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Annual report of the Special Representative of the Secretary-General on Violence against Children

Summary

In her report, the Special Representative of the Secretary-General on Violence against Children, Najat Maalla M'jid, outlines the impact that violence has on children's mental health and provides an overview of major initiatives and developments to sustain and scale up efforts to safeguard children's freedom from violence and advance implementation of the 2030 Agenda for Sustainable Development.

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I. Introduction

1. In the present report, the Special Representative of the Secretary-General on Violence against Children reviews developments she has promoted at the global, regional and national level and provides an overview of the results achieved. She also includes a thematic part that focuses on the impact that violence has on children's mental health.

2. Guided by General Assembly resolution 62/141, by which the Assembly established the mandate, the Special Representative is a global, independent advocate for the prevention and elimination of all forms of violence against children. On 1 July 2019, Najat Maalla M'jid took up the mandate of Special Representative.

3. A number of important milestones were marked in 2019: the tenth anniversary of the mandate, the thirtieth anniversary of the adoption of the Convention on the Rights of the Child and the review of the first four-year phase of implementation of the 2030 Agenda for Sustainable Development. For this purpose, a thematic report, entitled *Keeping the Promise: Ending Violence against Children by 2030*,[1] was developed by the Office of the Special Representative in cooperation with a wide range of partners, including children themselves. Thirty years after the adoption of the Convention and five years after the adoption of the 2030 Agenda, there is evidence in the report of some progress on children's rights, including children's protection from all forms of violence, but progress is too slow and there is a need for a greater sense of urgency for action.

4. Violence against children remains hidden and pervasive, which undermines the achievement of the Sustainable Development Goals and full implementation of the 2030 Agenda. It is estimated that up to 1 billion children aged from 2 to 17 have experienced physical, sexual, or emotional violence or neglect in the past year,[2] and that thus half of the world's children are victims of violence each year,[3] while 300 million children between two and four years of age are victims of physical and psychological abuse. Globally, one in five victims of human trafficking is a child and two in every five modern slaves are children.[4] Of increasing concern is children's safety when they are online.

5. The Special Representative led the United Nations task force that supported the development of the United Nations global study on children deprived of liberty. The study, launched on 9 November 2019, found that 7 million children were deprived of their liberty worldwide. Of them, 410,000 children were held in jails or prisons, 330,000 in immigration detention and between 430,000 and 680,000 were in institutions that meet the legal definition of deprivation of liberty.[5]

6. The Special Representative is concerned that these already staggering numbers of children affected by violence may be further increased through current disturbing trends that include climate change, protracted conflicts, humanitarian disasters, increasing numbers of children on the move, new technologies, the spread of terrorism and violent extremism, as well as harmful social norms, such as increasing disparities, poverty, social exclusion and discrimination.

7. Violence leaves long-lasting scars on children's lives. It often has irreversible consequences on their development and well-being and limits their opportunities to thrive later in life. It also weakens the very foundation of social progress, generating huge costs

[1] Available at https://violenceagainstchildren.un.org/sites/violenceagainstchildren.un.org/files/keeping_the_promise.pdf.

[2] See World Health Organization (WHO) key facts on violence against children, available at www.who.int/news-room/fact-sheets/detail/violence-against-children.

[3] Susan Hillis and others, "Global prevalence of past year violence against children: a systematic review and minimum estimates", *Pediatrics*, vol. 137, No. 3 (March 2016).

[4] International Labour Office and Walk Free Foundation, "Global estimates of modern slavery: forced labour and forced marriage" (2017).

[5] See https://omnibook.com/Global-Study-2019.

for society, according to some estimates up to $7 trillion per year, slowing economic development and eroding the human and social capital of States.[6]

8. In the present report, the Special Representative outlines the urgent need for stronger action if the targets of the Sustainable Development Goals related to violence and mental health are to be achieved and obligations under the Convention on the Rights of the Child fulfilled. A failure to tackle the issues of mental health and violence against children will therefore undermine the achievement of many targets under the 2030 Agenda for Sustainable Development.

II. Accelerating action to end violence against children by 2030

9. Thirty years ago, in the Convention on the Rights of the Child, understanding of children's agency and their power was reframed and children went from being passive recipients of services to individual rights holders with a voice. The Convention is one of the most comprehensive human rights instruments and this holistic approach was also adopted in the 2030 Agenda for Sustainable Development and its Sustainable Development Goals. The Goals are a crucial tool for realizing the rights in the Convention and they cannot be achieved if the rights in the Convention are not fulfilled.

10. Sustainable Development Goal 16 calls for the promotion of peaceful, just and inclusive societies as enablers of sustainable development, hence making clear the links between human rights and development. It also includes a distinct target (16.2) on ending abuse, exploitation, trafficking and all forms of violence against and torture of children. Goal 16 underpins all the other Goals: without increased equal access to justice, security and inclusiveness, without reaching vulnerable populations and paying specific attention to children, it will be impossible to create conditions for sustaining peace and development.

11. At the high-level political forum on sustainable development in July 2019, 40 out of 47 voluntary national reviews included references to the protection of children from violence. The reviews documented a wide range of measures, including the adoption of national plans and policies; the enactment or reform of legislation; the strengthening of institutions and partnerships; the training of professionals; and the consolidation of data and research. In addition, a number of States reported in their reviews various initiatives in which children were participating as stakeholders in the implementation processes of the Sustainable Development Goals.

12. The Special Representative delivered a statement at the opening session of the high-level forum on the subject of "Putting children at the heart of the 2030 Agenda", in which she emphasized that violence was a cross-cutting concern on the 2030 Agenda because of its negative impact on every aspect of development and that ending it must remain a priority. In closing, she posed a key question: if the costs of inaction on violence against children are so high and the solutions are known, why does it continue? What must be done to move better, faster and further in bringing it to an end? This strong message was also conveyed to the summit on the Sustainable Development Goals in September 2019.

13. The Special Representative was actively engaged in the review processes for the 2030 Agenda on Sustainable Development to help ensure that distinct attention was given to the violence-related targets of the Sustainable Development Goals and their role in achieving the vision of the 2030 Agenda. That included launching a call for action on justice for children, together with several partners, to promote accelerated progress through a greater focus on justice for children.[7]

14. The Special Representative also participated in a number of high-level events at which she promoted the 2030 Agenda, including at a ministerial conference on access to justice in The Hague; her cross-regional meeting on violence against children in Addis

[6] See Overseas Development Institute, "The costs and economic impact of violence against children" (September 2014).

[7] See Office of the Special Representative and others, "Justice for children, justice for all: the challenge to achieve SDG16+" (June 2019).

Ababa; as a key note speaker at the opening of the high-level political forum; at the high-level meeting on access to justice at the Organization for Economic Cooperation and Development; at a conference in Oman organized by the International Society for the Prevention of Child Abuse and Neglect; as a speaker at the high-level meeting on children and the digital world; and at the public launch of the report by the Broadband Commission for Sustainable Development on child online safety.

15. In November 2019, the Special Representative participated in a high-level meeting hosted by the Pontifical Academy of Sciences and the Interfaith Alliance for Safer Communities on the theme of "Promoting digital child dignity: from concept to action" and in a round table on artificial intelligence and child safety online organized by the World Childhood Foundation and the Global Child Forum. On both occasions, the Special Representative emphasized the crucial need to empower children to act as agents of change in advancing child protection online and the need for stronger action, coordination and accountability for key actors in this field.

