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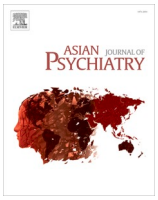

Mental health of adolescents in countries of South-East Asia: A policy review

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ABSTRACT

Background: In the World Health Organization (WHO) geographical region of South-East Asia, the mental health burden of adolescents appears high. Addressing this burden requires development of mental health policies consistent with international standards to assist governance, resource allocation and delivery of mental healthcare effectively. The aim was to identify current national mental health policies/plans/programs/legislation in South-East Asia, assess compliance with international standards and review inclusion of adolescents in these documents.

Methods: Searches were conducted on WHO MiNDbank, official government websites, Google and Google Scholar. Documents were compiled and screened, data were extracted and evaluated following WHO Guidelines on Monitoring and Evaluation of Mental Health Policies and Plans. Frequencies of checklist and subsection scores were calculated. Data were narratively synthesised.

Findings: Fourteen mental health policies/plans/programs/legislation from 8 countries met inclusion criteria. Maldivian and Bangladeshi documents complied the greatest with WHO guidelines. All 8 countries considered adolescents to some extent in their documents. Only Indian documents consulted child health groups during policy development. Intra/Inter sectoral collaboration with child health divisions was highlighted in documents from Sri Lanka, Bangladesh, India and Maldives.

Interpretation: Most South-East Asian nations had developed separate national mental health governance documents. However, their incorporation of adolescent mental health is rare and compliance with international standards were inconsistent. Binding mental health legislation separate from health legislation; inclusion of adolescents; addressing resource constraints; and guidelines for mental health policy development catered to low-and-middle-income countries are all essential to address the complex mental health needs of South-East Asian adolescents.

1. Introduction

In the World Health Organization (WHO) geographical region of South-East Asia, 260 million people (13.2 %) live with a mental health condition (World Health Organization, 2023). All 11 countries in the region, are classified as low- and middle-income (LMIC) (World Health Organization, 2024a). Addressing mental health problems (MHP) is a pressing global health concern, especially in South-East Asian countries that faces unique social, environmental and geopolitical challenges.

Adolescence, usually known as the 10–19-year age range, is a formative period of development where there is substantial physical, emotional and social growth (World Health Organization, 2017). During this developmental period, adolescents can be particularly vulnerable to developing MHPs (World Health Organization, 2017). Further, current research indicates that many MHPs are known to emerge during early life and can continue into adulthood (World Health Organization, 2017).

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In South-East Asia, adolescents constitute one fifth (18.8 % or 362.2 million people) of the total population (World Health Organization, 2017). Available data suggests a high prevalence of MHPs among adolescents (World Health Organization, 2017). However, the true burden cannot be accurately determined due to lack of a systematic process of data collection and the absence of well-functioning data collection authorities (Sharan et al., 2017; Vijayakumar, 2023). Additionally, factors such as stigma or discrimination may result in young people seeking care outside the healthcare system, which can obscure the true mental health burden for young people in this region (Sharan et al., 2017; Vijayakumar, 2023).

Further compounding the mental health burden, treatment gaps for MHPs in South-East Asia are estimated to be as high as 90 % (World Health Organization, 2023). Access represents a major concern, with most mental healthcare services concentrated in urban areas and institutions (World Health Organization, 2023). In many member states, child and adolescent mental health services are in urban hospitals (World Health Organization, 2023). There are few data from governments and the private sector on treatment gaps, so the actual treatment gap is also unknown (World Health Organization, 2023).

Factors affecting mental health of adolescents are complex and multifaceted. Emerging evidence highlight social determinants, which influence presence and severity of mental health problems (Lund et al., 2018). In South-East Asia, pervasive stigma, discrimination and lack of resources act as barriers to addressing mental health needs of young people (World Health Organization, 2023). Additionally, climate change-related factors, disasters and humanitarian emergencies pose new challenges to those already existing (World Health Organization, 2023). Failure to address these needs is a serious public health dilemma with important consequences on the achievement of basic development goals in LMICs (Kieling et al., 2011). Given the intersection between mental health, physical health, educational, social and developmental problems, prioritization of mental health needs of young people in South-East Asia is essential (World Health Organization, 2017).

