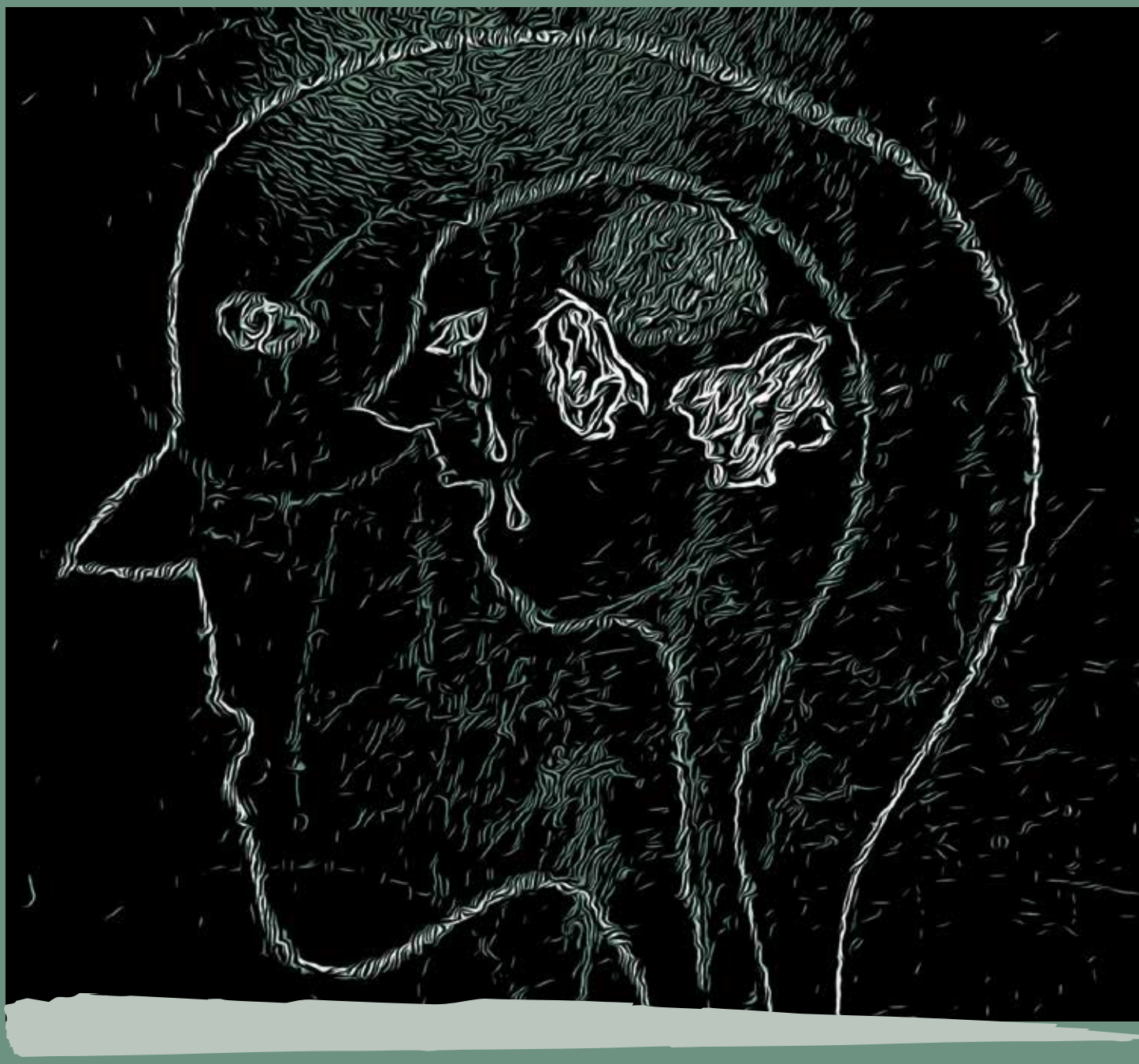
OFFICE OF THE SPECIAL REPRESENTATIVE OF THE SECRETARY-GENERAL ON
VIOLENCE AGAINST CHILDREN

Hidden scars: how violence harms the mental health of children



Hidden scars: how violence harms the mental health of children

Office of the Special Representative of the Secretary-General on Violence against Children

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Cover photo: © Miguel Caldeira

Caption: “Hidden suffering: the victim’s curse” – Chalk drawing

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Executive summary

More than 1 billion children – half of all children in the world – are exposed to violence every year. They face violence in many forms and in many places, whether they are online or offline, in their homes, schools or communities. A child can be the target of violence, can witness it, or be exposed to it. Children may often face a 'perfect storm' of violence: different forms of violence that occur together, or one form that leads to another along an appalling continuum.

It is clear that violence has a severe impact on the mental health of children. Exposure to violence is often traumatic, and it can evoke toxic responses to stress that cause both immediate and long-term physiological and psychological damage. The consequences of violence include depression, post-traumatic stress disorder, borderline personality disorder, anxiety, substance use disorders, sleep and eating disorders, and suicide.

The cumulative impact of violence on children's mental health is shaped by the way in which children experience violence as they move from early childhood to adolescence, with variations in both the forms of violence to which they are exposed and the consequences for their mental health. These consequences can be passed from one generation to the next, particularly for children whose childhoods have been characterized by exposure to intimate partner violence, and for mothers who experienced violence as they grew up.

Risk factors arise at the individual level, within relationships, and across communities and societies. The interaction between risk factors across the different levels is just as important as the influence of any particular factor within a single level.

There is an urgent need for more action to prevent and respond to the threat posed by violence to children's mental health. Yet there is a serious lack of investment and capacity to provide quality, rights-based, culturally appropriate mental health care globally, even though mental health is consistently identified by children themselves as a major concern. In addition, young people access mental health services less frequently than any other group because of stigma, failures to detect their needs and poor awareness of the services that do exist. As a result, few children with mental health problems receive the right support at the right time.

What works

There is growing evidence on the factors that protect children and on what works in responding effectively to the impact of violence on the mental health of children, although many gaps in knowledge remain.

Preventive interventions that focus on maternal mental health, mother–infant interaction, and play and stimulation have had positive and long-term benefits. Parenting and child welfare interventions have also proved to be crucial in breaking toxic cycles of inter-generational transmission of violence and mental illness. Community-based rehabilitation programmes and socio-emotional learning interventions in schools have been shown to be effective. And there is also evidence-based guidance for mental health professionals and others that can help them to support the mental health of child victims of violence, including in humanitarian settings.

States must now translate this knowledge into action, guided by international human rights standards and the pursuit of the Sustainable Development Goals (SDGs), which cannot be achieved without measures to tackle violence in all its forms. Comprehensive and coordinated action is needed, built on an inter-sectoral and multi-stakeholder approach.

The most important stakeholders are children themselves. Children are already taking a leading role in supporting their own mental health and well-being, such as in peer-to-peer initiatives.

They are heavily engaged in programming on mental health, both online and offline. But still, they struggle to make their voices heard and to make their opinions count. The views of children with lived experience of mental health conditions and psychosocial disabilities must shape the design, delivery and evaluation of responses.

What needs to happen

Effective action starts with prevention and early intervention, focusing on the factors that put children at risk of violence and those that can protect them within their families, their communities and their societies. This also demands a specific focus on the needs of children at a heightened risk of violence and mental health problems because of where and who they are.

Mental health services must be scaled up as an essential component of universal health coverage. Quality services should be provided in the community, avoiding institutionalization and medicalization where possible. This requires far more investment, including investment to ensure the right number and distribution of skilled professionals. Further investment is also needed to address the lack of data and research on children's mental health.

Finally, as the international community embarks on a Decade of Action to deliver the SDGs by 2030, monitoring and accountability frameworks must be put in place to keep the world on track. These must ensure that effective action is taken to promote the mental health of all children, to prevent mental health conditions among those who experience violence, and to provide treatment and care to every child who needs it.

A child's drawing depicts a face with scars and a bruised eye. Arnaldo, 6, drew the picture as part of an art therapy session at Beautiful Gate, a centre for abused and abandoned children in Lower Crossroads, a neighbourhood of the city of Cape Town.

1. Introduction

"Not speaking was like an emotional cancer … you don't begin to heal until you disclose."
Matthew McVarish, survivor and advocate, Scotland[1]

It is not only possible to prevent and respond to the harm caused by violence to children's mental health: it is essential that we do so.

The Convention on the Rights of the Child guarantees the right of every child to freedom from violence and to the highest attainable standard of mental health. Similarly, the 2030 Agenda for Sustainable Development pledges to end all forms of violence and to promote mental health and well-being. Many other provisions of both the Convention and the 2030 Agenda are crucial to guarantee that the foundations are in place to promote and safeguard good mental health.

Despite these obligations and commitments, violence against children continues to take a heavy toll on their mental health and their ability to learn, grow and develop to their full potential. Evidence from high-, middle- and low-income countries is clear: violent experiences increase the risk of damage to mental health. The consequences include depression, post-traumatic stress disorder (PTSD), borderline personality disorder, anxiety, sleep and eating disorders, substance use disorders, and suicide. In addition, exposure to childhood violence can increase a wide range of adult psychopathologies, including disorders that affect mood, anxiety levels and behaviour.[2]

Worldwide, 10-20 per cent of children and adolescents experience mental health conditions, and half of all mental illnesses begin by the age of 14. Suicide is the third leading cause of death in 15–19-year-olds.[3] Yet compared with physical health, mental health is relatively low on the list of priorities in the public policy agenda, and receives insufficient human and financial resources. This situation is aggravated when crises – such as the 2020 COVID-19 outbreak and protracted conflicts around the world – create additional risks for children's mental well-being, while also undermining the capacity of health and social care services to respond.

Without stronger action to address such challenges, the promises made to children through the Convention on the Rights of the Child and the 2030 Agenda will not be kept. As the international community begins a Decade of Action to deliver the Sustainable Development Goals (SDGs) by 2030, it is imperative that mental health be given more attention in measures to prevent and respond to violence against children.

This report aims to support this process. It provides an overview of international evidence on the different ways in which violence harms children's mental health, highlighting the urgent need for action. In doing so, the report considers diverse settings and forms of violence, the developmental differences in the effects of violence, and the most significant risk and protective factors. The report also highlights solutions, recognizing that despite the continuing gaps in our knowledge, there are effective approaches that should be pursued.

Box 1. Definition of mental health

Mental health is an integral and essential component of health. According to the World Health Organization (WHO): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[4] This implies that mental health is far more than just the absence of mental health conditions.

