“There is no one way that fits all contexts in terms of delivering services for child and youth mental health”: Chiara Servili and Ken Carswell of the World Health Organization on adapting evidence-based interventions to local systems and youth-led innovation

Holly Wise
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Holly Wise: Let's start with introductions. What is distinctive about your approach in the field of youth mental health?

Chiara Servili: I am Chiara Servili. I'm a technical officer in the Department of Noncommunicable Diseases and Mental Health at the World Health Organization. I'm the technical leader on young people’s mental health. We work with the overall aim of supporting countries, improving environments for them to enable and promote youth mental health, and improving access to promotion, prevention, and care.

In order to achieve this, a lot of efforts are intended to strengthen the intersectoral governance programming and accountability in countries, while also promoting implementation of catalytic changes at grassroot level, leveraging innovative community-based and youth-led initiatives for young people's mental health. Funding opportunities have enabled us to do so more intentionally than in the past. We have been looking at ways of strengthening all of these aspects, including a focus on subnational level capacity building and monitoring. This is capitalizing on the experience of working with countries in the space of youth mental health over the past few years. There has been an exponential increase in demands and readiness by governments, not only for the Ministry of Health but even for the Ministry of Education, and the Ministry of Youth. That has allowed us to help governments build a programming structure. This was happening quite smoothly in the countries we were working in.

We saw that that national-level programming was still a bit distant from the action on the ground. There was a bit of disconnect. We were reinforcing governance structures and programming at the national level, and then supporting implementation at different levels, including the groundwork, but we were not seeing the same ecosystem change in terms of strength, governance capacity, and understanding of youth mental health at the subnational level. This year we have decided to intentionally discuss with countries how that ecosystem could be strengthened, and opportunities to leverage the innovative youth-led work that is happening at the grassroots level and is so distant from national structures.

Holly Wise: You mentioned this increase in demand for youth mental health services. What do you think has helped to shift that mindset in recent years?

Chiara Servili: COVID definitely helped with destigmatizing mental health in general. It also provided a space for people to talk more freely about mental health, particularly young people. During the COVID pandemic, there have been many opportunities for youth to contribute to discussions around mental health. That has really influenced governments, making them more aware of the concerns of youth in relation to their mental health. The data are showing a worsening of mental health in young people, so that also is contributing to the narrative in the global social development space and in global public health conversations.

There have been influential talks at high ministerial levels in terms of opportunities to discuss with governments. On the other hand, there have been more opportunities for youths to become actors and to be consulted more meaningfully. We need to consider this aspect as well. The movement around making young people more capable of contributing to their own agendas has had a deep influence in terms of allowing the conversation around youth mental health concerns to be part of higher-level conversations and policy dialogue.

Holly Wise: You mentioned that you are in conversation with governments about how the ecosystem can be strengthened. In these conversations, did you see any common barriers to building and strengthening that ecosystem?

Chiara Servili: The first barrier that we face in this process is that in most of the countries where we work, there is no intentional programmatic work on mental health challenges for young people, to the extent that in some countries, there is not even a clear definition of who is dealing with young people's mental health. It's partly in child health programming, partly in mental health programming. When we come with dedicated attention and funding, then it becomes important that they define who does what and how they work together.

We encourage them [to define this] as one of the requirements for the collaboration. We support them to establish the ministerial working groups. That works quite well in most contexts. It helps also with some of the concrete work that we then facilitate, for instance, integration of mental health or strengthening of mental health components of school-based services, or improving policies in relation to well-being and mental health.

One of the common barriers that we reported about is the intersection between education and health. The school health service falls between the cracks of the two systems. We are having intentional conversations and dedicated funding, which means that they sort out how to collaborate and how to define roles. We ask the national counterparts to define action plans with clear responsibilities that engage all the different stakeholders, including youth.

Another element of the specific work we have been conducting this year is a youth engagement component, building on previous work and challenges, but also seeing this funding grant as an opportunity for us to do meaningful engagement of young people at the country level.

Holly Wise: Thank you. Ken, could you introduce yourself and add to what Chiara has shared?

Ken Carswell: I'm Ken Carswell. I'm in the same department and the same unit as Chiara. I'm a mental health specialist. I'm the focal point for work on digital innovation and scalable psychological interventions within our department. Our work straddles two areas. A lot of the work that I've been doing has been in what we call scalable psychological interventions. This isn't necessarily covered under the ICONIQ grant directly, but it's an important part of the work. That work is very much about developing the tools and support products that people need in order to scale psychological interventions and psychological services across the whole lifespan, including youth and adolescents. We've been aiming to develop, then test in randomized controlled trials, then release a series of evidence-based psychological interventions that can be delivered by non-specialists. They are essentially a reduced-session version of psychological therapies such as cognitive behaviorual therapy, such as our Problem Management Plus [PM+] intervention.