16. In 2019, the Special Representative made country visits to China, El Salvador, Mozambique and Oman. During her visit to El Salvador, the Special Representative met with the President and the First Lady to discuss the high prevalence of violence in the community and the importance of having a comprehensive child protection system in place. She also met with children and representatives of civil society and the National Council for Children and Adolescents.

17. In Oman, the Special Representative met with government representatives, visited a child welfare centre, the premises of a hotline, a school and a health clinic to observe and provide feedback on how the pilot system for case management of violence against children is operating. Discussions focused on the need to ensure that child victims of violence are placed at the centre of all interventions and to ensure that evidence, including through interviews, is gathered in a child-friendly way that minimizes their retraumatization.

18. During her visit to China, the Special Representative gained greater awareness of the positive steps taken by the Government to protect children in contact with the justice system. The Special Representative encourages all United Nations agencies in China to engage actively in the work on violence against children and include violence against children in the forthcoming common country assessment and sustainable development cooperation framework.

19. During her visit to Mozambique, the Special Representative met with high-level political leaders, senior government officials, the President of the parliament, children, representatives of civil society, the United Nations country team and donors, and visited child protection services in order to support national efforts to end violence against children, including harmful practices. She welcomed the efforts made by the Government and encouraged the Government and the United Nations country team to include violence against children in the five-year national strategy for the period 2020–2024, in the forthcoming country assessment and in the sustainable development cooperation framework.

Amplifying the voices of children

20. The Special Representative visited the largest World Scout jamboree, where she had the chance to interact with 40,000 children and young people from 150 countries. She commended the work of the organization in its efforts to protect children from violence by creating a mandatory training programme entitled "Safe from Harm" for adult scout leaders.

21. The first Asian children's summit on the theme of "Upholding justice for children and leaving no child behind" was held from 25 to 30 November in Bangkok. It gathered together child delegates from 22 countries in Asia and the Special Representative provided a video message to the event.

22. The views of children were also captured in the report of the Special Representative, which builds on interviews with several hundred girls and boys deprived of liberty and who have a parent or guardian deprived of liberty in eight Latin American countries.[8] Based on the recommendations from the children consulted, a set of materials was developed to promote the integration of a child rights approach into the penitentiary system.[9]

23. In March 2019, the Special Representative issued a child-friendly publication in collaboration with Save the Children on two joint general comments adopted by Committee on the Rights of the Child and the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families regarding the safeguarding of the rights of children in the context of international migration.[10]

24. The Special Representative welcomes the growing attention to voices of youth. However, it is crucial also to ensure a focus on children as a distinct group, as defined by the Convention on the Rights of the Child. The unique perspective of children cannot be replaced and we need to keep a focus on the whole life cycle of children and young people.

III. Reinforcing regional processes in support of the implementation of the 2030 Agenda for Sustainable Development

25. The Special Representative addressed member States of the Organization of American States during the twenty-second Pan American Congress on Children and Adolescents held in Cartagena, Colombia, from 28 to 30 October 2019, at which an action plan on child rights for the period 2020–2023 was adopted. The Special Representative stressed the importance of accelerating the implementation of the 2030 Agenda through strengthening national child protection systems.

26. The Special Representative provided inputs to the development by the Caribbean Community of a strategy on the prevention of violence against children for the period 2020–2029.

27. The Office of the Special Representative participated in the fifteenth session of the Committee on Violence against Children of the League of Arab States held in Nouakchott from 30 September to 2 October 2019. The Committee commissioned the secretariat of the League to prepare the fourth comparative report on the implementation by the Arab world of the recommendations of the United Nations study on violence against children (A/61/299) by 2021, in cooperation with the Office of the Special Representative.

28. The Special Representative provided inputs to the report of the United Nations Regional Centre for Peace, Disarmament and Development in Latin America and the Caribbean and participated in the related regional seminar on firearms in schools, held in Lima on 22 and 23 October, which mobilized technical experts working in ministries responsible for children's rights and on security and disarmament in Latin America and the Caribbean.

29. In November 2019, the Council of Europe hosted a high-level conference to mark the thirtieth anniversary of the Convention on the Rights of the Child and the midterm evaluation of the strategy for the rights of the child, in which the Special Representative participated as a keynote speaker. The mid-term evaluation found that overall, the priorities and actions of the strategy remained well-suited to the challenges facing the realization of children's rights in Member States. However, some scope for further action was noted in

[8] Office of the Special Representative, "Children speak about the impact of deprivation of liberty: the case of Latin America" (2016).

[9] Available at https://violenceagainstchildren.un.org/sites/violenceagainstchildren.un.org/files/children_declarations/child_participation/entre_hechos_y_derechos.pdf (in Spanish).

[10] Available at https://violenceagainstchildren.un.org/sites/violenceagainstchildren.un.org/files/children_declarations/child_participation/finalmis_derechos_viajan_conmigo_final.pdf (in Spanish).

areas such as deinstitutionalization, child poverty, environmental protection, children's mental health and child activists and human rights defenders.

30. The Special Representative supported the development of a report by the African Child Policy Forum entitled *Sexual Exploitation of Children in Africa, a Silent Emergency*[11] and participated in its launch in Maputo.

IV. Violence against children: a review of the research on its impact on children's mental health

A. Violence harms children's mental health

31. The Convention on the Rights of the Child guarantees every child's right to freedom from violence and to the highest attainable standard of mental health. The 2030 Agenda for Sustainable Development equally commits Member States to ending all forms of violence and promoting mental health and well-being.

32. Despite these obligations and commitments, children are increasingly exposed to violence, with a severe influence on their mental well-being as a result. This exposure can be direct, such as experiencing physical, sexual or emotional violence in their community, at home or at school, or indirect, such as witnessing violence and hearing or watching violent content online. Moreover, there is now a recognition that interpersonal violence spills from one setting to another, resulting in what is commonly known as poly-victimization.

33. Evidence from high-, middle- and low-income countries indicates clearly that violent experiences increase the risk of negative mental health consequences. These include depression, post-traumatic stress disorder, borderline personality disorder, anxiety, sleep and eating disorders, suicide and suicide attempts. In addition, exposure to childhood violence can increase a wide range of adult psychopathologies, including mood, anxiety, behaviour and substance disorders.[12]

34. Research has consistently shown that childhood adversity and violence are key risk factors for the onset and persistence of mental disorders. Exposure to adverse childhood experiences, such as violence, can be traumatic, evoking toxic stress responses that have immediate and long-term adverse physiological and psychological effects.[13]

35. The impact of violence on the architectural development of children's brains is of particular concern, as this is linked with consequent emotional and behavioural disorders, poor health and poor social outcomes.[14] Those effects are especially concerning in the light of the stark reality that more than 1 billion children – half of all children in the world – are exposed to violence every year.

36. Research has found associations between physical punishment and negative effects on children's mental health, including behaviour disorders, anxiety disorders, depression and hopelessness. The available evidence also indicates that there is an association between physical punishment and increased aggression, reduced empathy and poor moral internalization.[15]

[11] Available from http://africanchildforum.org/en/index.php/en/special-pages/child-sexual-exploitation.html.