Governance is key to addressing mental health burdens, gaps in treatment and overall delivery of mental healthcare. Particularly for adolescents, mental health promotion, prevention, early intervention and treatment are essential to preventing MHPs from manifesting into adulthood (Kieling et al., 2011). Mental health policies help to establish national priorities in planning, organizing and coordinating different components of a mental health system (Sharan et al., 2017). In South-East Asia and generally among LMICs, it has been exceptionally difficult to develop mental health policies to govern mental healthcare systems and delivery. This is attributed to low governmental priority, lack of financial and human resources, as well as the true burden and treatment gaps, especially among young people, being unknown (Sharan et al., 2017). In LMICs that have developed mental health policies, plans, programs or legislation, documents either do not reflect international standards or what is said to be implemented is starkly different from the reality of implementation at ground level (Sharan et al., 2017).

Addressing mental health needs of adolescents in South-East Asia requires the implementation of actions by sectors other than health, highlighting the need for a coordinated multisector approach with clear directions (World Health Organization, 2023). WHO Mental Health Action Plan targets for 2030 aim to develop or update policies and/or plans and/or legislation for mental health in line with international standards in order to assist governance and delivery of mental healthcare, so needs are met (World Health Organization, 2023).

The aims of this study are (1) to identify current national mental health policies, legislation, plans and programs in WHO South-East Asia Region, (2) assess compliance with international standards using the WHO Guidelines on Monitoring and Evaluation of Mental Health Policies and Plans and (3) review the inclusion of adolescent mental health in these documents.

2. Methods

2.1. Study design

A review of mental health policies, legislations, plans and programs in the WHO geographical region of South-East Asia targeting adolescents. This region comprises 11 countries: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste.

2.2. Search strategy

Documents were identified through three search strategies run in January 2024. First, WHO MiNDbank, an online repository of national and regional level mental health policies was searched (World Health Organization, 2024b). Documents from the 11 South-East Asian countries were compiled. Next, official government websites of the Ministries of Health in all South-East Asian countries were searched, and relevant documents were added. Third, a search was conducted through Google and Google Scholar to identify further relevant documents.

2.3. Inclusion and exclusion

A mental health policy provides the overall direction for mental health by defining the vision, values, principles, and objectives (Funk and Drew, 2015). A plan details strategies and activities that need to be implemented for achieving the objectives of the policy (World Health Organization, 2007). A program is a plan of action that includes broad and specific actions required to give effect to the policy or legislation (Saxena and Sharan, 2008). Policies, legislation, plans and programs work in conjunction (World Health Organization, 2007). Therefore, documents were eligible for inclusion if they were mental health policies, legislations, plans or programs; from South-East Asia; with national jurisdiction; were currently operational; and available in English.

Documents rendered inactive as of January 2024, non-operational documents where the document is in draft form and non-English documents were excluded.

2.4. Screening

Documents compiled during the search process were screened and full versions were obtained. Data extraction and evaluation were conducted on included documents. If a full version could not be found online, the Ministry of Health of the respective country was contacted via email to obtain an up to date, English translation of the document.

2.5. Data extraction and evaluation

Data were extracted and evaluated from all documents meeting the inclusion criteria using the WHO Guidelines on Monitoring and Evaluation of Mental Health Policies and Plans (World Health Organization, 2007). The guidelines, designed by WHO to address needs and priorities in mental health policy development and service planning, aim to assist policy-makers to: develop comprehensive strategies, use existing resources, provide effective services to populations in need and aid reintegration of people with MHPs into all aspects of community life (World Health Organization, 2007). There are two checklists in the Guidelines: The Checklist for Evaluating Mental Health Policy (Policy Checklist) and the Checklist for Evaluating Mental Health Plan (Plan Checklist) (Supplementary File 1).

The Policy Checklist was used to extract data and evaluate mental health policies and legislation. For countries with both, data were extracted and evaluated together. This Checklist comprised two subsections: process issues (6 questions) and content issues (22 questions) (Supplementary File 3).

The Plan Checklist was used to extract data and evaluate mental

health plans and programs. For countries with both, data were extracted and evaluated together. This Checklist comprised five subsections: process issues (7 questions), operational issues (1 question), strategies (3 questions), activities (6 questions), and content issues (14 questions). Items are scored using the same scale (Supplementary File 3).