We've also done digital self-help interventions where somebody uses an app or a website to look at a self-help story that tells them about depression or about psychological distress. They receive a telephone call or a text message for support from a trained non-specialist helper, and they get around 15 minutes of support from that person per week. Using this combination of a self-help tool and the telephone call has been shown to improve mental health. We have demonstrated this in a number of research trials. We've developed three of those digital interventions. They're some of the most innovative things we're doing. One is based on something called behavioral activation for depression. One is a stress management guide, mainly aimed at adults. We've also developed and tested a non-AI chatbot that's aimed at youth and adolescents.

If we think about that work within the context of the wider work at WHO, we work towards systemic change by firstly publishing guidelines saying, these are the things that help people. For example, we have guidelines that say, “For depression, self-help interventions are effective.” That guides governments towards knowing what should be effective. Then we often develop the tools and manuals and products that people need to then implement that. We've developed a suite of different interventions for

adolescents, as well as for adults, that can then be used by different actors: by governments, by NGOs, by health services, by everybody. Everything we do is open access, so everything is there to be used, adapted, and implemented. We also develop the implementation guidance, the recipe, and the ingredients for people to do these things.

My area in particular is about digital and psychological interventions. A lot of our work is in that realm where we're developing both the guidelines and the tools and packages for people to actually run it. The tools and packages are generally developed through big collaborations both with experts and with people with lived experience, so that we can make things that are scalable, useful, and helpful for different actors. That's one side of my work.

The other side of the work, which is also about digital, is that we are looking more and more at the impacts of digital environments, digital technologies, or digital determinants on the mental health of people, particularly youth and adolescents. What impacts do the internet, social media, online engagements have on mental health? Our colleagues in WHO Europe released a report on the impact of digital determinants on mental health. We've got a lot of other work going on to support this.

We're also looking at systematic reviews to try and better understand how these things might impact youth mental health. We're running a research prioritization exercise. We're aiming to be an evidence-based and trusted voice that is able to say, this is what we think is happening. That hopefully steers work in a direction that is helpful for improving mental health, or for preventing mental health difficulties.

Holly Wise: How do you track outcomes and evidence that these interventions are working?

Ken Carswell: A few ways. Firstly, I think it starts with conceptualization and development. We start from a conceptual point of view of trying to distill, say, what a psychologist would do into the most effective components and aspects, with aspects that might be most feasible across different settings and contexts, and delivered by non-specialists. Essentially, that means going for simple and effective techniques that might travel. Things like grounding exercises, things like stress management, breathing exercises, things like behavioral activation, such as making a plan to do small pleasurable things if you're feeling depressed.

The second step, which is outlined in our *Psychological Interventions Implementation Manual*, is that everything is culturally adapted. We advise this very strongly because we know that this helps improve the effect. You work with local communities, both during the development phase and to get feedback on the ideas. Does this work? You make sure that it's acceptable, relevant, and understandable. You work with populations to go through the content: community members, people with lived experience, and also experts. Everything gets culturally adapted. A great example is, we might use the term “depression” or “anxiety,” but a common term that's used in many countries around the

world is “overthinking.” Where it says “depression” and “anxiety” in our work, we would expect that to be changed to the local idiom.

We have provided all the advice and guidance in the psychological intervention manual to guide people towards the right thing, including advice on monitoring and evaluation to look at outcomes, piloting first, checking things out before you go large with them. In terms of how we monitor outcomes, it varies. Some of the projects we're involved in, we might be directly working with a country to support them, so we can look at outcomes. But there's a lot of work that goes on that we're not directly monitoring, because the work is out there and already released.

With a lot of our work in psychological interventions, we set ourselves a standard of having pooled positive results from two randomized controlled trials with different populations before we release, because if you do a randomized control trial on one population, it could be a chance result. You do a second trial, you've got a much higher probability that it's not a chance result. We felt that was a nice balance between allowing things to be feasible and scalable quickly, and not over-testing in every single environment, but also being relatively sure.