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Mental health matters for our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. The promotion, protection and restoration of mental health are, therefore, vital for individuals, communities and societies throughout the world.[5]

Mental health problems exist along a continuum from mild, timelimited distress to chronic, progressive, and severely disabling conditions.[6] The term psychosocial disabilities refers to the disabilities of children with either diagnosed or perceived mental health conditions and/or intellectual impairments, which may also be caused by stigma, discrimination and exclusion.[7]

A boy holds a paper with a yellow 'frown face' in front of his eyes at a child care centre run by Precious Jewels Ministry, a local NGO that supports AIDS-affected children in Manila, the Philippines. In this exercise, children play with various facial expressions to reveal their moods.

2. The urgent need for action

Violence against children: its prevalence, forms and settings

Every year, at least 1 billion children – half of the world's children – experience violence. No country is immune; no child is immune. From the growing body of evidence on the prevalence of violence against children, we know that this is a vast and severe rights violation (Box 2).

Children experience many different forms of violence. These include physical, psychological and sexual violence, as well as neglect, exploitation, sale, trafficking and harmful practices (such as female genital mutilation). Violence also takes place in multiple settings, including the home, schools, the community, the workplace and within institutions such as detention centres and orphanages, as well as in the online world. The different forms of violence are interlinked, as they share common root causes. They can occur together and one form can lead to another, creating a continuum of violence for children.

Box 2.
Violence against children: The numbers at a glance

- Every seven minutes, an adolescent somewhere in the world is killed by an act of violence.[8]
- Data for 24 countries show that sexual violence in childhood ranges from 8 per cent to 31 per cent for girls and from 3 per cent to 17 per cent for boys.[9]
- Worldwide, an estimated 750,000 individuals are trying to connect with children online for sexual purposes at any one time.[10]
- Children now account for 30 per cent of those who are trafficked.[11]
- Children with disabilities are almost four times more likely to experience violence than other children.[12] There is also evidence that children with mental or intellectual disabilities face a higher prevalence and risk of violence than children with other types of disability.[13]
- Almost one third of school students aged 11–15 years have been bullied by their peers at least once in the past month.[14]
- Close to 300 million children worldwide aged 2–4 years face violent discipline on a regular basis by their caregivers.[15]
- One in four children under the age of five lives with a mother who is a victim of intimate partner violence.[16]
- Globally, emotional abuse is estimated to have an impact on the lives of more than one in every three children.[17]
- The global prevalence of physical teen-dating violence in young people aged 13–18 years is estimated to be around 20 per cent, with the prevalence of sexual teen-dating violence standing at an estimated 9 per cent.[18]

"... there are some children that bring that from home; their parents insult them and hit them and all that ... They memorize that, and the child thinks that maybe that it is OK because in their home that happens, they get to school and there they take it out on other children."
Alexa (name changed), aged 12, Mexico[19]

When interpersonal violence spills from one setting to another, it results in what is known as poly-victimization.[20] A child who is abused at home or at school, for example, is more likely to be a victim of violence in the wider community. The rapid uptake in the use of the internet and mobile telephony has added another 'virtual' environment where violence occurs, and emerging evidence signals an overlap between offline and online victimization and the perpetration of violence.[21] Research has highlighted not only the inter-connected nature of different types of victimization, but also the way in which the cumulative impact can severely impair a child's development.[22]

In addition to experiencing violence directly, **children can witness violence** between others, as in situations of domestic violence, bullying or gang violence in the community. Equally, children can be exposed to violent material through the media or the internet.

Although all children can become victims of violence, **some children are at greater risk**. They include children living in alternative care; children without a legal identity; children living or working on the streets; children with disabilities; children living in poverty; children from ethnic, religious or linguistic minorities; lesbian, gay, bisexual or transgender children; and children who are on the move as migrants, refugees or as internally displaced people.[23] Different factors can intersect with each other, magnifying the risk of violence and the challenges for children's mental health.

It is essential to recognize the **gender dimension** of violence against children. Gender-based stereotypes, power imbalances, inequalities and discrimination create different risks for children. Girls, for example, are particularly vulnerable to sexual violence, intimate partner violence and a range of harmful practices. Boys are more likely to be victims of homicide and other forms of violence in the community.

Being a victim of child maltreatment can **increase the risk in later life** of becoming a victim or perpetrator of sexual violence, youth violence, self-directed violence and intimate partner violence. Children who witness intimate partner violence against their mother or stepmother are also more likely to experience such violence in later life – both as victims and as perpetrators.[24]

Children in humanitarian settings are extremely vulnerable to violence. War, climate disasters and disease outbreaks, such as the 2020 COVID-19 pandemic (Box 3), can result in the collapse of social systems, the separation of children from their caregivers and the damage or destruction of once safe environments.

Today, one in every four children in the world lives in a country affected by conflict or disaster. Nearly 50 million children have been uprooted from their homes as a result of violence, poverty or natural disaster.[25] And as such crises proliferate, more children than ever are becoming vulnerable to violence in all its forms.[26]

Box 3.
The COVID-19 pandemic and children's mental health

The COVID-19 pandemic that continues at the time of writing has major implications for children's mental health. Confinement measures, the additional stress placed on families and the disruption to already limited child protection services have exacerbated the vulnerability of children to various forms of violence. These include violence and abuse within the circle of trust (a circle that includes caregivers and other relatives), gender-based violence, and sexual exploitation both online and offline. The situation is aggravated by children's lack of access to school-friends, teachers, social workers and safe spaces. The negative impact of such violence on children's mental health compounds the wider anxiety, fear, insecurity and isolation caused by the pandemic more generally.[27]

A consultation by World Vision International with children and young people aged 8 to 18 from 13 countries on their understandings, experiences and perceptions of the COVID-19 crisis found that:

- 71 per cent of the children and young people said that they felt isolated and lonely since their schools were closed. They also pointed out that this had a negative impact on their learning and daily routines, and it increased their sense of isolation and despair.
- 91 per cent of respondents said that they were facing emotional distress and troubling experiences, including feelings of anxiety, anger and worry because of the uncertainty about how long this crisis would last and how to deal with isolation.
- 75 per cent of the children and young people acknowledged that it is emotionally challenging to deal with physical and social distancing restrictions.[28]

Despite its high prevalence, **violence against children is often hidden, unseen or under-reported.** As a result of fear, stigma and societal acceptance of violence, only a small proportion of affected children come forward to report their experiences.[29] The 'invisibility' of this violence is compounded by the lack of adequate child-sensitive complaint and reporting mechanisms, and the absence of adequate data-gathering.

In addition to the **devastating human cost of violence, it has a massive economic impact**. The global economic costs of violence against children are estimated to be as high as US$7 trillion.[30] In the United States of America alone, the total lifetime economic burden linked to substantiated cases of child maltreatment occurring in one year was $428 billion in 2015.[31] In the East Asia and Pacific region, the economic impact of some of the health consequences of child maltreatment is estimated to range from 1.4 per cent to 2.5 per cent of the region's annual gross domestic product (GDP).[32]

KEY MESSAGES

- Over 1 billion children are victims of violence every year.
- Children experience many forms of violence and in many settings, both online and offline.
- Violence often exists on a continuum: different forms can occur together and one form can lead to another.
- Children can be the target of violence, as well as witnessing or being exposed to it.
- Some children are at a heightened risk of experiencing violence.
- Being a victim of violence in childhood is associated with a higher risk of being a victim of violence in adulthood.
- Violence against children is often hidden and under-reported.
- In addition to the devastating human cost, violence has a massive economic impact.

The global mental health crisis: Not a priority in the public policy agenda

Violence has long-lasting consequences through childhood, into adulthood, inter-generationally and for society at large.[33] These consequences include the **severe impact on children's mental health**.

Yet less than half of the United Nations' Member States have a plan or strategy for child and adolescent mental health.[34] The Lancet Commission on Global Mental Health and Sustainable Development found that the quality of mental health services is routinely worse than the quality of services for physical health. It also found that "government investment and development assistance for mental health remain pitifully small".[35] The funds that are allocated to mental health are often ill-directed and are spent disproportionately on the consequences of chronic mental illness rather than on early intervention and prevention, where the return on investment would be far greater. The collective failure to respond to this global health crisis results in a monumental loss of human capabilities and in widespread suffering that could be avoided.[36]

The lack of priority given to child and adolescent mental health is also reflected in the limited global coverage of prevalence data for mental health conditions in this group. One review found that, out of 187 countries, 124 had no data at all for any disorder. Without focused strategies to address this lack of data, poor coverage in both high-income countries and in low- and middle-income countries will continue to hamper advocacy for child and adolescent mental health. The lack of data will also continue to impede the planning and allocation of the scarce resources that are currently available for child and adolescent mental health.[39]

Against this background, there is **an urgent need to give greater attention to child and adolescent mental health when responding to violence against children.**

Acting early in the course of a child's life is crucial to prevent mental health problems later on, given that most mental health conditions in adult life have their roots in childhood. Neurological changes during the highly sensitive periods of childhood and adolescence provide opportunities to affect the developing brain positively or negatively.

Mental health is also a **major concern for children themselves**. In its report *Voices of Children and Young People: Child helpline data for 2017 & 2018,* Child Helpline International notes that the two most significant concerns for children contacting its member helplines were abuse and violence on the one hand, and mental health on the other.[40] In terms of abuse and violence, children cited physical and emotional abuse as their major concerns. And in relation to mental health, children cited suicidal thoughts, fear and anxiety, in particular. The report is based on data from child helplines in 84 countries and territories around the world, underlining the global relevance of the findings.

As with violence against children in general, the **economic costs of mental ill-health are significant.** In 2011, the World Economic Forum (WEF) found that mental illness accounted for 35 per cent of the global economic burden of non-communicable diseases: more than cancer, diabetes and heart disease. WEF estimated that by 2030, mental health problems will cost the world $16 trillion in lost economic output each year.[41]

Box 4.
Children and young people are less likely to use mental health services

Young people access mental health services less frequently than any other age group. This lack of access is the combined result of under-detection of the mental health problems of young people, their own poor awareness of services and their reluctance to seek help, as well as policy frameworks that do not prioritize their mental health needs.[37] According to one estimate, about 70 per cent of children and adolescents with mental health conditions do not receive an appropriate intervention at the right time.[38] Mental health conditions at this young age can lead to life-long discrimination, stigma and exclusion, and may even limit wider access to vital social, education and health services.

KEY MESSAGES

- Violence against children is linked to a wide range of mental health problems. These include anxiety, depression, suicidal thoughts, post-traumatic stress disorder, substance misuse, aggressive behaviour and impaired cognitive functioning.
- The quality of mental health services is, routinely, worse than for physical health.
- There is not enough funding for mental health, and the funds that are currently available are rarely allocated in the best way.
- There is a lack of data on child and adolescent mental health.
- Most children with mental health conditions do not receive the right interventions at the right time.
- Mental health is a major concern for children and young people themselves.
- Acting early to prevent mental health problems has major benefits.
- Mental ill-health is a significant economic burden for countries and for the world as a whole.

