# Children's Mental Health and Wellbeing in Singapore

## A landscape brief of promotion, prevention, and literacy programmes for children aged 3-11

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*"Preparing the kids of today, in a world where technology and digital consumptions are over-stimulating the developing brains of this vulnerable audience."*

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# Abbreviations

**ASEAN** ..... Association of Southeast Asian Nations

**HPB** ..... Health Promotion Board

**IMH** ..... Institute of Mental Health

**MOE** ..... Ministry of Education

**MOH** ..... Ministry of Health

**MOHT** ..... Ministry of Health Office for Healthcare Transformation

**MSF** ..... Ministry of Social and Family Development

**NCSS** ..... National Council of Social Service

**NGO** ..... Non-Governmental Organisation

**NUS** ..... National University of Singapore

**UNICEF** ..... United Nations Children's Fund

**WHO** ..... World Health Organization

# Glossary of terms

**Accessible** programmes address structural or social barriers that may prevent its target population from accessing the programme. This could include financial, geographical, environmental, linguistic barriers, or lack of awareness/literacy needed to engage with the programme.

**Appropriate** programmes are culturally and developmentally appropriate for its target population group.

**Community-Embedded** programmes involve partnerships and engagement within civil society, including community groups, social service agencies, primary care providers, schools, etc. They also include co-design engagements, and community-delivered programmes.

**Continuously Improving** refers to how the programme has engaged with formal/informal evaluation and whether the programme is agile and can adapt to changing needs from their target population.

**Equitable and Inclusive** programmes are those that have been equitably offered to the population regardless of demographic markers (age, sex, race, ethnicity, socio-economic status, sexual orientation, political affiliation, neurodiversity, other disabilities, etc.) They also consider whether the programme is reaching those who traditionally have difficulty accessing mental healthcare.

**Human Rights-Based** programmes are designed to respect, protect and fulfil children and young people's human rights, including rights to information, privacy, confidentiality, non-discrimination, non-judgement and respect, inclusion and freedom from exploitation, violence and abuse.

**Mental Health** is a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well and contribute to their community. It is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right, and it is crucial to personal, community, and socio-economic development.

**Mental Health Literacy** refers to the knowledge and beliefs about mental disorders that facilitate their recognition, management, or prevention. This can include, for example, integration into school curriculum or training such as mental health first aid.

**Mental Health Prevention** refers to the efforts to reduce the incidence, prevalence and recurrence of mental health disorders and their associated disability. It may involve universal, targeted or indicated prevention strategies.

# Glossary of terms

**Mental Health Promotion** involves actions that improve psychological wellbeing including creating environments that support (positive) mental health.

**Mental Wellbeing** is the subjective evaluation of life satisfaction, social and personal circumstances that might be considered to contribute to a good life.

**Participatory Approach** in programmes refers to the involvement of children themselves in the programme development, implementation, decision-making, and feedback/evaluation mechanisms.

# Executive Summary

## *Project background & motivation*

Children's mental health is increasingly recognised as one of the most urgent public health priorities worldwide. Recent global data highlights a steady decline in children and young people's mental health over the past two decades. Globally, one in seven children and adolescents aged 10–19 live with a diagnosable mental health condition, whose education, relationships, employment prospects and long-term health are at risk. In ASEAN, mental disorders consistently rank among the top ten causes of disease burden. Singapore reports one of the highest proportions in the region, with mental disorders accounting for 28.2% of the total disease burden among children, adolescents, and young adults.

The criticality of these figures has prompted international and regional bodies, such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), to advocate for upstream, preventative strategies. Singapore has responded decisively with the launch of the National Mental Health and Well-being Strategy in 2023, guided by a tiered-care model which matches appropriate level of care based on the severity of mental health need. For children aged 3-11, this means building a system that combines promotion, prevention, and literacy, areas that align with WHO and UNICEF's recommended best practices.
Several government-led and supported initiatives illustrate this commitment. Alongside which, civil society and other Non-Governmental Organisations (NGOs) deliver complementary services, ranging from standalone community-based centres to embedded school programmes.

