’s public facilities where sustained gains were seen in reduced suicide levels up to one year after completion of the trial. In Viet Nam, a study of the Mental Health Country Profile tool, which maps the strengths and weaknesses of the mental health ecosystem, suggests that community-based interventions hold great promise (Niemi et al., 2010). Community-based systems are also of use in LMICs where many children



remain outside of the formal school system (Drescher et al., 2018; Darling et al., 2020). In describing the future of global mental health and integrated care services, Sweetland et al. (2014) argue that incorporating mental health into existing care systems is crucial. They argue that primary care institutions, schools and NGOs are the most pragmatic approaches to providing mental health access, also outlining the role of community institutions such as perinatal clinics, juvenile detention centres and prisons, churches, police stations and hospital emergency rooms.

3.2 Challenges

3.2.1 Inadequate evidence and challenges in evaluation

One of the biggest challenges in determining the best methods of support for youth MHPSS is the availability of good-quality evidence on impact and outcome measures. For community-based interventions, this inadequacy is well-noted throughout the literature. As Barry et al. (2013) note, the lack of evaluation evidence of multi-component approaches that address different aspects such as microfinance, HIV and vocational training makes it difficult to understand longer-term impacts. The absence of good data to measure effectiveness, and community-intervention evaluations in low-income countries, is raised by Cohen et al. (2011). This is also demonstrated by the Nae Disha intervention in India, which showed improvements in anxiety and depression from a community peer group intervention for urban poor women immediately post-intervention but lower pre-intervention levels six months into follow-up (Mathias et al., 2018). With regard to school-based interventions, many evaluations show positive impacts in using the platform through a whole-school approach for preventive and promotive programmes, but there are fewer studies that analyse the impact of these interventions on children with specific mental disorders or adversity (Fazel et al., 2014). Evidence for family-focused youth mental health interventions needs much more rigorous analysis, with much of these going unnoticed in LMICs (Iseselo et al., 2016). Eaton et al. (2011) discuss that across the different approaches, there is a paucity of evaluation data on programmes that

have been successfully taken to scale, which would be crucial for advancing the evidence base for programme design and implementation. The lack of sufficient culturally applicable implementation evidence in LMICs is also highlighted by Weinmann and Koesters (2016).

In reviewing the global literature on non-digital interventions, focusing on approaches used in LMICs, the inadequacy of quality evidence on effectiveness is well-documented. For instance, in two prominent systematic literature reviews, Barry et al. (2013) and Das et al. (2016) describe that most data is obtained from studies done in HICs, and that there is a dearth of evidence from LMICs. In looking at community-based interventions specifically, the minimal data is either based on conflict-affected contexts (either ongoing or post-conflict) or largely from systematic studies conducted in HICs, while LMICs are mostly reliant on toolkits for designing and implementing these systems.

3.2.2 Inadequate financial and human resources available for mental health

Inadequate resources for mental health services, well-documented in the literature, is one of the biggest reasons for the treatment gap in mental health access (Ginneken et al., 2013; Rodgers et al., 2017; Ryan et al., 2018). The unaffordability of care has led to cases of health-seeking from traditional healers in Tanzania (Ngoma et al., 2003; Solera-Deuchar et al., 2020), while in Kerala, India, those using primary care services for mental health are given prescription medication as the first resort and little psychosocial support (Kutcher et al., 2016; Lang, 2019). The lack of access to resources for mental health in LMICs causes significant challenges towards ensuring access and achieving the Sustainable Development Goals (SDGs). Most importantly, the lack of investment in these services means that large numbers of adolescent populations remain untreated despite having high levels of need, compounded by the challenges of routine adversity (Kutcher et al., 2016; van Breda, 2017; Mathias et al., 2018). Resource limitations in LMICs manifest through the absence of specialised mental health support but can also be seen through a privatised health care system where affordability of services forms a significant barrier to access.

3.2.3 Stigma and lack of privacy and confidentiality

The biggest strengths of non-digital approaches in supporting families and communities can also be viewed as a significant challenge for young people seeking mental health care. The stigma and challenges associated with exclusion due to mental disorders is well noted in LMICs, with these challenges highlighted as important considerations in Viet Nam and Tanzania

(van der Ham et al., 2011; Thuy and Berry, 2013; Kutcher et al., 2016). Preventive and promotive programmes that aim to spread mental health awareness, utilising evidence-based approaches, including parent/caregiver, teacher and health worker training, are crucial to improve perceptions and lower stigma on mental health challenges. These programmes also encourage positive health seeking behaviours (diagnosis, treatment and care) for mental health conditions.