Because our role is to release these products, we can't always follow up on everything. Two good examples where this has gone to scale are in Lebanon and in Thailand, they've now implemented at a national scale some of our digital mental health work. We tested it with colleagues in Lebanon. We got the models; you can almost call them blueprints. Now they've been scaled in two places, and we're working with those countries to also continue to help and support. There'll be lots of other places where work is going on that we're not directly involved in, which is a good thing, because it means it's all successful in many ways.

Holly Wise: When you say that the interventions are open access, does that mean that you might not always know who is using the interventions, or do they have to come to you and ask permission?

Ken Carswell: No, WHO has an open-access publishing policy. That means it is released under a Creative Commons license, which makes it easier to adapt and use. Everything's on the website. The manuals include very clear instructions on who can use it, who should not use it, what type of training and supervision are needed, and what conditions you need to use it successfully. Then we're available for advice if people contact us.

Holly Wise: Ken, how would you define current attitudes toward youth mental health? Have you seen those attitudes shift in your sector?

Ken Carswell: I would agree with Chiara. I think there's been a big change since COVID. It's my personal perception that there's a lot of interest and concern about youth mental health. I've seen that become a much bigger debate. There's been a bigger move towards seeing it as important and working on it. Some of the things we've been doing at WHO are trying to provide the guidance, the tools, the products to help people

to do that. When we talk about WHO, obviously, we're also talking about our regional-office and country-office colleagues, because all of us are there to support these efforts.

Holly Wise: What barriers do you think still exist toward changing the way that people think about youth mental health?

Ken Carswell: There's lots of barriers. Sometimes people find the evidence hard to believe. I'm talking about more than just adolescent and youth mental health here, but for example, we know very well that task sharing works—the idea that you can train non-specialists to deliver psychological interventions. We know it works. There's a lot of evidence from many areas to support that, particularly in psychological interventions, and we know that digital self-help works. But understandably, many professionals and providers might find it hard to believe that something that brief, like a self-help book with five 15-minute telephone calls, can actually support.

I think there's sometimes conceptual barriers in terms of thinking creatively, how we might address services, how we might innovate and use those innovations to address problems. A big barrier in terms of delivery is still funding. Such a small amount of funding is put into mental health services globally. But it's something we see changing.

Going back to the non-specialist aspect, sometimes there needs to be policy changes to allow some of those things to happen. For example, countries may have regulations that mean that the only people who can provide mental health support are trained professionals. That means that task-sharing interventions are harder to put in.

Chiara Servili: Two things come to mind immediately. One is helping governments set targets and become accountable towards youth mental health. Most countries are really being proactive in terms of integrating youth mental health into their policy documents and strategies, the action plan, and to a certain extent changing the system to be more responsive to youth mental health. There is a lagging behind in being very specific or intentional about what the governments are committing to achieve in the span of, say, 5 years, even 10 years. That is a bit more challenging. It is something that we are working towards, to help governments really commit and become vocal about what they would like to achieve.

The youth mental health budget usually sits within broader portfolios of either mental health or child health. Not having the commitments also means that there is no clarity around what the budget is in terms of specific allocation to youth mental health. That is at the national level. This is one thing that I wish we were better able to change.

The second element is the parenting or caregiver support element of the ecosystem. Whenever we talk with adolescents, we realize that one of their concerns and demands is for us to strengthen the competencies or the knowledge of parents, for parents to be better able to help them, by not being too harsh with them, having better style of communication, or understanding their needs. Parenting work in countries is very often focused around early childhood development, violence prevention, or parenting for kids

with specific conditions, including neurodevelopmental conditions. It is a very broad, universal parenting program, not specifically looking at mental health or adolescents. Parenting for adolescents' mental health is systemically neglected in the conversation at all levels, from global to country levels. We're making an intentional effort with countries to bring parenting for youth mental health to the table.

One opportunity that we have been discovering working with countries is school-based service. We realized that parents engage through schools; they don't engage as much through the health services. The engagement of parents through school staff is a great opportunity. We need to be evidence-informed. We have been distilling the elements of evidence-based parenting for youth mental health to guide countries and even school managers to adapt and tailor to the specific context. This is exciting.

Implementation of this approach in countries is still a challenge, but when it happens, it's really exciting to see, in some countries, parents so actively engaged, using very innovative modalities of communicating within the schools and with the students, using art and poetry to deliver some of the messages and really become champions within the schools, and to advocate for changes in school policies. There is huge potential.

Holly Wise: Is parent education led by grassroots organizations in the country, or is it something that your team is innovating around?

