The Service Delivery Chain of Youth Mental Health in Lithuania

Diagnostic I: School Context

2021

Strata

One of the Government's Strategic Analysis Center's STRATA objectives is to foster public policy innovation through the innovative public-policy making practices. These practices are based on a holistic approach and collaborative principles, including stakeholder and end-user's perspectives into the co-creative process, and experimentation with new ideas through the application of participatory design methods and other experimental approaches. The report *The Service Delivery Chain of Youth Mental Health in Lithuania. Diagnostic I: School Context* prepared by STRATA overviews the main bottlenecks in the youth mental health service delivery chain and provides recommendations on directions for potential interventions and innovative solutions. The study focuses on preventive activities and mental health services available for the school students aged 14 to 19 and studying in grades 9 to 12 (or grades 1 to 4 in gymnasium nomenclature). Administrative, quantitative survey, and qualitative interview data as well as broader co-creative sessions with involved parties are used to draw relevant insights.

The report was prepared by dr. Dalia Bagdžiūnaitė and Dovilė Gaižauskienė, *Policy Lab*. We would like to thank the World Bank's Bureaucracy Lab team for their expertise and insights provided during the report preparation and a peer-review process.

Vienas iš Vyriausybės strateginės analizės centro STRATA uždavinių yra skatinti viešosios politikos inovacijas pasitelkiant inovatyvias viešosios politikos formavimo praktikas, kurios remiasi holistiniu požiūriu, glaudaus bendradarbiavimo ir eksperimentavimo principais. Panaudojant dalyvaujamojo dizaino ir eksperimentinius metodus yra siekiama įtraukti suinteresuotąsias šalis ir galutinius vartotojus į bendros kūrybos procesus ir išbandyti naujas idėjas. STRATA parengtoje apžvalgoje *„Lietuvos jaunimo psichikos sveikatos paslaugų tiekimo grandinės diagnostika I: mokyklų kontekstas“* yra apžvelgiami psichikos sveikatos paslaugų tiekimo trukdžiai bei pateikiamos rekomendacijos intervencijų ir inovatyvių sprendimų įgyvendinimo kryptims. Tyrime dėmesys skiriamas prevencinėms veikloms, vykdomoms mokyklos kontekste, bei paslaugų sistemai, skirtai 14–19 metų amžiaus moksleiviams, besimokantiems 9–12 klasėse (arba 1–4 gimnazijos klasėse). Pateiktos įžvalgos yra grindžiamos pirminiais ir antriniais kiekybiniais ir kokybiniais duomenimis, bendros kūrybos sesijų metu surinkta medžiaga.

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Santrauka

Apžvalga *„Lietuvos jaunimo psichikos sveikatos paslaugų tiekimo grandinės diagnostika I: mokyklų kontekstas“* yra platesnio projekto, skirto jaunimo psichikos sveikatos gerinimui mokyklos kontekste, rezultatas. Šį projektą įgyvendina Vyriausybės strateginės analizės centro STRATA viešosios politikos laboratorija – *Policy Lab*, bendradarbiaudama su Sveikatos apsaugos ministerija, Švietimo, mokslo ir sporto ministerija, Socialinės apsaugos ir darbo ministerija ir Pasaulio banko biurokratijos laboratorija. Ši apžvalga yra pirmasis žingsnis nustatant giluminius iššūkius bei tolimesnių tyrimų bei eksperimentų įgyvendinimo galimybes.

Šioje apžvalgoje yra nagrinėjami jaunimo psichikos sveikatos paslaugų tiekimo grandinės trukdžiai žvelgiant į juos iš tiesioginių paslaugų vartotojų bei institucijų perspektyvų. Apžvalgoje pateikiamos rekomendacijos intervencijoms bei naujų sprendimų įgyvendinimo kryptims jaunimo psichikos sveikatai gerinti. Pagrindinis dėmesys yra skiriamas mokyklos kontekste vykdomoms prevencinėms veikloms bei paslaugų sistemai, skirtai 14–19 metų amžiaus moksleiviams, besimokantiems 9–12 klasėse (arba 1–4 gimnazijos klasėse).

Veiksmingas psichikos sveikatos sektorius vaidina svarbų vaidmenį užtikrinant visuomenės gerovę. Kiekvienas jaunimo psichikos sveikatos paslaugų tiekimo grandinės lygmuo, įskaitant viešosios politikos formuotojus ir valstybės tarnautojus ministerijose ir savivaldybėse, psichologines-pedagogines paslaugas teikiančias institucijas, visuomenės sveikatos biurus, nevyriausybines organizacijas, mokyklų atstovus ir kitus ekosistemos dalyvius, turi reikšmingą poveikį paslaugų prieinamumui ir veiksmingumui.

Psichikos sveikatos stiprinimas ir psichikos sveikatos sutrikimų prevencija yra pabrėžiama XVIII Lietuvos Respublikos Vyriausybės programoje. Gera fizinė ir psichikos sveikata padeda išlikti atspariems susidūrus su kritinėmis situacijomis, pavyzdžiui, COVID-19 pandemija. Visgi, dėl paslaugų tiekimo grandinės trukdžių bei egzistuojančių neigiamų nuostatų, Lietuvoje psichikos sveikatos paslaugos naudojamos nepakankamai. Atotrūkio tarp psichikos sveikatos poreikių ir veiksmingų paslaugų tiekimo mažinimas yra labai svarbus jaunimo grupei, ypatingai COVID-19 pandemijos metu sutrikus mokyklų veiklai.

Siekiant nustatyti jaunimo psichikos sveikatos paslaugų grandinės trukdžius bei jos tobulinimo kryptis įvairiais lygmenimis, šiame tyrime buvo naudojamos alternatyvios poveikio vertinimo praktikos – apžvalgoje pateiktos įžvalgos buvo generuotos pasitelkiant holistinį požiūrį bei analizuojant pirminius ir antrinius kiekybinius ir kokybinius duomenis. Apžvalgoje pateikiami įrodymai yra reikšmingi rengiant viešosios politikos intervencijas, jas įgyvendinant ir vertinant jų poveikį.

Apžvalgoje pateiktose rekomendacijose yra nurodomos kelios jaunimo psichikos sveikatos paslaugų tiekimo grandinės tobulinimo kryptys ir pasiūlyti veiksmai nustatytiems trukdžiams spręsti. Atlikto tyrimo rezultatai rodo, kad jaunimo psichikos sveikatos paslaugų tiekimo grandinė turi būti traktuojama kaip sudėtinga, kompleksinė, tarpusavio ryšiais susijusių elementų visuma. Paslaugų tiekimas joje gali būti veiksmingas tik tada, kai visi grandinės elementai bei procesai, vykstantys skirtinguose grandinės lygmenyse, veikia sistemingai ir efektyviai. Siekiant užtikrinti visos sistemos darną ir efektyvumą,

reikalingas sisteminis požiūris – visų ekosistemos dalyvių susitarimas dėl naudojamų sąvokų ir jų apibrėžimų; ilgalaikių prioritetų nustatymas; didesnis ir aktyvesnis aukščiausio lygmens politikos formuotojų įsitraukimas; veiksmingesnis tarpinstitucinis koordinavimas. Svarbu skatinti bendradarbiavimu ir sisteminiu požiūriu grįstas politikos formavimo ir įgyvendinimo praktikas, apibrėžiant skirtingų jaunimo psichikos sveikatos paslaugų tiekimo grandinės dalyvių funkcijas, jų tarpusavio ryšius. Rekomenduojama įsteigti koordinacinį vienetą, kuris užtikrintų aktyvų ekosistemos dalyvių bendradarbiavimą ir kryptingą pažangą siekiant bendrų tikslų; skatinti nuolatinį tarpinstitucinį įsitraukimą ir dialogą, aktyviau įtraukiant visus ekosistemos dalyvius, įskaitant nevyriausybines organizacijas ir tiesioginius paslaugų vartotojus – jaunimą, į psichikos sveikatos paslaugų, psichikos sveiktos stiprinimo ir prevencinių programų ir iniciatyvų kūrimo ir įgyvendinimo procesą.

Tyrimo rezultatai taip pat rodo, kad mokykla visoje jaunimo psichikos sveikatos ekosistemoje dažnai matoma kaip gana savarankiškas vienetas. Mokykloms trūksta galimybių dalyvauti jaunimo psichikos sveikatos gerinimo iniciatyvose, išskyrus sistemingai įgyvendinamas prevencines programas, todėl rekomenduojama skatinti darnesnę mokyklų integraciją į jaunimo psichikos sveikatos ekosistemą.

Mokytojai ir tėvai vaidina svarbų vaidmenį atpažįstant psichikos sveikatos iššūkius, taip pat nurodant bei paskatinant moksleivius pasinaudoti jaunimo psichikos sveikatos ištekliais mokykloje ir už jos ribų. Svarbu stiprinti mokytojų ir kitų mokyklos darbuotojų žinias ir kompetencijas šioje srityje. Taip pat yra poreikis apibrėžti ir standartizuoti jaunimo psichikos sveikatos puoselėjimui bei pagalbai skirtas procedūras ir gerąsias praktikas. Rekomenduojama kurti naujas ir optimizuoti esamas mokytojų žinių psichikos sveikatos klausimais stiprinimo programas. Taip pat raginama pasitelkti priemones ir intervencijas, kurios skatintų didesnį mokytojų įsitraukimą į šias programas.

Be to, siekiant mažinti neigiamas nuostatas į psichikos sveikatą bei psichikos sveikatos sutrikimus, svarbu atkreipti dėmesį į stigmas kuriančius ir palaikančius veiksnius, teisines kliūtis psichikos sveikatos paslaugų prieinamumui mokyklose. Daugiau dėmesio turėtų būti skiriama sisteminėms priemonėms, veikiančioms politikos formuotojų, mokyklų atstovų, tėvų, jaunimo ir plačiosios visuomenės nuostatas bei elgesio modelius.

Taip pat rekomenduojama skatinti mokslinių tyrimų ir eksperimentines veiklas ir stiprinti bei plėsti duomenų bazes psichikos sveikatos srityje.

Šioje apžvalgoje yra pateikiamas globalus bei nacionalinis jaunimo psichikos sveikatos kontekstas; pristatyta jaunimo psichikos sveikatos paslaugų tiekimo grandinės struktūra ir prevencinių programų rengimo ir įgyvendinimo procesas mokyklose; pateiktos moksleivių įžvalgos apie psichikos sveikatos sampratą, paslaugų tiekimo trukdžius ir galimybes novatoriškiems sprendimams mokyklose; pristatytos institucijų įžvalgos apie ekosistemos iššūkius bei galimus bendradarbiavimo modelius; pateikti rekomenduojami veiksmai paslaugų tiekimo grandinės veiksmingumui tobulinti; aprašytas tyrimo procesas ir pateikta papildoma medžiaga. Siekiant užtikrinti susijusių suinteresuotųjų šalių įsitraukimą, su dalyvaujančiomis institucijomis buvo konsultuojamasi kiekviename apžvalgos rengimo etape.

Rekomendacijos

Remiantis tyrimo metu gautomis įžvalgomis, atlikus kokybinę ir kiekybinę duomenų analizę, siūlomos devynios rekomendacijos. Šiose rekomendacijose pristatytos galimybės, kaip šalinti nustatytus jaunimo psichikos sveikatos tiekimo grandinės trukdžius, optimizuoti psichikos sveikatos paslaugų tiekimą ir gerinti jų prieinamumą mokyklų kontekste.

1 rekomendacija: bendru sutarimu apibrėžti psichikos sveikatos srityje naudojamas sąvokas, nustatyti ilgalaikius prioritetus ir tikslus bei vertinimo rodiklius visose institucijose. Rekomenduojama sukurti psichikos sveikatos srityje naudojamų apibrėžimų rinkinį; išgryninti sisteminius tikslus ir prioritetus; nustatyti konkrečių rodiklių pažangai vertinti sistemą. Siekiant kurti ir įgyvendinti sisteminius pokyčius yra labai svarbus visų ekosistemos dalyvių, įskaitant aukščiausio lygio viešosios politikos formuotojų – Vyriausybės, Seimo ir Prezidentūros – indėlis. 2021 m. rekomenduojama surengti renginių ciklą, pavyzdžiui, 3 forumus minėtiems aspektams aptarti, užtikrinant visų ekosistemos dalyvių įsitraukimą. Forumus turėtų organizuoti Vyriausybės kanceliarija arba pagrindinės ministerijos, dalyvaujančios jaunimo psichikos sveikatos paslaugų tiekimo grandinėje: Sveikatos apsaugos ministerija, Švietimo, mokslo ir sporto ministerija ir Socialinės apsaugos ir darbo ministerija. Siekiant paskatinti nuolatinį ekosistemos dalyvių įsitraukimą, rekomenduojama taikyti bendros kūrybos veiklas, kuriose būtų naudojami dalyvaujamo dizaino ir mąstymo apie ateitį metodai. Tokia praktika galėtų paskatinti gilesnę diskusiją įvairiuose lygmenyse ir visapusiškai įtraukti dalyvius į bendros kūrybos procesą.

2 rekomendacija: įsteigti tarpinstitucinį koordinacinį vienetą, kuris užtikrintų aktyvų ekosistemos dalyvių bendradarbiavimą ir kryptingą pažangą siekiant bendrų tikslų. Šis vienetas turėtų užtikrinti nuoseklų bendradarbiavimą tarp susijusių institucijų ir bendrų tikslų siekimą. Mokslininkai, stebėsenos ir vertinimo specialistai, politikos formuotojai ir tiesioginiai paslaugų vartotojai galėtų prisidėti prie koordinacinio vieneto veiklos bei jo efektyvaus funkcionavimo. Koordinacinis vienetas turėtų užtikrinti derančią visų tiesiogiai susijusių institucijų darbotvarkę, įskaitant pirmoje rekomendacijoje nurodytų veiklų įgyvendinimą; vykdyti įgyvendinamų veiklų, prevencinių programų stebėseną ir vertinimą; skatinti tarpinstitucinės duomenų bazės kūrimą; sisteminti jaunimo psichikos sveikatos paslaugas teikiančių institucijų ekosistemos dalyvių atliekamas funkcijas, išgryninti sąsajas, sukurti ekosistemos žemėlapį. Reguliarus veiklos vertinimas gali padėti sumažinti potencialų įgyvendinamų veiklų bei institucijų veiklos funkcijų dubliavimąsi, padidinti prevencinių programų ir kitų paslaugų poveikį. Koordinuojančio vieneto struktūra turėtų būti sudaryta proporcingo atstovavimo principu, įtraukiant skirtingas suinteresuotąsias šalis ir siekiant užtikrinti, kad skirtingi sektoriai ir kompetencijos sritys būtų vienodai atstovaujami. Koordinuojančios institucijos struktūrą, funkcijas ir vietą sistemoje turėtų aptarti suinteresuotosios šalys ir nustatyti bendru susitarimu viename iš 1-oje rekomendacijoje siūlomų forumų.