Maria, 12, stands and cries, at a marketplace in Kabul, the capital. The bag she is using for scavenging is heavy and a passer-by has taunted her, saying she is shameless to roam the streets like a beggar.

3. The impact of violence on the mental health of children

The mental health outcomes of violence against children

It has been proven, beyond any doubt, that violence undermines the mental health of children and poses a real risk for the onset and persistence of mental health conditions. Exposure to adverse childhood experiences (ACEs) such as violence can be traumatic, evoking toxic responses to stress that cause both immediate and long-term physiological and psychological damage.[42]

Three types of mental health problems are reported most commonly as a result of violence against children: **behavioural and emotional; cognitive and attitudinal; and long-term problems** (Figure 1).[43]

Behavioural and emotional disorders are more likely if children face cumulative exposure to violence in more than two contexts (for example, witnessing violence at home, sexual abuse and parenting stress).[44] Children affected by behavioural and emotional disorders may

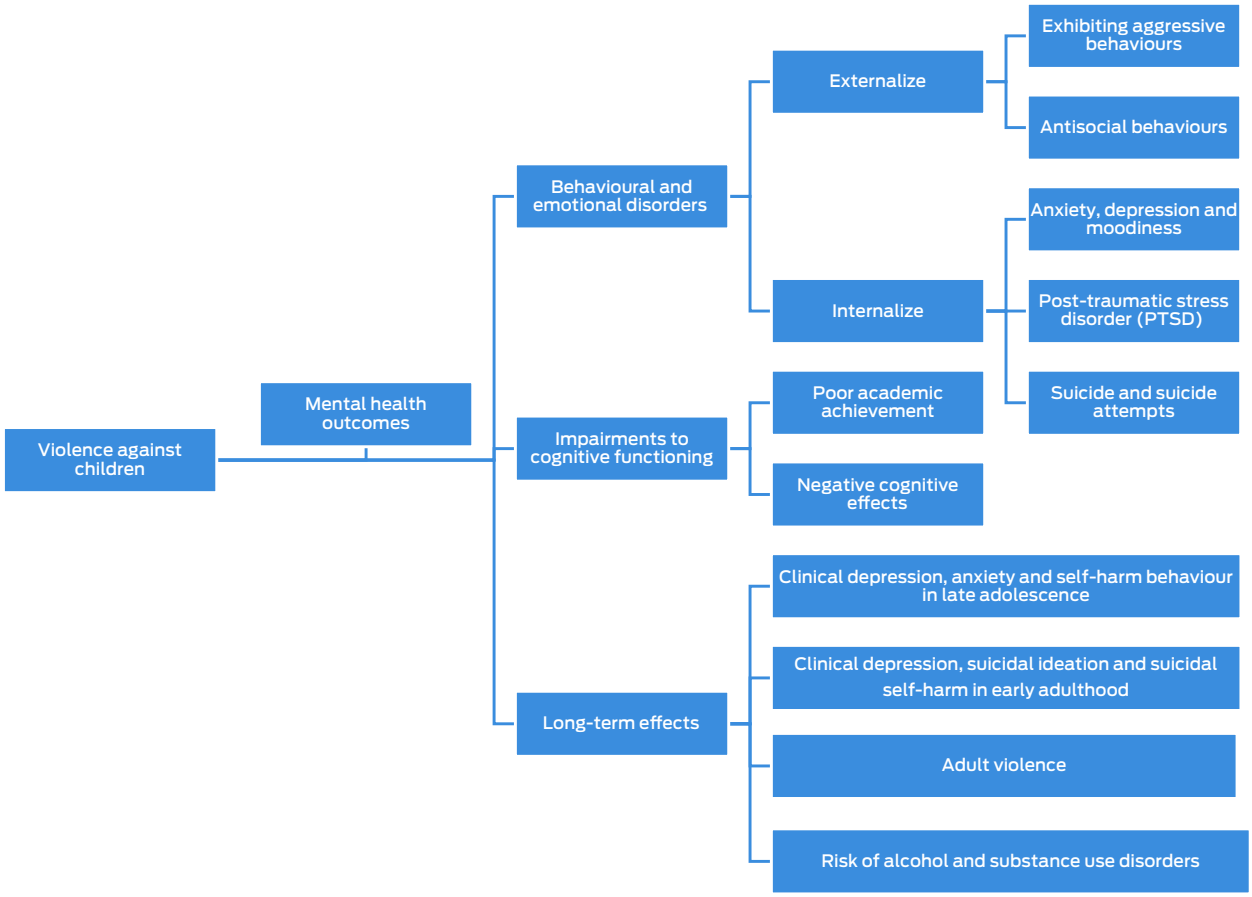


Figure 1: Overview of the main mental health outcomes of violence

Source: Professor Ghizlane Benjelloun

display externalizing symptoms that are directed outwards towards other people (such as greater levels of aggression, rule-violation and acting out). The external expression of mental health symptoms, such as aggressive or antisocial behaviour, is also more likely to increase the victimization of their peers.

Children may also display internalizing symptoms that are directed inwards. These include increased anxiety, depression and moodiness; PTSD; suicide attempts and actual suicide. Another consequence of trauma and violence during childhood can be behaviour that poses real risks to the health of the child. Children's drug and alcohol use has risen globally and should be seen as a child's way to cope and manage negative emotions.[45]

Box 5.
Links between violence during childhood, anxiety and depression

A 2015 study in Norway confirmed the close links between all combinations of childhood violence and anxiety or depression. Among participants who had been exposed to any form of childhood violence, those exposed to neglect and/or psychological violence reported more anxiety or depression than those exposed to sexual abuse or to family violence alone. Of those who were exposed to two types of violence during childhood, those participants who had been exposed to neglect or psychological violence in combination with sexual abuse and/or family violence reported more anxiety or depression than those who had experienced a combination of sexual abuse and family physical violence. Not surprisingly, the participants who had faced three types of violence during their childhoods had the highest scores for anxiety or depression.[46]

Those children who witness or are victims of violence can show symptoms of PTSD similar to those of soldiers coming back from war, with symptoms of distress increasing according to the number of violent acts they have witnessed or experienced. These symptoms include distractibility, intrusive and unwanted fears, and thoughts and feelings of not belonging.[47]

It is important to note, however, that there can be a risk of inappropriately medicalizing child responses to violence and abuse. Children's behavioural response to violence can sometimes lead to a mental health diagnosis despite being expected and proportionate responses to their situation.

Evidence on **impairments to cognitive functioning** shows that violence during childhood is linked to slower cognitive development, poor academic performance and poor school engagement. Mental health symptoms and disorders that predict poor academic achievement include PTSD, anxiety, aggressive behaviour and depression.

A child's exposure to trauma has also been associated with **long-term problems** that include depression, low self-esteem and substance abuse in late adolescence and early adulthood. ACEs can also undermine a person's ability to develop healthy ways to cope with difficulties and this can, in turn, affect their health behaviour and their opportunities throughout life, and even bring on an early death.[48]

Box 6.
Links between different types of violence exposure during childhood and mental health

A study on the links between different types of violence exposure during childhood and mental health in Malawi found:[49]

- a high correlation between past and recent exposure to violence
- the frequent clustering of exposure to three forms of violence, and
- the association of exposure to any single form of violence with higher levels of psychological distress – either directly or indirectly – as a result of its links to other forms of violence.

These results are consistent with a wide range of literature on the links between violence and mental health issues among children in other countries.[50]

ACEs have been linked specifically to the increased risk of alcohol and substance use disorders, suicide, mental health conditions, heart disease, other chronic illnesses and risky health behaviour throughout life. They have also been linked to reduced educational attainment, employment and income, all of which have a direct and indirect impact on health and well-being.

At least 5 of the 10 leading causes of death have been linked to exposure to ACEs, including several that contribute to declines in life expectancy, such as heart disease, pulmonary disease and obesity.[51] Analysis of ACEs from 17 countries has found that adults who were exposed to four or more ACEs before the age of 18 were 7 to 8 times more likely to be involved in interpersonal violence, and 30 times more likely to attempt suicide than adults with no ACE exposure.[52]

KEY MESSAGES

- Violence during childhood is a key risk for the onset and persistence of mental health conditions.
- Children's exposure to violence can evoke toxic responses to stress that cause immediate and long-term physiological and psychological damage.
- The most commonly reported mental health problems caused by violence against children are behavioural and emotional; cognitive and attitudinal; and long-term problems.
- Adverse childhood experiences have been linked to increased risks of disorders related to alcohol and substance use, suicide, mental health conditions, heart disease, other chronic illnesses and risky health behaviour throughout life.
- Adults who were exposed to four or more ACEs before the age of 18 were 7 to 8 times more likely to be involved in interpersonal violence and 30 times more likely to attempt suicide than adults with no ACE exposure.[53]

The mental health outcomes of violence against children across the life course

The impact of violence on children's mental health **depends on their experience of this violence as they grow and develop.** It can begin while the child is still in the womb, with violence posing a severe risk to the child's nervous system and brain. The greatest risk a child faces before they are born is domestic violence against their pregnant mother by a partner, spouse or other family members.

The early years

In the early years of childhood, difficult family circumstances cause stress in children that can lead to mental health problems in later life. Scientists have shown that maltreatment can become biologically 'embedded', and even alter the structures and functions of the young brain.[54]

The normal and healthy development of an infant until they reach pre-school age depends upon safe and secure relationships with those who are caring for them. Any disruption by, for example, exposure to violence, can interfere with every aspect of the child's development. More specifically, that child may never acquire healthy levels of trust or autonomy.[55] The exposure of a child to violence during infancy can derail their secure attachment to their caregivers, can introduce disturbed sleeping and eating patterns and can alter brain development (Box 7).