4 Conclusions, lessons learnt and gaps

Adapting the discussions in the UNICEF (2015) toolkit on community-based interventions for conflict settings to the literature on non-digital interventions, one thing is clear: the effectiveness of interventions designed to promote good mental health and psychosocial well-being (or to protect from poor mental health and psychosocial ill-being) is specific to the individual's gender, symptoms and context. Borrowing the words of Ryan et al. (2018), 'given the diversity of approaches used to implement psychological interventions in different contexts, and the scarcity of resources in LMICs, [it is] especially important that new research be guided by a clear understanding of what has already been tested, how, where and for whom'. This review reaffirms that each of these questions should be considered when designing suitable interventions, to choose the most appropriate actors, mediums, activities and target groups.

This review has shown that some of the most important approaches for youth MHPSS in LMICs are the use of schools and communities as platforms for delivering these services. In particular, after-school activities in school settings, either conducted by teachers and other school staff or NGOs and CBOs, are influential in expanding access, especially when using peer group-based means of delivery. Diverse activities such as visual mediums, quizzes or games are important to ensure that young people interact. Approaches based on problem-solving, especially those focused on future planning and asset building, have been important protective interventions for youth to recognise feelings of accomplishment, self-efficacy, confidence and resilience. Youth are particularly likely to prefer preventive and promotive interventions

in a school setting, although it is unclear why. Communities and caregivers (especially parents) provide a stabilising environment for children and ensuring that these relationships are upheld through community-based programmes that allow young people and caregivers to work jointly (in community settings, home-based interventions or those where sessions are held at home) are also focus areas for adolescent mental health. However, as these programmes illustrate, ensuring caregiver attendance is one of the main challenges. An interesting approach that is seen across interventions is the focus on fidelity to the original programme goals and, in some cases, adherence to curriculum. This has been measured by using investigators to attend some sessions and through protocols and checklists, which appears to be one of the reasons why programmes are successful and well-attended.

Although the literature highlights differences in the frequency of delivering interventions and the use of structured and semi-structured formats, differences in impact are not addressed. Similarly, in delivering facilitation training to actors, there is not much explanation of how actors' previous experience and qualifications influence the intervention (nor do previous experience and qualifications appear to affect changes in the training they receive prior to the intervention). Some interventions have used reward systems to ensure punctuality and attendance, but the impact of these components has not been studied.

4.1 Lessons learnt

Based on this rapid review of the literature, we can identify some key lessons for strengthening non-digital interventions for youth MHPSS.

4.1.1 Importance of refresher training as part of training-based interventions

Teacher training interventions play a huge role in improving youth mental health, working to improve awareness, stigma and early detection of CMDs. As Kutcher et al. (2016) highlight, using the example of mental health literacy training in Tanzania, teacher training programmes that include a refresher session, six months apart, showed good results in making the trainees (teachers) more comfortable with the subject and more open to learning and using their learning. This example also showed that between the two teacher training sessions, teachers grew more acutely aware of mental health needs among their students and their own needs, spreading the word in the community more widely. While perhaps not fully attributable to this intervention, a community mental health clinic service was built in the area, which allowed referral services for students diagnosed with disorders after the second round of training. The overall benefits of lowered stigma and acceptability of mental health disorders are also shown by an intervention (also in Tanzania) on adolescent depression with community healthcare providers (Kutcher et al., 2017). Alluding to the benefits of refresher training in this example as well, the second training for community healthcare providers was held four months after the first, using a question and answer format that offered participants the chance to ask questions and lead the training. Many contextual questions were clarified in this intervention, based on the real experiences of adolescents who had presented with symptoms, and the approach allowed community health practitioners to address cultural and contextual concerns not sufficiently addressed in the literature. However, the decision about timings of refresher (second) training to achieve maximum impact will depend on the intervention's objectives and other implementation considerations.

4.1.2 Incorporating gender and single-sex based approaches

Girls' clubs and youth clubs are peer-based support interventions that have been shown to support the needs of young people. In addition to working on positive reinforcements for mental

well-being, these safe spaces also offer a chance to discuss social and environmental risk factors for mental health. Using innovative activities such as quizzes, games, competitions and role plays, Plan International, as part of the Because I am a Girl project in Viet Nam, set up girls' clubs for both school-attending and out-of-school girls. In Tanzania, community-based women's support/peer groups have also shown good results in building confidence, sharing experiences and providing support for young women. In the Sauti ya Vijana (the voice of youth intervention) in Tanzania, same-sex groups were encouraged, while Nae Disha in India also discussed the importance of a same-sex facilitator to help young women be more open and participate fully. This was also echoed by the experience of a female psychologist-facilitated support group for mothers of autistic children in Lebanon (Pegon and Calvot, 2017).