[12] See Susan D. Hillis, James A. Mercy and Janet R. Saul, "The enduring impact of violence against children", *Psychology, Health & Medicine*, vol. 22, No. 4 (2017).

[13] Ibid.

[14] See Andrew S. Garner and others, "Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health", *Pediatrics*, vol. 129, No. 1 (January 2012).

[15] See Global Initiative to End All Corporal Punishment of Children, "Corporal punishment of children: review of research on its impact and associations" (June 2016).

37. Bullying has been linked to a variety of negative child well-being outcomes, including poorer education results and mental health problems, such as anxiety and depression symptoms, suicidal thoughts and actions, self-harm and violent behaviour, which have been found to persist into adulthood. Moreover, bullying is not only a concern for the victim's well-being; research has shown that being the child that bullies is also associated with poorer child and later-life outcomes. In particular, bullies have been shown to exhibit higher antisocial and risk-taking behaviour, as well as later criminal offending. Importantly, being both a perpetrator of bullying and a victim further compounds the risks for psychological and conduct problems.[16]

38. Online exposure of children to violence and to inappropriate content (such as child abuse material, pornography, hate-speech material and material advocating unhealthy or dangerous behaviour, such as self-harm, suicide and anorexia) is consistently associated with problem behaviour, such as increases in aggression, anxiety and post-traumatic stress symptoms. Children could also end up with lower levels of empathy and compassion for others. Adolescents exposed to high levels of violence reported high levels of anger and depression. They also reported higher rates of wanting to hurt or kill themselves compared to adolescents in groups with a lower exposure to violence.[17] Equally, being online brings risks related to contact and conduct, as in cases where children are induced or coerced into sharing sexual images of themselves that are then used for extortion or to humiliate them publicly.

39. More generally, experiencing sexual violence can have a range of adverse outcomes, including depression, post-traumatic stress disorder, suicide risk, substance use, teenage pregnancy, risky sexual behaviour, poorer educational outcomes and poorer self-rated health.[18] The psychological and emotional impact of child sexual abuse can be particularly devastating because the surrounding secrecy, shame and stigma mean children who experience this often have to cope alone. In the context of a culture of disbelief or victim blaming, where victims are seen as responsible, shamed and shunned, it will be very difficult for a child or young person to tell anybody what has happened.[19]

40. The impact of institutionalization and deprivation of liberty can include severe developmental delays, disability, irreversible psychological damage and increased rates of suicide and recidivism (A/61/299, para. 54).

41. Harmful practices can have both immediate and prolonged negative psychological consequences. With regard to female genital mutilation, for example, studies have found that girls and women who have experienced it may have higher rates of mental health disorders, particularly depression, anxiety disorders, post-traumatic stress disorder and somatic (physical) complaints with no organic cause (for example, aches and pains).[20]

42. Emergencies create a wide range of problems experienced at the individual, family, community and society levels. Emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality. [21] Parents and other attachment figures may be killed, disabled or traumatized; schools may be damaged or become targets for military attack; and opportunities for play and friendship are often diminished as families are displaced and safe

[16] See Office of the Special Representative, *Ending the Torment: Tackling Bullying from Schoolyard to Cyberspace* (October 2016).

[17] See Daniel J. Flannery and Mark I. Singer, "Here's how witnessing violence harms children's mental health", available from http://theconversation.com/heres-how-witnessing-violence-harms-childrens-mental-health-53321.

[18] Sophie Khadr and others, "Mental and sexual health outcomes following sexual assault in adolescents: a prospective cohort study", *The Lancet Child and Adolescent Health*, vol. 2, No. 9 (September 2018).

[19] Lorraine Radford, Debra Allnock and Patricia Hynes, *Promising Programmes to Prevent and Respond to Child Sexual Abuse and Exploitation* (New York, UNICEF, 2015).

[20] WHO, *Care of Girls and Women Living with Female Genital Mutilation: a Clinical Handbook* (Geneva, 2018).

[21] Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (Geneva, 2007).

communal spaces disappear. Such situations can induce problems of a psychological nature, such as grief, non-pathological distress, depression and anxiety disorders, including post-traumatic stress disorder. Cumulative trauma experienced pre- and post-migration also contributes to overall child distress.[22]

43. As noted by the World Health Organization (WHO), mental health is more than the absence of mental disorders; mental health is fundamental to health and overall well-being.[23]

44. According to WHO, up to 50 per cent of mental disorders during adulthood have their onset in adolescence and up to 20 per cent of children and adolescents experience mental disorders.[24] An important problem is that about 70 per cent of children and adolescents with mental disorders do not receive an appropriate intervention at the right time.[25]

45. Despite this grave situation, mental health issues among children and adolescents are often neglected owing to lack of awareness or existing stigma of mental disorders and they remain untreated. If left untreated, mental disorders may have far-reaching negative impacts on a young person's development, educational attainment and transition to adulthood.[26] Mental disorders at a young age can lead to discrimination, stigma and exclusion, and may even result in limited access to social, education and health services.

46. The lack of priority accorded to child and adolescent mental health is also reflected in the limited global coverage of prevalence data for mental disorders in this group. Average global coverage of prevalence data for mental disorders in children and adolescents aged 5 to 17 was 6.7 per cent. Of 187 countries, 124 had no data for any disorder. Without focused strategies to address the paucity of epidemiological data, poor coverage in both high-income countries and low- and middle-income countries will present a major challenge for child and adolescent mental health advocacy and the planning and allocation of the scarce resources available for child and adolescent mental health.[27]

47. Mental health is also a major concern for children themselves. In its report entitled "Voices of children and young people: child helpline data for 2017 & 2018", Child Helpline International indicated that the two most significant concerns for children contacting its member helplines related to abuse and violence on the one hand and to mental health on the other. Suicidal thoughts, fear and anxiety were the most significant issues children and young people talked about in relation to mental health. Physical and emotional abuse were the most significant issues in the abuse and violence category. The findings were based on data received from child helplines in 84 countries and territories around the world, underlining their global relevance.

B. Main negative effects of violence on children's mental health

48. In considering the impact of violence on children's mental health, it is important to recall the different types of negative effects it can have, as well as the differences between children's experience of violence across the life course.

[22] Teena M. McGuinness and Simone C. Durand, "Mental health of young refugees", *Journal of Psychosocial Nursing and Mental Health Services*, vol. 53, No. 12 (December 2015).

[23] WHO, "Mental health action plan 2013–2020" (2013).

[24] See WHO key facts on adolescent mental health, available at www.who.int/news-room/fact-sheets/detail/adolescent-mental-health.

[25] Mental Health Foundation, "Children and young people", available at www.mentalhealth.org.uk/a-to-z/c/children-and-young-people.

[26] See WHO key facts on adolescent mental health.

[27] See H.E. Erskine and others, "The global coverage of prevalence data for mental disorders in children and adolescents", *Epidemiology and Psychiatric Sciences*, vol. 26, No. 4 (August 2017).