Documents were reviewed, ratings assigned and data were extracted by author CM. The research team then reviewed and discussed uncertainties. In both Checklists, each question is rated on a scale of 1–4. 1 =yes/to a great degree was assigned where the document clearly, to a great degree answered the question item of the respective Checklist; 2 =to some extent was assigned where the documents vaguely or to some extend answered the question item; and 3 =no/not at all was assigned where the question item could not be answered or the answer could not be found in the document. In accordance with previous studies (Bhugra et al., 2018), the *4 =unknown* rating was not used for either checklist. Only information written into the document was considered. If something was not mentioned in the document, it was rated as '3 = no/not at all'. Lower scores indicate a greater compliance with WHO recommendations.

2.6. Data analysis

The documents' compliance with WHO guidelines were evaluated for both checklists separately for each country by summarising the proportions of the ratings (1) *yes*, (2) *to some extent* and (3) *not/not at all* in the two checklists. These proportions were also calculated for each subsection of the checklists.

The data from 3 questions of the Policy Checklist (questions 4, 18, 20) and 3 questions of the Plans Checklist (questions 7, 29, 30) relevant to children and adolescents were grouped to determine prioritization of adolescent mental health in South-East Asia.

2.7. Role of funding source

Primary investigator CM is supported by a Monash University Research Training Program Scholarship. Corresponding author is supported by the Finkel Professorial Fellowship, funded by the Finkel Family Foundation. Funders had no role in the study design, data collection, data analysis, data interpretation or writing.

3. Results

The initial search yielded 47 mental health policy, plan, program and legislation documents. Of these, 14 documents belonging to 8 countries met inclusion criteria (see Fig. 1). These documents were screened and evaluated using the relevant WHO Checklists (Supplementary File 2).

Of the 11 South-East Asian countries, only 3 (27 %) have separate binding legislation for mental health, distinct from the state's general