3 rekomendacija: skatinti reguliarią tarpinstitucinę žinių sklaidą. Reguliarus ir nuoseklus bendravimas, dalijimasis žiniomis, darbotvarkės derinimas ir institucijų bendradarbiavimas gali padėti veiksmingiau kurti viešosios politikos sprendimus bei didinti jaunimo psichikos sveikatos programų ir paslaugų poveikio efektyvumą. Sisteminė žinių sklaida galėtų vykti kuriant skaitmeninę platformą, kurioje būtų dalijamasi bendra informacija, susijusia su jaunimo psichikos sveikata, naudojant kitas skaitmenines priemones arba integruojant esamas skaitmenines priemones, pavyzdžiui, skaitmeninę platformą „Pagalba sau“, kurios užtikrintų

dažną ir sklandžią institucijų tarpusavio komunikaciją bei informacijos valdymą. Siekiant užtikrinti efektyvią žinių sklaidą, tokio tipo platformas ar kitus skaitmeninius sprendimus ir jų naudojimą rekomenduojama pristatyti jaunimui, naudojantis pagrindiniais jų komunikacijos kanalais.

4 rekomendacija: nuosekliai integruoti mokyklas į jaunimo psichikos sveikatos ekosistemą. Atliktos apžvalgos rezultatai rodo, kad mokykla jaunimo psichikos sveikatos ekosistemoje dažnai matoma tiek kaip autonominis vienetas, tiek kaip pagrindinė institucija, susijusi su psichikos sveikatos gerinimu ir palaikymu, todėl būtina skatinti nuoseklią mokyklų integraciją į jaunimo psichikos sveikatos ekosistemą. Prevencinių programų įgyvendinimo sprendimus dažnai lemia mokyklų vadovų ar mokyklos administracijos prioritetai – sistemoje susidaro galimybė subjektyvių sprendimų priėmimui ir psichikos sveikatos programų bei iniciatyvų rezultatų fragmentacijai mokyklose. Rekomenduojama praplėsti mokyklose teikiamų paslaugų sąrašą, įtraukiant aktyvų psichikos sveikatos puoselėjimą; numatyti mechanizmus bei finansinį modelį, kurie leistų mokyklose pasitelkti nevyriausybinių organizacijų ir socialinių darbuotojų patirtį. Pavyzdžiui, nevyriausybinės organizacijos ir socialiniai darbuotojai galėtų dažniau konsultuoti bei dalytis savo žiniomis ir įžvalgomis – tai leistų pasidalyti atsakomybe ir darbo krūviu, o mokyklos ir toliau pagrindinį dėmesį galėtų skirti mokymosi procesui. Sisteminiu lygiu rekomenduojama apžvelgti esamus teisinius ir finansinius apribojimus, kurie trukdo tokio tipo veiklų įgyvendinimui.

5 rekomendacija: skatinti labiau į vartotoją orientuotą jaunimo psichikos sveikatos paslaugų kūrimo, tobulinimo ir įgyvendinimo procesą, aktyviai bendradarbiaujant su jaunimu – tiesioginiais paslaugų vartotojais, kurie gali suteikti svarbių įžvalgų apie psichikos sveikatos stiprinimo ir prevencinių programų ir iniciatyvų kūrimą ir įgyvendinimą. Jaunimo psichikos sveikatos paslaugų tiekimo grandinė turi būti traktuojama kaip sudėtinga sistema, susidedanti iš susijusių elementų ir skirtingų grandinės dalyvių. Tvaria horizontaliąja grandinės jungtimi yra laikytinas jaunimas ir jo poreikiai, todėl reikėtų skirti daugiau dėmesio aktyviam jaunimo įtraukimui į psichikos sveikatos sprendimų paiešką ir įgyvendinimą. Aktyvus ir gilus jaunimo įtraukimas į sprendimų formavimo ir įgyvendinimo procesus gali padėti užtikrinti, kad mokymosi formos, prevencinės programos ar kitos iniciatyvos ir tiekiamos paslaugos taptų aktualesnėmis ir paprasčiau pasiekiamomis galutiniam vartotojui. Sprendimai turėtų atspindėti psichikos sveikatos problemų įvairovę ir galutinių vartotojų kolektyvinius ir individualius poreikius bei siekius. Rekomenduojama įgyvendinti reguliarius jaunimo požiūrio į esamas paslaugas ir jų tobulinimo poreikio vertinimus ir užtikrinti įgytų žinių sklaidą visoje grandinėje. Taip pat skatinama aktyviai remtis jaunimo organizacijų veikla bei atkreipti dėmesį į jaunimo, kuris nebesimoko mokykloje, situaciją.

Jaunimo siūlymuose (pateiktuose 4.3 skyriuje) rekomenduojama, kad iniciatyvose ir programose, skirtose jaunimo psichologinei gerovei skatinti būtų akcentuojamas asmeninis santykis, neformalumas, pritaikomumas ir mokytojo ar lektoriaus ekspertizė. Taip pat atkreipiamas dėmesys į mokytojų ir studentų santykių gerinimą, naujų žinių teikimo ir mokymosi formų diegimą (pvz., praktinį mokymąsi, festivalių ir grupinių užsiėmimų organizavimą). Moksleiviai pabrėžia savo bendraamžių svarbą įveikiant psichikos sveikatos iššūkius, todėl kai kurios įgalinimo priemonės gali būti sukurtos specialiai jaunimui. Integruodamos jaunuolių įžvalgas kuriant jiems skirtus sprendimus, institucijos gali efektyviau patenkinti moksleivių poreikius ir susieti juos su turimais ištekliais.

6 rekomendacija: stiprinti mokytojų ir kitų mokyklos darbuotojų žinias ir kompetencijas bei apibrėžti jaunimo psichikos sveikatos puoselėjimui bei pagalbai skirtas procedūras ir gerąsias praktikas. Apžvalgos rezultatai rodo, kad mokyklos darbuotojai turi galimybes nustatyti ir atliepti jaunimo psichikos sveikatos poreikius. Visgi kol kas trūksta nustatytų protokolų, kuriais vadovaujantis mokyklos darbuotojai galėtų įgyvendinti reikalingus žingsnius. Jaunimas teigia, kad mokytojai vaidina svarbų vaidmenį atpažįstant psichikos sveikatos iššūkius bei nukreipiant juos į tinkamus šaltinius, psichikos sveikatos išteklius, ypač COVID-19 pandemijos akivaizdoje. Rekomenduojama stiprinti jaunimo ir mokytojų santykį, taip pat daugiau dėmesio skirti psichikos sveikatos raštingumui mokykloje gerinti ir mokyklos darbuotojų gebėjimams suteikti reikiamą pagalbą lavinti. Taip pat siūloma aiškiau apibrėžti protokolus ir nustatyti bei komunikuoti geriausios praktikos pavyzdžius, susijusius su jaunimo psichikos sveikatos paslaugomis mokyklose

2021 m. Sveikatos apsaugos ministerija visoje Lietuvoje imasi įgyvendinti ankstyvųjų psichikos sveikatos sunkumų atpažinimo ir nukreipimo pagalbai kompetencijų ugdymo programą, skirtą mokyklos darbuotojams. 8 valandų virtualus modulis bus pasiekiamas mokyklų darbuotojams visoje Lietuvoje. Įvairios intervencijos, pavyzdžiui, žinučių siuntimas ar kitos komunikacijos formos, gali padidinti šių mokymų poveikį. Daugelio siuntėjų, įskaitant Visuomenės sveikatos biurus ir ministerijas, tekstiniai, elektroninio pašto ir kitais būdais siunčiami pranešimai, turinio ir tonų įvairovė, gali būti adresuoti mokytojams, siekiant didinti jų dalyvavimą mokymuose ir įsitraukimą. Šių komunikacijos eksperimentų vertinimas galėtų atskleisti efektyviausius pranešimų siuntimo metodus ir informuoti būsimus mokytojų įtraukimo veiksmus. Taip pat svarbu įvertinti ir papildomos mokytojų skatinimo sistemos sukūrimo galimybes.

7 rekomendacija: panaikinti teisines kliūtis psichikos sveikatos paslaugų prieinamumui. Rekomenduojama atkreipti dėmesį į teisinius psichikos sveikatos paslaugų naudojimą mokyklose ribojančius veiksnius. Konfidencialumo ir anonimiškumo trūkumas yra pagrindiniai trukdžiai mokiniams naudotis psichikos sveikatos paslaugomis mokyklose. Reikėtų pašalinti teisines kliūtis, kurios stabdo psichikos sveikatos paslaugų kūrimą, įgyvendinimą ir prieinamumą. Be to, reikėtų integruoti inovatyvius viešosios politikos formavimo principus, investuoti į eksperimentines veiklas ir skatinti įrodymais grįstą alternatyvių sprendimų poveikio vertinimą. Tai galėtų padėti geriau nustatyti kliūtis ir rasti alternatyvių nereguliacinių sprendimų, skirtų veiksmingesnei jaunimo psichikos sveikatos politikai kurti.

8 rekomendacija: diegti sisteminius sprendimus siekiant sumažinti neigiamas nuostatas į psichikos sveikatą. Apžvalga rodo, kad tiek jaunimo, tiek suaugusiųjų tarpe (mokytojų, tėvų, mokyklos administracijos) vyrauja neigiamos nuostatos į psichikos sveikatą. Šios nuostatos veikia psichikos sveikatos paslaugų kokybę ir riboja naudojimąsi jomis, gali neigiamai veikti visos jaunimo psichikos sveikatos paslaugų tiekimo grandinės efektyvumą. Pavyzdžiui, valstybės tarnautojai, kurie turi neigiamas nuostatas į psichikos sveikatos iššūkius ir problemas, gali skirti mažiau išteklių ir dėmesio šiai sričiai; mokyklos direktoriai ir mokytojai gali būti mažiau linkę perimti geriausias ankstyvo jaunimo psichikos sveikatos iššūkių ir sutrikimų atpažinimo praktikas; tiesioginiai vartotojai – jaunimas – gali būti linkę rečiau naudotis esamomis paslaugomis. Skirtingos intervencijos, pavyzdžiui, tikslinės žinutės ir komunikacija, įvairaus tipo mokymai, informacinės ir socialinės kampanijos, įgyvendinamos skirtinguose lygmenyse, įskaitant politikos formavimo, mokyklų, tėvų, jaunimo ir visuomenės, gali padėti siekti sisteminio neigiamų nuostatų ir nepalankaus elgesio pokyčių.

9 rekomendacija: skatinti geriausių jaunimo psichikos sveikatos paslaugų tiekimo praktikų tyrimus, įskaitant eksperimentinius bandymus, bei vystyti duomenų rinkimo veiklas, jų sistemingą integraciją į vieningą duomenų bazę. Gerinant psichikos sveikatos paslaugas jaunimui, reikalingas holistinis požiūris ir žinios apie visus psichikos sveikatos paslaugų tiekimo grandinės dalyvius, įskaitant mokytojus, administraciją ir psichikos sveikatos specialistus, kurie formuoja psichikos sveikatos klimatą mokykloje. Rekomenduojama įgyvendinti kiekybinius ir kokybinius tyrimus (pavyzdžiui, valstybės tarnybos, mokytojų ir mokyklos administracijos apklausas), rinkti administracinius duomenis. Surinkti duomenys gali padėti įgyti geresnį visos jaunimo psichikos sveikatos paslaugų tiekimo grandinės supratimą, padėti nustatyti esamus trukdžius ir, remiantis gautais įrodymas, padėti formuoti veiksmingesnę sistemą. Didelę vertę gali sukurti duomenys apie mokyklos personalo požiūrį į psichikos sveikatos iššūkius ir sutrikimus, turimas kompetencijas atpažinti psichikos sveikatos iššūkius ir sutrikimus bei žinias, reikalingas nukreipti pagalbos ieškančius jaunuolius į tinkamus informacijos šaltinius, taip pat duomenys, suteikiantys daugiau informacijos apie moksleivių psichikos sveikatos požymius/būklę. Administraciniai duomenys gali padėti geriau įvertinti valstybės tarnybos valdymo procesus, paskatų struktūras, institucinę aplinką ir nustatyti, kaip šie veiksniai gali veikti kuriamų ir įgyvendinamų viešosios politikos sprendimų ir, specifiškai, prevencinių programų rezultatus, paslaugų tiekimą, poveikį visuomenei. Ypatingai svarbios yra šios duomenų grupės: požiūris į jaunimo psichikos sveikatos iššūkius ir problemas; biudžeto skyrimo motyvacija bei argumentacija; psichikos sveikatos srities prioritetai. Moksleivių duomenys, įskaitant apsilankymus pas psichologą ar socialinį darbuotoją; moksleivių elgesio problemos mokykloje; pažymiai; požiūris į psichikos sveikatos iššūkius, problemas, jų įveikimo mechanizmus ir kitus, gali suteikti reikšmingos informacijos apie esamą jaunimo psichikos sveikatos situaciją; padėti kurti programas ir formuoti jaunimo psichikos sveikatos politiką; palyginti skirtingų veiklų ir sprendimų poveikį; nustatyti potencialą turinčias ateities politikos kryptis.