Chiara Servili: What I was referring to in terms of the innovative modalities has really been led by countries and by parents themselves. We have some guidelines that define what is evidence-based parenting for youth mental health, but these were published a few years back. We have organized some workshops with different stakeholders on evidence-based parenting for youth mental health, but then it is grassroots level organizations that take the lead and design the program that they want to see running in the context of schools. What WHO does is provide the evidence-based element to assist with adaptation, and then document good practice experiences. It may be that some of these efforts are already ongoing, but the role of the WHO in that case is to help the governments realize which experience constitutes a good practice example that can be scaled up or shared with other provinces or even other countries. This is something that we are doing proactively this year—establishing networks of knowledge exchange opportunities, also in between countries.

Holly Wise: What is something that you've tried in your work that hasn't worked, but that you've learned from—an instructive failure?

Ken Carswell: The biggest learning for me in the time I've been at WHO doing digital mental health has been that my thinking, and I think our thinking, has moved from the idea of building an app and then working out how that can be scaled globally or in different countries, and instead moving more toward thinking about content that can be used in multiple platforms. If we go back a few years, everyone was talking about the power of apps. We did have to build some apps in order to run randomized control trials, but we soon found out that it was not going to be possible for us to continue to

build, maintain, and ensure security, GDPR compliance, HIPAA compliance—all the regulations.

Our thinking pivoted to the idea that what you actually need is evidence-based content that can be delivered across multiple channels. When it comes to our digital self-help products, two of them are essentially stories that you follow, about a group of people who are experiencing a lot of stress in their lives, or an individual who's experiencing depression. These people then get advice from a trusted narrator in the story or a trusted character, like a doctor or a wise elder. Through that, they then learn the techniques. One of the biggest learnings was that the key is the content, because then that content can be used in different ways. We've seen this happening. We've seen the interventions that we've developed, which are illustrated, being turned into WhatsApp versions and adapted and demonstrated in other ways.

This thinking fed into our non-AI chatbot, because we developed that using human-centered design. We've had over 200 adolescents from multiple countries and territories taking part in the process, being interviewed about how they use the internet, prototyping interventions and designs, running through it with them. In that project, when we applied for the funding, we started off with, “We're going to build an app for adolescents.” We found out very quickly from talking to adolescents that they didn't want an app, because they didn't have space on their phones.

The other assumption we'd made was that it needed to be an app because they wouldn't be able to easily access the internet. We found out that even in very difficult places and situations, they were able to access the internet. Obviously there's still a big digital divide. That needs to be kept in account, and never should everything all be digital. It was a really important learning that content is key, because then it can be given out on digital platforms, it can be given out as a self-help book, and so on.

Holly Wise: What emerging work in your field are you excited about?

Chiara Servili: I can tell you what we're excited about and what youth are excited about. I was reading feedback from youth just this weekend. It is the co-designing of models to deliver interventions. There is a document provided by WHO called “Mental Health of Children and Young People: Service Guidance.” Basically, it says there is no one way that fits all contexts in terms of delivering services for child and youth mental health. Every country can start with what they have, and they can improve the network of services. There is a lot that we can learn from each country. The document distills the elements of the opportunities at the community level to deliver services for prevention and care. And it provides some examples taken from different contexts about what met the criteria of good practice examples.

We have taken that approach to the countries, and engage with the governments, intersectoral task groups, and young people, for them to analyze their context and how they can improve it. We engaged with Orygen to run some youth capacity-building workshops, with the intent of capacitating young people to inform the government and to share advice and suggestions on co-designing solutions for organizing services, such

as establishing a system of peer mentors. Then, we as WHO can say, yes, the evidence says that peer mentors in schools have been able to deliver this type of intervention with these results. We can then help youth advocate with the government.

This is an exciting process that I've seen just starting this year, with really proactive engagement of young people who are being given the knowledge and skills to articulate what the evidence says and what others have done, and we support them in partnership with Orygen to shape the message in a way that can be conveyed and can be convincing to the government and country stakeholders.

Holly Wise: If I'm understanding this correctly, the workshops are held to teach youth how to advocate and petition for themselves in front of governments and ministries?

Chiara Servili: Yes. We orient them on the different opportunities for integrating interventions for youth mental health.

Holly Wise: Is this the youth engagement component that you mentioned at the very beginning?

Chiara Servili: Yes.

Ken Carswell: Just to second what Chiara's saying, co-creation across different policies and work is something I'm also seeing. For example, there's a much bigger call around digital environments, digital determinants, digital technologies, and the impact of mental health for youth to be involved in that discussion and to be also supporting policies around what governments do in response to ensure that digital technologies are helpful and that harms are reduced. It's exciting to see.