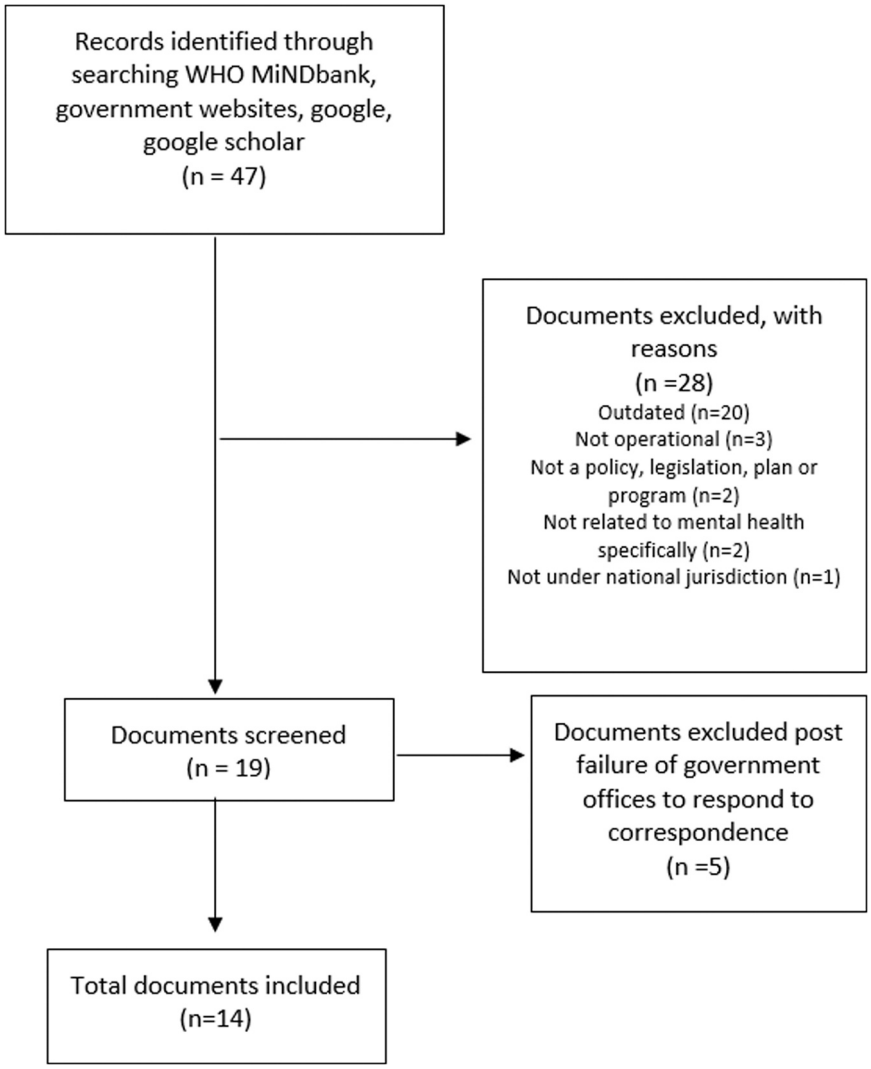

Fig. 1. Flow diagram of the search process.

health legislation. Three (27 %) did not have any national mental health policy, legislation, plan or program. The documents of each country are described in Table 1.

A national mental health policy/legislation was identified in six (55 %) countries of South-East Asia (Table 2). The Maldivian policy complied to the greatest extent with the WHO guidelines on mental health policies by receiving the highest 'yes' scores for all items of the Policy Checklist.

Across the two subsections of the Policy Checklist: the Maldivian policy addressed process and content issues to the greatest extent (Table 2).

A national mental health plan/program was identified in four (36 %) countries (Table 3). The Bangladeshi plan complied to the greatest extent with WHO guidelines on mental health plans.

Across the five sections of the Plan Checklist: Indian documents addressed process issues to the greatest extent; plans/programs of Bangladesh, India and Maldives scored the highest in the operational issues and strategies sections; the Maldivian plan scored the highest in the activities section; and the Bangladeshi plan addressed content issues to the greatest extent (Table 3).

From each checklist, data related to children and adolescents were disaggregated (Table 4 and Table 5). Of the Policy Checklist, none of the countries consulted child health groups prior to policy/legislation development. Intra-sectoral collaboration with child health divisions is comprehensively addressed in Sri Lankan documents. Child and adolescent health groups have been considered to a great degree in Indian and Maldivian documents.

Of the Plan Checklist, only India consulted child health groups to some extent prior to mental health plan/program development. Both Indian and Bangladeshi documents clearly indicate strategies for intra-sectoral collaboration with child or adolescent health divisions, while both these countries and Maldives considered inter-sectoral collaboration to a great degree.

Table 1
National Mental Health Policies, Legislation, Plans and Programs in Countries of the WHO South-East Asia Region.

Country	Policies and Legislation	Plans and Programs
Bangladesh	NA	National Mental Health Strategic Plan (2020–2030)
Bhutan	NA	National Mental Health Program (1997)
Democratic People's Republic of Korea	NA	NA
India	• National Mental Health Policy of India (2014) • Mental Health Act (2017)	• Guidelines for implementing District level activities under the National Mental Health Programme during the 12th Five Year Plan • Guidelines for implementing Tertiary/Central level activities under the National Mental Health Programme during the 12th Five Year Plan • National Mental Health Program (1982) • District Mental health Program 12th Plan (2012)
Indonesia	Law of the Republic of Indonesia Number 18 of 2014 About Mental Health	NA
Maldives	National Mental Health Policy (2015–2025)	Central and Regional Mental Health Services Development Plan
Myanmar	National Mental Health Policy and Strategic Plan for Mental Health (2021–2025)	NA
Nepal	NA	NA
Sri Lanka	National Mental Health Policy (2020–2030)	NA
Thailand	Mental Health Act, B.E. 2551 (2008, second amendment 2019)	NA
Timor Leste	NA	NA

National mental health policies, legislation, plans and programs in the countries of South-East Asia, as defined by the World Health Organisation. All documents meet the inclusion criteria of this review. NA: Not Applicable, where documents meeting the inclusion criteria of this review could not be identified.

Table 2
Mental health policies and legislations of South-East Asian countries and their compliance with components of the WHO Checklist for Evaluating a Mental Health Policy (Policy Checklist).