4.1.3 Addressing resource constraints in primary care

One of the key reasons why traditional healer-led mental health-seeking is used in LMICs, particularly in Tanzania, is the failure of primary care systems to be able to provide for people's mental health needs. This is also evidenced by the treatment gaps in care-seeking across LMICs and notably in sub-Saharan Africa (Patel et al., 2011a). This understanding is central to two overlapping intervention components, as follows.

- **Task shifting or task sharing:** The inclusion of non-specialist health workers and other professionals with health roles as actors delivering interventions has been widely recommended across LMICs. In suggesting this approach, Sweetland et al. (2014) discuss the importance of a stepped care approach to ease burdens on the primary care system. This is beneficial to ensure that the entire continuum of care (prevention, diagnosis and treatment) is covered in a step-by-step method of movement across various streams, based on severity of the disorder or condition. This will require lay health workers and teachers to be trained in providing the most basic services, while psychiatrists (of which there are few) remain available for inpatient

and more intensive cases. One example is where lay workers deliver mental health services to patients under the supervision of specialists. (Ola and Atilola, 2019; Verhey et al., 2020).

- **Moving away from exclusively pharmacological treatments:** One of the points highlighted in the literature is the treatment-based approach at primary care settings in LMICs (Lang, 2019). Psychotherapeutic options are less accessible, as they are more time consuming, and also require trained psychiatrists while prescriptions for medications can be done by non-specialist health workers as long as they have received training. In Tanzania, it is encouraging to note that in the training provided to community healthcare providers, there is emphasis on psychotherapy interventions as a first treatment option for adolescents, with medical prescriptions only to be used when this shows no improvement (Kutcher et al., 2017). Talking therapies built on IPT and CBT-based frameworks have also been delivered by lay health counsellors in India (Patel et al., 2011b), while Chowdhary et al. (2013) demonstrate the cultural adaptation possibilities of these therapies for different contexts. Ryan et al. (2018) argue that lay workers can be effective in delivering talking therapies in conflict or humanitarian settings as well.

4.1.4 Training cascade and apprenticeship-based approaches for programme scale-up

One of the often-cited gaps in mental health literature is the absence of contextual evidence and the focus of evaluations and programme design in HIC contexts. Some interventions train groups of actors such as teachers or community healthcare providers (Kutcher et al. 2016 and 2017 elaborate on Canadian training materials adapted for use in Tanzania and Malawi), while others train facilitators to use materials conceptualised and used in Western contexts as part of a training cascade approach, whereby researchers train ‘trainers’ who then train the target groups. This training cascade has proved useful in establishing a replicable and sustainable solution in LMICs. Similarly,

Murray et al. (2011) demonstrate the benefits of an apprenticeship-based training approach for lay workers, where they receive feedback, job coaching and, most importantly, continuous supervision to ensure their learning.

4.2 Gaps

Non-digital individual and family approaches to youth MHPSS are much less studied in the context of LMICs, with the only examples including those that target self-help and self-advocacy of the individual in relation to his/her own mental health problems. While there are a few guides and toolkits on this topic, their utility for younger populations remains in question; it is much more likely that they are used by young people’s caregivers. Another prominent gap is the paucity of discussions on funding for these interventions. While in humanitarian settings there is a clear introduction of external funding support, the data is much less clear for community interventions and school-based approaches. Within community settings, in some cases, voluntary organisations such as FBOs can be seen providing support, but this is not the case for many school-based interventions. There also appears to be little guidance in the literature in terms of monitoring and evaluation methods used in several studies. For example, the follow-up period for many interventions ranges from 6–15 months, at which point these approaches are shown to be effective, but effectiveness appears to taper off as more time elapses. Given that mental health approaches show life-long transformation, the issue of follow-up should be addressed more thoroughly. As has been suggested by many studies, mental health, as with physical health, should be integrated into comprehensive health coverage policies. There is little discussion of this in the reviewed literature, at the community level and school level, especially in LMIC contexts. In using a self-advocacy or toolkits-based approach, there is an intrinsic assumption that caregivers and young people will be able to voice their agendas and concerns and feed these into programmes and policies, which may not be the case.

In designing adolescent mental health approaches, caution must be exercised in

recognising availability of resources and access to services, as well as other cultural and ethical barriers such as gender, stigma and education levels, which will differ according to context. For instance, in some cases, many young people might be out of the school system or young women may be excluded from mental health discussions, and the choice of delivery platform, actors and activities will be dictated by these considerations. In cases where these delivery structures are not necessarily available, such as in humanitarian settings or those recovering from natural hazard-related disasters or other adversity, a key approach is to ensure that spaces can be transformed to be youth-friendly, creative, and offering positive means of engagement.