Infants and toddlers who witness violence either at home or in their community show excessive irritability, immature behaviour, sleep disturbance, emotional distress, fear of being alone and regression in toileting and language.[56]

Box 7.
Violence during childhood derails normal development

Exposure to trauma, especially violence in the family, interferes with a child's normal development of trust and, during adolescence, the normal tendency to explore and push boundaries, which helps a young person to develop autonomy.[57]

Recent reports have noted symptoms in young children that are very similar to post-traumatic stress disorder in adults, including the repeated re-experiencing of the traumatic event, avoidance and the 'numbing' of responsiveness.[58]

Pre-schoolers are not yet able to fully control their own emotions. Research has set out some of the behavioural effects of being exposed to violence at this age, including ambivalence towards parents, acting out, whining and clinging or crying – all of which may result from anxiety and post-traumatic stress.[59]

Childhood

Between the ages of 6 and 12 years, children begin to recognize what is expected of them and start to build their sense of self by comparing themselves with others around them. Research suggests that the effects of domestic violence on children in this age group can include feelings of guilt and shame, as well as anxiety and symptoms of PTSD.[60] A child may begin to struggle at school and their relationships with their peers can suffer. They may lack motivation or find it difficult to concentrate because of intrusive thoughts. This is also the time of life when gender socialization starts, and when children begin to make judgements about fairness and whether their needs are being met in the best way.[61]

It is possible that children of school-age are better able than pre-schoolers to grasp the circumstances around any violence they experience or witness. Children of this age may be able to draw on more internal resources (such as more sophisticated perceptions) and external resources (such as school professionals and perhaps education about family violence) that could help them cope.[62]

Nevertheless, as with pre-schoolers, school-age children who are exposed to violence are more likely to show increases in sleep disturbances and are less likely to explore, play freely or show any motivation to master their environment.[63] In addition, school-age children are more likely to understand that the violence that they witness or experience is intentional and may worry about what they could have done to prevent it, or that they caused the violence to begin with.

Box 8.
The impact of community violence on school-age children

Several studies support a link between exposure to community violence and symptoms of anxiety, depression and aggressive behaviour in school-age children living in violent urban neighbourhoods.[64] In extreme cases of exposure to chronic community violence, school-age children may also exhibit symptoms that are similar to post-traumatic stress disorder. Some studies have highlighted the link between children witnessing violence and nightmares, children's fear of leaving their homes, anxiety and a 'numbing' effect.[65]

Tommy [NAME CHANGED], 16 years-old stands in Dublin, Ireland. In his community, Tommy has been subject to violence and intimidation from the police and his peers. Tommy has identified the lack of recreational space and facilities as one of the main reasons for violent encounters in his community.

Box 9.
Key data on adolescents and mental health

- The effects of exposure to violence on adolescents can include depression and suicidal thoughts, dating violence, substance abuse and the use of violence as a control tactic. Up to 20 per cent of adolescents (aged 15–19 years) globally experience mental health conditions.
- Suicide is the third leading cause of death among adolescents (aged 15–19) worldwide.
- Around 15 per cent of adolescents in low- and middle-income countries have considered suicide.
- Today, globally, mental and substance use disorders are the leading cause of disability in children and young people.[66]

Adolescence

Cognitive psychology and neuroscience studies have transformed our understanding of the potential reasons for the onset of **mental health conditions in adolescence**. One unique transition that occurs during adolescence is that the opinion of peers begins to be more important than the views of parents and other relatives. The power of this peer influence leaves adolescents very sensitive to social stimuli and increases their propensity for risky behaviour.

Adolescence involves the active search for identity, and a lack of guidance at this crucial stage can lead to poor choices.[67] The sexual coming-of-age and the onset of sexual experiences can be skewed by the results of exposure to violence and the perpetuation of violent norms of behaviour. It may be difficult for adolescents to get the right type or level of help they need because exposure to violence has had an impact on them that may be masked by their own norm- and law-breaking or violent behaviour.

Considerable research on adolescent youth violence indicates that adolescents exposed to violence, particularly chronic community violence, throughout their lives, tend to show high levels of aggression and acting out. This is often accompanied by anxiety, behavioural problems, problems with academic performance, truancy and revenge-seeking.

The more severe effects may be related to adolescents' greater exposure to violence than younger children. A chronically traumatized adolescent can appear deadened to feelings and to pain, and can show restricted emotional development over time. Alternatively, they may attach themselves to peer groups and gangs as a substitute for family and may incorporate violence into their lives as a way to deal with disputes or frustration.[68]

Inter-generational aspects

"They can be adolescents or parents that had a very difficult childhood, and so that has stayed with them and they can't let go of it. So they make other children pay for it so that they feel like they did when they were young."
Ava (name changed), Canada[69]

Evidence on the **inter-generational aspects** of violence and mental health from high-income countries demonstrates that maternal ACEs have far-reaching consequences that can last for an entire lifetime, but that also span generations.[70] These consequences include disrupted parenting, impaired attachment, and poor educational and mental health outcomes in children.

In low- and middle-income countries, recent studies have demonstrated that maternal maltreatment and exposure to violence can trigger an increase in violent attitudes and tendencies towards children.[71] Maternal depression has also been linked to childhood disturbances in emotional, behavioural and cognitive development, including self-reported mental health problems, increased risk of violence and substance use, and poor educational achievement.[72]

Children can also be harmed when those who are caring for them are subjected to **intimate partner violence or when children witness it taking place**. Research has shown that children who witness violence at home or live with mothers who are victims of intimate partner violence are

Fatima [NAME CHANGED], 16, holds her newborn, in a shelter for girls and women who have endured sexual and gender-based violence, in Mogadishu, Somalia. Fatima became pregnant with the infant after a group of men raped her.

KEY MESSAGES

- The impact of violence on children's mental health depends on their experience of it as they grow and develop.
- Violence in early childhood can impede secure attachment, disturb sleep and eating habits, and alter brain development.
- Infants and toddlers who witness violence can show excessive irritability, fear of being alone and regression in toileting and language.
- School-age children are likely to have a greater understanding than younger children about the intentionality of violence and worry about what they could have done to prevent or stop it.
- Adolescence brings with it a greater sensitivity to peer influence and an increased propensity for risky behaviour. The effects of exposure to violence on adolescents can include depression and suicidal thoughts, substance abuse and the use of violence as a control tactic.
- Experiences of violence have inter-generational mental health effects, especially those effects that arise from maternal adverse childhood experiences and intimate partner violence.

at a heightened risk of experiencing abuse within the home. There is also evidence to suggest that children exposed to domestic violence are more likely to act aggressively towards their peers or siblings and to carry violence into their adult lives as either victims or perpetrators. Witnessing violence between parents or caregivers can also shape children's attitudes about its acceptability within the family and close relationships; these attitudes can, in turn, be passed down to the next generation, perpetuating the cycle of violence.

The mental health outcomes of different settings and forms of violence against children

In addition to varying across the life course, the impact of violence on the mental health of children depends on the forms of violence they experience and the settings in which the violence takes place. Table 1 summarizes the main mental health outcomes of different forms of violence and across different settings.

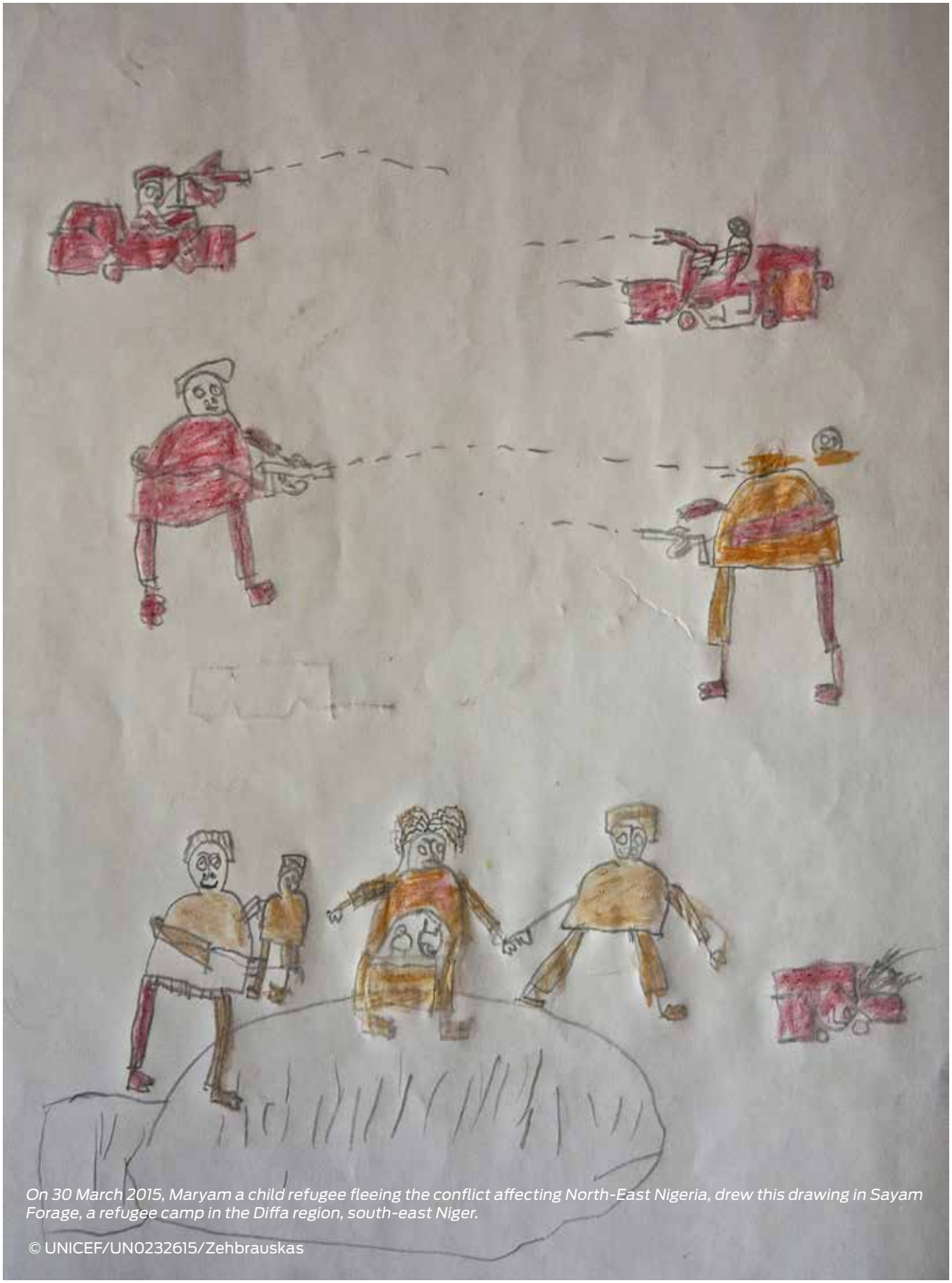
It is important to note that exposure to violence is not itself a diagnosis. Not all people affected by a particular type of violence will react in the same way or benefit from the same intervention.