Apibendrinant, šiame tyrime pateiktos įžvalgos ir inovatyvios viešosios politikos formavimo praktikos yra svarbios toliau plėtojant įrodymais grįstas viešosios politikos intervencijas ir skatinant viešojo valdymo inovacijų kūrimo ir jų įgyvendinimo procesus. Apžvalgoje pristatytos rekomendacijos buvo aptartos su suinteresuotomis šalimis. Šių diskusijų metu buvo prioretizuotos kitame etape toliau vystyti pasirinktos tyrimų ir intervencijų kryptys: mokyklų integracijos į ekosistemą klausimas; labiau į vartotoją orientuoto jaunimo psichikos sveikatos paslaugų kūrimo, tobulinimo ir įgyvendinimo proceso, vykdomo aktyviai bendradarbiaujant su jaunimu – tiesioginiais paslaugų vartotojais, įgyvendinimas; mokyklos darbuotojų gebėjimų ir kompetencijų stiprinimas. Šie aspektai bus toliau nagrinėjami bendros kūrybos su moksleiviais pasirinktose mokyklose sesijų metu ir įgyvendinant valstybės tarnautojų, mokyklos administracijos ir mokytojų apklausas bei vykdant mokytojų mokymų bei motyvavimo sistemos poveikio vertinimą.

Executive Summary

The diagnostic report – The Service Delivery Chain of Youth Mental Health in Lithuania Diagnostic I: School Context – is the first comprehensive output of a broader project implemented by STRATA, the Government's Strategic Analysis Center's Policy Lab, in collaboration with the Ministry of Health; Ministry of Education, Science and Sport; Ministry of Social Security and Labor; and the World Bank's Bureaucracy Lab on youth mental health focusing mostly on the Lithuanian school context. This report serves as a first step in identifying tensions in the youth mental health service delivery chain and highlights opportunities for further research and experimentation activities.

This report introduces insights from a study of the main bottlenecks in the youth mental health service delivery chain in the school context explored through the youth and institutional perspectives and provides recommendations on directions for potential interventions and innovative solutions. The study focuses on preventive activities and mental health services available for school students aged 14 to 19 who are enrolled in grades 9 to 12 (or the 1st to 4th gymnasium grades).

Improving mental health and preventing the onset of mental illnesses are emphasized in the Program of the XVIII Government of the Republic of Lithuania. A well-functioning mental health sector plays an important role in ensuring broad societal well-being; and both physical and mental health have been shown to be the key to resilience during critical situations, such as the COVID-19 pandemic. Unfortunately, due to challenges in the design and delivery of mental health services as well as the stigma associated with both providing and utilizing these services, mental health services in Lithuania are still underutilized. The current disconnect between the mental health needs and service availability today is particularly acute for the youth. Due to the COVID-19 pandemic, the main channel of mental health service delivery, schools, has been disrupted by closures.

A range of organizations and decision-makers in central ministries, municipal offices, Psychological-pedagogical Service institutions, Public Health Bureaus, non-governmental organizations (NGOs), and schools affect mental health service delivery to youth. Each step of this delivery chain feeds into the next, and bottlenecks at one point affect all the later stages and ultimately the final user. Thus, a positive change at a given step of the chain can have meaningful ripple effects.

To identify and understand the bottlenecks in different levels, this project employs the alternative impact assessment practices: a holistic approach taken through the implementation of action research and co-creative methods. The insights provided in the report serves as a relevant evidence which can contribute for further policy intervention design, implementation, and its impact assessment. Unlike in traditional impact assessment process, the focus in this project is set on the development and analysis of possible directions of innovative solutions and interventions. For this purpose, quantitative and qualitative data collection methods are employed.

The findings presented in this report point out several directions for the service delivery chain improvement and suggest key actions to be taken to address the identified bottlenecks. Study results demonstrate that mental health service delivery to the youth is a complex system and must be viewed as a coherent whole. To ensure the coherence, there is a need for a systematic framework outlining the common understanding between different institutions within the mental health ecosystem; and higher involvement at a higher political level; agreement on mental health terms and definitions; settlement of the long-term priorities; and more effective cross-institutional coordination. Furthermore, a more comprehensive and collaborative policy development and implementation practices, including clearly defined functions and systematic relationships, should be also developed as well as the coordinating body ensuring the active collaboration across institutions and progress towards collective objectives should be established. The ongoing cross-institutional engagement and dialogue should be fostered by more actively engaging all relevant institutions and actors, including non-governmental institutions and the service end-users' – the youth – into the process of program and other initiatives development and delivery process.

Furthermore, study findings also show that school in the entire youth mental health ecosystem is often perceived as a relatively autonomous unit. Schools do not obtain many openings for external initiatives except systematically implemented prevention programs therefore a more cohesive integration of the schools into the ecosystem network is recommended.

Teachers and parents play important roles in the identification of mental health challenges, as well as the promotion and guidance towards mental health support resources, therefore there is a need for strengthening teachers and school staff knowledge on youth mental health. Additionally, more clear definition of protocols and best practices surrounding youth mental health services in schools is needed. The interventions targeting the teacher's motivation to engage into mental health related initiatives are also suggested to be implemented.

Additionally, to address the existing stigma factors, regulations, and legal barriers for mental health service uptake at schools, more attention should be paid towards systematic efforts aimed at attitude and behavioral change.

Finally, fostering the research and experimentation practices in the field of youth mental health and strengthening and expanding databases on school personnel, public administration and policymakers, and student mental health are also strongly advised.

The report proceeds as follows: the background section introduces into the global and national youth mental health context; the youth mental health service delivery chain section presents the service delivery chain structure and the process of policymaking, program design and implementation for schools; the youth perspectives section summarizes the school students insights on mental health concepts and service delivery and uptake bottlenecks in schools; the institutional players perspectives section presents the main tensions in the youth mental health ecosystem and potential models for collaborations; the recommendation section includes the key action steps; the appendix section summarizes the research process and includes the supplementing material. To ensure the engagement of relevant stakeholders throughout the entire process, the insights stemming from each step have been regularly presented and discussed with the involved parties.

1. Background

1.1. Mental Health as a Global Priority

National and international organizations have devoted greater attention to mental health in the last decade.[1] The increased focus on high quality mental health services reflects a growing understanding of the critical role mental health plays in broader health and development outcomes. The World Health Organization (WHO) defines mental health *"as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".*[2] Mental health status is predictive of both individual and societal well-being. Poor mental health can be linked to a higher tendency for self-harm and risk-taking behavior, whereas good mental health can have a positive impact on outcomes such as life satisfaction and productivity.

Mental health affects and interacts with a multitude of well-being and economic factors. For instance, it has been shown that mental health has a bilateral relationship to physical health indicators, as poor mental well-being can significantly increase risk of many physical conditions, and poor physical health can lead to an increased risk of mental health challenges.[3] Similarly, mental health is inextricably linked to economic outcomes - it is predictive of undesirable economic conditions, such as poverty. Research shows that individuals with mental health challenges are likely to experience a reduction in employment and income.[4] These effects can further loop back through a new-found sense of instability, insecurity, and hopelessness, potentially causing more serious mental health disorders.[5]

Mental health disorders[i], such as depression, can have even more significant effects on individual well-being. For example, depression is one of the leading causes for disability worldwide, and people with severe conditions often die as much as two decades earlier than non-affected individuals.[6] Mental health disorders lessen quality of life through multiple channels. For instance, it has been shown that mental disorders are closely linked to serious common, long-term, non-communicable diseases, including heart disease and diabetes.[7]

Mental disorders can also affect educational attainment, as well as employment, housing, and social prospects. In Organization for Economic Co-operation and Development (OECD) countries, people with mild-to-moderate mental health conditions are 2 to 3 times more likely to be unemployed than people without a mental health condition. For people with severe mental health conditions, the likelihood is 6 to 7 times greater.[8]

In addition, mental disorders remain a large share of the global disease burden. An estimated 697.9 million people had at least one mental disorder in 2019. Across all age groups, mental disorders comprised 12.46% of total Years Lived with Disability (YLD). For people ages 15 to 49, mental disorders were the leading cause of YLD and the second leading cause of Disability-Adjusted Life Years (DALYs).[9] The incidence of mental disorders is likely to increase

[i] A term „mental disorders" covers anxiety disorders, bipolar disorders, conduct disorders, depressive disorders, eating disorders, and schizophrenia. The original IHME definition also covers attention-deficit/hyperactivity disorder, autism spectrum disorders, idiopathic developmental intellectual disability, and other.

sharply in 2020 owing to the COVID-19 pandemic, which led to a surge in the number of people reporting anxiety and depression, among other mental and emotional challenges.

The limited data available on funding for mental health show that this type of funding comprises only a small share of health expenditures. Median government expenditure per capita on mental health equaled USD 2.5 in 2015, amounting to less than 2% of the median government expenditure per capita on overall health at the time (USD 141).[10] In contrast, mental disorders made up almost 10% of health disorders, on average, across countries in 2015.[11] Government expenditures on mental health per capita also vary widely within regions. For example, Latvia and Lithuania each devoted slightly more than 19 Euros per capita to mental health in 2017, while Cyprus and Germany spent 748.66 and 350.62 Euros per capita, respectively. [12,13,14,15]

1.2. Mental Health in Lithuania

Lithuania has particularly poor mental health outcomes. According to the most recent data available, Lithuania has the highest suicide mortality rate in the world (*Figure I, see Appendix section 8.2*). The number of deaths in Lithuania per 100,000 people due to intentional self-harm differ substantially by county and gender. The overall rate in 2019 ranged from 16.6 to 37.8 across counties but the male-only rate ranged from 30.7 to 61.9 (*Table 1, see Appendix section 8.3*).[16] Many indicators of mental health show similarly stark gender disparities. For example, Lithuanian women in the lowest wealth quintile reported chronic depression at a rate more than double the rate reported by Lithuanian men in the lowest wealth quintile.[17] Likewise, legal alcohol consumption per person age 15 and above in Lithuania equaled 11,1 liters of alcohol in 2019.[18] Together, substance abuse and mental disorders accounted for 16.2% of years lived with disability as well as 7.5% of disability adjusted life years in Lithuania in 2019.[19]

Mental disorders often emerge in adolescence, and adolescents in Lithuania face numerous challenges to their mental health. The Health Behavior in School-aged Children (HBSC) survey (2013-2014) found the percentage of Lithuanian students who reported being bullied at school at least two to three times in the past couple of months topped the percentage reported in every other OECD country, even when disaggregating by gender and age.[20,21] Lithuania continued to top all other OECD countries in this metric, regardless of age or gender breakdown, in the 2017/2018 HBSC (*Figure II, see Appendix section 8.2*).[22] Only the percentage of 11-year-old boys who reported being bullied declined by a statistically significant amount across surveys (*Table 2, see Appendix section 8.3*). In addition, the 2018 Program for International Student Assessment found almost 45% of 11- to 15-year-old Lithuanian students reported feeling either too fat or too thin, and only 71% of 15-year-old students agreed or strongly agreed they make friends easily. Additionally, as much as 31% of school students report experiencing low levels of psychological well-being.[23] These challenges have significant consequences for mental health outcomes among adolescents. For Lithuanians ages 17 and younger, the prevalence of mental and behavioral disorders is second only to the prevalence of respiratory diseases.[24] Moreover, the suicide rate per 100,000 adolescents ages 15 to 19 in Lithuania averaged over three years (18.2) exceeds that of all OECD/European Union countries.[25]

Financial, personnel, and infrastructure resources for mental health have improved, but need to continue growing to meet demand. Lithuania's health expenditure as a percentage of its Gross Domestic Product (GDP) and its per capita spending on mental health are among the lowest in the European Union.[26] Lithuania's per capita expenditure on mental health in 2017 (19.61 Euros) also represented only 2% of its per capita expenditure on health (966.1 Euros).[27,28] This is slightly better than the 1% of GDP Lithuania spent on mental health in 2015 when the direct and indirect costs of mental health problems accounted for 2.64% of GDP.[29] Compared to other countries in the WHO European Region, Lithuania has relatively high population-adjusted levels of mental health personnel and infrastructure. Lithuania had 97.62 hospital beds for psychiatric care per 100,000 inhabitants and 23.31 psychiatrists per 100,000 inhabitants in 2018.[30,31] Access to mental health personnel among youth was much lower with only 12.94 practicing child psychiatrists per 100,000 people ages 0 to 14.[32]

Over the last few years, more attention has also been paid to the implementation of prevention programs, which partly aim to improve mental health outcomes at schools. The number of schools implementing prevention programs has gone up significantly from 2017 to 2019 across all municipalities. In particular, 89.4% of schools (in rural areas – 93.4%, in urban areas – 87%) carried out at least one prevention program in 2019, while only 65.8% of them did that in 2017. At least one prevention program in each school was implemented in 22 municipalities. In 2019 educational funds were allocated to the implementation of the educational plan; textbooks and other teaching aids; cognitive activities and vocational guidance of students; activities to improve the qualifications of teachers and other persons involved in the educational process; implementation of information and communication technologies; educational assistance in schools and institutions providing pedagogical psychological assistance; organization and evaluation of learning achievements; implementation of the complementary education programs. In 2019 13,4 Euros of class funds were allocated for organizing pedagogical and psychological support.[33]

1.3. Mental Health Policy and Strategy in Lithuania

Numerous national policies and initiatives aim to tackle mental health problems in Lithuania. The government introduced a standalone law on mental health in 2005 and a standalone plan for mental health in 2016.[34] In 2019, the government doubled the number of institutions providing psychiatric day care treatment for youth and started funding Public Health Bureaus to promote mental health prevention in schools.[35] The new National Plan on Suicide Prevention for 2020-2024 also aims to reduces the number of suicides in Lithuania.[36] Additionally, the Ministry of Health initiated the declaration the 2020 to be the Year of Children's Emotional Well-Being[37]. The aim was to draw the public's attention to the importance of children's emotional well-being, to strengthen the conditions for ensuring it in Lithuania, to improve children's mental health and well-being, and at the same time to create a healthier and happier society.

As a concrete step, in 2016, a correction to the law for the implementation of prevention programs in schools was introduced by the Ministry of Education, Science and Sport. This change was made following the evidence[38] of low-uptake rates in prevention programs as collected by the Ministry of Education, Science and Sport. The change in the law mandated that *"The school must ensure a healthy, safe environment that prevents violence, coercion and harmful habits, the implementation of education, training, study, educational programs,*

openness to the local community, the conclusion of a teaching contract and the fulfillment of agreed obligations, good quality education. Every educational institution must provide conditions for every student to continuously participate in at least one continuous, long-term social-emotional competency program including prevention of violence, alcohol, tobacco and other psychoactive substances, promotion of healthy lifestyle, implementing the recommendations on violence approved by the Minister of Education and Science".[39] As aforementioned, this change has led to much increased levels of prevention program implementation in schools.