49. Research has demonstrated that the most commonly reported problems fall into three categories: behavioural and emotional, cognitive and attitudinal, and long-term problems.[28]

50. In terms of behavioural and emotional disorders, research has found that those who are exposed to violence during their lifetime, including violence at home, violence in the community and war trauma exposure, are more likely to develop mental health problems including post-traumatic stress disorder, depression, psychological distress, aggression and significantly harmful effects on the development process.[29]

51. Children tend to either externalize (exhibiting greater levels of aggression, rule-violation and acting out) or they internalize (suffering from increased anxiety, depression and moodiness). For example, in various studies it has been reported that neglected children are more likely to suffer from behavioural, cognitive and internalizing problems, as well as physical and mental health problems.[30]

52. In terms of externalizing disorders, one consequence of experiencing trauma and violence during childhood can be the adoption of behaviour that poses health risks. Drug and alcohol use by children has risen globally and in the context of children should be viewed as a means of coping and managing negative emotions.[31] Children who experience violence and maltreatment in one setting are at risk of also experiencing violence in other settings.[32] The external expression of mental health symptoms, such as aggressive or antisocial behaviour, is more likely to result in increased peer victimization.

53. As regards internalizing disorders, in a study carried out in Norway, all combinations of childhood violence were significantly associated with anxiety or depression. Among participants exposed to one childhood violence category, those exposed to neglect and/or psychological violence reported more anxiety or depression than those exposed to sexual abuse alone or to family violence alone. Of those who were exposed to two childhood violence categories, those exposed to neglect or psychological violence in combination with sexual abuse and/or family violence reported more anxiety or depression than individuals reporting a combination of sexual abuse and family physical violence. Individuals experiencing three childhood violence categories had the highest anxiety or depression scores.[33]

54. There is also now convincing evidence of a causative association between peer bullying and depression, anxiety and self-harm.[34] Peer bully victims are at increased risk of internalizing disorders, whereas peer bullies are at increased risk of externalizing disorders,

[28] See Jane G. Stapleton and others, "The mental health needs of children exposed to violence in their homes", New Hampshire Coalition against Domestic and Sexual Violence.

[29] See, for example, Kevin Fiscella and Harriet Kitzman H. "Disparities in academic achievement and health: the intersection of child education and health policy", *Pediatrics*, vol. 123, No. 3 (March 2009); and Steven A. Haas and Nathan Edward Fosse, "Health and the educational attainment of adolescents: evidence from the NLSY97", *Journal of Health and Social Behavior*, vol. 49, No. 2 (June 2008).

[30] See Dexter R. Voisin, Torsten B. Neilands and Shannon Hunnicutt, "Mechanisms linking violence exposure and school engagement among African American adolescents: examining the roles of psychological problem behaviors and gender", *American Journal of Orthopsychiatry*, vol. 81, No. 1 (January 2011); and Vangie Ann Foshee and others, "A longitudinal examination of psychological, behavioral, academic, and relationship consequences of dating abuse victimization among a primarily rural sample of adolescents", *Journal of Adolescent Health*, vol. 53, No. 6 (December 2013).

[31] See Kevin D. Murphy and others, "'You don't feel': the experience of youth benzodiazepine misuse in Ireland", *Journal of Psychoactive Drugs*, vol. 50, No. 2 (2018).

[32] See David Finkelhor, Richard K. Ormrod and Heather A. Turner, "Poly-victimization: a neglected component in child victimization", *Child Abuse & Neglect*, vol. 31 (2007).

[33] See Siri Thoresen and others, "Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population", *European Journal of Psychotraumatology*, vol. 6, No. 1 (January 2015).

[34] See William E. Copeland and others, "Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence", *JAMA Psychiatry*, vol. 70, No. 4 (April 2013).

with peer bully victims suffering the greatest adult consequences, including both more internalizing and externalizing disorders.[35]

55. Peer victimization has been specifically associated with an elevated risk of anxiety disorders, depression, self-harm, suicidal ideation and suicide attempts, even after accounting for other major childhood risk factors, trauma and genetic liability.[36] Research on a sample of over 6,900 children from the Avon longitudinal sample of parents and children in the United Kingdom of Great Britain and Northern Ireland found that sibling bullying increased the risk of depression, anxiety and self-harm twofold, with results remaining similar in strength for depression and self-harm even after accounting for a range of childhood confounders.[37]

56. The effects of sibling and peer bullying were found to be cumulative for depression, suicidal ideation and suicidal self-harm. Peer and sibling bullying are traumas that should be considered on a par with traumas such as physical or sexual abuse.[38]

57. Those who witness or are victims of violence can show symptoms of post-traumatic stress disorder similar to those of soldiers coming back from war, with the distress symptoms increasing according to the number of violent acts witnessed or experienced. Symptoms included distractibility, intrusive and unwanted fears, and thoughts and feelings of not belonging.[39]

58. As regards impairments to cognitive functioning, evidence shows that physical punishment negatively impacts intellectual learning. School violence can severely hamper a child's ability to learn and adversely affect their development.[40] Previous studies conducted in East Africa indicated that harsh punishment was related to negative consequences, including internalizing and externalizing problems, poor cognitive functioning and poor school performance.[41] Researchers are also finding that physical punishment is linked to slower cognitive development and adversely affects academic achievement. In addition, physical punishment can cause alterations in the dopaminergic regions associated with vulnerability to the abuse of drugs and alcohol.

59. Children and adolescents exposed to chronic childhood trauma show a significant risk of increasing mental health disorders with subsequent poor academic achievement.[42] Exposure to community violence inversely affects school engagement and performance when mental health disorders are included.[43] Mental health symptoms and disorders that predict poor academic achievement are post-traumatic stress disorder, anxiety, aggressive behaviour and depression. Reviews show that there are elevated levels of violence experienced within institutions and negative cognitive effects associated with

[35] See Slava Dantchev and others, "The independent and cumulative effects of sibling and peer bullying in childhood on depression, anxiety, suicidal ideation, and self-harm in adulthood", *Frontiers in Psychiatry*, vol. 10 (2019).

[36] Ibid.

[37] Ibid.

[38] Ibid.

[39] See Silje Kolltveit and others, "Risk factors for PTSD, anxiety, and depression among adolescents in Gaza", *Journal of Traumatic Stress*, vol. 2, No. 2 (April 2012).

[40] See Soraya Lester, Cayleigh Lawrence and Catherine L. Ward, "What do we know about preventing school violence? A systematic review of systematic reviews", *Psychology, Health & Medicine*, vol. 22, supplement No. 1 (2017).

[41] See Tobias Hecker and others, "Child neglect and its relation to emotional and behavioral problems: a cross-sectional study of primary school-aged children in Tanzania", *Development and Psychopathology*, vol. 31, special issue No. 1 (February 2019).

[42] See Melissa K. Holt, David Finkelhor and Glenda Kaufman Kantor, "Multiple victimization experiences of urban elementary school students: associations with psychosocial functioning and academic performance". *Child Abuse and Neglect*, vol. 31, No. 5 (May 2007).

[43] See Danielle R. Busby, Sharon F. Lambert and Nicholas S. Ialongo, "Psychological symptoms linking exposure to community violence and academic functioning in African American adolescents", *Journal of Youth and Adolescence*, vol. 42, No. 2 (February 2013).

institutionalization, especially for younger children and those who spend long periods in institutions.[44]

60. As regards long-term effects, exposure to trauma has been associated with depression, low self-esteem and substance abuse in late adolescence and early adulthood. Adverse childhood experiences can also compromise the development of healthy coping strategies, which can in turn affect health behaviour, physical and mental health and life opportunities and bring on premature death.[45] Adverse childhood experiences have been linked to increased risk for alcohol and substance use disorders, suicide, mental health conditions, heart disease, other chronic illnesses and health risk behaviour throughout life.