Despite the breadth of initiatives, important gaps remain. Programmes vary widely in scale, evidence base, age group coverage, and sustainability. Many promising interventions exist, but without systematic mapping, it is difficult to know whether they adequately meet children's needs, which groups remain underserved, or determine how resources can be better aligned with global best practices.

This study, supported by the Octava Foundation, sought to address that gap by conducting a comprehensive landscape mapping of mental health promotion, prevention, and literacy interventions for children aged 3-11 in Singapore.

A multi-phase, mixed-methods approach was used over six months (February–July 2025) to map the landscape of mental health and wellbeing programmes for children aged 3–11 in Singapore. The core mapping exercise combined a semi-structured survey and in-depth interviews with key informants from public, private, NGO, and civil society organisations. To ensure robustness, findings were further validated through a stakeholder workshop with 47 local experts, where the barriers, enablers, and opportunities for strengthening children's mental health promotion, prevention, and literacy were explored.

## *Landscape of children's mental health & wellbeing programmes*

A total of 43 programmes supporting the mental health and wellbeing of children (aged 3–11) were mapped through a survey spanning public, private, NGO, and civil society providers in Singapore. While many of these programmes address multiple domains (n=16), most programmes emphasise mental health promotion (n=30) and prevention (n=30), with literacy (n=24) also widely featured.

Mental health promotion programmes are largely strengths-based and holistic, focusing on resilience, life skills, and emotional intelligence. Delivered in diverse settings like schools, community centres, family service centres, enrichment academies, and arts organisations, these initiatives prioritise safe and supportive environments where children can build empathy, communication, and conflict-resolution skills, while also normalising conversations around mental health. Some key components across promotion programmes are that these are iterative, flexible programmes that use multiple modalities to deliver services.

Mental health prevention programmes, in contrast, are tiered, tailored, and targeted to children at risk of distress or those displaying early symptoms. These include screening and trauma-informed services, typically embedded in schools or healthcare systems. The initiatives focus on early detection, psychoeducation, and short-term skill-building to prevent escalation of mental health issues.

Mental health literacy programmes seek to raise awareness, reduce stigma, and encourage help-seeking, providing child-friendly information to help children, parents, and teachers better recognise emotions, psychosomatic symptoms, and find support. They are often flexible, delivered through one-off workshops or recurring activities, and are typically paired with social-emotional learning or family support initiatives. Notably, programmes reported concerted efforts to involve parents and teachers, recognising their critical role in shaping children's attitudes and reducing stigma within households and schools.

Key findings from 32 interviews highlight that programme design is frequently driven by the lived experiences and personal observations of founders (n=8) rather than large-scale needs assessments, underscoring grassroots and context-sensitive orientation. Educators, parents, and practitioners drew on their firsthand experiences of unmet needs to shape these initiatives.

Qualitative analysis of key programme domains highlight that children's mental health and wellbeing programmes need to be grounded in principles of human rights, equity, participation, and inclusion to ensure they are ethical, empowering, and sustainable.

## *Programme domains*

A closer look into the programmes across WHO-UNICEF service guidance domains demonstrate notable commitment to accessibility and inclusion, with 34 programmes incorporating age-appropriate content, 26 using culturally sensitive approaches, 13 adapting content into different languages, and 10 making deliberate accommodations for children with disabilities. Several programmes emphasised real-time responsiveness, with facilitators dynamically adapting content and pacing to children's emerging needs.

It also revealed potential scope for prioritising human rights and participatory approaches. While 17 programmes reported efforts to safeguard children's wellbeing through trauma-informed training and confidentiality protocols, only 4 organisations explicitly described practices that uphold children's autonomy, and merely 6 reported efforts to inform children of their rights. This imbalance indicates that most implementers interpret children's rights through a narrow lens of protection rather than fostering voice, choice, and decision-

making power. In terms of participatory design, mental health professionals, social workers, psychiatrists and psychologists played the most active role in programme development (n=24), followed by parents and caregivers (n=19), while children themselves contributed feedback in only 18 programmes. Interview respondents consistently highlighted the importance of user testing and feedback loops, yet meaningful co-design with younger children presents unique challenges due to limited access to children's perspectives and difficulties in identifying age-appropriate consultation methods.