Societal well-being is set as one of the strategic directions in the National Progress Plan for 2021-2030[40], which is aimed at Lithuania's National Progress Strategy "Lithuania 2030"[41] implementation. *Strategic Goal 2* seeks to increase the social well-being and inclusion of the population, strengthen health, and improve the demographic situation in Lithuania. This goal requires the mobilization of resources needed to build a more resilient current health system; and ensure improved access, efficiency, and quality of health services. Several objectives have been raised to achieve the proposed paramount goal.

O*bjective 2.11* aims to promote health preservation and enhancement activities and to strengthen the psychological (emotional) resilience of society. One category of measures that refer to its achievement include a significant reduction in suicide rates and addictions. In particular, it is desired that implemented preventive measures would result in the reduction of the mortality rates from 303 (2017) to 160 (2030) people per 100 000 residents, and that there would also be a reduction in the use of drugs, alcohol and nicotine consumption.

Objective 2.11 further accentuates the psychological state of children. The government has set out to work to reduce the proportion of students with low levels of psychological well-being from 31,3 % (2018) to 22 % (2030). It is worth mentioning that the quality of the healthcare system and the increase in the effectiveness of treatments have also been mentioned as desirable outcomes *(Objectives 2.12, 2.13 in the strategic document*).

The strengthening of mental health indicators and the implementation of preventive measures is outlined in the program of the Government of the Republic of Lithuania. The program generally emphasizes an efficient and transparent health care system and the implementation of an active program to combat harmful habits. This is meant to be achieved by increasing attention towards mental health prevention and strengthening mental health services, especially through increasing the availability of the mental health services *(paragraphs 53-57).* All of these directions have been defined by the former Government in its program[42], which came into effect in 2016. Mental health has remained an area of relevance in the newly elected government's program.[43] In particular, the government paid even stronger attention to psychological well-being, as well as preventive measures and programs that can help to prevent the long-term negative health consequences *(initiative 8.1.2.).* The purpose of these government goals is to focus on the increase of life expectancy and quality of life.

1.4. Schools and Mental Health

Mental health needs typically start emerging around adolescence. Roughly half of all mental health conditions start by age 14.[44] Pressure to look or act a certain way, questions about sexual identity, increased risk-taking behaviors, and greater exposure to physical or verbal violence become much more pronounced during this period. At the same time, children are generally ill-equipped to deal with the gravity of these new experiences alone. Adolescents often report using informal networks, such as friends or classmates, for mental health advice, before reaching out to their parents or professionals.[45] Delayed access to a diagnosis or treatment regime can negatively affect well-being in the long-term.

Addressing the prevalence of mental disorders and mental health challenges requires a comprehensive approach, and schools present a key entry point for interventions. Children spend a significant portion of their early and adolescent years in school. Secondary students in OECD countries spent, on average, 919 hours in compulsory education in 2018.[46] Students' interactions with teachers, school administrators, and classmates thus have significant implications for their mental health, even into adulthood.[47] Educators and administrators can also leverage the time they have with students to monitor changes in student behavior. Researchers have found school-based mental health interventions reduce the stigma of seeking help and can assist in maintaining treatment gains, among other effects.[48] Other studies have found early intervention programs, including social and emotional learning programs in schools, cost-effective, though additional research is needed on the subject.[49,50] Devoting resources to students' mental health needs may also benefit educators by reducing the incidence of disruptive behaviors, leading to improved working conditions.[51]

Special attention should be paid to improving mental health to manage the challenges posed to young people by the COVID-19 pandemic. One of the groups most strongly affected by the COVID-19 pandemic is school students. School disruptions have imposed limitations on service delivery and new challenges have emerged due to structural changes in working, learning and life environments. This, in turn, has resulted in increased anxiety levels and concerns about one's health, social relationships, and the future among the school population.

2. Youth Mental Health Service Delivery Chain

Methodology[ii]: a systematic overview of the relevant documents, data and insights stemming from interviews and continuous conversations with different representatives from relevant institutions has been conducted to shed more light on the main structure and processes for policy-making, program design and implementation in the youth mental health service delivery chain.

2.1. Youth Mental Health Service Delivery Chain Structure

Two main government structures for delivering youth mental health services exist in Lithuania. Firstly, mental health services are provided to the entire population through the public health system and is managed by the Ministry of Health (*Figure 1, lower*). Secondly, mental health services are provided to the youth specifically in schools under the management of the Ministry of Education, Science and Sport (*Figure 1, upper*). In addition to these two main channels, youth mental health is further supported through auxiliary institutions, including mental health helplines and youth organizations, such as open youth centers who fall under the management of the Ministry of Social Security and Labor, that exist alongside to these two main channels.

Figure 1. Youth Mental Health Service Delivery Chain

None of these systems exist in isolation. Instead, they can frequently interact with one another in both directions and between different levels. For example, a child receiving psychological care at school may also be referred to a mental health specialist outside school in pertinent cases or may receive informal support via helplines or participation in prevention programs. The youth mental health service delivery chain can be seen as part of a larger ecosystem of actors working together to achieve the goal of strengthening youth mental health. This section

[ii] The entire process of study implementation is provided in the Appendix section 8.1.

outlines the chains of service delivery existing in the two main government structures, focusing in particular on how mental health services reach school students aged 14-19. Further comments are made on general health structures only where appropriate.

The Ministry of Health is responsible for the well-functioning of the whole national health system, including mental health service delivery. The ministry is responsible both for high-level policy making, as well as supporting institutions in the national health system. These include both institutions responsible for public health, such as municipality health and Public Health Bureaus as well as national, budgetary and municipality Personal Health Care institutions. As such, services are provided both in a direct fashion through personal health care institutions and through the efforts of Public Health Bureaus. Individual youth can request mental health help either through their health care provider (family doctor) or by directly requesting a consultation with a psychologist or psychiatrist at Mental health center.

The Ministry of Health also plays a part in school mental health care through Public Health Bureaus and Public Health Specialists placed at schools. Public Health Bureaus are responsible for implementing public health measures, including preventive mental health measures, both generally and in schools. In addition to this, all schools house public health specialists from bureaus. These specialists organize a variety of public health initiatives, where certain of them focus or are related to the topic of mental health. In particular, it is worth noting that since 2019, the Ministry of Health has conducted school staff trainings focused on both improving their mental health, as well as their capabilities in recognizing and supporting students with mental health challenges.

Since 2015[52,53] the State Fund for strengthening public health has been established. Projects funded by the Fund cover a variety of topics in health promotion, disease prevention, and the promotion of healthy lifestyles: from the importance of vaccination, the promotion of mental health to the abandonment of harmful habits.

The general mental health service provision in schools is conducted according to the principles outlined in the general education law[54]. Most current school efforts fall under the responsibility of the Ministry of Education, Science and Sport. The ministry is responsible for high-level policy making and the co-ordination of grand-scale education efforts, but most responsibilities in the education sector are delegated to municipality education offices. The ministry and its institutions play a coordinating role, making sure that municipalities fulfil their duties as described by law. Municipality education offices, in turn, work directly with school administrators to ensure quality education and support services for the student population. At the top level, The Ministry of Education, Science and Sport supports a number of initiatives meant to strengthen mental health capacities of students that are then further delegated to municipality management:

Firstly, municipalities and schools are encouraged to employ school psychologists (esp. in schools with over 300 students), who directly respond to student mental health problems at schools. These school psychologists directly advise students and create initiatives meant to strengthen the mental health of the school community.

Secondly, the ministry requires schools to maintain a prevention program at all times by law. As per the National Agency for education, prevention programs are "*a set of planned and systematic measures to strengthen the protection of the student's personality and*

environment and to reduce the impact of risk factors". The successful provision of these programs is managed by municipalities. In nearly all cases, these programs are implemented by external partners, such as non-government organizations. Although these programs do not exclusively focus on mental health but rather socio-emotional education, some of them include mental health related topics such as bullying, usage of psychotropic substances or alcohol, and other important themes. This makes prevention programs one of the main channels through which mental health is discussed at schools.

Thirdly, as a result of the pedagogical-psychological help order[55], many municipalities have regional Psychological-Pedagogical Services institutions. These organizations employ psychologists and social workers, and provide direct consultations to parents and youth, support schools in crisis situations, and conduct various testing and accreditation services related to student mental health or special learning needs.

Finally, the ministry encourages both school administrators and teachers to cover mental health topics by including socio-emotional competence indicators as a required outcome of the general school program. The requirements for these competencies are currently under consideration for revision. According to the guidelines for the renewal of the General Program Law passed in 2019[56], socio-emotional competence development together with other competences, including creative thinking as well as civic, cognitive, and other skills, will become an integral part of the school subject's content.

The Ministry of Social Security and Labor is also an important player for the youth mental health policy development and implementation. The activities of youth policy structures are regulated by the Law on the Framework of Youth Policy of the Republic of Lithuania[57]. It establishes the main concepts of youth policy, defines the principles of its implementation, defines the areas of youth policy, and determines the organization and management of the implementation of youth policy. This law singles out the following concepts that are important for youth policy in relation to mental health services: youth policy is a set of measures that address issues relevant to young people and aim to facilitate the development of a young person's personality and integration into society; a young person is a person between 14 and 29 years of age. Coordination of youth policy is entrusted to the Ministry of Social Security and Labor. The Ministry of Social Security and Labor formulates youth policy, organizes, coordinates, and controls its implementation.

This showcases that from the end-user perspective, the two main channels of mental health services are de-jure accessible, either through direct consultation or through general mental health education, for example, as provided by Public Health Bureaus and prevention programs. However, some parts of the health system and the school routes may have potential service delivery hurdles that do not exist in auxiliary channels. One example of this is the requirement of parental consent for in-depth counselling. Youth cannot access neither public health services, nor school psychologist services without written consent as provided by their caregivers. This may prove to be a significant barrier to children whose parents hold stigmatized attitudes towards mental health issues. Consequently, in a best case, this may lead youth to seek help elsewhere, whether that be their peers, or an anonymous helpline. Otherwise, they may miss help altogether. Thus, it is imperative to take a comprehensive look at the existing channels, as well as their corresponding strengths and weaknesses. In particular, we focus on how mental health provision is secured in schools.

2.2. Policymaking, Program Design, and Implementation for Schools

2.2.1. Service Delivery Chain: Policymaking for Youth Mental Health

The mental health service delivery process starts at the central policy-making level. Laws dictate the functions and general purpose of all public institutions in the country and thus affect their day-to-day activities. Often, it is true that municipalities and schools have relative autonomy in how these policies are implemented within a certain framework. However, central level policies are most often formulated as necessary to implement. Therefore, for the first step of the chain, policies conducive to mental health improvement can have a strong effect on eventual outcomes.

2.2.1.1. Central Government and Institutions

The two main central institutions involved with work on mental health in schools are the Ministry of Education, Science and Sport, and the Ministry of Health. These institutions are responsible for the successful implementation of policies and laws at the central level. This means that for the ministries to act, or make changes to the current system, they need to pass laws or make amendments. This process has the potential to change the landscape of mental health initiatives, but is reported as difficult and time-consuming.

To showcase one of the more successful examples, in 2016, the Ministry of Education, Science and Sport was able to successfully change the law[58] regarding the implementation of prevention programs in schools. As previously mentioned, this change was made due to evidence[59] of low-uptake rates in prevention programs as collected by the Ministry of Education, Science and Sport. The change in the law mandated that *"every educational institution must provide conditions for every student to continuously participate in at least one continuous, long-term social-emotional competency program … at all times".* At least from the perspective of school take-up of prevention programs, the change in the law was very successful, as the percentage of schools participating in prevention programs increased from around 60% to almost full compliance. Despite this, some interviewees have expressed concerns that this may have led to less intrinsic motivation from participating schools. Nevertheless, from the ministry perspective, this success showcases a useful decision-making model for central institutions to follow – collect evidence of the current situation, and make policies designed to address present issues.

2.2.1.2. Municipal Level Institutions

Municipalities and municipal institutions follow general policy directives as proposed by central government and associated agencies. However, we note that municipalities have certain agency in the way these directives are implemented. This is particularly true in Education, as municipality education sections are de-jure owners of schools and are thus responsible for their functions. In health, a similar structure exists both for municipality personal health institutions and Public Health Bureaus, as both are owned by municipalities. This creates regional level variation in the way central level policies are implemented. For example, municipality education sectors may differ in the specific way of how they monitor the implementation of prevention programs at schools.

In addition to how central level policy making interacts with municipalities, it is worth noting that municipality budgets allow for individual initiatives, as long as they follow broad goals outlined by central level government. This means the possibility of local, context-based programs. Since regions differ significantly in mental health outcomes, this can prove a crucial policy-making tool for municipalities. One successful example of this is the often covered Kupiškis suicide prevention algorithm.[60] Finally, any budget that is left over from traditional activities can also be re-distributed as chosen by the municipality. Unfortunately, mental health spending is amongst the least chosen categories.

2.2.1.3. Schools

Similarly, by law, schools follow directives both from the central government and municipal level institutions. In a similar capacity, school staff and officials have limited autonomy in executing these directives. For example, in following the aforementioned prevention program law, school principals are free to choose from a multitude of prevention programs (including, but not limited to the list of recommended prevention programs[61] as provided by the Ministry of Education), as long as they make sure each child takes part.

In addition to this, school-based staff, such as teachers, psychologists and public health specialists follow broad guidelines in service provision from the policy perspective. Teachers, for instance, are responsible for conducting education along the general education program as provided by the Ministry of Education, Science and Sport. However, due to the broad nature of such documentation, teachers have a high level of autonomy in the implementation of policy, including school-based strengthening of mental health, such as education on socio-emotional competency.

2.2.2. Service Delivery Chain: Program Design and Implementation for Youth Mental Health

Government policy and goals set guidelines for youth mental health prevention programs to follow. Several levels of key institutions are involved in the design and implementation of school-based mental health programs.

2.2.2.1. Central Government and Institutions

There are a number of central government schemes designed to improve mental health factors of students. When it comes to programs, most school initiatives do not come directly from the government but are rather managed by the government at the policy-making level and implemented by other organizations.