61. Adverse childhood experiences have also been linked to reduced educational attainment, employment and income, which directly and indirectly affect health and well-being. At least 5 of the 10 leading causes of death have been associated with exposure to adverse childhood experiences, including several contributors to declines in life expectancy.[46] Depression, heavy drinking, smoking, lower educational attainment, lack of health insurance and unemployment are significantly associated with them.[47]

62. Cumulative exposure to violence in more than two contexts (for example, witnessing violence at home, sexual abuse, parenting stress) leads to greater behavioural and emotional problems in children, as well as post-traumatic stress disorder.[48]

63. One study found that for both men and women, there was a strong and significant relationship between childhood violence and violence in adulthood that was not restricted to violence within a similar category. Childhood exposure was associated with a 2.2–5 times higher occurrence of adult violence.[49]

C. Differences between children's experience of violence across the life cycle

64. The nature of the impact of violence on children's mental health depends on their experience of violence across the life course.

65. The experience of violence can set in as early as pregnancy, with a high risk of problems in the child's nervous system and brain. Domestic violence against pregnant women by their partners, spouses and other members of the family is the most substantial risk before birth.

66. Normal and healthy development of infants through to preschool age depends upon secure relationships with caregivers. Disruption of this process, for instance by exposure to violence, can interfere with all aspects of children's development. More specifically, children may not acquire a healthy level of trust and autonomy.[50] In infancy, secure attachment may be derailed, sleep and eating disturbances introduced and even brain development may be altered.

67. Pre-schoolers have not achieved the ability to control their own emotions. The literature sets out some of the behavioural effects of being exposed to violence at this age,

[44] Lorraine Sherr, Kathryn J. Roberts and Natasha Gandhi, "Child violence experiences in institutionalised/orphanage care", *Psychology, Health & Medicine*, vol. 22, supplement No. 1 (2017).

[45] Melissa T. Merrick and others, "Vital signs: estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention – 25 states 2015–2017", *Morbidity and Mortality Weekly Report*, vol. 68, No. 44 (November 2019).

[46] Ibid.

[47] Ibid.

[48] See Jane G. Stapleton and others, "The mental health needs of children exposed to violence in their homes".

[49] See Siri Thoresen and others, "Violence against children, later victimisation, and mental health".

[50] See Joy D. Osofsky, "The impact of violence on children", *The Future of Children*, vol. 9, No. 3 (winter 1999).

including ambivalence toward parents, acting out, whining and clinging or crying that may result from anxiety and post-traumatic stress.[51]

68. Infants and toddlers who witness violence either in their homes or in their community show excessive irritability, immature behaviour, sleep disturbance, emotional distress, fear of being alone and regression in toileting and language. Exposure to trauma, especially violence in the family, interferes with a child's normal development of trust and later exploratory behaviour, which lead to the development of autonomy.[52]

69. In recent reports, the presence of symptoms in young children has been noted that is very similar to post-traumatic stress disorder in adults, including repeated re-experiencing of the traumatic event, avoidance, numbing of responsiveness and increased arousal.[53]

70. Between the ages of 6 and 12, children begin to recognize normative standards and derive their sense of self from comparisons with others around them. Research indicates that the effects of domestic violence on latency-age children can include feelings of guilt and shame, as well as anxiety and symptoms of post-traumatic stress disorder.[54]These children may begin to do poorly in school and peer relationships can suffer. They may lack motivation or have difficulty concentrating owing to intrusive thoughts. Gender socialization is occurring at this age and children are making judgments about fairness and appropriate means to having their needs met.[55]

71. As with pre-schoolers, school-age children exposed to violence are more likely to show increases in sleep disturbances and are less likely to explore and play freely and show motivation to master their environment.[56] They often have difficulty paying attention and concentrating because they are distracted by intrusive thoughts. In addition, school-age children are likely to understand more about the intentionality of the violence and worry about what they could have done to prevent or stop it.

72. Several studies support a link between exposure to community violence and symptoms of anxiety, depression, and aggressive behaviour in school-age children living in violent urban neighbourhoods.[57] In extreme cases of exposure to chronic community violence, school-age children may also exhibit symptoms akin to post-traumatic stress disorder. Some studies have highlighted the link between the witnessing of violence and such symptoms as nightmares, fear of leaving their homes, anxiety and a numbing of affect.[58]

73. Other studies have reported that school-age children who are exposed to family violence are affected in a similar way to those exposed to community violence. Such children often show a greater frequency of internalizing and externalizing behaviour problems in comparison to children from non-violent families. Overall functioning, attitudes, social competence and school performance are often negatively affected. In addition, studies show that as children get older, those who have been abused and neglected

[51] See Ruby Charak and others, "Patterns of childhood maltreatment and intimate partner violence, emotion dysregulation, and mental health symptoms among lesbian, gay, and bisexual emerging adults: a three-step latent class Approach", *Child Abuse & Neglect*, vol. 89 (March 2019).

[52] Ibid.

[53] See Tracie O. Afifi and others, "Examining the relationships between parent experiences and youth self-reports of slapping/spanking: a population-based cross-sectional study", *BMC Public Health*, vol. 19 (October 2019).

[54] See Joy D. Osofsky, "The impact of violence on children".

[55] See Linda L. Baker and Allison J. Cunningham, "Learning to listen, learning to help: understanding woman abuse and its effects on children", Centre for Children & Families in the Justice System (2005).

[56] See Joy D. Osofsky, "The effects of exposure to violence on young children", *American Psychologist*, vol. 50, No. 9 (September 1995).

[57] See Deborah Gorman-Smith and Patrick Tolan, "The role of exposure to community violence and developmental problems among inner-city youth", *Development and Psychopathology*, vol. 10, No. 1 (March 1998).

[58] See Michele R. Cooley-Quille, Samuel M. Turner and Deborah B. Beidel, "Emotional impact of children's exposure to community violence: a preliminary study", *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 34, No. 10 (October 1995).

are more likely to perform poorly in school, to commit crimes and to experience emotional problems, sexual problems and alcohol or substance abuse.[59]

74. Cognitive psychology and neuroscience studies have transformed our understanding of the potential reasons for the onset of mental disorders in adolescence. One of the unique transitions that occurs during adolescence is that the opinion of peers begins to take precedence over that of family members and parents. That sensitivity to peer influence leads to adolescents being sensitive to social stimuli and having an increased propensity for risky behaviour. Delayed maturation of the prefrontal cortex, involved in impulse control and the reward system, could be responsible for behaviour related to impulsivity and risk-taking.[60]

75. As children begin to become more independent and interact with peer groups, they become more susceptible to interpersonal violence. Generally, children aged 10 to 18 become vulnerable to all forms of violence but the most prevalent form of violence is physical violence for both boys and girls by a member of their peer group. Along with physical attacks, that age group sees an increase in fighting between children and sometimes with violent means such as a firearm.[61]

76. The effects on adolescents of exposure to violence can include depression and suicidal ideation, dating violence, substance abuse and use of violence as a control tactic.