Programmes make concerted efforts to address financial hardships of their target participants, with many initiatives being provided at little or no cost, and some programmes making services SkillsFuture Credit-eligible to support participants. Efforts to make programmes culturally appropriate are evident with frameworks such as the adaptation of Mindfulness-Based Stress Reduction into culturally responsive formats like Mindfulness-Based Wellbeing Enhancement, for greater relevance to Asian contexts. Programme developers also tailor interventions to developmental stages, neurodiversity, and varying risk levels, with children having special needs often receiving individualised sessions while neurotypical children participate in group activities.

Additionally, community embedding emerges as a relative strength, with programmes building partnerships across schools, volunteer networks, and government agencies. Schools and teachers serve as crucial partners, acting as hosts and facilitators, while volunteers and university students support programme delivery and logistics. Mental health professionals provide essential clinical supervision and referral pathways, supported by multidisciplinary teams including play therapists, speech therapists, and specialised educators. Government agencies, hospitals, and corporations contribute through funding alignment and resource provision, fostering multi-sector coordination that bridges schools, healthcare providers, and local communities.

## *Monitoring and evaluation of programmes*

The monitoring and evaluation landscape reveals significant opportunities for methodical assessment of impact of the programmes. Of the 41 programmes responding to evaluation questions, 66% (n=27) have engaged in some monitoring and evaluation processes, while 14 have yet to conduct any evaluation. Among those conducting evaluations, some programmes involve internal staff in impact measurement (n=18), followed by academia (n=8) and non-profit organisations (n=5). Programmes prioritise participant engagement and participation levels as the most important success outcomes (n=23), alongside participant and caregiver satisfaction levels (n=22), with some indicating social behaviour changes (n=18) and others focusing on mental health symptom improvement (n=14). While 26 programmes seek feedback from participants including children, parents, and staff, only 20 conduct pre- and post-programme assessments, and 5 use more rigorous methodologies such as control groups or randomisation.

Interview respondents highlighted significant challenges in obtaining formal, long-term feedback, citing developmental barriers in working with younger children, funding limitations for comprehensive evaluations, difficulty establishing impact without comparison groups or baseline measures, staff burden from constant surveying, and loss to follow-up affecting longer-term data collection.

## *Funding*

In Singapore, funding for child mental health programmes comes from diverse sources, including government agencies, private organisations, philanthropic contributions, and resources provided through schools. Government agencies provide the majority of grants and subsidies across hospitals, schools, and community settings, followed by external funding by private organisations. Philanthropic support also plays a crucial role in ensuring sustainability for services not covered by government or private sources.

However, organisations face significant funding challenges especially with short-term grants of one to three years that prioritise quick outcomes over sustained long-term impact, difficulties maintaining free or low-cost services that prioritise accessibility, high costs of hiring skilled professionals such as social workers and counsellors, and school budget decisions that may not prioritise mental health programming.

## *Implementation Barriers*

Survey findings identify shortage of adequately trained professionals as the most prominent barrier, followed by low stakeholder engagement, insufficient funding, and limited public awareness of mental health issues. Interview data reinforces these challenges while revealing additional systemic constraints. The limited pool of professionals equipped to address children's complex mental health needs is compounded by funding limitations that restrict scalability and sustainability. Stigma presents another significant barrier, with mental health often viewed through an illness-centred lens that creates discomfort and avoidance.

Parental engagement challenges persist, as parents may be unfamiliar with therapeutic approaches or lack sufficient time for active participation. These barriers are particularly pronounced among families with lower literacy levels who may additionally struggle to understand programme benefits.

Logistical barriers compound these challenges, with schools' packed timetables making it difficult to find time for programmes, resulting in low sign-up rates, while programmes without dedicated school spaces struggle with rising rental costs for external venues that limit capacity for consistent and scalable interventions.

## *Recommendations*

These findings point to a need for coordinated and collaborative action across funding structures, implementation practices, and policy frameworks to strengthen further Singapore's children's mental health ecosystem. Some recommendations for funding organisations and implementing organisations have emerged through the gap analysis.