In recognising the nature of adolescence as a period of confusion and anxiety, mental health must also be seen as an integral part of other activities such as sexual and reproductive health education and other schemes like employment and academic opportunities. There must also be active steps to include mental health in primary care services, particularly in countries where affordability has severe impacts on health-seeking behaviours. Integration also ensures that these services are not stigmatised, as they are included

alongside several others and allow individuals seeking care to retain their anonymity.

Lastly and most importantly, youth voice is central to all efforts to improve mental health; designing interventions without young people's input, or the input of their teachers or caregivers, will undermine impact, missing key elements that young people are looking for the service to deliver. Young people themselves are also best placed to identify their own barriers to access and to address these through interventions. To make these interventions sustainable, replicable and useful, ownership should stay with stakeholders in-country. Similarly, contextual and cultural issues must be incorporated, with regular consultations with young people, and offering positions of leadership within the design and steering committees attached to interventions. These mediating factors for successful non-digital interventions can be built using face-to-face means of programme design and development; a good example is Stepping Stones in Tanzania, where final materials were developed alongside the children in workshops. This intervention had zero 'dropouts' and made pre-school children and their caregivers feel more able to discuss taboo issues such as HIV and sexual health.

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Annex 1 Examples of non-digital approaches for addressing mental ill-health

Table A1 Some examples of non-digital approaches for addressing mental ill-health across Asia and Africa (focusing on Viet Nam and Tanzania)

Type of approach	Main activities and features	Actor(s) delivering intervention(s)	Target group and country	Impact evaluations	Name of intervention and source
Examples from Asia and Africa					
School-based approaches					
Peer groups and networks	16 psychosocial semi-structured exercises using problem-solving approaches (1 hour each, 2 exercises a week over 10 weeks). Exercise topics and problem identification through role plays, poems, stories and visuals, using activities such as name games, blindfolded walks, sharing and talking, and a 'big hug' exercise to connect physically with peers to build trust.	Trained primary teachers from participating schools facilitated group sharing process and encouraged student participation, under weekly supervision of a professional counsellor (for any mental health breakdowns during study) and a researcher.	AIDS orphans (lost one or both of their parents) aged 10–15 in Mbarara district of southwestern Uganda.	This cluster randomised trial found that self-reported scores of depression, anxiety, self-concept collected and scored pre and post intervention, based on the Beck Youth Inventories (BYI) tools, showed that orphans in the intervention group had significantly lower scores for anxiety, depression, and anger at follow-up than at baseline, whereas orphans in the control group showed increases compared to baseline.	After-school peer support intervention Kumakech et al., 2009
	Discussions with participants (cluster size 5–16 children) and programme concluded with action-oriented planning to solve problem.	Teachers trained by a researcher to deliver peer intervention.		The peer group intervention alone showed significant improvements in 3 BYI aspects – anxiety, depression and anger – although no significant effect of peer group on self-concept observed.	
	15 sessions of classroom-based structured programmes over 5 weeks where children (in groups of up to 15) focused on CBT-based approaches facilitated by activities like cooperative play, expression through arts (drama, song, dance), psychological education components, stabilisation, self-esteem and trauma narratives (through silent stories and drama games) and resiliency based social connections.	Intervention delivered by selected volunteers aged at least 18 with high school education from the local target community, chosen based on their social skills as assessed by role plays.	School children (mean age 9.9 years) in 14 schools in political violence-affected communities in Poso district, central Sulawesi, Indonesia	Baseline and follow-up data (1 week and 6 months after intervention) collected using symptom checklists with trained psychologists. Fidelity to training manual checked through video recordings and a structured checklist.	School-based group mental health intervention Tol et al., 2008
	Pre-developed training manuals used in a phased weekly approach divided into structured sessions.	Interventionists received two weeks of training once selected.		A variety of tools based on children's self-reporting used to measure post-traumatic stress disorder (PTSD), depression, parental violence, impaired functioning and hope, used for measurement in this cluster randomised trial, which reported statistically significant effect of treatment on changes over time for PTSD symptoms and hope, but not other outcomes. Treatment effects on 3 aspects (hope, functioning and PTSD) for girls and only 1 (hope) for boys, indicating that gender is a determinant of impact.	