77. Adolescence involves the active search for identity and a lack of guidance at this stage could lead to poor choices.[62] The sexual coming of age and onset of sexual experiences may be adversely influenced by the results of exposure to violence and the perpetuation of violent norms of behaviour. It may be difficult for adolescents to get the appropriate style or level of help they need because the effects of exposure to violence may be masked by their own law-breaking or violent behaviour.

78. Considerable research has been done on adolescent youth violence. Such research indicates that adolescents exposed to violence, particularly those exposed to chronic community violence throughout their lives, tend to show high levels of aggression and acting out, accompanied by anxiety, behavioural problems, school problems, truancy and revenge-seeking.

79. The more severe effects on adolescents of exposure to violence may be related to the fact that they are exposed to much more violence than younger children. Such chronically traumatized youths often appear deadened to feelings and pain and show restricted emotional development over time. Alternatively, such youths may attach themselves to peer groups and gangs as a substitute for family and incorporate violence as a method of dealing with disputes or frustration.[63]

80. In low- and middle-income countries, recent studies have demonstrated that maternal maltreatment and exposure to violence are predictive of an increase in violent attitudes and tendencies towards children.[64] Maternal depression has also been linked to childhood disturbances in emotional, behavioural and cognitive development, including

[59] See Dante Cicchetti and Sheree L. Toth, *Developmental Perspectives on Trauma: Theory, Research, and Intervention* (Rochester, New York, University of Rochester Press, 1998).

[60] See Vikram Patel and others, "The Lancet Commission on global mental health and sustainable development", *The Lancet*, vol. 392 (October 2018).

[61] See UNICEF, *Hidden in Plain Sight: a statistical analysis of violence against children* (New York, UNICEF, 2014).

[62] See Esther J. Jenkins and Carl C. Bell, "Exposure and response to community violence among children and adolescents", in *Children in a Violent Society*, Joy D. Osofsky, ed. (New York, Guilford Press, 1998).

[63] See Joy D. Osofsky, "Children who witness domestic violence: the invisible victims", *Social Policy Report*, vol. 9, No. 3 (December 1995).

[64] Michael L. Goodman and others, "Childhood exposure to emotional abuse and later life stress among Kenyan women: a mediation analysis of cross-sectional data", *Anxiety, Stress and Coping*, vol. 30, No. 4 (2017).

self-reported mental health problems, increased risk of violence and substance use and deficits in educational achievement.[65]

81. Children can also be harmed when their caregivers are subjected to intimate partner violence or when they witness it taking place. Research has shown that children who witness violence at home or live with mothers who are victims of intimate partner violence are at a heightened risk of experiencing abuse within the home. There is also evidence to suggest that children exposed to domestic violence are more likely to act aggressively towards peers or siblings and to carry violence into adulthood as either victims or perpetrators. Witnessing violence between parents or caregivers can also influence children's attitudes about its acceptability within the family and close relationships; in turn, this could be passed down to the children, thus perpetuating the cycle of violence.

D. Main risk and protective factors

82. Identifying risk and protective factors for violence against children provides the foundation for effective prevention, as an integrated approach to increasing protection and decreasing risk underlies successful prevention in the years ahead.

83. Some risk factors correspond to a particular form of violence but more generally the various types of violence have several risk factors in common. The prevalence of poly-victimization involving different forms of violence reflects this reality.[66] Risk factors can be grouped into four categories: individual, relational, community and society.[67]

84. Individual factors include biological and demographic characteristics that increase the risk that a person will be a victim of violence, such as gender, age, low level of education, low income levels, disability or mental health issues, being lesbian, gay, bisexual or transgender, harmful use of alcohol and drugs, and having a history of exposure to violence.

85. Relational factors arise from relationships with peers, intimate partners and family members. They include lack of emotional attachment between children and parents or caregivers; poor parenting practice; family dysfunction and separation; association with peers in illegal activities; witnessing violence between parents or caregivers; and early or forced marriage.

86. Community-level risk factors include how the characteristics of settings such as schools, workplaces and neighbourhoods increase the risk of violence. They include poverty, high population density, transient populations, low social cohesion, unsafe physical environments, high crime rates and the existence of a local drug trade.

87. Society-level risk factors include legal and social norms that create a climate in which violence is encouraged or normalized. They also include cultural norms according to which it is acceptable to use violence to resolve conflicts; norms that affirm men's domination over women and children; standards by which parental rights outweigh the well-being of children; health, economic, educational and social policies that maintain economic, gender or social inequalities; absent or inadequate social protection; social fragility owing to conflict and post-conflict situations or natural disasters; weak governance; and poor law enforcement.

88. The interaction between factors at the different levels is just as important as the influence of factors within a single level. Several other common risk factors, such as family dysfunction, poor parenting skills and low social cohesion within the community, place

[65] See Rebecca M. Pearson and others, "Maternal depression during pregnancy and the postnatal period: risks and possible mechanisms for offspring depression at age 18 years", *JAMA Psychiatry*, vol. 70, No. 12 (December 2013).

[66] See David Finkelhor, Richard K. Ormrod and Heather A. Turner, "Poly-victimization: A neglected component in child victimization".

[67] WHO and others, *INSPIRE: Seven Strategies for Ending Violence against Children* (WHO, Geneva, 2016).

some children at much greater risk than others. In addition, as humanitarian crises, including war, mass refugee movements, economic migration, climate disasters and disease outbreaks proliferate, more children than ever are becoming vulnerable to violence of all forms.[68]

89. Protective factors can be grouped into two main categories relating to the child and the family.

90. Child factors include adaptability, optimism and coping style. Other elements may be the child's attribution and appraisal of events, personality and locus of control. The child's most important personal quality in this context is average or above-average intellectual development with good attention and interpersonal skills. Additional protective factors cited in studies include feelings of self-esteem and self-efficacy, attractiveness to others in both personality and appearance, individual talents, religious affiliation, socioeconomic advantage, opportunities for good schooling and employment, and contact with people and environments that are positive for development.[69]

91. Research on an ecological stress process model has explored relations between children's exposure to family and community violence and child mental health, and emotionally regulated coping as a protective factor among Latino, European-American and African-American school-age children living in single-parent families who were either homeless and residing in emergency shelters or housed but living in poverty.[70] The results highlight the critical role of child-adaptive coping strategies, specifically emotionally regulated coping, as a protective resource in relation to mental health symptoms in the presence of multiple forms of violence. Children who perceive their emotional coping as more effective report fewer mental health symptoms. Children's coping strategies, whether as prevention or a treatment strategy, could buffer the detrimental effects of some exposure to violence.[71]

92. Protective family factors include the strength and nature of the relationship with the non-offending parent or the presence and relationship with siblings and/or extended family members. The most important protective resource to enable a child to cope with exposure to violence is a strong relationship with a competent, caring, positive adult, most often a parent. With the support of good parenting by either a parent or other significant adult, a child's cognitive and social development can proceed positively even in adversity.

93. An important area concerns the issue of resilience, which is the ability to determine which children will experience fewer negative effects in response to exposure to violence.[72] Results from several studies of resilient infants, young children and youths exposed to community violence consistently identify a small number of crucial protective factors for development, including a caring adult, a community safe haven and a child's own internal resources.

E. Effectiveness of interventions to prevent and provide care to children who experience or are exposed to violence

94. There is more data, research and other evidence on interventions to prevent and respond to violence against children than ever before. However, there are still significant data gaps that must be addressed, particularly the dearth of evaluations on interventions in low- and middle-income countries.[73]

[68] Ibid.