For funders:

- **Increase the funding base for children's mental health and wellbeing** for additional key players in the space.
- **Increase support for long-term delivery and scale** beyond the current short-term grants of 1-3 years.
- **Adopt broad and flexible funding practices** to foster equity that blend structure with adaptability, enabling programmes to respond to diverse community needs.
- **Foster ecosystem collaboration and knowledge exchange** for cross-sectoral coordination to ensure a continuum of services.
- **Support comprehensive and multi-domain programmes** that integrate prevention, promotion, and literacy components across individual, family, school, and community settings.

For implementers & practitioners:

- **Strengthen evaluation and sustainability planning** by integrating robust mixed-methods evaluation frameworks from programme design phase.
- **Effectively engage parents and other trusted adults** beyond basic mental health literacy.
- **Participate and collaborate in the ecosystem** for knowledge exchange, skills training, and best practice development.
- **Embed children's rights as a guiding principle** beyond protection to centre children's agency and autonomy in programme development.

Singapore's evolving focus on children's mental health represents a promising shift from solely adolescent-centred approaches toward early intervention strategies. While the current landscape features passionate implementers and practitioners developing innovative programmes across multiple sectors, significant barriers including funding constraints, parental engagement challenges, and coordination gaps prevent these initiatives from reaching necessary scale and integration.

This comprehensive assessment of Singapore's children's mental health ecosystem serves as both a resource for stakeholders and a foundation for future innovations, partnerships, and investments that can transform fragmented efforts into a coordinated system of care capable of supporting children's mental wellbeing at the population level.

# 1

# Introduction

Childhood is a critical and foundational period for mental health, as it establishes the basis for future emotional, social and cognitive development. It shapes lifelong health, social, and economic outcomes. Youth mental health has emerged as one of the most pressing public health challenges of our time with a recent report from the Lancet Psychiatry Commission revealing a steady decline in young people's mental health over the past two decades (McGorry et al., 2024). Globally, it is estimated that one in seven children and adolescents aged 10–19 years' experience a diagnosable mental health condition (World Health Organization & United Nations Children's Fund (UNICEF), 2024). This translates to over 166 million young people worldwide living with conditions that can affect education, relationships, and long-term health. Anxiety disorders, depressive disorders, and conduct problems are consistently ranked among the most common, while neurodevelopmental conditions such as ADHD and autism spectrum disorders add to the complexity of needs (Polanczyk et al., 2015).

## *Global and regional trends and the case for early intervention*

The Global Burden of Disease (GBD) Study 2019 underscores the magnitude of the issue: mental and substance use disorders are the fifth leading cause of disability-adjusted life years (DALYs) among children and adolescents globally, accounting for approximately 14% of the total burden of disease in this age group (Vos et al., 2020). When years lived with disability (YLDs) are considered alone, mental health conditions consistently rank as the top contributor to non-fatal health loss across childhood and adolescence.

The Association of Southeast Asian Nations (ASEAN) region further illustrates these challenges vividly. Recent Global Burden of Disease analyses demonstrate that the burden of mental disorders has been increasing across Asian countries over the past three decades. Mental disorders ranked among the top ten causes of disease burden in nearly all ASEAN countries, specifically accounting for 28.2% of disease burden in children, adolescents, and young adults in Singapore (Szücs et al., 2025). This places Singapore among the countries with the highest relative burden in ASEAN, despite its strong health infrastructure, indicating that rise of social media, high academic pressures, and shifting family dynamics may exacerbate risk factors for mental distress (Teo, 2025).

The Singapore Youth Epidemiology and Resilience (YEAR) study and other national data reinforce these concerns. Approximately one in three adolescents in Singapore report symptoms of depression, anxiety, or loneliness, and 8–12% meet criteria for a mental disorder diagnosis before the age of 18 (Subramaniam et al., 2019). Furthermore, the COVID-19 pandemic amplified vulnerabilities: local surveys found that families with children experienced increased stress with significant changes in family dynamics, childcare arrangements, and daily activities, impacting household conflicts and subsequent mental health of family members (Yang et al., 2023).