Each ministry has their own scheme for school-based mental health programming. The Ministry of Education, Science and Sport supports the list of prevention programs that are mandated to be implemented at schools. These programs present education on a list of different topics, including socio-emotional competency, bullying, mental health, substance abuse prevention and many others. While the ministry is not directly involved in designing any specific program, it is worth mentioning its daughter institution, the National Agency for Education, has designed and maintains four prevention programs[62] on the topics of bullying,

crisis and psycho-active substance abuse. In addition to this, the National Agency for Education also used to provide recommendations to municipalities for which prevention programs to choose. This has been replaced by the recommended list of prevention programs supplied by the Ministry of Education, Science and Sport.

Meanwhile, the Ministry of Health has designed the mental health capacity supervision and training program for general education school staff.[63] This is an initiative created by the Ministry of Health to address a multitude of issues in school mental health. The relatively new program aims to support school staff with their personal mental health, to teach them how to support students in this area, and how to improve the general mental health environment at their school. As such, the program may prove to be a great step in making mental health services at school better. The successful coordination and implementation of this scheme is left up to Public Health Bureaus and individual psychology experts; the core program ideas have been designed by the ministry itself.

2.2.2.2. Municipal Level Institutions

Our conversations with the ministries and municipalities indicate that there are significant differences in how municipalities choose to implement certain central government directives. Similarly, since there is space for individual spending by municipalities, some municipality governments, as owners of schools, may choose to implement measures for improving student mental health outside of central government initiatives. In practice, we have not come across any independent municipality initiatives aimed directly at improving mental health in schools. This could potentially indicate that a central government push is preferable.

Public Health Bureaus are owned by municipalities but maintain a connection to the Ministry of Health. Public Health Bureaus interact with school mental health in two important ways. First, they maintain a strong link to public health at schools since each school house one public health specialist, who consults school's community, organizes various events in the school – discussions, lessons, prepares annual plan. These specialists work on improving a variety of health measures at school, including mental health.

Secondly, Public Health Bureaus are responsible for the implementation of the Ministry of Health school staff mental health capacity building training. In particular, Public Health Bureaus are responsible for both contacting service providers to conduct the training as well as encouraging the schools and teachers to partake. In addition to this, Public Health Bureaus are also responsible for monitoring the success of the program in each administrative area. This autonomy allows Public Health Bureaus to choose what they believe are the most effective and useful means of communication and administration of the program. In turn, due to differences in Public Health Bureau actor beliefs, this can mean a large distribution of methods. For example, after reviewing a small sample of four Public Health Bureaus, we have found that in contacting schools, different bureaus use the following methods: 1) poster and direct invitation 2) direct communication by public health specialists at schools 3) an invitation letter, phone, and email 4) official letter, phone, email, and live meetings. For now, it is impossible to tell whether any of these methods of communication are preferable, but this example clearly showcases that municipal level institutions hold a significant level of autonomy in how they organize activities mandated by central level government, as long as core goals

are met. This example accentuates the importance of municipal level institutions in the well-functioning of the mental health sector.

2.2.2.3. Auxiliary Institutions

Most prevention programs, as mandated by the Ministry of Education, Science and Sport and implemented at schools, are provided by external NGOs. As such, these programs are designed outside the public service, and instead rely on the expertise and knowledge of external experts. Many prevention programs are brought from abroad and implemented locally and have been used for decades in outside contexts. Among the most implemented programs[64] are Olweus[65], Lion's Quest[66], Zippy's Friends[67], and Apple's Friends[68]. Each of the prevention programs has a specific purpose, unique content, and an implementation plan. Some of those programs have a built-in monitoring system for the process and results assessment. Interestingly, some of the programs are implemented via empowerment of school's administrative staff and teachers who then later work directly with students. The duration of the programs is different too.

Pedagogical-psychological service institutions report to municipality education sectors and provide a supporting role in mental health service provision. Psychologists and social workers working in these organizations often provide prevention program seminars, as well as offer direct consultations to parents and youth, supporting the mental health of the school community. As service providers in both prevention programs, and consultation, these specialists maintain a strong level of feedback to program designers, work with special needs youth, and actively contribute to the crisis management situations at school. Yet, there is a need for more specialists working in these institutions to satisfy the level of existing demand.

2.2.3. Service Delivery Chain: Final Program Implementers for Youth Mental Health at School

The successful implementation of policies and programs that are created to strengthen school mental health relies on a number of closely connected ground-level actors.

As top school administrators, principals have power to set the agenda regarding mental health. During qualitative interviews, our teacher respondents have strongly emphasized the role of the principal in maintaining the staff engaged on school and classroom level mental health issues. In particular, principals that can prioritize mental health and produce an environment where such issues are an open topic were viewed favorably. In addition to this, principals hold the administrative reins to decide which programs their school participates in. For example, the principals choose the prevention program the school will enroll in and can choose to participate in the Ministry of Health training. This facilitating role makes principals incredibly important actors to leverage in combating mental health challenges and stigma.

Teachers are crucial actors in monitoring and addressing student mental health challenges as they have extended, day-to-day ground level contact with students. There are a multitude of ways in which teachers can help maintain the school mental health

environment, including, but not limited to: engaging in and integrating mental health topics during lesson content, noticing significant student performance and visible mood deviations, sensitively approaching students who seem to be doing badly, helping instill a culture of acceptance and tolerance in their lessons and refer students to mental health specialists at school. As such, it is not surprising that many prevention programs and other mental health initiatives, including the Ministry of Health supervision program are focused on improving the mental health capacities of teachers. In qualitative interviews, teachers have indicated that issues of mental health are especially important to them, and that more resources are crucially needed.

Public Health Specialists are the primary general health care unit at schools. As per the initiative of the Ministry of Health, recently, Public Health Specialists have increased their focus on mental health challenges. In particular, Public Health Specialists organize various initiatives to inform the school community of the importance of mental health, and what steps students can take to help themselves. Some illustrated examples of this include mental health information stands at school, consultations, events, lectures, discussions. Finally, some Public Health Bureaus leverage Public Health Specialists to successfully manage the teacher training program. Further integration of Public Health Specialists into the school mental health system can help ensure the ongoing continuity and quality of central and municipal level programs. The school is the actual workplace of public health specialists, but they are accountable to Public Health Bureaus.

School psychologists are the primary mental help providers in schools. Their primary role includes supporting students through direct consultations, which can be accessed by any student with parental consent. In addition to this, many psychologists are involved in individual efforts to improve the public school understanding of mental health. In our interviews, teachers have noted that having a strong and active psychologist at the school can make an incredible difference both in the school community understanding of health, and the engagement of other school staff, such as teachers. As such, the availability of high-quality school psychologists is an essential first step to address initial mental health challenges. Unfortunately, it is noted that psychologists often struggle with high workloads and are not able to provide consultations to all students in need. Additionally, not all schools, especially smaller ones, currently employ a psychologist and not all the psychologists who work in school have relevant qualifications or a relevant support system suggesting that there are several areas for the improvement. Committees for educational psychology operate in the Union of Psychologists but the Union itself does not have much contact with the Ministry of Education, Science and Sport. In addition, some interviewers have mentioned that social pedagogues often work in close collaboration with the psychologists in the schools that have the psychologists, and in those that do not have any, the social pedagogues become the main specialists to address the mental health challenges of the youth. Ensuring the psychological well-being at school is only one of their areas of responsibility, thus this may lead to a lack of sufficient attention being allocated to solving these issues. Since in this study the existing bottlenecks related to the work of the social pedagogues has not been explored through the direct interviews with these specialists, there is a need for more research to be done to get a deeper insight.

Despite relative evidence of success, several constraints exist for policy-making, program design, and program implementation for youth mental health. Based on the qualitative insights collected and provided, policymaking is still a difficult-to-manage process that lacks consistency, continuity, and evidence-based decision-making practices. Additionally, the respondents in all levels of the supply chain have indicated the difficulty of translating policy into action and the lack of systematic continuity in the policy making process. This can be illustrated by one of the interviewed teachers' responses: "if you take a look at the law, it's great, there's everything that you could need, but we lack the tools to make those laws a reality" or "laws are issued but no one is interested whether human resources are provided". Other respondents have noted that "each time the government changes it is the same - groups are formed, discussions are held, small actions are taken, and the term runs out". A continuous decision-making process is a necessity for complex issues, such as mental health.

3. Youth Perspectives

Methodology*[iii]*: *an explorative study with 134 students from 29 municipalities, ranging from 14 to 19 to years old, was conducted during the Summer Forum organized by the Lithuanian School Student Union (LSSU) held in August 2020. The study sample was limited to the youth, particularly, representatives of the school's self-governance bodies who were distributed from Grade 8 to Grade 12, with most of them falling between Grade 10 (32%) and Grade 11 (38%). 72% of respondents were females and 28% were males. 81% of them came from urban areas while 19% came from non-urban areas. During a 3-hour interactive session, participants filled out two questionnaires and participated in a co-creative session. The summarized insights derived from the study are further provided. In addition to this, readers are invited to read the full report on the youth forum[69].*

3.1. Understanding of Mental Health Concepts from the Youth Perspective

Both negative and positive associations are linked to the concept of mental health, including, fear, anxiety, uncertainty, communication and socialization constraints, depression, and bullying; as well as self-knowledge, the act of opening up, talking the tensions out, and overcoming one's fears. Additionally, students indicate that the perception of their mental state strongly depends on the context as well as the situation in which that state is experienced (e.g., being at home, being alone, being with friends, being busy or involved in the task or activity).

Students express that they are unlikely to view the school as a neutral place, instead students view schools' effect either from a negative (30%) or a positive (70%) perspective. Interestingly, more males than females indicate a positive view of school (43% and 69%, accordingly).

Students' mental well-being is strongly linked to their learning achievement, and their relationships with themselves, their peers and their teachers have been identified as the most important ones when it comes to students' psychological well-being. Out of the eight factors, relationships with themselves (72%), with their peers (41%), and teachers (11%) have been ranked as the most influential factors for their mental well-being at school. The school building and surrounding environment, psychological support and service, educational support (e.g., prevention programs), and the relationship with their parents had been identified as less impactful factors. Respect for one another, friendly atmosphere and classmates, and inclusive and responsible community are important aspects identified by students reflecting on the "ideal" environment for discovering mental health knowledge.

[iii] The entire process of study implementation is provided in the Appendix section 8.1.

3.2. Challenges

The inefficient uptake of the existing services is linked to mental health stigma that is prominent in both students and adults, including teachers, school administrators, parents, social workers, and school psychologists. The majority of students did not link a person's experience of a mental health challenge to a sign of weakness or personal failure, however, at the same time they indicated a reluctance in talking about mental health and emotional well-being or seeking help. Interestingly, mental health challenges have been shown to be less stigmatized as compared to the mental health diagnosis.

Additionally, social stigma associated with mental health remained lower in non-urban areas than in larger cities. Students from small cities have been more likely to indicate positive personal, family and school service attitudes towards individuals with mental health challenges. Females have also shown a slightly higher willingness to become friends with or spend an evening together with a person experiencing a mental health challenge or diagnosed with a mental health disorder than males.

Students have also indicated relative hesitation when it comes to communicating about mental health and mental well-being themselves, especially to adults. 31% of students have reported talking to no one, and the majority of students have indicated their preference of talking to peers rather than their parents or personnel (23% would never talk to parents and 31% would never talk to personnel). Students from small cities and villages, older students, and males indicated they talk less frequently about mental health than students from larger cities and than older students.

Finally, students also believe their friends would be reluctant to seek help when facing emotional challenges (30% of students indicated that their friend would seek help) or being diagnosed with a mental condition (49% of students indicated that their friend would seek help). This refers to the difference in the perceived versus social stigma.

A lack of consistency, trustworthiness, and clarity in the existing mental health support resources; negative associations linked to a visit to the psychologist or psychologist itself, and existing requirements for the parents' consent for a visit are the main constraints for the mental health service uptake. While students have shown an interest in gaining more knowledge on mental health, they also identified a lack of clarity on where and how to seek help and get trustworthy support at school. Most students identified the internet as the dominant source for information seeking and gain. Others also indicated psychologists, friends, parents, school or school psychologists or other specialists as additional sources of information and support.

Stress (79%), bullying (86%), anxiety (81%), social anxiety (79%), depression (76%), worrying (62%) and self-harm (60%) were indicated to be the main reasons for visiting the psychologist. Yet, more than half of respondents have identified a belief that visiting a school psychologist can lead to bullying. This belief has been shown to be more prevalent in small cities and villages, where over 60% of students have expressed that concern. Additionally, while being asked to reflect on the other concerns regarding their visit to psychologist, students also have mentioned a fear of being rejected, not understood, feeling ashamed.

Unfortunately, students have also predominantly associated psychologists and social educators with distrust, lack of confidentiality, ineffectiveness, or personal distance and dissociation. Males and younger students have been shown to be more confident in school psychologists' efficacy and confidentiality. In addition to this, most students (73%) have reported that mandatory parental consent is bothersome.

Finally, students report teachers and parents as being expected to play the main roles in identifying and supporting youth mental health challenges. This seems to indicate that according to our youth sample, psychologists are expected to play a supplementary, rather than the main role in providing mental health support.

3.3. Future Hopes

Students were observed to implicitly communicate their desire to gain more insights into human psychology, co-create a safe space and a dialogue to explore the notion of self and their will to instead of providing answers pose relevant questions. The broad range of topics of interest on mental health for further exploration have evolved during the session, including the following topics: self-awareness, anxiety, other emotional challenges, eating disorders, healthy lifestyles, relationships with their close environments (including schoolteachers, other peers, and parents), LGBTQ rights, sexuality, addiction, the relationship between mental health and career choices. Additionally, students have shown the need for not only gaining more knowledge but also getting practical insights on its real-world applications. Anonymity and the ability to take part in the group discussion about mental health have been mentioned to be the two most important conditions for individual growth and the sense of belonging to peer groups.

A need for new methods and forms of knowledge design and delivery process have also been indicated. Students have suggested several solutions, including real-life experience-based teaching, more interactive teaching style, unlimited time dedicated for discussions, educational applications, virtual consultations, authentic conversations and communication, less formalized space, or more unconventional arrangements. Some students have indicated that the lecturer delivering mental health knowledge would preferably be an expert in the subject, base his knowledge on practical experience, be inclusive, and be open. Human contact has been identified as more preferable to digital outreach. Students imagined lectures on mental health would be given regularly, be supplemented with one-time events or activities, and should be delivered even from the first grade.