Table 1. FORMS, SETTINGS AND MENTAL HEALTH OUTCOMES OF VIOLENCE

Forms and settings	Mental health outcomes
Psychological violence	Increased risk of a lifelong pattern of depression, anxiety, low self-esteem, inappropriate or troubled relationships, and a lack of empathy. Possible delays in developmental progress during childhood.
Sexual violence	A range of outcomes include depression, post-traumatic stress disorder (PTSD), suicide risk, substance use, eating disorders, teenage pregnancy, risky sexual behaviour, poorer educational outcomes, and perceptions among victims of their own poorer health.[73] May disrupt bodily sensations such as pain intensity and hunger,[74] as well as attention span and working memory.[75] The psychological and emotional impact can be particularly devastating because secrecy, shame and stigma – underpinned by harmful gender norms – mean that boys and girls who experience sexual abuse often have to cope alone.
Physical violence and punishment	Associated with behaviour disorders, anxiety disorders, depression and substance use. Available evidence indicates an association between physical punishment and increased aggression, reduced empathy and the way in which children absorb and follow moral rules.[76] Linked to slower cognitive development and poorer academic achievement.
Neglect	Associated with a range of behavioural, cognitive, developmental and internalizing problems,[77] and as harmful, potentially, as other forms of maltreatment.[78]
Bullying	Associated with poorer education results and mental health problems – including anxiety and depression, suicidal thoughts and actions, self-harm and violent behaviour – that have been found to persist into adulthood. Cyberbullying results in many of the same outcomes and has also been linked to a greater likelihood of problem drinking, cigarette smoking and gambling.[79] Bullying affects not only its victims: being the child who bullies is also linked to poorer outcomes during childhood and in later life. Children who bully exhibit more externalizing problems like antisocial and risk-taking behaviour, as well as later criminal offending. Being a perpetrator of bullying and a victim compounds the risks of psychological and behavioural problems.
Violence online	Online exposure of children to violence and inappropriate content (such as child abuse material, pornography, hate-speech material and material advocating unhealthy or dangerous behaviour like self-harm, suicide and anorexia) is associated with problematic behaviour, including aggression, anxiety and PTSD symptoms. Children can also end up with lower levels of empathy and compassion for others. The portrayal of suicide online that can lead to imitation or "copycat" suicides is particularly problematic.[80]
Children in institutional care	There is strong and consistent evidence on the negative impact of institutional care on children's mental health, particularly in terms of high rates of psychiatric symptoms, and emotional and behavioural problems. Systematic reviews often highlight associations between severe institutional neglect and delayed cognitive development; it can also result in permanent disability.[81] Research has confirmed the particularly negative cognitive effects for younger children and those who spend long periods in institutions.[82]

Forms and settings	Mental health outcomes
Children deprived of liberty	Children in justice-related detention have markedly higher levels of mental health conditions than other children in their community, in particular substance use disorders, behavioural disorders and depression. Many children in detention also experience PTSD and other severe mental health conditions that warrant immediate treatment. Importantly, mental health conditions in detained children have been found to be highly comorbid, i.e. existing alongside other conditions.[83] Self-harm and suicidal behaviour are higher among children in detention than among their community peers. Adolescents who have been in detention are four times more likely to die by suicide than other adolescents.[84] Children in detention as a response to immigration are vulnerable to serious mental health disorders as a result of a range of factors, including torture and trauma before their arrival, the breakdown of families within detention, the length of detention and uncertainty about the future, and witnessing trauma within detention.[85]
Harmful practices	Harmful practices can cause both immediate and prolonged psychological damage. Girls and women who have experienced female genital mutilation, for example, may have higher rates of mental health disorders, particularly depression, anxiety disorders, PTSD and somatic complaints, such as aches and pains, that have no apparent physical cause.[86] Research on child marriage and psychological well-being in Niger and Ethiopia has found significant and negative associations between early marriage and psychological well-being, including depression and anxiety, as well as vitality and general health. These associations remained even after adjusting for the prevalence of child marriage, violence and average psychological well-being at the community level. This suggests that early marriage is detrimental to psychological well-being even after accounting for social norms captured by the child marriage and other community variables.[87]
Armed violence in the community	Research indicates that children exposed to gun violence may experience negative short- and long-term psychological effects. These include anger, withdrawal, PTSD, de-sensitization to violence, disturbed sleep, intrusive thoughts about the traumatic event, difficulty concentrating in the classroom, deteriorating academic performance, and lower educational and career aspirations. Other outcomes include increased aggressive behaviour, risky sexual behaviours and substance misuse.[88] The impact is more acute for children who are direct victims of gun violence, or who live in communities where they witness repeated gun violence.
Refugee children	Refugees fleeing persecution, torture, or sexual violence are at high risk of developing both acute and chronic psychological disorders. Cumulative trauma experienced before displacement (such as threats of harm, witnessing violence suffered by others, and lack of access to basic needs) and afterwards (such as protection concerns, lack of statehood and detention) also contributes to a child's overall distress.[89] Children who live through these experiences face a far higher risk of serious mental health problems, particularly post-traumatic stress disorder and depression in later life.[90] A meta-analysis of 30 studies on refugees found a prevalence range of 0–87 per cent for children who meet the criteria for post-traumatic stress disorder.[91] Children reported fear of recalling traumatic events, fear the events would happen again, headaches, weight loss, general anxiety and insomnia. The prevalence of depressive symptoms ranged from 35 per cent to 90 per cent across the studies. The prevalence of aggression or conduct problems among youth in refugee camps is around 36 per cent, with boys displaying more aggression than girls.[92]

Forms and settings	Mental health outcomes
Disease outbreak	Confinement measures can place children at greater risk of violence and exploitation. The disruption of services to children in abusive households, in alternative care, in street situations and in humanitarian settings, for example, can mean that lifelines of safety and support are cut off. As well as the impact of violence at home, online or in other settings, the isolation caused by confinement measures during disease outbreaks is linked to a range of effects on children's mental health. Children may struggle with the disruption of their daily routines, as this interferes with their sense of structure, predictability and security. Children may also worry about their own safety and the safety of their loved ones, how their basic needs will be met and what will happen in the future. Children who have already been traumatized or who have pre-existing mental, physical or developmental problems are at particularly high risk of emotional disturbances. How a child reacts and the common signs of distress can vary according to their age, previous experiences and how they typically cope with stress. Some common changes include: ▪ excessive crying or irritation in younger children ▪ returning to behaviour they have outgrown (such as toileting accidents or bedwetting) ▪ excessive worry or sadness ▪ irritability and 'acting out' behaviour in teens ▪ poor school performance ▪ avoiding activities they used to enjoy ▪ unexplained headaches or body pain ▪ use of alcohol, tobacco or other drugs.
International and internal armed conflict	All the evidence confirms the damaging impact of war and military violence on the mental health of children and adults, increasing PTSD, depression, anxiety and dissociative symptoms (e.g. having flashbacks to traumatic events; feeling that you are briefly losing touch with events going on around you; being unable to remember anything for a period of time).[93] Traumatic brain injury (TBI) is a major problem for children in conflict zones and increases the chances of subsequent mental health problems.[94] It is important to remember that stressors in these settings are interconnected, and that the negative impact of violence is compounded by lack of access to the support services children need to survive and to cope with stress. Systematic violence is particularly traumatic for the victims, and for those who treat and assist them.[95] One example is the extreme violence, torture, enslavement, systematic sexual violence and recruitment of child soldiers committed against the Yazidi minority in Northern Iraq by ISIL/Da'esh. Nearly half (42.9 per cent) of the victims who escaped from ISIL show full PTSD and 39.5 per cent suffer from major depression. Among the ISIL victims, women are more likely than men to suffer from PTSD and major depression. Torture and sexual violence are strong predictors for the development of PTSD and comorbid depression.[96]



On 30 March 2015, Maryam a child refugee fleeing the conflict affecting North-East Nigeria, drew this drawing in Sayam Forage, a refugee camp in the Diffa region, south-east Niger.

4. Understanding risk and protective factors

The foundation for effective action lies in the identification of the factors that put children at risk of violence and mental health problems, and the factors that can protect them against both. What's more, an integrated approach to decrease their risks and increase their protection underpins any successful prevention and response efforts.

Risk factors

Some risk factors correspond to a particular form of violence against children but, more generally, the various types of violence have several risk factors in common. This is reflected in the prevalence of poly-victimization, which involves different forms of violence.[97] Risks can be found at the individual level, within relationships, and across communities and societies, in line with the social ecological model.[98] Similarly, the determinants of mental health span multiple biological, psychological, social and environmental factors.[99]

Individual factors include biological and demographic characteristics that increase the risk that a child or young person will be a victim of violence, such as their gender, age, low level of education, low income levels, disability or mental health issues; being lesbian, gay, bisexual or transgender; harmful use of alcohol and drugs; and having a history of exposure to violence. Many of these characteristics also shape mental health in general. Here, it is important to consider the magnified effects of intersectionality on mental health disparities and outcomes.[100]

Relational factors arise from relationships with peers, intimate partners and family members. They include a lack of emotional attachment between a child and their parents or caregivers; poor parenting; family dysfunction and separation; joining peers in illegal activities; witnessing violence between parents or caregivers; and early or forced marriage. The loss of a parent or close relative, poor maternal mental health and substance abuse by caregivers are also linked to negative mental health outcomes in children.[101]

Community-level risk factors include the way in which the characteristics of, for example, schools, workplaces and neighbourhoods increase the risk of violence during childhood. They include poverty, high population density, transient populations, low social cohesion, unsafe physical environments, high crime rates and the presence of a local drug trade. Research points to the higher risk of multiple exposures to violence for children who live in conditions of poverty, coupled with other demographic risk factors (e.g., single-parent households, racial-ethnic minority status), regardless of children's housing status or whether they are homeless.[102]

Society-level risk factors include the legal and social norms that create a climate in which violence is encouraged or normalized. They also include cultural norms that see it as acceptable to use violence to resolve conflict, that affirm men's domination over women and children, and that see parental rights as outweighing the well-being of children. But they also include health, economic, educational and social policies that maintain economic, gender or social inequalities; absent or inadequate social protection; weak governance; and poor law enforcement.

Box 10. Attitudes towards violence

Attitudes towards violence are crucial in shaping its risk across a range of settings. A 2017 longitudinal study in nine countries by Lansford et al. found that community acceptance of violence was a predictor for violent discipline by parents.[103] When societies accept the use of violence, their children will accept and rationalize the use of violence, particularly as a way to impose discipline.[104] Research also shows that the beliefs and attitudes of teachers around violence will determine levels of violence in their classrooms, given their major influence over what constitutes 'normal' or appropriate behaviour. Teachers' beliefs, even if they merely result in inaction, may increase the prevalence and frequency of bullying behaviour in their classrooms.[105]

Emergencies, such as conflicts, natural disasters and disease outbreaks, make societies fragile and erode the support that could protect children under normal circumstances. Parents and other adults who matter to a child may be killed, disabled or traumatized and children may have to take on adult caring responsibilities.