Table A1 Some examples of non-digital approaches for addressing mental ill-health across Asia and Africa (focusing on Viet Nam and Tanzania) (continued)

Type of approach	Main activities and features	Actor(s) delivering intervention(s)	Target group and country	Impact evaluations	Name of intervention and source
Mentorship programmes	<p>Students in the intervention arm received an after-school, positive youth development-based (PYD) sports mentorship session weekly (lasting 90 minutes) for 18 weeks.</p> <p>Sports mentorship was delivered in small groups of 12–19 adolescents and students picked one sport to learn. A semi-structured curriculum, with deliberate play to introduce the sport by mentor, crafting and setting sporting goals by students, building sport skills through mentors and peers, also solving problems and experiential learning, and reflection and skill consolidation.</p> <p>Students in the control group received exclusive access to a health education website where they could play a quiz game.</p> <p>Programme was implemented in schools, also community centres when schools unavailable.</p>	<p>Intervention delivered by sports coaches (mentors) who hold certifications from relevant local sports associations and were trained in sports psychology and PYD techniques.</p> <p>Mentors receive 1-day workshop from researchers prior to intervention, as a refresher on PYD, problem solving with sports. They did not teach, but only facilitated in this approach.</p>	Students in 12 secondary schools in Hong Kong	<p>A questionnaire and physical test were taken at baseline from students and 1-month post intervention. As well as scales and tools to measure components, students also reported their impressions (5-point Likert scale as a measure of acceptability). Investigators attended 25% random sessions to ensure programme fidelity.</p> <p>The effectiveness in this randomised controlled trial (RCT) was measured using intention-to-treat analysis and showed that 1-month post-intervention students had better mental well-being and reported positive relationships with mentors, holistic well-being, and resilience.</p>	<p>Positive youth development-based sports mentorship programme</p> <p>Ho et al., 2017</p>
Life-skills programmes	<p>3 main components:</p> <ol style="list-style-type: none"> 1) workshops focused on asset-building and future planning including 12 training sessions (1–2 hours each) on career planning, and financial planning; 2) a monthly mentorship programme for adolescents with peer mentors on life options; 3) a Child Development Account (CDA), dedicated to paying for secondary schooling, vocational training and/or a family small business. 		AIDS-orphaned children, in 15 primary schools in Rakai district, Uganda	<p>Measured using a quantitative self-assessment tool called the Tennessee Self-Concept Scale, participants in the treatment group reported higher self-esteem at the 10-month follow-up.</p> <p>Economic empowerment through the CDA is positively associated with self-rated health functioning, which is positively associated with self-esteem. Among asset ownership variables, adolescents with more gardens are likely to report better self-rated health functioning. Aspects such as gender and household size are not associated with adolescent self-rated health functioning.</p> <p>Children with the presence of their mother reported better health functioning.</p>	<p>SUUBI (Hope)</p> <p>Ssewamala et al., 2009</p>
Community-based approaches					
Peer groups and networks	<p>Based on a youth resilience and PYD approach, 15-module mental health and resilience curriculum on topics such as self-esteem, managing emotions, communication, relationship-building, self-care and future planning.</p> <p>8 groups of 12–15 participants met at one of the participants' homes after permission from household members for 15 consecutive weeks.</p>	<p>Interested community-based female peers aged 20–30 years recruited from the local areas and given 5 days of training on curriculum content and group activity facilitation, followed by a 2-day refresher training after delivering 8 modules.</p> <p>A team leader from each group supported facilitators and stepped into the role in their absence.</p>	Young women in an urban slum in Dehradun, northern India	<p>A combination of 5 self-report psychometric tools on self-efficacy, resilience, depression, anxiety and gender attitudes were administered to participants pre and post intervention and 8 months after completion.</p> <p>Sustained improvements were noticeable across all 5 scales, with reductions in anxiety and depression and increased scores in attitudes towards gender equality, self-efficacy and resilience. Improvements in anxiety and depression scores were seen in the 8-month follow-up while resilience score increases declined to pre-intervention levels at 8 months.</p>	<p>Nae Disha</p> <p>Mathias et al., 2018</p>

Table A1 Some examples of non-digital approaches for addressing mental ill-health across Asia and Africa (focusing on Viet Nam and Tanzania) (continued)