The age of onset adds urgency to this challenge. The onset of mental illness follows a distinctive pattern, with most conditions emerging during the formative years from childhood through early adulthood. Evidence from a large systematic review and meta-analysis covering 192 epidemiological studies and over 700,000 individuals shows that by age 14, more than one-third (34.6%) of all mental disorders have already appeared. This rises to nearly half (48.4%) by age 18 and almost two-thirds (62.5%) by age 25 (Solmi et al., 2022). Childhood and early adolescence thus represent a decisive window for intervention: failure to identify and support children at this stage increases the risk of long-term consequences, including reduced educational attainment, unemployment, chronic physical conditions, substance misuse, and suicide

(Copeland et al., 2015).

The economic costs of inaction are substantial. A 2020 UNICEF-WHO-World Bank joint report estimated that failure to address mental health conditions in children and adolescents results in global economic losses of USD 390 billion annually due to reduced productivity, healthcare costs, and social welfare burden (UNICEF, 2021). Investing in children's mental health is therefore not only a moral imperative but also an economic necessity.

Global epidemiological patterns reveal both commonalities and disparities. The Lancet Commission on Global Mental Health and Sustainable Development (2018) highlighted the "triple gap" of treatment, investment, and prevention (Patel et al., 2018). Even in high-income countries, only 20-30% of children with mental health conditions receive adequate care (World Health Organization, 2022). Across Asia, UNICEF reports that suicide is a leading cause of death among young people aged 15-19, underscoring the urgent need for upstream interventions in younger age groups (UNICEF, 2021).

Globally, the evidence base demonstrates that promotion, prevention, and literacy interventions are effective and cost-efficient (Le et al., 2021). Parenting programmes, another cornerstone of promotion and prevention, have demonstrated significant reductions in child behavioural problems and improved parental wellbeing, with cost–benefit analyses showing returns of USD 2–3 per dollar invested (Sampaio et al., 2024).

The global response to children's mental health challenges has catalysed numerous innovative approaches and interventions. The UNICEF'S Mind the Gap Report called for a radical shift towards prevention and promotion, highlighting that too many systems remain reactive, focusing on treatment after problems have already emerged (UNICEF Innocenti, 2022). In 2024, WHO and UNICEF published a comprehensive framework titled "Mental Health of Children and Young People: Service Guidance" to support the transformation of mental health services for children and adolescents, recognising the need for evidence-based, scalable solutions (World Health Organization & United Nations Children's Fund (UNICEF), 2024). This emphasises three priorities: (1) promoting nurturing environments and socio-emotional learning, (2) preventing risk factors such as violence, bullying, and toxic stress, and (3) building literacy among children, parents, and educators to enhance early identification and help-seeking.

In the Western Pacific region, the WHO regional framework (2023) provides several options for implementing upstream preventative initiatives, including preventing violence against children, providing early childhood programmes that address cognitive, sensory-motor, and psychosocial development, promoting healthy child-caregiver relationships, and developing universal and targeted school-based programmes to foster socioemotional development (World Health Organization. Regional Office for the Western Pacific, 2023).

Importantly, all these frameworks stress that mental health is not the sole responsibility of health systems. Schools, community organisations, digital platforms, and families are all critical arenas for action. However, equity concerns remain, as children from disadvantaged backgrounds or minority language groups often face barriers in accessing many of these resources (Patel et al., 2018).

## *Current initiatives in Singapore: Barriers and opportunities*

In response to this context, Singapore has taken decisive policy and programmatic action, launching the National Mental

Health and Well-being Strategy in 2023 (Ministry of Health et al., 2023). This strategy maps initiatives within a tiered-care model, which is central to Singapore's approach. Tier 1 focuses on promoting wellbeing for healthy individuals to prevent mental health conditions, while Tier 2 targets those with low mental health needs to facilitate coping and prevent symptom escalation.

For children aged 3-11, interventions within these tiers focus on promotion, prevention, and literacy, which are vital for addressing their emotional and psychological needs. The strategic focus on promotion, prevention, and literacy aligns with international best practices and guidance from the World Health Organization and UNICEF, which advocates for integrated, community-based support systems for children (World Health Organization & United Nations Children's Fund (UNICEF), 2024).