Countries		Process Issues (%)	Content Issues (%)	All Items of Checklist (%)
India	Yes (1)	6	37	31
	To Some Extent (2)	13	39	33
	No (3)	81	24	36
Indonesia	Yes (1)	31	22	24
	To Some Extent (2)	0	25	20
	No (3)	69	53	56
Maldives	Yes (1)	50	78	72
	To Some Extent (2)	19	15	16
	No (3)	31	7	12
Myanmar	Yes (1)	12	54	45
	To Some Extent (2)	19	24	23
	No (3)	69	22	32
Sri Lanka	Yes (1)	6	56	45
	To Some Extent (2)	0	17	14
	No (3)	94	27	41
Thailand	Yes (1)	13	15	15
	To Some Extent (2)	6	9	8
	No (3)	81	76	77

Sections of the Policy Checklist stratified according to South-East Asian countries and scale cores. Each cell represents the percentage of the policy/legislation in compliance with the WHO guidelines on mental health policies. Yes (1): where the policy/legislation complied with the Policy Checklist; To Some Extent (2): where the policy/legislation complied with the Policy Checklist to some extent; No (3): where the policy/legislation did not comply with the Policy Checklist.

4. Discussion

A majority of South-East Asian member states have developed and implemented a separate national mental health policy, plan, program or legislation. The degree to which adolescent mental health is incorporated in these documents is varied and, in most instances, limited. Furthermore, the documents' compliance with international standards are inconsistent across countries.

A diverse range of mental health legislation, policies, plans and programs were identified. The findings of this review are consistent with WHO findings that 8 countries in the South-East Asia region have a stand-alone mental health governance document (World Health Organization, 2020). A policy was the most used method of governance of a mental health system. A majority of documents were non-enforceable-either a policy, plan or program- highlighting strategies, actions and directions for mental health in the state's population. Only 3 countries, India, Indonesia and Thailand, established binding mental health legislation, separate to the country's general health legislation. This may be a wider indication of several challenges in mental health governance in this region. In most South-East Asian countries, mental health policy development is not prioritized from government authorities, the policies are extremely difficult to be approved through parliament, hence several countries have drafted new legislation awaiting approval and enactment (Sharan et al., 2017; Trivedi and Tripathi, 2015). Additionally, developing mental health legislation for a large multi-ethnic, multi-religious, multi-cultural population lacks clear guidelines and precedence, which

Table 3
Mental health plans and programs of South-East Asian countries and their compliance with components of the WHO Checklist for Evaluating a Mental Health Plan (Plan Checklist).

Countries		Process Issues (%)	Operational Issues (%)	Strategies (%)	Activities (%)	Content Issues (%)	All Items of Checklist (%)
Bangladesh	Yes (1)	12	100	67	43	54	49
	To Some Extent (2)	35	0	0	0	27	26
	No (3)	53	0	33	57	19	25
Bhutan	Yes (1)	18	0	17	14	20	19
	To Some Extent (2)	29	100	33	29	21	23
	No (3)	53	0	50	57	59	58
India	Yes (1)	30	100	67	29	34	35
	To Some Extent (2)	35	0	0	57	36	35
	No (3)	35	0	33	14	30	30
Maldives	Yes (1)	47	100	67	57	40	43
	To Some Extent (2)	12	0	33	14	18	18
	No (3)	41	0	0	29	42	39

Sections of the Plan Checklist stratified according to South-East Asian countries and scale scores. Each cell represents the percentage of the plan/program in compliance with the WHO guidelines on mental health plans. Yes (1): where the plan/program complied with the Plan Checklist; To Some Extent (2): where the plan/program complied with the Plan Checklist to some extent; No (3): where the plan/program did not comply with the Plan Checklist.

Table 4
Inclusion of Children and Adolescents in Mental Health Policies/Legislation of South-East Asian Countries.