Type of approach	Main activities and features	Actor(s) delivering intervention(s)	Target group and country	Impact evaluations	Name of intervention and source
Examples from Tanzania					
School-based approaches					
Mental health literacy training	<p>3-day teacher training workshops, a teachers' study guide, a self-evaluation test, and 6 classroom-ready modules; mental health as interspersed with regular school curriculum. Teachers who had received previous training on the guide returned for a refresher course.</p> <p>The two trainings were held 6 months apart and the latest training included referrals as community health worker cadre for MHPSS had been established in the midst of training sessions.</p> <p>Used the adapted version of the classroom-ready African Guide (AG) for use in Tanzania.</p>	Master Trainers Team (MTT) made up of 4 mental health experts (2 psychiatrists and 2 psychologists) were trained over a period of 2 days on the AG and its use by the lead developer. The MTT then trained the teachers.	<p>Teachers purposively selected by educational administrative authorities from 35 secondary schools of the Arusha and Meru District Council.</p> <p>61 teachers completed the 3-day training.</p> <p>[Part of Grand Challenges-funded project to reduce depression in Malawi and Tanzania]</p>	<p>Questionnaires used to measure participant knowledge on MHPSS before and after 3-day training was completed (Likert scales and yes and no questions) to measure mental health knowledge, curriculum-specific knowledge and stigma/attitudes. The assessments showed significant improvements in teachers' overall knowledge including on mental health. Teachers' stigma about mental illness decreased significantly and more students were diagnosed for mental disorders and referred since the refresher training. Over half the teachers sought help for their own mental health and for their students, friends, family members and peers.</p> <p>Repeat refresher training maybe helpful after one round of training.</p>	<p>The African Guide (AG)</p> <p>Kutcher et al., 2016</p>
	<p>Treatment group assigned the school-based resilience improving and pro-social behaviour intervention (ESPS), while the control group assigned a social study curriculum.</p> <p>Original ESPS programme was adapted by Tanzanian mental health professionals to reflect local idioms of distress and indigenous practices.</p>	<i>No details available</i>	Primary school (grade 4–6) children in Tanzania	<p>Student resilience measured post-intervention and 8 months following programme ending by assessing social difficulties, hyperactivity, somatisation, level of anxiety, pro-social behaviours and school functioning as well as academic achievements and disciplinary problems.</p> <p>Significant improvement seen on all outcome measures for the intervention group compared to the control group in both follow-ups. ESPS intervention found equally effective on most measures for students experiencing different adversity levels.</p>	<p>ERSAE-Stress-Prosocial (ESPS) intervention</p> <p>Berger et al., 2018</p>
Community-based approaches					
Support groups or peer groups and networks	<p>Combination of 10 same-sex small group (8–10 youth) sessions of 90 minutes (2 jointly with youth and caregivers and 1 home visit) and 2 individual sessions focused on building resiliency. All sessions delivered in Kiswahili. Activities include deep breathing and mindfulness, CBT techniques, trauma narratives based on interpersonal psychotherapy, motivational interviewing to identify personal values, and role playing to disclose HIV status to family and community members.</p> <p>All participants received telephone reminders, snacks and transport reimbursements to ensure attendance. As a reward system for punctuality in group sessions, gifts such as soap, socks and sugar and a sticker were given.</p>	<p>Group sessions were led by trained leaders aged 24–30, 3 male and 3 female. Leaders either had lived experience of HIV or had previously delivered mental health interventions.</p> <p>All leaders received 2-week intensive training from the US-based principal investigator and psychologist with pre-planned scripts for each group meeting.</p> <p>Two leaders led each training and one kept notes for each youth.</p>	58 Tanzanian youth aged 12–24 living with HIV in Moshi, Tanzania	<p>A session-specific fidelity checklist to ensure protocol was maintained by note-taking leads in each meeting and reviewed after each weekly session at supervisory meetings.</p> <p>Leader notes from group sessions suggest youth were interested to learn about mental health and resilience and that sessions fostered peer support. The use of the cognitive triangle/CBT approach was key to addressing stigma. One of the boys went on to become a peer youth leader/role model for HIV at an adolescent clinic.</p> <p>Youth reported utilisation of new coping skills, improved peer and caregiver relationships, reduced stigma and improved confidence. Good youth attendance and fidelity checklist suggest feasibility of the intervention.</p>	<p>Sauti ya Vijana (The voice of youth)</p> <p>Dow et al., 2016</p>

Table A1 Some examples of non-digital approaches for addressing mental ill-health across Asia and Africa (focusing on Viet Nam and Tanzania) (continued)