[69] Ibid.

[70] See Esror Tamim Mohammad and others, "Impacts of family and community violence exposure on child coping and mental health", *Journal of Abnormal Child Psychology*, vol. 43 (2015).

[71] Ibid.

[72] See Joy D. Osofsky, "The impact of violence on children".

[73] Office of the Special Representative, *Keeping the Promise: Ending Violence against Children by 2030.*

95. The report by WHO and others entitled *INSPIRE: Seven Strategies for Ending Violence against Children* is a resource that highlights a select group of strategies based on the best available evidence to help countries and communities intensify their focus on the prevention programmes and services with the greatest potential to reduce violence against children. With respect to response and support services that support the mental health of child victims, the report highlights important evidence on the effectiveness of trauma-focused cognitive behavioural therapy for individuals and groups in reducing trauma symptoms and long-term negative psychological and emotional outcomes in children and adolescents who have experienced violence – reducing them by up to 37 per cent for individuals and 56 per cent for group participants.

96. For example, in Lusaka, 257 boys and girls aged 5 to 18, who had experienced at least one traumatic incident (including abuse and exploitation) and reported significant trauma-related symptoms (such as post-traumatic stress disorder) were recruited from five communities. The children were randomly assigned either to an intervention group where they received between 10 and 16 sessions of trauma-focused cognitive behavioural therapy, or to a comparison group where they received the "treatment as usual" offered to orphaned and vulnerable children. Treatment as usual included psychosocial counselling, peer education, support groups and testing for and treatment of HIV/AIDS. Importantly, the trauma-focused cognitive behavioural therapy was delivered by trained and supervised lay counsellors rather than specialist mental health providers. The study found that trauma symptoms were reduced by 82 per cent in the intervention group compared to a 21 per cent reduction in the group receiving treatment as usual. Functional impairment was reduced by 89 per cent by the therapy intervention compared to a 68 per cent reduction from treatment as usual. Trauma-focused cognitive behavioural therapy was significantly more effective than treatment as usual. Those findings are especially important given that there are unlikely to be sufficient resources in most low-income settings to recruit specialist mental health-care providers or train lay workers in more than one approach to dealing with the effects of trauma.[74]

97. The report entitled *Promising Programmes to Prevent and Respond to Child Sexual Abuse and Exploitation*, commissioned by UNICEF, has also drawn attention to the increasing focus by mental health professionals on evidenced-based practices for the treatment of child abuse and trauma. In high-income countries trauma-focused cognitive behavioural therapy, creative therapies, eye-movement desensitization and reprocessing and counselling are recognized as potential models of intervention for sexually abused children and young people. Creative therapies such as play, dance or music offer children an alternative for healing and restoration, and there are examples of this approach being used in low- and middle-income countries. A meta-analysis of play therapy for children in high-income countries found positive impact across modalities, settings, age and gender, with the most significant impact seen with humanistic, non-directive play therapy approaches.

98. The Know Violence in Childhood global learning initiative has also highlighted important evidence to inform action on violence prevention, including:

(a) The potential of parenting programmes to both prevent and reduce the risk of child maltreatment and to act as an entry point to address vulnerabilities and risks within home environments;

(b) Opportunities for greater synergies between intimate partner violence and child maltreatment programmes;

(c) The importance of coordinated and multisectoral responses to reduce the likelihood of children being separated from their families;

(d) The value of investing in changing social norms and linking initiatives to end violence against children with those aimed at ending violence against women;

[74] See WHO and others, *INSPIRE: Seven Strategies for Ending Violence against Children* (2016).

(e) The good schools toolkit, implemented in Uganda, which has demonstrated significant positive results in addressing the dynamics of violence at multiple levels, across multiple stakeholder groups and with the potential to succeed at scale;

(f) Effective changes in institutions that can alleviate violence either by structural and code of conduct interventions or policy changes that avert such placements or expedite onward movement to family-type environments;

(g) Strategies to build resilient communities that are successfully reducing violence in cities and urban communities with high levels of homicide and gang violence, particularly in Latin America, Central America and the Caribbean;

(h) Community-based initiatives to engage at-risk youth in skill-building, vocational training, music, and art.[75]

99. WHO has noted that there is increasing evidence of the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents.[76] WHO itself has a number of initiatives aimed at increasing the information and evidence based on mental health, with a view to strengthening mental health-care systems.[77]

100. The Lancet Commission on global mental health and sustainable development identified a range of interventions it considered necessary to prevent mental and substance use disorders and provide treatment and care to enhance recovery.[78] It stressed innovative interventions with the potential for scaling up, which could be delivered either through routine health care or other platforms.

101. Preventive interventions focusing on maternal mental health, mother–infant interaction and play and stimulation, have positive long-term benefits for both infants and mothers. Interventions that promote early initiation of breastfeeding, close physical contact with the mother and enhance maternal responsiveness contribute to secure attachment. Such programmes focusing on the early interaction between newborn babies and their caregivers, and in particular on improving sensitive responsiveness, can also reduce the risk of child maltreatment. Additionally, parent education and multi-component interventions (which typically combine family support, preschool education, parenting skills and child care) also show promising effectiveness in preventing child maltreatment and reducing mental health problems in children exposed to adversity and children affected by armed conflict.[79]

102. A meta-analysis of 193 studies reported that maternal depression was significantly associated with increased internalizing and externalizing of mental disorders among children. Strong evidence exists for the effectiveness of interventions for maternal mental disorders in reducing internalizing and externalizing problems, and preventing the onset of childhood mental disorders. Home-visiting programmes for new mothers and their babies integrate the detection and treatment of maternal depression, including the delivery of psychosocial interventions, within routine pre- and postnatal care services.[80]

103. Parenting and child welfare interventions are key investments for breaking toxic cycles of transgenerational transmission of violence, poverty and mental illness. For example, a psychosocial stimulation and parenting support intervention among growth-stunted toddlers led to substantial gains in adult functioning and labour market outcomes later in life. Within schools, life skills training focusing on the development of social, emotional, problem-solving and coping skills is considered best practice for building emotional and social competencies in children of all ages.[81]

[75] See Know Violence in Childhood, *Ending Violence in Childhood. Global Report 2017*.
[76] See WHO, "Mental health action plan".
[77] See www.who.int/mental_health/evidence/en/.
[78] See Vikram Patel and others, "The Lancet Commission on global mental health and sustainable development".
[79] Ibid.
[80] Ibid.
[81] Ibid.