In conclusion, study results demonstrate that there is a need for new practices in public policymaking to better address the actual needs of the youth. This may include new methods and forms of the knowledge design and delivery processes. Additionally, the identified bottlenecks such as existing stigma and barriers for the service uptake should also be addressed.

4. Institutional Players Perspectives

Methodology[iv]: *fieldwork during the months of July to December, including semi-structured interviews with independent experts and NGOs representatives and a co-creative session with key institutional players in youth mental health ecosystem was conducted. In total 19 semi-structured interviews up to one-hour length were conducted with experts directly or indirectly working within the field of mental health, including independent experts as well as NGOs representatives to explore the current structure, state, challenges, and opportunities linked to the youth mental health initiatives and service provision processes. Additionally, a co-creative 2-hour session with 11 participants from different institutions, including representatives of ministries of Health, Education, Science and Sport, NGOs, Public Health Bureau, and other relevant institutions sought to shed more light on the concept of mental health, existing priorities in the ecosystem, and potential collaboration models. In this stage, participatory design methods facilitated collaborative work and dialogue between different parties.*

4.1. Expert Views on the Challenges

There is a lack of clear and consistent long-term priorities in the youth mental health strategy. Fieldwork findings have shown that most of the interviewed NGOs work in specialized fields within narrow topics (e.g., bullying prevention; victims of violence; prevention of drug addiction, etc.) and that most prevention programs are specialized too. This helps to ensure high-quality, expertise-driven service content and delivery but might create several challenges too. When it comes to the functioning of each of the NGOs, most of the initiatives aimed at youth mental health improvement or work with youth stems from the NGOs themselves. The institutions take a proactive role in fund-seeking, e.g., preparation of project applications and participation in competitions for funding. Most of their activities are project driven and strongly depend on the available funds. They usually initiate work with schools. The constant need to fundraise creates uncertainty that threatens the sustainability of their initiated activities, and more importantly, impedes the likelihood of reaching long-term goals. Additionally, organizations report that the priorities of the entire youth mental health policy system are unclear and a consistent strategy for youth mental health efforts is lacking. Organizations pose the following questions: *"what is more important today - to solve specific problems or orient all the efforts towards the broad prevention programs?", "what are the higher-level priorities – to provide the support system for the kids experiencing challenges or act on the teachers and parents training and education"? "what does prevention mean for different domains, for example, in the case of violence?*

Additionally, experts highlight that there is a need for a broader understanding of mental health by highlighting 1) the role of prevention and reinforcement of mental well-being in all areas; 2) help in promotion and development of self-help skills; 3) promotion of social innovations; 4) transition from medication to combination therapy.

School is often viewed as a so-called "small kingdom" instead of the "youth territory". Several respondents highlighted the fact that school is often relatively isolated from the surrounding community, and that implementation of youth-related practices primarily depends on the will and priorities set by the principal or deputy director for education. The NGOs working within the field of social work, on the other hand, have reported that they prioritize

[iv] The entire process of study implementation is provided in the Appendix section 8.1.

strategies that could foster the youth engagement and involvement. Thus, some of the organizations run their activities in the field, by going to the streets or spaces where the youth can be found and promoting new collaboration opportunities in public spaces through more direct contact with youth. According to one of the respondents "*the process of building the contact with young people is essential to help them to unveil, express and address their worries and psychological challenges.*" Thus, entering their territory, instead of inviting into the unknown space can provide youth with emotional safety and strengthen their trust. Questions for further investigation emerge – do youth perceive school as their territory? How do kids with various difficulties perceive school – is it still their space? Organizations tend to raise the following questions on "*how school could become the "youth territory" – i.e., the space where school children could feel safe, trust the environment, and open up?*", *"how school can become more open for the informal initiatives and practices with more active engagement and collaborative efforts of young people?"*

One additional important insight stems from conversations with helpline representatives. While virtual space and online interaction or conversation is often used by the youth while seeking help, especially after the challenges imposed by COVID-19, the use of virtual tools for service provision from the service providers' point of view is different in comparison to a real meeting or phone call. Even though virtual space is quite a natural environment for young people, the conversations that are being held online are often very fragmented, there are more difficulties in creating in-depth conversation and building connections with a young person.

There is a need for varying levels of youth involvement. Fieldwork findings also demonstrate that the prevention system as it is designed right now primarily focuses on a structured approach with a chain of services being provided independently of the person or situation-dependent circumstances. The social work approach is driven by a more agile practice. They organize festivals, camps, mobile street activities, pop-up initiatives that are being held in the youth environment as an experiential experience that can provide an alternative view in the moment together with the youth. Some of the respondents mention that the level of participant involvement can rise over time, starting from observation and resulting in proactive involvement and even behavior change. Practical examples from drug/alcohol prevention camps are alternative sources of leisure activities that can provide satisfaction without the drug/alcohol use.

Additionally, greater engagement of youth in the process strengthens their responsibility and involvement in the long-term relationship which is essential when it comes to the opening up or recovery processes. Kids who experience prolonged emotional and psychological challenges are particularly vulnerable and have difficulties in contact building, thus working with them calls for the different, incremental level of involvement, as it takes time to evolve. Focusing on empowering young people to face their challenges themselves by teaching them the toolkit and how to practically apply it, instead of taking participation for granted might be a useful strategy for managing levels of involvement. Several experts highlight that at school often due to the high load of work, only the so-called serious cases have been noticed „*the strongest attention to the youth mental health is most often paid only in the instances of the tragic events such as suicide* ".

There are still negative attitudes towards the youth in the society. Interviewees also have raised a very important concern that often the youth in general are viewed from a negative perspective, in other words, *"as problematic teenagers".* The youth, on the other hand, want to prove their adulthood and rebel against the views and control of the adults. This leads to the miscommunications between the two parties. Furthermore, young people tend to associate

mental health services with punishment instead of help. Several respondents have mentioned that there is still a common medical approach towards mental health challenges experienced by the youth, as indicated by one of the respondents *"there is still a belief that so-called bad behavior can be treated".* Respondents also highlight that instead of empowering the youth by teaching them the tools for self-help, the power is given to the experts who decide what is best for the youth or the person that seeks help.

Experts also highlight that mental health stigma exists in the general population, and it can stem from systematic foundations, such as existing regulations, insufficient service evaluation system, limited availability of mental health services in regions, lack of clarity in information provision, low general mental health literacy. More attention needs to be paid to the anti-stigma campaigns promoting changes in social norms and improving mental health literacy at schools.

Active collaboration and built network are essential elements for a well-functioning youth mental health service delivery system. Respondents also have mentioned that there is lack of integration between different elements of mental health support and services that could help the youth to be directed from one element to another. For example, it is not clear whether it is possible to use engagement with one of the elements, for example, attending prevention program activities at school to gain knowledge about other alternatives or support tools. The kids and youth helplines that provide the support also focus mostly on the instant help, however, less attention or none is paid towards long-term assistance. One of the interviewees compared the school psychologist to family doctor – he is a specialist who is not specialized but rather understands mental health broadly and can help navigate through a system of support. Importance of right competencies for such a specialist working in a specific school setting was also mentioned – from good consultation skills in working directly with youth to good organization skills for implementing broad prevention programs for the entire school community and even working in crisis situations.

In conclusion, the biggest challenges in the existing youth mental health support and services ecosystem are to prioritize the actions and funding, to make the existing ties between various elements of the ecosystem stronger or initiate new ones, and to make school specific activities more user friendly, empowering and part of the entire ecosystem.

4.2. Understanding of Mental Health Concepts and Potential Ecosystem Models for Institutional Players

Methodology[v]**:** *a co-creative 2-hour session was conducted in December 2020. The session was divided into two parts. The first part of the session sought to get more insights into the current situation, priorities, themes of interest, and key messages on youth mental health from different institutions. Thus, each participant was invited to imagine writing up the headline for the popular media news portal or the Ministry's internet page reflecting their key message to the respective audience on mental health subjects. Additionally, all participants were invited to present their choices by reflecting on their ideas and choosing only one headline each as a key message. The second part of the session aimed to better understand the existing*

[v] The entire process of study implementation is provided in the Appendix section 8.1.

ecosystem and study how it is perceived amongst its members as well as explore the potential "ideal" ecosystem collaboration models for the fictitious prevention program development. Participants were divided into two groups and invited to first reflect on the concept of "mental health" and then work with a visual board in which different youth mental health ecosystem actors and their relationships reflecting visual elements were depicted (i.e., different forms indicating different institutional bodies, associations, group of people or individuals; and one-sided, two-sided, or dotted arrows indicating different types of relationships). Each participant was asked to identify, depict, and argue for the actors (institutions or organizations, departments of organizations, persons) to be involved in this "ideal" ecosystem for the fictitious prevention program development. Then, the entire group was asked to together decide on prioritization of different actors, depict their relationships, and reflect on their choices. After the session, each group was asked to present developed model prototypes and discuss strategic steps needed for their potential implementation. Deducted insights are further summarized.

4.2.1. Understanding of Mental Health Concepts

All parties settle on a common understanding of mental health as generally it is viewed as a person's emotional and mental well-being and capacity to live a fulfilling life and cope with emerging challenges. Different definitions for the mental health have been provided during the co-creative session, including the following examples: *"mental health reflects the emotional stability and ability to adequately respond and deal with the emerging uncertain and unexpected situations"; "mental health reflects a personal well-being and the ability to live a fulfilling life, be a part of the community, and cope with emerging difficulties and challenges"; "mental health refers to the adequate response to the environment, including other people and their feelings", "mental health is understood as a stable emotional well-being while being with oneself and with everyone else".*

The headlines given to the popular media channel communicate current concerns regarding the COVID-19 pandemic and its impact on youth mental health; address the need for more attention to mental health literacy in general society; and turn the focus towards end-users – the youth perspective. Examples of the provided headlines include the following: „*The youth is lacking the youth during quarantine", "Pandemic-exams-stress-depression. 2021: graduate's perspective?", „Emotional support is available to everyone", "Bad emotions do not exist", "How to take care of children's mental health: tips for parents and teachers", "Myths about child mental health", "Youth organizations say children and young people feel unheard", "Challenges for schools in ensuring a mentally healthy environment", "Patience and emotion - is it compatible?", "Are we ready to accept children with various special needs in general education schools?"*

The headlines encoded with the messages provided for the fictitious Ministry news portal highlight the steps that should be taken to improve youth mental health and the more directional focus on teachers' role in the school context. The headlines provided include the following statements: "*there is an increasing focus on the social and emotional education of children in schools", "Teachers are invited to strengthen their competence in the field of mental health", "What is the responsibility of the educator in strengthening the mental health of young people", "Research has shown that young people need tailor-made services", "Forms of informal work with youth are the future of the state", "Teachers, talk to young people - they hear you!", "Let's talk more with students".*

While being asked to reflect upon the main messages to be chosen, all the participants from different institutions highlighted numerous directions within the youth mental health domain. Some participants stress the fact that still there is more work to be done when it comes to mental health and emotional literacy, that there is a lack of youth inclusion in the policy making as well as a lack of conversation being held between youth and teachers and calls to action for the collaborative effort. These insights might indicate that strategic priorities are not entirely clear and there is a need for a more coordinated youth involvement in the development of the solutions to address mental health challenges.

4.2.2. Mapping the Potential Ecosystem Models for Collaboration

Two versions of visual prototypes (i.e., fast sketches) for the potential collaborations created during the co-creative session reflect the "ideal" ecosystem and processes within the ecosystem necessary for the national prevention program development and for ensuring youth mental health literacy.

4.2.2.1. A Collaborative Model for the National Youth Mental Health Prevention Program Development Ensuring the Needs of the Society

The process for the national prevention program development. In this prototype, three tiers of institutions develop the agenda for the national prevention program:

- **Tier 1:** Lithuanian Government bodies, including the Government Office, President and Parliament provide the directions for the youth mental health policy and actively promote the mental health topic and initiatives necessary to improve the mental well-being in youth.
- **Tier 2:** the Ministry of Health; Ministry of Education, Science and Sports; and the National Education Agency collaboratively initiate the development of the prevention program.
- **Tier 3:** the Board constituted out of experts within the field, including scientists, researchers who contribute to the decision-making process and program development process with the expertise on methodology and scientific knowledge is established. The Board continuously contributes with its expertise during the co-creative and participatory work. Additionally, other representatives from important groups, including the school community, youth Parliament, Psychology Association, and NGOs contribute to the entire process by continuous feedback, reflections, and suggestions during the entire process of the program development.