Question	India	Indonesia	Maldives	Myanmar	Sri Lanka	Thailand
Q4. Has a thorough consultation process taken place with the following group?	No/Not at All	No/Not at All	No/Not at All	No/Not at All	No/Not at All	No/Not at All
- Child health						
Q18. To what extent do the areas for action comprehensively address intra-sectoral collaboration within the health sector? Does the policy:	To Some Extent	No/Not at All	To Some Extent	No/Not at All	Yes/ To a Great Degree	No/Not at All
(a) Emphasize collaboration with the [child health] division within the health sector	No/Not at All	No/Not at All	No/Not at All	No/Not at All	Yes/ To a Great Degree	No/Not at All
(b) Contain clear statements of what role the department will play in each area for action?						
Q20. Has the following group been considered: Children and adolescents?	Yes/ To a Great Degree	To Some Extent	Yes/ To a Great Degree	To Some Extent	To Some Extent	No/Not at All

Mental health policies/legislation and their compliance with components of the Policy Checklist that is relevant to children and adolescents, stratified according to country.

subsequently results in lesser prioritisation by government authorities to develop such legislation (Sharan et al., 2017; Trivedi and Tripathi, 2015).

There is very limited prioritisation of adolescent mental health in mental health documents of South-East Asian states. Eight countries considered adolescents in their documents to a varying degree. For example, Bangladeshi, Indian and Maldivian documents thoroughly discuss the development of school-based mental health programs, curricula, and other effective prevention and promotion strategies to specifically address adolescent mental health (Government of India, 1982; Government of India, 2012; Government of India, 2015; Government of People's Republic of Bangladesh, 2020; India Go, 2015; Ministry of Health Maldives, 2015). Contrastingly, documents from Sri Lankan and Myanmar only discusses adolescent mental health in terms of mental health of vulnerable groups (Ministry of Health Sri Lanka, 2020; The Republic of the Union of Myanmar, 2021). Similarly, the Indonesian legislation considers adolescent mental health in terms of institutionalization of adolescents with severe MHPs (Law of the Republic of Indonesia, 2014). Although population level epidemiological data on adolescent mental health in South-East Asian countries may be limited, (World Health Organization, 2017) the lack of incorporation of adolescents in the mental health governance documents of these countries is a significant missed opportunity for early intervention of MHPs (World Health Organization, 2017).

It is further evident through this review that mental health needs of young people in South-East Asia are not considered separately from mental health needs of adults. For example, while many groups were consulted throughout the policy development process, only in India were child health groups consulted prior to development of mental health governance documents (Government of India, 2012; Government of India, 2015; India Go, 2015). Further, only Indian, Sri Lankan and Bangladeshi documents clearly discuss intra-sectoral coordination with child health divisions within the health sector to address mental health of young people (Government of India, 1982; Government of India, 2012; Government of India, 2015; Government of People's Republic of Bangladesh, 2020; India Go, 2015; Ministry of Health Sri Lanka, 2020). While Maldivian and Bhutan documents simply mention this need (Ministry of Health Maldives, 2015; Royal Government of Bhutan, 1997). This aggregation of mental health needs of young people, with those of adults is often the case in resource constraint settings (Zhou et al., 2020). Adolescents should not be considered as passive recipients of mental health strategies targeted towards adults (Zhou et al., 2020). In addition to consultation, collaboration and coordination from child health groups/sectors, adolescent specific health groups that are distinct from child health groups should be given a separate voice during policy development (Zhou et al., 2020). This will align with the Mental Health Action Plan for the WHO South-East Asia region, which highlights the need for a strong, multisectoral approach to addressing mental health across the lifespan (World Health Organization, 2023–2030).

Documents identified in this review, inconsistently complied with international standards. Some documents included have been developed in a way to align to a certain degree with processes that may lead to their success. For example, needs assessments and consultation with key groups may have been conducted during development processes (Supplementary File 2). Further, content related to strategies and actions have been incorporated to most documents (Supplementary File 2). This

Table 5
Inclusion of Children and Adolescents in Mental Health Plans/Programs of South-East Asian Countries.