Singapore has implemented initiatives in both community and school settings to incorporate mental health promotion and literacy into early childhood development. For example, the "A Healthy Start for your growing kid" programme by the Health Promotion Board (HPB) promotes emotional wellbeing alongside physical health in early childhood settings. Programmes like Mindline.sg by the Ministry of Health's Office for Healthcare Transformation (MOHT) for older youth provide resources that can be adapted for younger children to build resilience and coping skills. The National Council of Social Service (NCSS) leads efforts such as the "Beyond the Label" campaign, which aims to reduce mental health stigma and promote early help-seeking behaviours across all age groups, including young children.

In schools, social and emotional learning is already included in the secondary school curriculum and is being extended to primary level, teaches children essential skills like emotional regulation and empathy, which contribute to both mental health promotion and literacy. School-based counselling services, supported by the Ministry of Education (MOE), provide early intervention and support for children showing signs of emotional or psychological difficulties. These are complemented by social services in schools, which NCSS supports, ensuring a holistic approach to mental health promotion within educational settings or parenting programmes aiming at enhancing parenting skills to promote child mental health and improve family functioning (Goh et al., 2023).

Prevention of mental health disorders in children involves early detection and timely intervention. It aims to reduce the incidence and prevalence of mental health disorders by addressing risk factors and enhancing protective factors, often targeting individuals or groups at higher risk for developing mental health issues. Singapore's Response, Early Intervention, and Assessment in Community Mental Health (REACH) programme, led by the Institute of Mental Health (IMH), provides mental health services directly in schools and community settings for students below 19, focusing on early identification and necessary support. As IMH also provides specialised clinical services to children and adolescents, the REACH programme serves to ensure the crucial continuity of care- linking community-based support and clinical interventions.

These efforts are further complemented by civil society and NGOs who provide both standalone, centre-based services and run programmes embedded into schools or community settings. However, while many of these interventions are promising and address identified needs, they vary widely in scale, evidence base, age group and sustainability. Without systematic mapping, it is difficult to assess whether the current ecosystem sufficiently addresses current and emerging needs, identify which populations remain underserved, and determine how best to align resources with global best practices.

## *Mapping the landscape in Singapore*

This mapping responds to that gap by conducting a comprehensive landscape mapping of children's mental health and wellbeing interventions for children aged 3-11 in Singapore.

This study received an exemption from the National University of Singapore's Institutional Review Board (NUS-IRB) review, with the reference code: NUS-IRB-2024-1117. To ensure analytical rigour, the mapping of interventions was structurally guided by a tripartite framework of internationally recognised standards, including WHO's 2022 Network of Community-Based Mental Health Services, the WHO-UNICEF Standards for Mental Health Care 2024, and the WHO Guide for Evidence-Informed Decision Making 2022. Using the promotion-prevention-literacy framework drawn from WHO and UNICEF guidance documents, the study classifies existing programmes, examines their alignment with international evidence, and identifies strengths and gaps in the ecosystem. The methodology combined surveys, key informant interviews, and a stakeholder validation workshop enabling a broad overview. The authors note that this mapping is still non-exhaustive, with limitations to including public educational settings and limitations in conducting in-depth interviews with all survey respondents and vice-versa. (Details of methodology in Appendix A)

Finally, by providing a robust overview of the current state of children's mental health support, this report aims to offer actionable recommendations for policymakers, funders, and service providers/programme implementers. The goal is to strengthen the ecosystem, ensure that investments are channelled towards effective and sustainable programmes, and ultimately secure the mental wellbeing of Singapore's next generation.

# 2

# Landscape of Children's Mental Health & Wellbeing Programmes

*The 43 participating programmes that address children's mental health and wellbeing in Singapore combine locally-informed practice with elements from international frameworks, tackling promotion, prevention, and literacy through inclusive, hands-on approaches that put early intervention and society-wide collaboration at the heart of children's wellbeing.*

This chapter explores how children's mental health and wellbeing programmes are designed and their suitability for the target context.