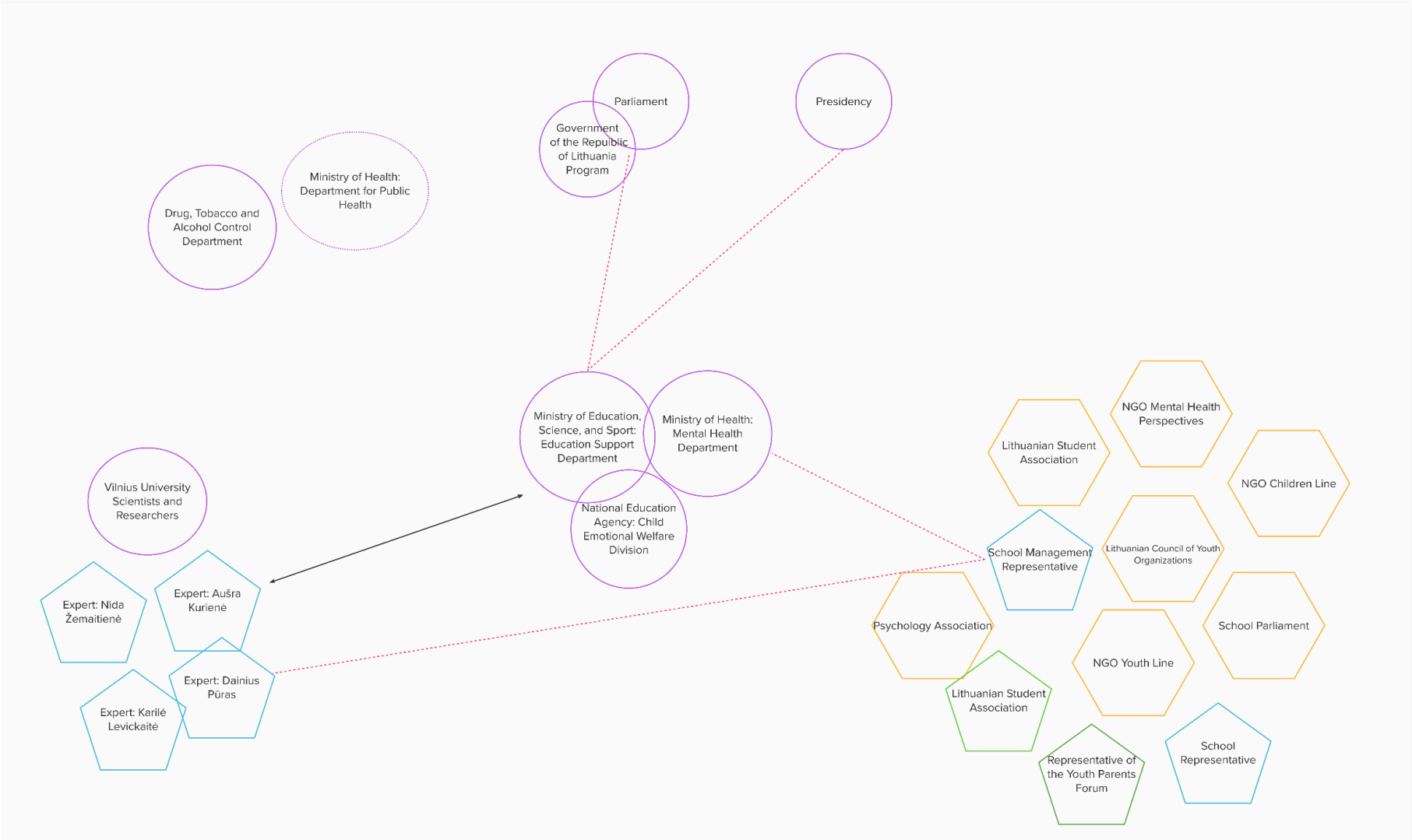

Figure 2. The prototype of the "ideal" model for the national prevention program development. A snapshot from a digital workspace for visual collaboration MURAL

In the "ideal" ecosystem model the strong advocacy of the mental health is particularly prominent at the highest political level. The institutions work collaboratively by engaging all the members into policy-making and ensuring the most effective resource allocation to have the integral and efficient reach of the set mental health outcomes. The strategic goal of this model is to promote inclusion, integrity, and effectiveness, so that the system itself would not work on its own but would work effectively to meet needs of the youth and society.

4.2.2.2. An Optimal Model for Ensuring the Mental Health Literacy of Young People

The process for developing a program on the mental health literacy of young people. There is still a lack of systematic coordination between different institutions and activities and objectives within the field of youth mental health. Most activities are independently coordinated and implemented without inter-institutional coordination. As a result of that, institutions lack of clarity on their respective roles and risk inefficiencies associated with overlapping but uncoordinated work.

The designed model consists of three levels:

1) **Conceptual agreement** in which all involved parties, including the Ministries of Health and Education, Science and Sports, Social Security and Labor, researchers, NGOs, and politicians identify common objectives in youth mental health; establish a common foundation of understanding through defining terms and concepts; and set a common agenda. The process of conceptual agreement development commences through Forum which is initiated by anyone who has the motivation, skills, and resources necessary for program development and implementation. Then, the agreement also needs support from the Government. In this case, a permanent work group such as the Steering committee can be established. This interinstitutional, cross sectoral body would play a coordinating role and ensure the agreement implementation and problem solving.
2) **Coordination and legislation at the national level of ministries and its subordinate institutions.** In this level, it would be very important to ensure the common foundation for the Ministries of Health, Education, Science and Sport in their understanding of what mental health is, what literacy is and clearly division of functions and their interactions between coordinating and implementing bodies. The Ministry of Social Security and Labor and social service providers also would take an important role in the implementation of the model.
3) **Implementation activities at the local level.** The municipality would take the central role in implementation activities of this type of program by bringing together various organizations, including Public Health Bureaus, Psychological Service Council, Open Youth Centers, school, NGOs, Child Welfare Commission, State Child Rights Protection and the Adoption Agency, and social service providers involved in program implementation.

The “ideal” model would also include the subordinate bodies responsible for the program monitoring and evaluation activities, as well as the coordinating centers, including Youth Centers, Training and Skill Support Centers and the media responsible for the coordinated program implementation.

Figure 3. The prototype of the "ideal" model for ensuring the mental health literacy of young people. A snapshot from a digital workspace for visual collaboration MURAL

In the "ideal" ecosystem model there is a systematic approach starting from the common understanding of the terms, definitions, concepts, goals, and priorities. The duplication of functions is eliminated, and all relevant parties are involved in the co-creative process. Support at the highest level has been provided by establishing a coordinating body and subordinate institutions responsible for monitoring, evaluation, and coordination of the implementation.

In conclusion, participants discussed the differences between two models and emphasized that the first model more closely reflected the existing relationships and processes in developing prevention programs, and the second more closely reflected the desired situation and focus on increasing public mental health literacy. The observations made also have shown that there is still a lack of common agreement for the systematic framework encompassing the terms, definitions, concepts employed in the field mental health as well as a need for more comprehensive and collaborative policy development and implementation practices, including clearly defined functions and systematic relationships. The session has also demonstrated that there is a high engagement into the debates of these challenges. The session where institutions have met, shared experiences, discussed and visualized challenges is one of the first steps to start inter-institutional dialogue.

5. Recommendations

Significant opportunities to address the existing bottlenecks and optimize the youth mental health service delivery and uptake to youth in schools exist. Based on the qualitative and quantitative findings outlined in this report, 9 action points are recommended.

Recommendation 1: Develop common definitions, objectives, and indicators across institutions. It is recommended for institutions to establish a commonly understood set of definitions of mental health topics; clearly define cross-institutional objectives for systematic change; and identify a set of concrete indicators to measure and benchmark progress. Input from all actors, including those in highest-level Government, Parliament, and Presidential posts, is key in effectively establishing this framework. To implement this step, it is recommended to organize a series of events, for example, 3 forums in a year of 2021. The forums should be organized either by the Government Office or the key Ministries involved in the youth mental health service delivery chain: the Ministry of Health; the Ministry of Education, Science, and Sport; and the Ministry of Social Security and Labor. To foster an ongoing engagement, it is recommended to include co-creative sessions, held virtually or in-person, that use participatory design and future-thinking methods. Such sessions could facilitate discussion across various levels of the ecosystem and comprehensively include all actors in the co-creative process.

Recommendation 2: Establish a cross-institutional coordinating body. A coordinating body for youth mental health could help ensure coherent collaboration across institutions and progress towards collective objectives. Researchers, scientists, monitoring and evaluation specialists, policymakers, and end-users could all provide important input into the coordinating body's work. The coordinating body could ensure cohesive agenda-setting across institutions, including the activities outlined in Recommendation 1; oversee monitoring and evaluation of programs across institutions; foster cross-institutional databases on mental health; and map the ecosystem of institutions involved in youth mental health services. Regularly taking stock of activities can help mitigate duplication of efforts and maximize the impact of programs. The coordinating body structure should be built by proportionally including different stakeholders within existing ecosystem to ensure that different sectors and fields of expertise are equally represented. The structure of the coordinating body, its functions and placement in the system should be discussed between different parties and set upon the common agreement in one of the forums suggested in the Recommendation 1.

Recommendation 3: Foster ongoing cross-institutional knowledge dissemination. Ongoing communication, knowledge sharing, agenda alignment, and collaboration between institutions can employ complementarities and increase the efficiency and reach of policymaking and programs for youth mental health. Several solutions to foster a more systematic knowledge sharing and dissemination between different institutions could be suggested by the development of a new digital platform, employing other digital tools, or redesigning the existing solutions (e.g., "Help yourself" platform) that would connect institutions for data- and agenda-sharing. To ensure the most efficient knowledge dissemination this type of platform or other digital solution and its usability is recommended to be introduced to the youth through their main communication channels.

Recommendation 4: Integrate schools into the ecosystem network. Data indicates that schools are often viewed as an exclusive autonomous unit when it comes to the mental health service and support provision. At the same time, the school is the broadest and most important channel for the promotion of mental health and well-being of the youth. Decision-making regarding the prevention programs implementation is often driven by the school principals or school administration, which can lead to the more subjective decision-making and fragmentation of mental health outcomes between different schools. More focus should be paid to incorporating the school into the broader mental health service ecosystem and linking activities in the school to activities outside of it. For example, the expertise and the experience of the NGOs and social workers should be more inclusively integrated into schools by more frequent consultations and invitations of sharing the experiences on their practices. That would also allow for sharing of the responsibilities and workload too since schools primarily focus on the study process. Potentially, the more frequent and stronger inclusion of schools in service provision could be ensured by allocating necessary funding and other needed resources as well as more intensively outsourcing certain services provision. Additionally, the existing legal and financial restrictions should be overviewed at the systematic level and a new model that would ensure the implementation of these activities should be developed and implemented.

Recommendation 5. Implement a user-centered design process through active engagement with students. The youth mental health service delivery chain must be viewed as a complex system with a set of interrelated elements, linkages, and different actors across the chain. The youth and their needs can be viewed as a sustainable link in the chain, thus more attention should be paid towards an active engagement of the students into the mental health programming. Active and deep engagement of students can ensure that learning process, programs or other services or initiatives are relevant to, understood by, and easily accessible for the end-user. Due to the variety of mental health challenges and end users' needs and aspirations the solutions provided should balance the collective and individual factors. It is recommended to continuously implement the assessment of young people's attitudes towards the existing services and their needs for improvement. The dissemination of gained knowledge within the entire chain should be also ensured. It is also encouraged to actively rely on the activities of youth organizations and to pay attention to the situation of the young people who are no longer in school.

Additionally, student recommendations expressed in Section 4.3, for example, suggest that mental health programming be in-person, informal, applied, practical, and implemented by experts. The study points out towards the improvement of the relationships between teachers and students, introduction of new forms of knowledge delivery and learning (e.g., including the practice-based learning, organizing festivals and group sessions). Students highlight the importance of their peers in overcoming mental challenges so some empowerment tools can be designed specifically for young audiences. By integrating such insights into program design, institutions may more efficiently meet student needs and connect them to resources.

Recommendation 6: Foster school staff capacities. Qualitative and quantitative research indicates that while school staff are well-positioned to identify and respond to youth mental health needs, few to no protocols exist to do so within the school context. Youth, on the other hand, identify that teachers play an important role in their mindsets for the identification, promotion, and guidance for the uptake of mental health resources while faced with different challenges at schools, especially responding to the COVID-19 pandemic caused challenges. It is recommended to strengthen the relationship between the youth and the teachers, also pay more attention towards improvement of the mental health literacy at school and building school

staff capacity to provide necessary help. Additionally, a more clear definition of the protocols and identification and communication of the best practices surrounding youth mental health services in schools are also suggested. A range of current initiatives can be scaled, expanded, or optimized. In 2021, for example, The Ministry of Health rolls out an early-recognition youth mental health program for school staff across Lithuania. A uniform 8-hour online module will be made available publicly across Lithuania on a voluntary basis as part of the training. A range of interventions can maximize the impact of this training, including messaging and communication strategies to increase uptake. Messages via text, email, and other mediums from a range of senders, including Public Health Bureaus and ministries, and with a variety of content and tones could experimentally target teachers to increase participation and engagement in the training. Experimental evaluation could reveal insights about most effective messaging methods to inform future efforts to engage teachers. The incentivization system for the teachers should not be overlooked.

Recommendation 7: Break down legal barriers to mental health service uptake. More attention towards the restrictions imposed by legal acts and regulations should be addressed. Further, confidentiality and anonymity concerns inhibit student uptake of mental health services in schools. Frameworks should be redesigned to break down legal barriers that otherwise systematically inhibit the design, implementation, and uptake of mental health services. Additionally, the integration of the innovative public policy-making principles, investment in the experimental efforts, and promotion of the evidence-based impact assessment of alternative solutions should be encouraged. This could help to better identify barriers and find alternative non-regulatory solutions aimed at more effective youth mental health policies.

Recommendation 8. Introduce systematic efforts to reduce mental health stigma. Significant mental health stigma exists amongst both the youth as well as adults (teachers, parents, school administration), which reduces both the quality and the uptake of youth mental health services at school. Negative attitudes and stigma towards mental health can deter progress in policy making and programming throughout the service-delivery chain. For example, public officials that display negative attitudes towards mental-health issues may be less likely to dedicate resources and attention to this area; principals and teachers may be less likely to take on the best practices in early recognition and referrals; users may be less likely to use existing services. Different interventions, such as targeted messages, exposure- and perspective-based training actions, information campaigns, and societal campaigns aimed at the social norms change, might be carried out in different levels, including the policy-making, schools, parents, the youth, and general society, to reach for a systematic attitude and behavioral change.

Recommendation 9: Foster research and experimentation on best practices for youth mental health services and strengthen the data collection and its systematic integration into the database. Improving mental health services for youth requires a holistic view of the teachers, administrators, and mental health professionals that form the mental health landscape in schools. Survey and administrative data of these individuals can provide a snapshot of the service delivery chain of mental health services, allow for identification of bottlenecks, and help to formulate best practices to create a system that fosters positive attitudes and actions towards mental health in schools across Lithuania. Particular data of interest on school personnel includes that on attitudes, preferences, and motivations surrounding mental health; knowledge and learning behavior on mental health outcomes; and work metrics related to student mental health outcomes. A more comprehensive view derived

from the data at the administrative level may shed more light on the civil service management practices, incentive structures, and institutional environments; and how these variables may impact policy and program design; service delivery; and societal outcomes. This can help to better illuminate the links between civil service practices and service delivery outcomes and allow for a more comprehensive analysis of the mental health environment among school-aged children across the country. Particular data of interest includes that on attitudes, preferences, and motivations surrounding mental health; budget and policy preferences for mental health; and co-production behavior with schools regarding youth mental health services. Administrative and survey data at the student level can provide meaningful insights into current realities of youth mental health. Harnessing a more robust set of existing administrative student-level mental health and school performance data can help to guide program design and policy-making for youth mental health; and can support in benchmarking outcomes to better inform future directions. Particular data of interest includes student visits to the psychologist or social workers; data on student behavioral challenges at school including bullying; student grades; and student awareness of mental health challenges, coping mechanisms, and resources; among others.