Questions	Bangladesh	Bhutan	India	Maldives
Q7. Has a thorough consultation process taken place with the following group? - Child health	No/Not at All	No/Not at All	To Some Extent	No/Not at All
Q29. Does the plan include relevant strategies and activities for intra-sectoral collaboration? (b) Is collaboration with the [child health] department within the health sector included in the plan?	Yes/ To a Great Degree	To Some Extent	Yes/ To a Great Degree	To Some Extent
Q30. Does the plan include relevant strategies and activities for intersectoral collaboration? (d) Have the following groups been considered? Children and adolescents?	Yes/ To a Great Degree	To Some Extent	Yes/ To a Great Degree	Yes/ To a Great Degree

Mental health plans/programs and their compliance with components of the Plan Checklist that is relevant to children and adolescents, stratified according to country.

may include mental health promotion and prevention strategies or actions for service delivery. However, implementation and funding were not thoroughly addressed by the mental health governance documents of a majority of countries. In this region it may be difficult to indicate how the mental health policy, program, plan, or legislation can be operationalised, implemented, or funded. This difficulty may be attributed to significant resource constraints (Sharan et al., 2017; Trivedi and Tripathi, 2015).

Resource constraints are underlined by government health funding in South-East Asia, which averages approximately 2 % of a state's GDP (Maddok et al., 2021). Of this, allocation towards mental health are as low as 0.06 % in India to 4 % in Thailand (Sharan et al., 2017). Renewed efforts to address mental health needs call for a tiered approach, which incorporates mental health promotion, prevention, early intervention and treatment (World Health Organization, 2023–2030). This is especially crucial to adolescents, for whom MHPs can manifest into adulthood (World Health Organization, 2023–2030). Hence early intervention and long-term promotion strategies are key (Kieling et al., 2011). In South-East Asia, limited funding poses significant barriers to implementing the tiered approaches. For example, of the already minimal funding towards mental health, 80–90 % is provided for hospital-based mental health services (Maddok et al., 2021). Moreover, these services are concentrated in urban areas, and are inaccessible or unaffordable to rural populations (Maddok et al., 2021). Funding limitations have further led to chronic shortages in mental health services and trained mental health professionals (Maddok et al., 2021). These resource limitations married with the mental health needs of a large diverse young population makes it difficult to estimate the operationality on ground of a mental health policy in this region, its implementation and exact funding needs. Consequently, a majority of documents identified in this review inconsistently complied with international standards for mental health policies.

This study had several strengths. Rigorous search strategies were used to identify mental health policies, plans, programs and legislation, which are currently operational, with national jurisdiction. Relevant documents from all countries of South-East Asia were screened. The documents were evaluated using a comprehensive WHO developed checklist to assess compliance with international standards.

Nevertheless, there were some limitations. First, although considerable effort was made to capture all evidence, only official documents translated to English were included. Countries noted as not having a mental health governance document may have a policy, plan, program or legislation in a language other than English. This limitation will influence the findings of this study. Second, only documents that are currently operational in 2024 were included. There may be relevant policies, plans, programs or legislation that have lapsed operationality in 2023 and new updates of such documents are awaiting parliamentary approval in draft stages.

The findings of this review have several important implications. First, adequate binding mental health legislation, separate from a country's health legislation is needed urgently in several countries currently completely missing it. Next, mental health governance documents must incorporate strategies and actions specifically targeting the unique mental health needs of adolescents. These targets cannot be achieved without the involvement of adolescent groups throughout policy formulation. Third, resource constraints in South-East Asia needs to be addressed. Next, it is evident through this review that mental health policies of this region- predominantly made up of LMICs- cannot solely be evaluated and its compliance assessed by one international standard against policies of high-income countries. This is due to the difference in operationality of these policies and resources on ground in South-East Asia compared to high-income nations. Guidelines for mental health policy development and evaluation that is catered to LMICs should be developed so policies can be evaluated and enhanced accordingly. Finally, this review can be used as a resource for researchers, policy makers and organizations that are involved in developing mental health policy in the South-East Asia region.

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CRediT authorship contribution statement

Tran Thach: Writing – review & editing, Supervision, Methodology, Investigation, Conceptualization. **Mudunna Chethana:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Fisher Jane:** Writing – review & editing, Supervision, Investigation, Conceptualization. **Chandradasa Miyuru:** Writing – review & editing, Supervision, Investigation, Conceptualization. **Antoniades Josefine:** Writing – review & editing, Supervision, Investigation, Conceptualization.

Declaration of Competing Interest

None.