Type of approach	Main activities and features	Actor(s) delivering intervention(s)	Target group and country	Impact evaluations	Name of intervention and source
	Structured, small group (6–8 youth) counselling using problem-solving therapy approach for 6 weekly sessions on mental health, access to HIV treatments, disclosure of HIV status (<i>components not mentioned</i>).	Groups facilitated by trained psychiatric nurse/social worker.	HIV-positive pregnant women in Dar es Salaam, Tanzania, receiving prevention of mother-to-child transmission (PMTCT) services	<p>Prenatal psychosocial assessment, as measured by the Hopkins scale for major depressive disorder (MDD), showed a marginally significant reduction in depressive symptoms for women receiving intervention (60% of women in the intervention group were depressed at the outcome assessment as against 73% in the control group).</p> <p>Some women reported psychosocial benefits from the group such as empowerment, reduction in stress, and feeling comfortable disclosing HIV status (better prepared women to treat anxiety and fallout from disclosure) and transitioned to income generating activities.</p>	<p>Group counselling</p> <p>Kaaya et al. 2013</p>
	<p>Education programme on reproductive health instituted into health facilities, with peer network as one component among 15 women of said age group.</p> <p>Main activities included lectures, reading of a short story booklet, <i>Nne ne Tano</i>, and two 40-minute focus group discussions (FGDs) of 7–8 women each to conclude.</p>	Researchers and research assistant led the 2 FGDs.	Pregnant adolescent women aged 15–19 in rural Tanzania	<p>This mixed-method study involved questionnaires with 4 unique subscales, including one on social support (10 questions) answered using the Likert scale. FGDs provided qualitative data, one question on social support and one on peer networks.</p> <p>Responses showed that participants welcomed the idea of a peer network, as a means of information and support and sometimes even financing. It helped women discuss danger signs of pregnancy, awareness on how to identify them, and improve acceptance.</p>	<p>Nipo Nawe! (I am with you!)</p> <p>Mwiliike et al., 2018</p>
Non-specialised health worker training	<p>Initial training consisted of a general overview of adolescent mental health, including depression, which extended into clinical competencies for identifying, diagnosing and treating adolescent depression through diagnostic checklists, treatment guidelines and understanding severity and outcome measures from tools used. For treatment, training addressed pharmacological prescription of one antidepressant only in combination or failure of Effective Helping (EF), a psychotherapy intervention in the African context using CBT and counselling-based methods.</p> <p>Refresher training using participant-driven question and answer (Q&A) approach applied the same topics in greater detail and others for which participants requested more support.</p>	<p>Using a training cascade model, 4 master trainers with extensive mental health experience were trained by the Canadian module developer/author.</p> <p>Master trainers then trained a large group of lead trainers who then trained available health care providers over 5 consecutive days. A 4-day refresher training was held 4 months after the first.</p>	<p>Community-based healthcare providers (HCPs), midwives, nurses, junior and senior clinicians working in participating community clinics in Arusha and Meru regions, Tanzania, with no previous psychiatric experience</p> <p>[Part of Grand Challenges-funded project to reduce depression in Malawi and Tanzania]</p>	<p>Outcomes assessed using a paper-pen questionnaire made up of 6 components which analysed HCPs' knowledge, confidence in identifying and diagnosing adolescents with depression, and also corroborated that against the number of patients diagnosed and treated, feelings and emotions (anxiety, discomfort) in working with these patients, and their own mental health-seeking behavioural changes as well as those of their friends and family.</p> <p>Results show that knowledge was significantly improved after initial and refresher training, and there was improved provider self-confidence and reduced stigma, and improved attitudes towards mental health.</p> <p>Training methods showed sustainability, as Q&A approach of refresher training allowed contextual questions to be clarified.</p> <p>Improvements in HCPs' health-seeking behaviours for their own mental health and that of their families and friends.</p>	<p>Training in how to identify, diagnose and treat adolescent depression</p> <p>Kutcher et al., 2017</p>

Table A1 Some examples of non-digital approaches for addressing mental ill-health across Asia and Africa (focusing on Viet Nam and Tanzania) (continued)

Type of approach	Main activities and features	Actor(s) delivering intervention(s)	Target group and country	Impact evaluations	Name of intervention and source
Individual/ family-based approaches					
Life-skills programme	Youth given computer classes, sports, traditional dance and craft learning opportunities. Family visits and parenting workshops, vocational workshops and microloans for families to set up small business. All youth and families set up in the community for all services – schools, clinic, and empowerment opportunities for caregivers. Also, linking youth and caregivers with government entitlements, parent–teacher associations, NGOs, FBOs and informal support groups for youth and caregivers.	Model implemented by the Salaama Centre in Moshi where youth cared for by families are offered services (food, medical care and education) as one unit. An advisory group for all caregivers directs the Centre's activities. Programme has been running since 2008. Social workers are the main actors.	Orphaned children and youth who are affected by HIV/AIDS and their caregivers in Moshi, Tanzania	In-depth interviews of case analyses based on 8 orphans and caregivers aged 14–17 who have been enrolled at the Centre since activities began. Personnel at the Centre such as staff, teachers, case managers, co-directors were also interviewed. Notes about home visits to the family, attendance and school-score records also consulted. Measurements to evaluate intervention based on social capital theories of bonding (keeping children in the care of families), bridging (ability to upskill and generate income) and linking (connecting families to resources). Empowerment through the Centre's holistic provision of services allowed all 3 above and realisation of values. Social workers as important means of growing social capital for families and youth.	Better Future International (BFI) Family Care Model Kail et al., 2020
Caregiver intervention	Curriculum-based intervention for parents and caregivers designed for positive parenting and sexual health messaging for 9–12-year-olds where 5 three-hour sessions were delivered weekly to 12–18 parent groups. Sessions are interactive, with role playing, audio-visual aids, and group discussions. In the last session, parents bring their children with them and practice what they have learnt. Programme implemented by an NGO, under advice from the Centers for Disease Control and Prevention (CDC), to use the Families Matter! Programme (FMP) adaptation from the United States.	Trained FMP facilitators who pass a certification and are then given regular mentoring.	Parents and pre-adolescent children, Tanzania	Pre- and post-intervention evaluation showed changed attitudes towards sexual education and discussions. Parent–child relationship, positive reinforcement and parental monitoring about child's whereabouts. However, no major increases were seen in parent–child relationship scores between pre and post intervention but were already high during the pre-intervention survey. All trainers monitored by supervisors to ensure fidelity to programme.	Families Matter! (FMP) Kamala et al., 2017, cited in Marcus et al., 2019