Holly Wise: How do you connect with youth voices? Do you work through organizations in each country and partner with those organizations to bring youth together? How does that process work?

Chiara Servili: We ask the WHO country office to lead in terms of identifying civil society organizations that represent young people. Governments also have suggestions. It is a consolidated approach to try and identify youth that are already leading work on youth mental health or in a position to contribute.

We have given some stipends to the youth to engage in this effort. We have created opportunities for youth, the Ministry of Health and Education, as well as the WHO staff in the countries, to meet in person. These youth capacity workshops were held at the WHO country office or at the ministry country office to overcome barriers in terms of connectivity. We create an opportunity for them to be there in the same space. We also ran some webinars of intercountry exchange with young people, some with the ministry and the WHO together, and some with only young people, to have a safe space for them to exchange opportunities and challenges.

Holly Wise: What insights or teachable lessons can be taken from your work that others might find useful?

Ken Carswell: The importance of planning, conceptualization, and thinking carefully about how you fit things to the context that you're in is one of the biggest teachable aspects. If I think about our work on psychological interventions, we started it more than 10 years ago, developing Problem Management Plus, a five-session cognitive behavioral intervention for adults. Over time, as we released all these different interventions, we then have a suite of interventions. But one of the questions that we often get is, “How do I choose which one? Why should I choose this one over this one?”

As we've gone through it and developed things and looked at experiences from other countries, we've been thinking more now about how to fit these interventions together. Sometimes it's called stepped care, stratified care, or matched care. What's the service that you need around it in order to run things? Rather than giving everybody the same thing, maybe some people need a bit less. Some people need a bit more. Thinking about that, conceptualizing that, thinking about the pathways within that, who might get what, and why.

For me, one of the biggest learning points is the importance of thinking that through and thinking how you adapt things. For example, you might be able to do an intervention that's delivered by a non-specialist, but maybe training and supervision opportunities are restricted. They're still needed, but maybe they can't be given that widely. In that case, instead of going for a heavier intervention, you could go for an intervention that's a bit lighter, that still requires training and supervision, but requires maybe a little bit less guided self-help, versus an intervention that's delivered fully by a non-specialist. To me, it's that creative thinking and that conceptual thinking that's super important.

Chiara Servili: Each country has different context-specific opportunities. There are context-specific catalytic opportunities. Opportunities where even a small investment of funding can trigger a change that can make a difference in the system and can be sustained. The difficult part is finding these context-specific opportunities for catalytic change. That requires in-depth assessment of the ecosystem and a very intentional engagement of the different stakeholders, including grass-roots players, but also different sectors, and of course young people, and the stakeholders that can ensure that whatever is being done is evidence-based. Because we don't want change to happen and then interventions not to be aligned with evidence.

Holly Wise: Is there anything else that either of you would like to add?

Chiara Servili: I want to mention that throughout this year, and with the funding, we have been able to focus a lot on schools, and also to bring in other partners, including at the global level. For the first year, we have been working collaboratively with UNESCO. That has important possible repercussions at different levels of work, including at the country level, because we are publishing together some documents that will be co-branded by UNICEF, WHO, and UNESCO. That we ensure alignment with having the same guidance as reference throughout the health and education sectors.

Ken Carswell: This has been an interesting interview, to also be hearing what Chiara is saying. It's making me reflect on how we work at WHO, and some of the important aspects are about providing the tools and the advice and the guidance that others use. Obviously, other agencies might also do this in other areas. I think that's quite a welcomed role in many ways, because it provides the foundation for people to use it and build off of it.

Chiara Servili: Can I add a challenge we have? I also work specifically on neurodevelopmental conditions and neurodiversities. This has come up in some conversations on youth mental health in countries. I think we are still struggling with ensuring that even when we engage young people, there is a representative engagement of young people that includes the ones that are not living in the capital city, the ones that represent ethnic minorities or neurodivergencies, and how that intentional engagement of these different groups could help also shape the co-designing of solution that may be more intentional and inclusive of these vulnerable populations.

Holly Wise: Thank you both for your time.

Holly Wise is a two-time Fulbright-Nehru Teaching Scholar with extensive experience in solutions journalism and academia. She has held multiple roles at the Solutions Journalism Network, including its first director of journalism school engagement and later its first program director. She is a certified leadership and cross-cultural coach, based in Bengaluru, India. She holds a bachelor's degree in journalism and a master's in mass communication from Murray State University.

** This interview has been edited and condensed.*