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CM contributed to conception and design of the work, data collection, data analysis and interpretation, drafting the article, critical revisions of the article and final approval of the version to be submitted. TT contributed to supervision, design of the work, data interpretation, critical revisions of the article and final approval of the version to be

submitted. JA contributed to supervision, design of the work, data interpretation, critical revisions of the article and final approval of the version to be submitted. MC contributed to supervision, design of the work, data interpretation, critical revisions of the article and final approval of the version to be submitted. JF contributed to supervision, design of the work, data interpretation, critical revisions of the article and final approval of the version to be submitted.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.ajp.2025.104386.

References

Bhugra, D., Pathare, S., Joshi, R., Kalra, G., Torales, J., Ventriglio, A., 2018. A review of mental health policies from Commonwealth countries. Int. J. Soc. Psychiatry 64 (1).

Funk, M.K., Drew, N.J., 2015. Mental health policy and strategic plan. World Health Organ. East. Mediterr. Health J. 21 (7).

Government of India. National Mental Health Programme (NMHP). In: Health Mo, editor. India 1982.

Government of India. XIIth Plan District Mental Health Programme. India 2012.

Government of India. Guidelines for implementing District level activities under the National Mental Health Programme during thr 12th Five Year Plan. In: Welfare DoHaF, editor. India: Ministry of Health and Family Welfare; 2015.

Government of People's Republic of Bangladesh. National Mental Health Strategic Plan 2020-2030. In: Diseases DoN-C, editor. Bangladesh: Ministry of Health and Family Welfare; 2020.

India Go. Guidelines for implementing Tertiary/Central level activities under the National Mental Health Programme during thr 12th Five Year Plan. In: Welfare DoHaF, editor. India: Ministry of Health and Family Welfare; 2015.

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., et al., 2011. Child and adolescent mental health worldwide: evidence for action. Lancet 378 (9801), 1515–1525.

Law of the Republic of Indonesia Number 18 of 2014 Regarding Mental Health, (2014).

Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E.C., Breuer, E., Chandra, P., et al., 2018. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. Lancet Psychiatry 5 (4), 357–369.

Maddok, A., Blair, C., Ean, N., Best, P., 2021. Psychological and social interventions for mental health issues and disorders in Southeast Asia: a systematic review. Int. J. Ment. Health Syst. 56.

Ministry of Health Maldives. National Mental Health Policy 2015-2025. In: Agency HP, editor. Maldives: World Health Organization; 2015.

Ministry of Health Sri Lanka. National Mental Health Policy 2020-2030. Sri Lanka 2020.

Royal Government of Bhutan. National Mental Health Program. Bhutan: Royal Government of Bhutan; 1997.

Saxena, S., Sharan, P., 2008. Int. Encycl. Public Health.

Sharan, P., Sagar, R., Kumar, S., 2017. Mental health policies in South-East Asia and the public health role of screening instruments for depression. WHO South-East Asia J. Public Health 6 (1), 5–11.

The Republic of the Union of Myanmar. National Mental Health Policy and Strategic Plan for Mental Health. Myanmar: Ministry of Health and Sports; 2021.

Trivedi J.K., Tripathi A. Mental Health in South Asia: Ethics, Resources, Programs and Legislation. 2 ed. India: Springer; 2015.

Vijayakumar, L., 2023. The need for mental health research in Southeast Asia. Lancet Reg. Health Southeast Asia 13.

World Health Organization. Monitoring and evaluation of mental health policies and plans. Geneva; 2007.

World Health Organization, 2017. Mental Health Status of Adolescents in South-East Asia: Evidence for Action. World Health Organization Regional Office South-East Asia, New Delhi.

World Health Organization. Mental Health Atlas. Geneva: World Health Organization; 2020.

World Health Organization. Mental health action plan for the WHO South-East Asia Region 2023–2030.

World Health Organization, 2024a. About WHO in the South-East Asia Region. World Health Organization Regional Office for South-East Asia. ⟨https://www.who.int/southeastasia/about⟩ ([Available from).

World Health Organization. WHO MiNDbank, 2024b.

Zhou, W., Ouyang, F., Nergui, O.E., Bangura, J., B, Acheampong, K., Massey, I.Y., et al., 2020. Child and adolescent mental health policy in low- and middle-income countries: challenges and lessons for policy development and implementation. Front. Psychiatry 11.