Table A1 Some examples of non-digital approaches for addressing mental ill-health across Asia and Africa (focusing on Viet Nam and Tanzania) (continued)

Type of approach	Main activities and features	Actor(s) delivering intervention(s)	Target group and country	Impact evaluations	Name of intervention and source
Training programme	<p>Workshops (held at schools and parish grounds on school holidays) with children, parents/caregivers and, in some cases, siblings in an HIV context, using an assets-based, solution-focused, appreciative enquiry approach focused on positive values and affirmation rather than problems.</p> <p>Most activities split into groups of younger and older children and their caregivers, using a peer group set-up. Sessions held every weekday morning and afternoon.</p> <p>Training manuals developed alongside children through stakeholder meetings and material development workshops and piloted materials with 4 communities before finalising the approach.</p> <p>Manual contains 29 training sessions spread over two parts: Part 1 on psychosocial well-being, resilience, relationships, and living with HIV status; and Part 2 on sexual health and rights. A counselling guide is also available alongside the training manual to improve the caregiving and counselling practice for children with HIV.</p>	<p>Volunteer facilitators who had previous experience running Stepping Stones workshops were trained for 3 weeks and received practice in running these activities.</p> <p>Facilitators were paid a fee to reimburse opportunity and travel costs. They were supported by paid staff to conduct additional sessions to collect data at baseline, midline, endline and 6-month follow-up.</p>	Parents and children aged 5–14 living with HIV, in Dar es Salaam, Tanzania	<p>This mixed-methods study showed that caregivers and children responded well to the programme content, including controversial subjects, and there were no recorded 'drop-outs'.</p> <p>Physical health improvements reported in CD4 cell count and weight gain, and mental health benefits seen in children's and caregivers' self-esteem, self-determination, resilience, safety, belonging and school attendance.</p> <p>Caregivers were seen sharing information with children, and violence against children was reduced.</p>	<p>Stepping Stones with Children</p> <p>Holden et al., 2019</p>
Examples from Viet Nam					
School-based approaches					
Peer-based networks, support groups and youth clubs	Plan International runs a girls' club which meets twice a month. Uses Q&A sessions, role plays, games, competitions, dramas, quizzes and other participatory activities.	Facilitated by teachers/club leaders, with the motto of building trust and developing the 'equation' between teachers and girls, to <i>'talk like sisters, not teachers'</i> .	All school-attending lower secondary girls (11–15 years) in Ha Giang province, Viet Nam	<p>Safe spaces to discuss child marriage, sexual health and other problems.</p> <p>Girls reported feeling empowered, committed to stay in school and advance, better social relationships, greater confidence, and delayed age at marriage.</p> <p>Participatory approaches and competitions most preferred by young girls.</p>	<p>Girls' clubs, part of 'Because I am a Girl' programme</p> <p>Marcus and Brodbeck, 2015</p>
Community-based approaches					
Peer-based networks, support groups and youth clubs	<p>Plan International has a village girls' club (similar to the school-based counterpart above) which meets every month.</p> <p>Less participatory compared to the school-based club as the girls are older and often tired from working.</p>	Facilitated by a male Plan International staff member	Older adolescent girls (15–19 years) no longer in school in Can Chua Phin commune, Ha Giang province, Viet Nam	<i>No details available</i>	<p>Girls' clubs, part of 'Because I am a Girl' programme</p> <p>Marcus and Brodbeck, 2015</p>



ODI is an independent, global think tank, working for a sustainable and peaceful world in which every person thrives. We harness the power of evidence and ideas through research and partnership to confront challenges, develop solutions, and create change.

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