Schools – which are protective in many ways and also provide an entry point for mental health and psychosocial support – may be closed, damaged or become targets for military attacks. Opportunities for play and friendship are often lost as families are displaced or forced into lockdown, and as safe communal spaces disappear.

Box 11.
Mental health and conflict: "After some time, [the violence] became part of me"

There is growing evidence on the impact on children's mental health caused by changes in societal structure, norms and roles during conflict. Several studies describe changes in sexual behaviour, including having sex at an earlier age and child marriage. A child who is displaced and separated from their family may well face an increased risk of exploitation, high-risk sexual behaviour, sexually transmitted infection, and teen pregnancy.[106] The toll on child soldiers can be extreme: in a number of studies, children describe the process of their indoctrination and methods of control, including regular physical and psychological abuse, torture and the normalization of violence.[107] In the words of one child: "After some time, [the violence] became part of me".[108]

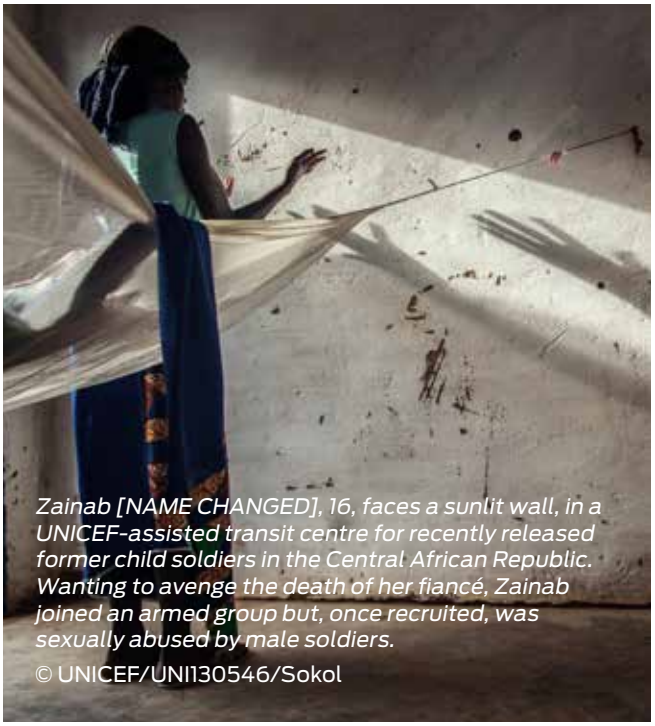
The way in which all of these factors interact across all levels of the social ecological model is just as important as the influence of any one factor within a single level.

Box 12.
Children's mental health and violence in Zimbabwe

The first study in Zimbabwe to estimate the risk factors for childhood emotional and physical violence (using nationally representative data) found strong associations between poor mental health and harmful behaviours, in line with international research. Chigiji et al. confirmed that, for girls, the significant risk factors for experiencing physical violence are: having ever experienced emotional abuse before the age of 13; adult illness in the home; socioeconomic status; and age. Boys' risk factors include peer relationships and socioeconomic status, while protective factors include caring teachers and trusted community members. Risk factors for emotional abuse vary, but include family relationships, teacher and school-level variables, socioeconomic status, and community trust and security.[109]

Protective factors

Protective factors can be grouped into three main categories: child factors, family factors and extra-familial factors.



Zainab [NAME CHANGED], 16, faces a sunlit wall, in a UNICEF-assisted transit centre for recently released former child soldiers in the Central African Republic. Wanting to avenge the death of her fiancé, Zainab joined an armed group but, once recruited, was sexually abused by male soldiers.

Child factors include a child's adaptability, personality, optimism and coping style, as well as the way in which a child understands and appraises the events around him or herself. Additional protective factors cited in studies include self-esteem and self-efficacy, attractiveness to others in personality and appearance, individual talents, religious affiliation, socioeconomic advantage, opportunities for good schooling and employment, and contact with people and environments that are positive for development.[110] In other words: children who have the opportunities, support and confidence that stem from a safe and nurturing childhood.

Box 13. Children's coping strategies in the face of violence

Research highlights the critical role of children's emotionally regulated coping strategies – which many researchers define as the ability to enhance or reduce your emotions as needed - as a way to protect yourself from mental health symptoms in the face of multiple forms of violence. Children who think that they are able to cope emotionally report fewer mental health symptoms. Children's own coping strategies could, therefore, buffer the most harmful effects of some exposure to violence, whether as part of prevention or treatment strategies.[111]

Resilience is a key issue and may determine which children will experience fewer harmful effects in response to exposure to violence.[112] Resilience is about the capacity of an individual to navigate their way to resources that can support and sustain their health and well-being. It is partly a personal trait, and partly a process that is shaped by culture and context. Results from several studies of resilient infants, young children and youths who have been exposed to community violence are consistent in identifying a small number of crucial protective factors for development. These protective factors include a caring adult, a community 'safe haven' and a child's own internal resources. The evidence also suggests that the impact of environmental risk factors on a child or young person can be reduced or even prevented by helping them to strengthen their own resilience.[113]

Family factors include the strength and nature of a child's relationship with their parents, siblings and extended family members. The protective resource that is most important in helping a child to cope with exposure to violence is a strong relationship with a competent, caring, positive adult – most often a parent. With good parenting by a mother or father or by another significant adult, a child's cognitive and social development can continue even in adversity.

Maternal education is a protective factor that may play a key role in easing the risks associated with intra- and extra-familial difficulties.[114] Low levels of maternal education in high-income countries, for example, are associated with increased risk for childhood cognitive, behavioural and emotional challenges.[115] A mother who has had a higher education in a resource-poor setting is more likely to have better quality interactions with her child(ren) and greater knowledge of child development, and to provide higher quality home stimulation with a likelihood of having more books in the home. The integration of child stimulation into health and nutrition interventions can also have a protective effective, including in humanitarian settings.

Extra-familial factors include positive relationships and social support from peers or adults, such as teachers and community leaders. There is evidence that a positive school climate can protect against mental health problems and peer victimization, even in places with high levels of community violence. In general, students who have experienced high community violence coupled with a negative school climate have demonstrated the worst development.[116] Cultural practices, social norms and legal frameworks that protect against discrimination are also crucial.

KEY MESSAGES

- The foundation for effective action to prevent and to respond to violence during childhood and its effects on mental health lies in the identification of the factors that put children at risk and the factors that could protect them.
- Risk factors can be found at every level: individual, family/relationships, community and society.
- The interaction between these risk factors across the different levels is just as important as the influence of any particular factor within a single level.
- Protective factors can be grouped into three main categories: child factors, family factors and extra-familial factors.

A child's smiling self-portrait was drawn as part of an art therapy session at Beautiful Gate, a centre for abused and abandoned children in Lower Crossroads, a neighbourhood of the city of Cape Town.

5. What works: Evidence on effective prevention and response

"Victims don't want the experience to be what defines them for the rest of their lives. Why do we have a system in which I feel shameful for the wrong that was done to me? Why are we the ones hiding our faces in shame? I won't give my abuser the opportunity to write my story."
Sophie, survivor and advocate, Kenya[117]

We have more data, research and other evidence on interventions to prevent and respond to violence against children than ever before.[118] WHO has noted **increasing evidence on the effectiveness and cost-effectiveness of interventions** to promote children's mental health, and to prevent and treat mental health conditions, as set out in its *Mental Health Action Plan 2013–2020*.[119] WHO itself has initiatives that aim to strengthen mental health care systems and the provision of psychosocial interventions for promotion, prevention, and the care of children and adolescents.[120]

The Lancet Commission on Global Mental Health and Sustainable Development has also identified a range of interventions that are necessary to prevent mental illness and substance use conditions, and to provide treatment and care to enhance recovery.[121] The Commission has stressed **innovative interventions that have the potential to be scaled up**, and that could be delivered either through routine health care or other existing platforms.

Preventive interventions that focus on **maternal mental health, mother-infant interaction, and play and stimulation** have positive long-term benefits for both infants and mothers. Those that promote early initiation of breastfeeding and close physical contact with the mother and enhance maternal responsiveness are particularly important, as they build attachments and reduce the risk of child maltreatment. In addition, **parent education and multi-component interventions** (those that combine **family support, pre-school education, parenting skills and child care**) show promise in preventing child maltreatment and reducing mental health problems in children exposed to adversity, and those affected by armed conflict.[122]

A 2018 meta-analysis of 193 studies by Patel et al. for the Lancet Commission reported strong links between **maternal depression** and increased mental health conditions (both internalizing and externalizing) among their children. Equally, there is strong evidence that interventions to support mothers with mental health conditions help to reduce internalizing and externalizing problems among their children, and prevent the onset of childhood mental health problems. **Home-visiting programmes** for new mothers and their babies are particularly useful when they include the detection and treatment of maternal depression and the delivery of **psychosocial interventions** as part of routine prenatal care and post-natal care services.[123]

Investing in parenting and child-welfare interventions is vital to **break toxic cycles of trans-generational transmission of violence, poverty and mental illness**. Parenting interventions aim to modify aspects of caregiving that could pose a risk to children by, for example, promoting non-violent discipline or by improving parental knowledge of the potential effect of violence on the development of their children. According to the American Psychological Association, a wide range of family-focused prevention programmes have been tested and have had a real impact, while several have also been shown to be cost-effective.[124] The Nurse Family Partnership home-visiting programme in the United States, for example, has been shown to save from $3 to $6 for every dollar invested.[125]

The Lancet Commission found that an intervention for growth-stunted toddlers that provided psychosocial stimulation and parenting support led to major gains in adult functioning and labour market outcomes later in life. And within schools, life-skills training that is focused

on the development of social and emotional skills, problem-solving and ways to cope is seen as best practice for building emotional and social competencies in children of all ages.[126]

In terms of treatment, care and rehabilitation for mental health problems among children in low-resource settings, a basic package of interventions for children could include training programmes for parenting skills, which have been shown to work well for children with developmental, behavioural and emotional problems.[127]

The community-based rehabilitation model, for example, is a rights-based approach that builds on the inherent strengths of the community and involves people with disabilities, family members and volunteers. Such approaches should be supported by local health professionals so that they can be incorporated into mainstream services where possible. The approaches should also be tailored to specific local needs and resources.