104. In terms of treatment, care and rehabilitation within low-resource settings, a basic package of interventions for children could include training programmes on parenting skills, which are effective for children with developmental, behavioural and emotional problems. The community-based rehabilitation model is a rights-based approach, building on the inherent strengths of the community and involving people with disabilities, family members and volunteers. The approach should be supported by local health professionals to facilitate inclusion in mainstream services, when possible, and tailored to local specific needs and resources. The evidence from community-based rehabilitation programmes is mostly supportive of their acceptability and beneficial effects.[82]

105. Late childhood and adolescence present further opportunities for ameliorating the effects of early disadvantage, building resilience and reducing the harmful consequences of conditions that have an onset in this period. Family, parents, peers, school and community can provide the crucial protective inner circle. Universal socio-emotional learning interventions in communities and schools promote children's social and emotional functioning, improve academic performance and reduce risk behaviour, including smoking and teenage pregnancy. Such interventions can be delivered by peers, teachers and counsellors through integrating them into youth programmes or school curricula (for example, the HealthWise programme in South Africa). The most effective interventions use a whole-school approach in which socio-emotional learning is supported by a school ethos and a physical and social environment that is health-enabling, involving staff, students, parents and the local community. Such interventions act directly by promoting self-efficacy and trust, and through reducing risk factors such as bullying. Economic analyses indicate that socio-emotional learning interventions in schools are cost-effective, resulting in savings from improved health outcomes and reduced expenditure on the criminal justice system.[83]

106. Suicidality among adolescents is a major public health concern. Multimodal programmes, including community and school-based skills training for students, screening for at-risk young people, education of primary care physicians, media education and lethal-means restriction, offer the most promising prevention strategies (for example, the "Going Off, Growing Strong" programme in Canada). Targeted or indicated preventive interventions focus on young people who have had experiences that increase their vulnerability to mental disorders or who show sub-threshold symptoms. Interventions that promote coping and resilience, including cognitive skills training, help to prevent the onset of anxiety, depression and suicide.[84]

107. A substantial body of evidence exists on effective clinical interventions for people with mental disorders in humanitarian emergencies. The Inter-Agency Standing Committee guidelines on mental health and psychosocial support in emergency settings include reinforcement of existing community resilience, avoiding medicalization of distress, proactive case identification with referrals to appropriate interventions, integration into emergency medical and social care responses, and actively promoting service use. Through a range of psychosocial interventions, mental health and psychosocial support is now more strongly aligned in the humanitarian context and other global mental health initiatives than previously. An active role for members of local communities and local authorities at every stage of organizing mental health care in these contexts is essential for successful, coordinated action and the enhancement of local capacities and sustainability. A coordinated response should ensure that the response builds the foundation of a sustainable mental health-care system.[85]

[82] Ibid.
[83] Ibid.
[84] Ibid.
[85] Ibid.

F. Towards enabling and effective strategies to protect children's mental health and well-being

108. Efforts to address mental health and violence against children should be guided by international human rights standards and the sustainable development framework, but they should also reflect a modern public health approach. One of the key principles of this approach is that good mental health means much more than the absence of a mental impairment: it is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.

109. Realizing the right of child victims and witnesses of violence to the highest attainable standard of mental health requires comprehensive and coordinated action. It requires an intersectoral and multi-stakeholder approach that encompasses both policies and actions to create an environment that decreases risks and vulnerabilities, as well as developing and strengthening services to provide timely and comprehensive mental health care to people who need it.[86] There are already important frameworks in place to guide the actions of Member States in this field, such as the WHO mental health action plan 2013–2020 and the Lancet Commission on global mental health and sustainable development.

110. The starting point is the need to protect and promote everyone's mental health and well-being. It is essential to create the conditions that will allow children to develop, thrive and reach their potential. To achieve this, it is necessary to address the social and environmental determinants that have a crucial influence on mental health at developmentally sensitive periods, particularly in childhood and adolescence. Many of the Sustainable Development Goals explicitly address these determinants and progress towards their attainment has the potential to promote mental health and reduce the global burden of mental disorders.

111. Prevention requires a combination of universal and targeted interventions that address the barriers and threats to mental health, especially those that present in early childhood. They include action to reduce stigmatization, discrimination and human rights violations that undermine children's mental health. Prevention also requires specific action to address the needs of vulnerable groups across the lifespan in a manner that is integrated with wider health promotion strategies. In addition, prevention efforts must respond to the increasing threats to mental health arising from global challenges, such as climate change and growing inequality.

112. Mental health services must be scaled up as an essential component of universal health coverage and should be fully integrated with other strategies in the fields of health and violence prevention. Comprehensive community-based health and social care services must be developed that ensure continuity of care between providers, effective collaboration between formal and informal care providers and the promotion of self-care. Children and adolescents with mental disorders should be provided with evidence-based psychosocial and other non-pharmacological interventions and be based in the community, avoiding institutionalization and medicalization. Early intervention is essential.

113. The empowerment of children to take an active part in decisions regarding their own care is a fundamental component of a rights-based approach to mental health. The views and experiences of children with lived experience of mental disorders and psychosocial disabilities must shape the design, delivery and evaluation of services.

114. It is essential to have the right number and equitable distribution of competent, sensitive and appropriately skilled health professionals, and to build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented services. New opportunities should be embraced in this domain, including those offered by the innovative use of trained non-specialist individuals and digital technologies to deliver a range of mental health interventions.

[86] Ibid.

115. Substantial additional investments are required for promoting and protecting mental health. Although additional resources are essential, an immediate opportunity exists for efficient and effective use of existing resources. That could include, for example, the redistribution of mental health budgets from large hospitals to district hospitals and community-based local services; the introduction of early interventions for emerging mental disorders; and the reallocation of budgets for other health priorities to promote the integration of mental health care into established platforms of delivery.

116. Investments in research and innovation should also continue to grow. The imbalance whereby most research is conducted in and by high-income countries needs to be corrected in order to ensure that low- and middle-income countries have culturally appropriate and cost-effective strategies to respond to mental health needs and priorities. The crucial information needed to take effective action includes the prevalence and nature of mental health problems; coverage of policies and legislation, interventions and services; health outcome data; and social and economic outcome data. Those data need to be disaggregated by sex and age and reflect the diverse needs of subpopulations, including individuals from geographically diverse communities and vulnerable populations.

117. Finally, as the international community looks ahead to the decade of action for the Sustainable Development Goals, delivery for sustainable development, monitoring and accountability frameworks must be put in place to ensure that effective action is being taken to promote the mental health of all, prevent mental disorders among children who experience violence and others at high risk, and provide treatment and care to those who need it.

V. Looking forward

118. Since assuming her role in July 2019, the Special Representative has developed her strategy for this mandate period through a consultative and participatory process. The new strategy includes three priority areas: (a) advocacy and mobilization of all key stakeholders at the global, regional and national levels for the accelerated implementation of target 16.2 of the Sustainable Development Goals and of other related Goals; (b) ensuring that all forms of violence are included in the implementation of the 2030 Agenda for Sustainable Development, thereby ensuring that no child is left behind; and (c) amplifying the voices of children, with particular attention paid to the most vulnerable.

119. Effective cooperation between the many actors in this field is critical. Children's lives are not divided thematically to correspond to the mandates of the organizations working on their behalf: they are often exposed to more than one form of violence and in more than one setting. Mobilizing partnerships at all levels and involving all stakeholders is essential to generate the necessary resources and spur action. The Special Representative will use a participatory and consultative approach to support cooperation and constructive dialogue with all relevant stakeholders at the national, regional and international levels to respond effectively to the continuum of violence that child victims face.

120. The most important partners in ending violence are children themselves. The active and meaningful involvement of children in identifying the challenges to sustainable development and how to overcome them both realizes their right to participation and provides an effective way to accelerate progress. The Special Representative will pursue close collaboration with child-led and child-focused organizations to ensure that the mandate amplifies children's voices and takes their views fully into account. Particular attention will be paid to including the most invisible and vulnerable children in order to ensure that no child is left behind.