With the establishment of a more robust database comes the opportunity to conduct policy-relevant research that measures the effectiveness of new and existing initiatives in mental health service delivery. Such research can play an instrumental role in guiding future efforts. It is recommended to measure causal impacts of programming; calculate the costs and benefits of different programmatic options; and empirically research policy directions to best inform practices that cohesively and effectively improve youth mental health across institutions and in schools throughout Lithuania.

In conclusion, this study provides the insights and innovative public policy-making practices that are relevant in further development of evidence-based public policy interventions and in promoting public administration innovation and its implementation processes. These recommendations were presented and discussed with the involved stakeholders. The main directions for further research and particular intervention design and testing have been set based on the insights provided by the main parties. These directions include addressing the integration of the schools into the ecosystem network; implementation of a user-centered design process through active engagement with students; fostering the school staff capacities. These aspects will further be addressed through the co-creative sessions held with the youth students in selected schools, the implementation of the public administration, school administration, and teachers' surveys, and impact assessment activities of the teacher training and motivation program.

Appendices: Research Process and Supplementary Material

Action research was employed to approach the questions of interest. Action research is a "practice-based"[70] approach that is collaborative, critical, and fosters the learning experience. It aims to understand and generate knowledge about educational practices and their complexity and constitutes both problem posing and problem solving. Action research can be used in settings where problems, people, tasks, and procedures need an elaborate solution. Action research principles[71] include dialogue, participation, adaptiveness to the situation, and the use of feedback from data in an ongoing iterative process. Application of these principles during research provides an opportunity to better understand complex social situations, as well as the processes that can help to change complex systems. This aims to avoid the traditional research paradigm that isolates and controls variables. Action research may come in many forms, including participatory research, diagnostic research, practitioner research, classroom-based action research, empirical action research and many others.

Appendix 1: Diagnostic Implementation Process and Methods

Different methods were employed to reach the study goal. The data collection is being conducted in stages to approach the studied phenomenon from different perspectives. Administrative data, quantitative and qualitative data collection methods have been used to understand the main bottlenecks of the service delivery and uptake and behavioral biases that cause stigma, and, accordingly, to identify potential interventions and directions for innovative solutions. Data collection was gathered through administrative data, a survey of key stakeholders involved in service delivery, and user-centered co-creative workshops to paint a comprehensive picture of the constraints in mental health service delivery to youth.

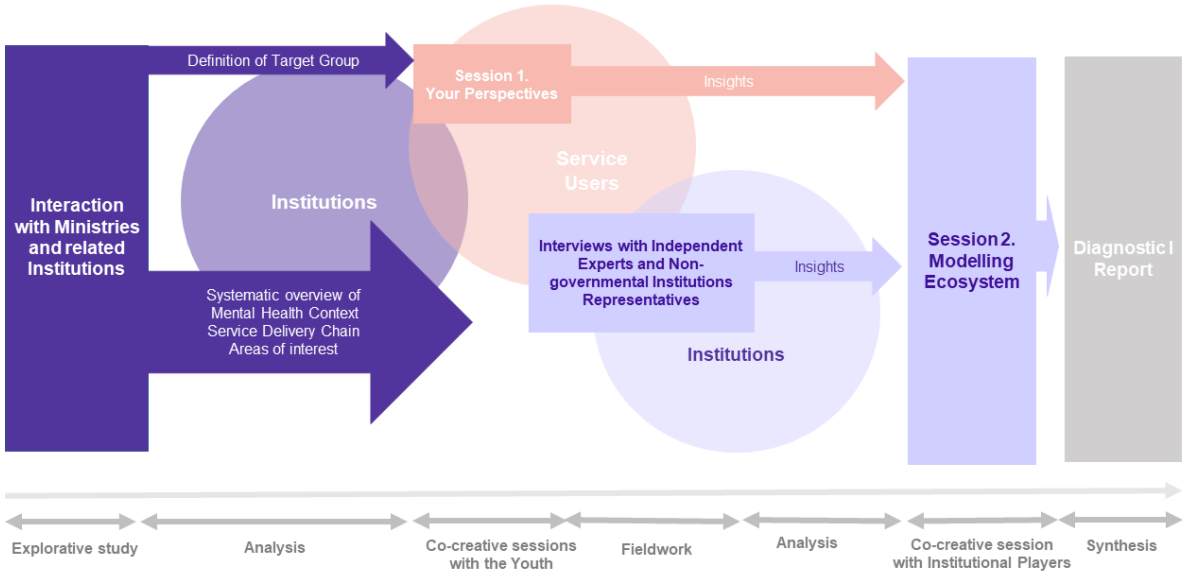

Figure 4. Diagnostic implementation process

Explorative Study. As a first step in the research process a number of meetings and sessions have been initiated with the collaborating institutions to narrow down the main target group, identify the key players in the service delivery chain and pose the main research questions for further research direction. During the entire process, at each stage of the process, the data and insights were presented and discussed with the relevant parties to ensure the iterative and feedback-based action research process. The aim of the first stage was to identify the directions for co-creation of the design process.

Co-Creative Session with Users: Session 1. Youth Perspectives. After identifying the main target group for further analysis, co-creative work with the mental health service delivery chain end -users - the youth have been conducted. For that purpose, an explorative study with 134 students from 29 municipalities, ranging from 14 to 19 to years old, was run during the Summer Forum organized by the Lithuanian School Student Union (LSSU) in August 2020. The study aimed to gain a user's perspective on the "mental health" concept, the supply and demand side constraints to design, delivery, uptake, and efficacy of mental health services. The study sample was limited to the youth, particularly, representatives of the school's self-governance bodies who were distributed from Grade 8 to Grade 12, with most of them falling between Grade 10 (32%) and Grade 11 (38%). 72% of respondents were females and 28% were males. 81% of them came from urban areas while 19% came from non-urban areas. During a 3-hour interactive session, participants filled out two questionnaires and participated in a co-creative session. The questionnaires were designed to collect the information regarding demographics, student's opinion towards factors that influence mental health, and their attitudes towards the mental health service design and delivery process at school. The co-creative session aimed to capture student's perceptions on the "mental health" concept, explore the prevailing topics of interest, and study the forms and channels of ideal service(s) or solution(s) design and delivery process. Participatory design methods were used to facilitate the co-creative discussion and reflect on the potential innovative solutions.[72]

Fieldwork: Interviews with NGOs Representatives and Independent Experts. To further understand the main tensions related to the efficient mental health service provision, delivery and uptake, fieldwork activities were taken. For that purpose, 19 semi-structured up to 1-hour long interviews have been conducted with the experts directly or indirectly working within a field of mental health, including independent experts as well as NGOs representatives. The goal of the fieldwork was to explore the current structure, state, challenges, and opportunities linked to the youth mental health initiatives and service provision processes. The chosen sample included a range of organizations within different narrowly specialized fields of expertise and activity contexts (e.g., certain prevention program implementation at school; helplines; different types of social work; teacher training, etc.). During the interviews, the following themes of interest have been explored: 1) existing challenges and opportunities in the youth mental health system; 2) the most concerning youth groups and their challenges; 3) existing initiatives, including prevention programs, aimed at mental health support and prevention; 4) financial opportunities and funding models; 5) existing partnerships with the schools and within the ecosystem. The area of interest was set to the services or the challenges related to the youth of 14-19 years of age. Data was collected by noting down the relevant insights: themes, thoughts, ideas, direct citations, and general observations obtained during interviews, some interviews were audio recorded and transcribed.

Co-creative Session with Institutions: Modelling Ecosystem. To shed more light on the concept of mental health, existing priorities in the ecosystem, existing members and their relationships, a co-creative 2-hour length session was conducted with 11 participants from different institutions, including the representatives of the ministries, NGO's, health bureaus and other institutions working within the field of youth mental health. To facilitate the collaborative work as well as the dialogue between different parties, the participatory design methods have been used. Participants were invited to work on the online Mural platform. The goal of the first part of the session was to get a deeper insight into the current situation, priorities, and strategic messages of different institutions. Each participant was invited to imagine writing the headline for the popular news portal or the internet page of the Ministry that would best reflect the situation in the youth mental health domain. Then, each participant was invited to reflect on their choices and choose one or several key messages. During the second part of the session, the goal was to better understand the existing ecosystem and study potential collaboration models. Thus, participants were divided into two groups and were invited to first reflect on the concept of "mental health" and then work on the board by arranging the visual elements reflecting different actors of the youth mental health ecosystem and their existing or potential relationships. Participants were asked to draw the "ideal" model for collaboration in the ecosystem necessary for a fictitious prevention program development by identifying all the actors (institutions, departments, people), visualizing the relationships between different actors, and reflecting upon their choices. After both participatory design exercises were finished, both groups were invited to present their models and reflect on their choices.

Appendix 2: Supplementary Material

Figures

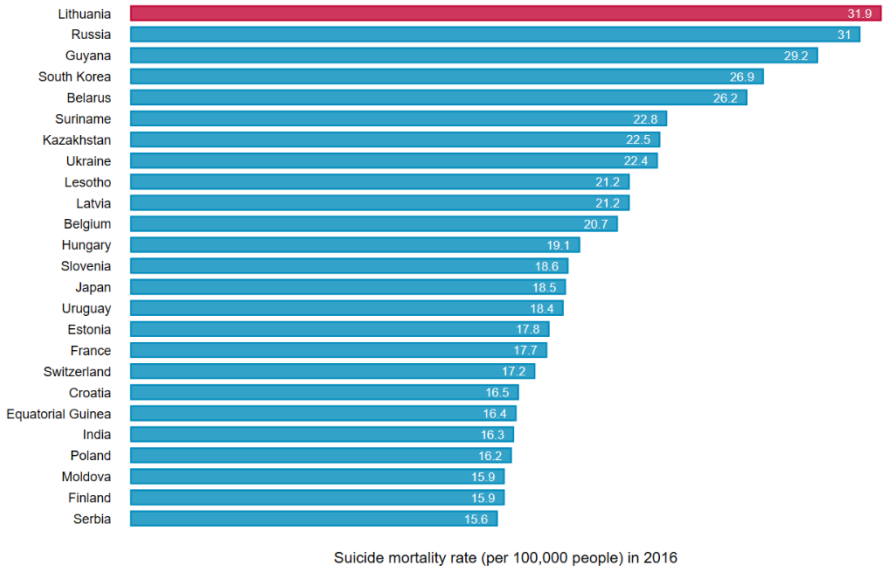

Figure I. Countries with the 25 highest suicide mortality rates globally

Source: World Bank World Development Indicators

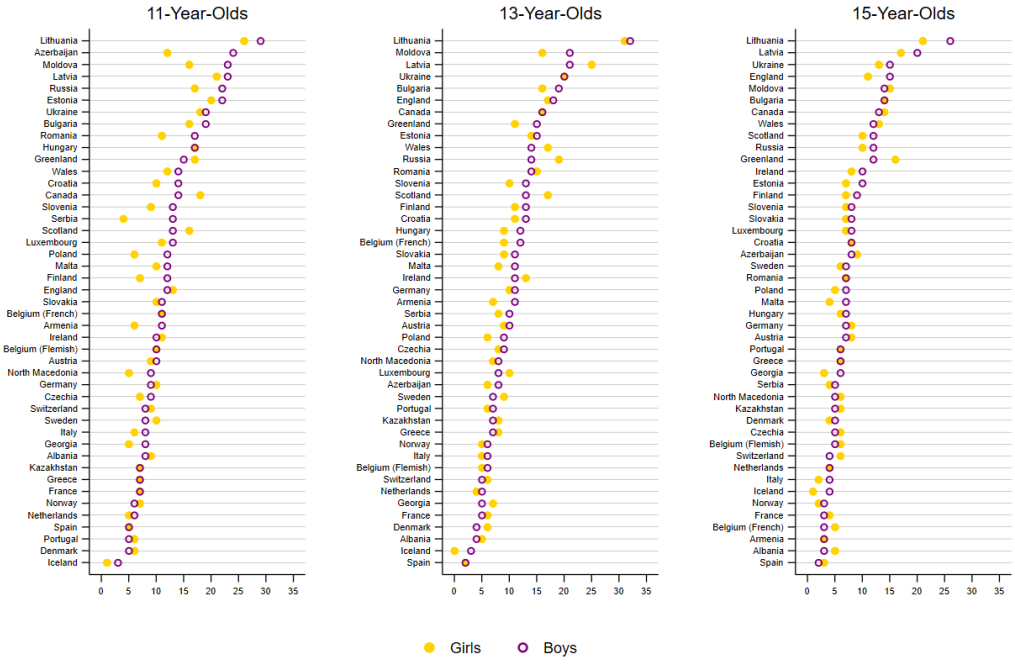

Figure II. Percentage of students who reported being bullied at least two to three times in the past couple of months, by country, sex, and age group

Source: Inchley et al. (2020)

Tables

Table 1. Deaths due to intentional self-harm in 2019, by county and gender

	Number of deaths			**Number of deaths per 100,000 population**		
Counties	*Overall*	*Males*	*Females*	*Overall*	*Males*	*Females*
Vilniaus	135	116	19	16.6	30.7	4.3
Alytaus	51	39	12	37.8	61.9	16.7
Kauno	151	128	23	26.9	49.5	7.6
Klaipėdos	61	48	13	19.1	32.1	7.7
Marijampolės	38	30	8	27.6	45.7	11.1
Panevėžio	68	51	17	31.9	52.1	14.8
Šiaulių	63	51	12	24	41.4	8.6
Tauragės	23	19	4	24.8	43.5	8.2
Telšių	28	23	5	21.3	37.3	7.2
Utenos	40	34	6	31.7	57.4	9.0
Total	658	539	119	23.5	41.5	8.0

Source: Health Information Centre of Institute of Hygiene (2020)

Table 2. Percentage of Lithuanian students who reported being bullied at school at least two to three times in the past couple of months, by age group, gender, and HBSC survey

	Boys		Girls	
	2013/2014 HBSC	2017/2018 HBSC	2013/2014 HBSC	2017/2018 HBSC
11-year-olds	35%	29%*	29%	26%
13-year-olds	31%	32%	29%	31%
15-year-olds	29%	26%	22%	21%

*Note: * signifies a statistically significant difference between 2013/2014 and 2017/2018 survey levels*

Source: Inchley et al. (2020)

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