Evidence on community-based rehabilitation programmes for children with developmental delays and disorders highlights both their acceptance by local communities and their benefits.[128] There is also evidence supporting the use of peer support groups – for both parents and children – and respite services for children with psychosocial disabilities.[129]

Box 14.
Waves for Change (W4C) – South Africa

"Waves for Change taught me to be independent and have a hope for tomorrow. If I fall, I know that I can rise again. Life is full of challenges, but I will not give up."

W4C participant

Waves for Change (W4C) Surf Therapy provides mental health services to vulnerable young people living in unstable communities in Cape Town, South Africa. Young people referred to the programme have experienced any number of adverse childhood events that have had a major impact on their mental health:

- 37 per cent have witnessed someone being shot, stabbed or attacked
- 35 per cent have had someone in their household die
- 28 per cent are often hungry and have no food to eat at home
- 21 per cent have been physically assaulted by an adult.

W4C combines evidence-based mind and body therapy with surfing to address mental and physical health concerns. The programme is delivered by community coaches who have been trained to engage and support young people by using the local surfing environment.

Young people are referred from schools, community services and government agencies. They connect with the programme for 12 months and take part in weekly surf clinics where they establish a rapport with their mentor and with others.

After 12 months, most participants demonstrate improved emotional regulation and are more optimistic. Both teachers and parents have noted that participants are calmer, more engaged at school and more resilient to stress.

The W4C programme has now been expanded to five locations across South Africa and a new programme has also been established in Liberia.[130]

"In the past, I used to become so aggressive when bullied by other children but the village counsellor has been such a help. I can now cope with different situations and people."
Girl from SOS Children's Village[131]

Late childhood and adolescence present more opportunities to ease the effects of early disadvantage, to **build resilience,** and to reduce the harmful consequences of conditions that start to take hold during this time of life. Interventions to strengthen social and emotional competencies – often aiming to enhance the regulation of emotions and packaged as life-skills education, mindfulness, or even yoga – can have preventive effects.[132] At the same time, parents and other family members, peers, schools and communities can form a crucial inner circle to protect the adolescent. Interventions that include positive mentorship and livelihood opportunities can also have a beneficial effect.

The WHO-UNICEF Helping Adolescents Thrive initiative aims to provide programmatic guidance on community-, family- and adolescent-focused strategies for the promotion of mental health, prevention of mental health conditions, and reduction of self-harm and other risk behaviours in adolescents.[133]

Universal socio-emotional learning (SEL) interventions in communities and schools promote children's social and emotional functioning, improve their academic performance and reduce their risky behaviours, including smoking and teenage pregnancy. SEL interventions can be delivered by peers, teachers and counsellors by integrating activities into youth programmes or school curricula (for example, the HealthWise programme in South Africa).[134]

The most effective interventions use a **whole-school approach**, with SEL supported by a school ethos and physical and social environments that promote and support good mental health, and that involve staff, students, parents and the local community. These interventions act directly by promoting self-efficacy and trust, and by reducing risks such as bullying. Economic analyses show that SEL interventions in schools are cost-effective, generating savings through better health outcomes and reduced spending on the criminal justice system.[135]

"The teacher showed us a sheet of paper and said we could scribble on it, stamp on it, crumple it — but not tear it. Then she asked us to try and straighten it out again, but it was impossible to smooth out all the creases. Then she said this is what it's like when someone gets bullied"
11-year-old boy, Norway[136]

Efforts to tackle suicide among adolescents are critical, given that suicidal thoughts and suicide among adolescents are major public health concerns. Prevention strategies include community- and school-based skills training for students, the identification of young people at risk, education of primary care physicians, education of media professionals on the responsible reporting of suicide, and restriction of access to means of suicide (such as firearms, pesticides and medication).

One example of an effective school-based intervention is Youth Aware of Mental Health (YAM), which involves training to develop the problem-solving and coping skills of teenagers.[137] The *Going Off, Growing Strong* programme in Canada is an example of an effective community-based intervention. It gives at-risk youth the chance to take part in community- and land-based activities and to build relationships with positive adult role models in Nain, Nunatsiavut (Labrador).

Targeted preventive interventions focus on young people who have had experiences that increase their vulnerability to mental health conditions or who show symptoms that suggest they are on the threshold of such conditions. Interventions that help adolescents to cope and build their resilience, including cognitive-skills training, help to prevent anxiety, depression and suicide.[138]

WHO has issued **clinical guidelines** on responding to children and adolescents who have been sexually abused, as well as more general guidelines on health-sector responses to child maltreatment. The guidelines aim to help front-line health workers to provide evidence-based, good quality and trauma-informed care. They address psychological

An adolescent girl clutches a plush bear at the Ignacia Centre, in Santa Cruz, Bolivia. The centre provides shelter and other support, including counselling and education, for survivors of sexual abuse.

and mental health interventions, including cognitive behavioural therapy (CBT) with a focus on trauma and the involvement of non-offending caregivers where it is safe to do so.[139]

Box 15.
An example of cognitive behavioural therapy with a trauma focus

Trauma-focused cognitive behaviour therapy (TF-CBT) is a structured, short-term treatment model that improves a range of outcomes for traumatized children and parents or caregivers with PTSD and other difficulties related to traumatic life events. Treatment generally consists of 8 to 16 sessions lasting from 60 to 90 minutes, with children and/or non-offending caregivers, individually or in groups.

Children learn coping skills to help them manage their emotional response to traumatic memories. This approach can also help parents to cope with their child's experience of trauma.

TF-CBT is now widely implemented and its impact has been evaluated extensively. Evidence on its effectiveness has emerged from both high- and low-resource settings and in response to diverse, multiple and complex trauma experiences.

The model has, for example, been used with individuals and their families in Zambia, with groups of boys and girls in Congo, and within existing service or programme structures in groups affected by traumatic grief in Kenya. It is ongoing in Kenya, Tanzania and Zambia. A TF-CBT programme has also been built into the work of shelters for sex-trafficked youth in Cambodia.[140]

WHO has also produced the *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings*,[141] which sets out the integrated management of priority conditions using protocols for clinical decision-making by non-specialist providers. It includes a module on children and adolescents, which has a focus on ecological and psychosocial approaches to care.

WHO's *Psychological First Aid: Guide for field workers* provides guidance on skills and competencies that enable people working with children to reduce the initial distress caused by accidents, natural disasters, conflict, interpersonal violence or other crises.[142] Other important resources include Save the Children's *Psychological First Aid Training Manual for Child Practitioners* and the *Children's Resilience Programme* developed by Save the Children and the Psychosocial Centre of the International Federation of Red Cross and Red Crescent Societies.[143]

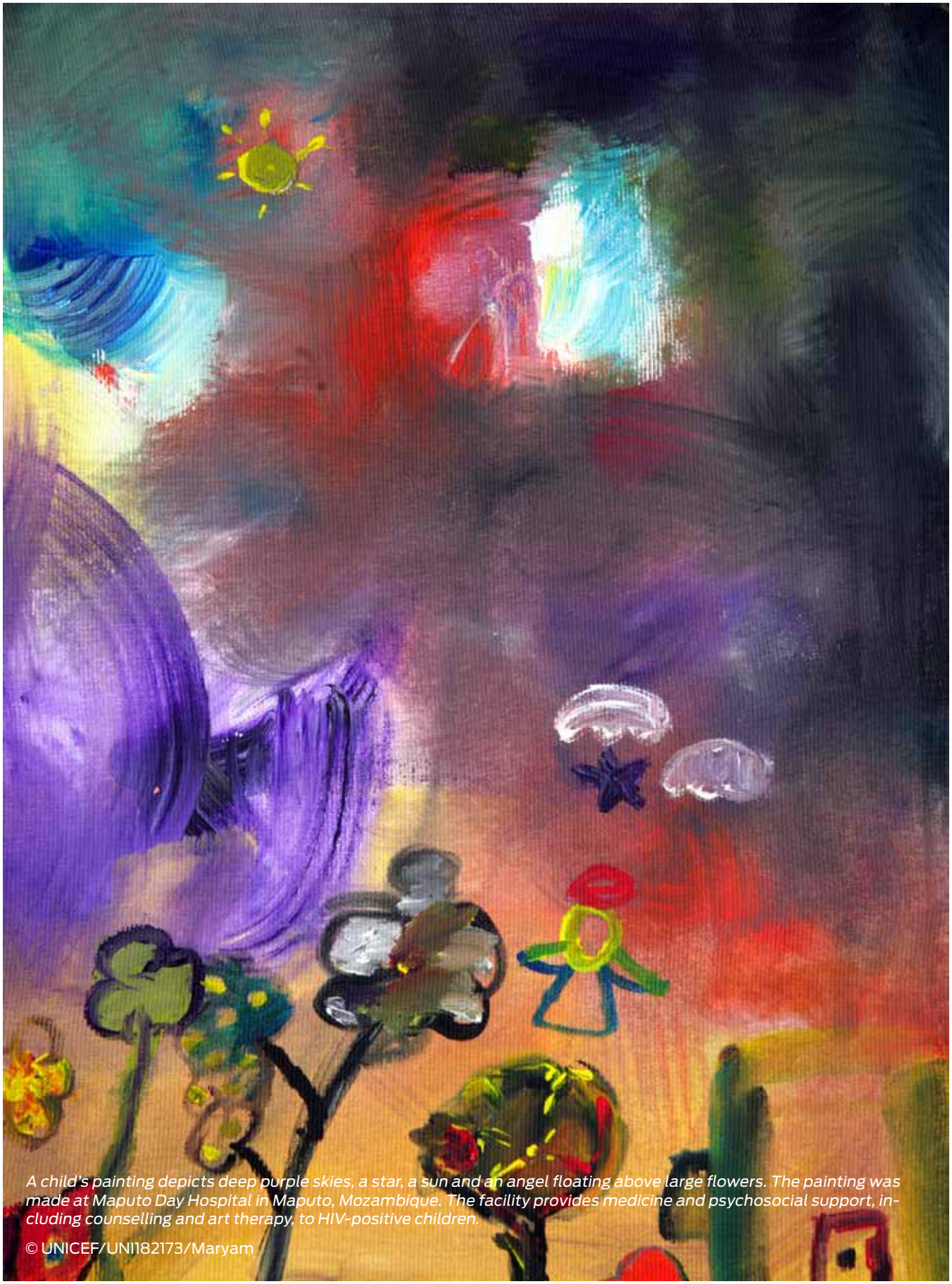
The Inter-Agency Standing Committee (IASC) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*[144] aim to reinforce existing community resilience, avoid the medicalization of distress and actively promote service use. They also aim to proactively identify cases and referrals to appropriate interventions, and integrate mental health into emergency medical and social care responses. An active role for members of local communities and authorities is essential at every stage for successful,

coordinated action and to enhance local capacities and sustainability. A coordinated response should ensure that actions and interventions build the foundations for a sustainable mental health-care system.[145] The IASC has also developed operational guidance for multisectoral mental health and psychosocial support programmes during the COVID-19 pandemic, which includes a specific chapter on children.[146]

UNICEF's *Operational guidelines on community-based mental health and psychosocial support in humanitarian settings* give guidance on the spectrum of supports that are required for children, from basic services to family/community supports to clinical mental health care.[147] Furthermore, UNICEF and WHO are developing a costed Minimum Services Package for mental health and psychosocial support to be delivered in both new emergencies and ongoing protracted conflict settings. The Minimum Services Package will encompass health, education and protection, and will help build a safety net for children in these critical areas.

KEY MESSAGES

- There is increasing evidence on the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental health conditions among children and adolescents, including those who have experienced violence.
- Preventive interventions that focus on maternal mental health, mother-infant interaction, and play and stimulation have positive and long-term benefits for children and young people.
- Parenting and child welfare interventions are key investments for breaking toxic cycles of trans-generational violence, poverty and mental illness.
- The evidence on community-based rehabilitation programmes suggests that they are locally acceptable and have positive benefits for children with developmental disabilities.
- Life-skills training within schools is an example of best practice for building the emotional and social competencies of children of all ages.
- Socio-emotional learning interventions in schools result in real savings as a result of improved health outcomes and reduced expenditures in the criminal justice system.
- The most promising suicide prevention strategies for adolescents include skills training, education of primary care physicians, responsible reporting of suicide by the media, and restricting access to means of suicide.
- WHO has issued clinical guidelines to support front-line health workers and mental health workers in providing evidence-based, quality and trauma-informed care to child victims of violence, as well as mental health care and psychosocial support for children experiencing developmental delays and emotional or behavioural problems.
- There is a growing body of evidence on effective clinical interventions for children with mental health conditions in emergency settings.



A child's painting depicts deep purple skies, a star, a sun and an angel floating above large flowers. The painting was made at Maputo Day Hospital in Maputo, Mozambique. The facility provides medicine and psychosocial support, including counselling and art therapy, to HIV-positive children.

6. Building a nurturing, protective and empowering environment for and with children

Efforts to address the mental health impact of violence against children should be **guided by international human rights standards,** such as the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. They should also be aligned with **the 2030 Agenda for Sustainable Development**. They must equally reflect a modern public health approach. One key principle of this approach is that good mental health means much more than the absence of mental illness.

Upholding the right of child victims of violence to the highest possible standard of mental health requires **comprehensive and coordinated action**, underpinned by a robust legal and policy framework. Mental health support must be part of core protection services for children and should be developed through a child-rights based and multi-sectoral approach. Such an approach needs to tackle the risks that children face at every level and ensure good quality mental health care to all of those who need it. Important frameworks are already in place to guide States' action in this field, such as the WHO Mental Health Action Plan 2013–2020[148] and the Lancet Commission on Global Mental Health and Sustainable Development.[149]

The starting point for building a nurturing, protective and empowering environment for children is **to protect and promote the mental well-being of everyone** and to address the socioeconomic determinants of mental health. This is essential to create the conditions that will allow children to develop, thrive and reach their potential.

To achieve this, it is vital to address the social and environmental factors that shape mental health at the most developmentally sensitive times of life, tackling risks at all levels of the socio-ecological model. Many of the SDGs address these factors specifically, and progress towards the Goals has the potential to promote mental health and reduce the global burden of mental health conditions.

Prevention requires a combination of universal and targeted interventions, with a specific focus on the needs of vulnerable groups. This includes action to tackle stigma, discrimination, harmful social norms and human rights violations that undermine children's mental health. In addition, prevention efforts must respond to the increasing threats to mental health that are posed by global challenges such as climate change, growing inequality and outbreaks of disease.

Mental health services for children must be scaled up as an **essential part of universal health coverage** and should be integrated fully into other strategies for health and for violence prevention. Quality services should be provided in the community, avoiding institutionalization and medicalization wherever possible. When developing services, it is best to avoid creating mental health services that are only for victims of violence, as this can be stigmatizing.

Comprehensive community-based health and social care services must be developed to ensure continuity of care between providers, effective collaboration between formal and informal care providers and the promotion of self-care. Early detection and intervention for children's mental health are also crucial.

The **empowerment of children** to participate in decisions about their own care – a right enshrined in the Convention on the Rights of the Child – is fundamental for a rights-based approach to mental health. Many young people are already taking the lead in supporting their own mental health and well-being, as well as in peer-to-peer initiatives.[150] They are heavily engaged in programming on mental health, both online and offline. Yet still, their voices are rarely heard. The views and experiences of children who have lived with the experience of mental health conditions and psychosocial disabilities must shape the design, delivery and evaluation of responses.

"I had to choose between acceptance and destruction. I realized that if I did not accept my past, it would destroy me. Letting go of the pain was not the easiest thing to do, but I knew it was for the best."

'Lee', a survivor and police officer, Thailand[151]

It is essential to have the right number and equitable distribution of **competent, sensitive and appropriately skilled** health and social service professionals. It is equally important to build the knowledge and skills of general and specialized health and social service workers

Box 16.
The perspectives of children and young people on how to promote and protect their mental health

The European Network of Young Advisors (ENYA), which advises the European Network of Ombudspersons for Children (ENOC), carried out a project in 2018 on how to promote and protect children's mental health in general. This culminated in recommendations for the education and health sectors, as well as governments, communities and the media.[152]

Education

- More training for teachers to improve prevention and detection of mental health issues among children.
- More education for children on their rights, on mental health and on diversity.
- More discussion in schools about mental health to help reduce stigma and discrimination.
- The creation of safe spaces where children can ask for help without fear of judgement.
- Equal importance given to emotional development in schools and not only a focus on academic success.

Health

- More awareness-raising campaigns to reduce stigma and encourage young people to ask for help, especially peer-to-peer initiatives.
- More positive messages and a greater focus on practical solutions for mental health such as healthy eating, regular exercise and having a support network of trusted people.
- Children should be able to ask for professional help without the consent of their parents: the age of medical consent should, at least, be lowered to the age of 16.
- Reduce waiting lists in child mental health services, ensuring treatment is provided by those properly trained on children's issues.
- Provide children with access to community-based services as much as possible.
- Make child helplines available 24/7 to provide information and support.
- Adopt approaches that are not only based on medicating children and adolescents, but that also promote positive family relationships, solve conflicts, instil trust and reduce aggression.

Media

- Increase public awareness of mental health issues in a way that protects people with mental health problems from stigma.
- Use platforms and content that are accessible to, and often used by, children.

Government

- Educate parents on children's rights, child development and signs of distress in their children.
- Provide workshops for children and parents on promoting healthy relationships.
- Provide financial assistance to families in need in a discreet way.
- Provide effective services for children with disabilities and those who face health issues so that they can ask for support when they need it, backed by appropriate infrastructure (such as ramps) to ensure they can participate fully in all activities.
- Ensure that laws do not discriminate against anyone suffering from mental health conditions.

Community

- Create spaces within communities where children and adults can discuss any issues that affect them.
- Provide opportunities for free participation of children in sports and cultural activities during their leisure time.

to deliver mental health, psychosocial and protective services that are evidence-based, culturally appropriate and human rights-oriented. Links between the education, health and child protection sectors must also be strengthened, including to ensure appropriate referrals among them.

Substantial additional investments are needed to promote and protect children's mental health. This is particularly true as the world confronts the heavy toll of the COVID-19 pandemic and its undoubted impact on the mental health of parents and children *(see Box 3)*. It is vital to reinforce health systems in the aftermath of the pandemic, and this reinforcement must include the strengthening of mental health services for children and adolescents, as well as wider child protection systems.

At the same time, however, there is an immediate opportunity to make the most efficient and effective use of the resources that already exist. This opportunity includes:

- the redistribution of mental health budgets from large hospitals to district hospitals and community-based local services
- the introduction of early interventions for emerging mental health conditions among children and young people
- the development of intermediate structures in child and adolescent psychiatry (such as 'teen houses') to reduce hospitalizations and stigmatization, and to improve access to child-centred and adolescent-responsive care
- the integration of mental health promotion, prevention and care into established platforms for the delivery of good health and well-being for children and young people, including through schools and digital platforms[153]
- supporting teacher training in socio-emotional learning.

Meanwhile, **investments in research and innovation need to grow**. There is a need to correct the current imbalance whereby most research is conducted in and by high-income countries to ensure that low-income and middle-income countries have culturally appropriate and cost-effective strategies to respond to the mental health needs and priorities of children, particularly those who are exposed to violence. The crucial information needed for effective action to support their mental health includes:

- the prevalence and nature of their mental health problems
- coverage of policies and legislation, interventions and services
- health outcome data
- social and economic outcome data, and
- research that is child and youth led.

These data need to be disaggregated by sex and age and reflect the diverse needs of sub-populations, including individuals from geographically diverse and vulnerable communities.

Finally, as the international community makes its way through the **Decade of Action to deliver the SDGs by 2030**, monitoring and accountability frameworks must be put in place. These frameworks must ensure that effective action is taken to promote the mental health of all children, to prevent mental health conditions among children who experience violence, and to provide treatment and care to all those who need it.

KEY MESSAGES

- The Convention on the Rights of the Child and the 2030 Agenda for Sustainable Development should guide action to tackle the harmful impact of violence on the mental health of children.
- Good mental health means much more than the absence of a mental impairment.
- It is essential to create the conditions that allow all children to develop, thrive and reach their potential.
- Comprehensive and coordinated action is needed to protect the mental and physical health of children, built on an inter-sectoral and multi-stakeholder approach.
- It is essential to prioritize the prevention of mental health problems that arise from exposure to violence and tackle risks at all levels of the socio-ecological model, from the individual child, to family and community systems, to social norms and policies.
- Prevention requires a combination of universal and targeted interventions, with a specific focus on the needs of vulnerable groups.
- Mental health services for children must be scaled up as an essential component of universal health coverage.
- Quality services should be provided in the community, avoiding institutionalization and medicalization wherever possible.
- The ethical and meaningful participation of children must be at the heart of action on this issue, including through support for peer-to-peer initiatives.
- It is essential to have the right number and distribution of skilled mental health professionals, community mental health workers, social service workers, trained pedagogues and school counsellors, in order to ensure access to protective and promotive mental health and psychosocial services.
- Substantial additional investments are required in mental health systems and services for children and young people, as well as research and innovation, while action is needed to make the best possible use of the investments that already exist.
- Robust monitoring and accountability frameworks must be put in place to ensure effective action to support the mental health of children who experience violence.

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