Our survey mapped 43 programmes addressing the mental health and wellbeing of children aged 3-11 in Singapore. A diverse range of organisations deliver mental health and wellbeing promotion, prevention, and literacy interventions for children, often working across all three domains (n=16) rather than in silos. Figure 1 illustrates that a majority of programmes adopt a mental health promotion (n=30) and mental health prevention (n=30) approach. Out of a total of 43 programmes, more than half feature mental health literacy (n=24) as a key component. Many interventions combine trauma-informed care with social-emotional learning and family support, blurring the lines between early intervention and broader awareness-building.

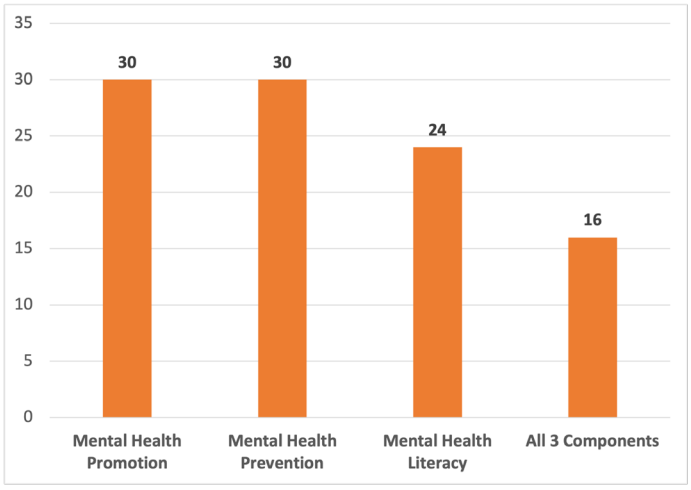


*Figure 1: Programme counts by components (n=43)*

Figure 2 shows that a majority of the programmes are designed for children aged 6-8 and 9-11, with comparatively fewer targeting younger children aged 3-5, suggesting a potential gap in early-years support.

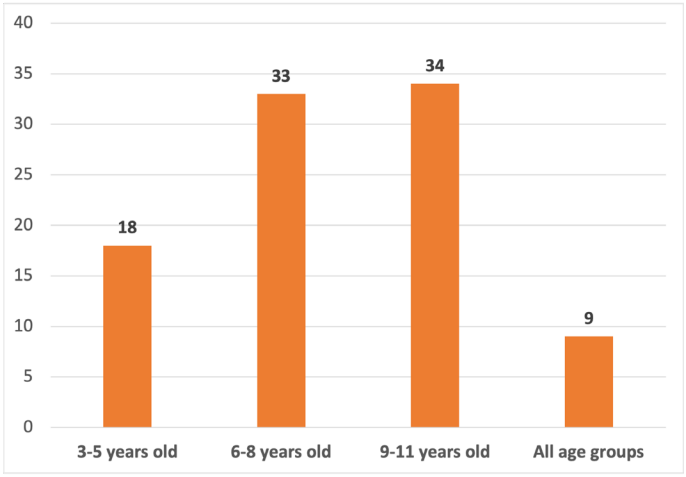


*Figure 2: Programme counts by age groups (n=43)*

From our interviews, child mental health and wellbeing programmes have largely emerged from the personal observations (n=8), lived experiences, and motivations of their founders, rather than solely from formal needs assessments or large-scale population-level data. In practice, this means that programme design is often rooted in the founders' proximity to the everyday struggles of children. For example, educators and school leaders may notice recurring patterns of stress, disengagement, or disruptive behaviour in classrooms; mental health and wellbeing practitioners may observe gaps in accessible care for children outside of clinical settings; and parents, confronted with the challenges faced by their own children, may seek to create more supportive environments.

Of the organisations interviewed, 18 designed their programmes for Singapore's unique cultural, linguistic, and social context, whereas 11 adapted established overseas models and frameworks to suit local needs. These included guidelines on screentime for children by the WHO, Safe Place to Grow and Positive Youth Development models from the United States of America (USA), LivingWorks Education's suicide prevention training from Canada, and the Ginsburg Theory of Resilience's "7Cs of Resilience" framework. Programme teams also reviewed and incorporated research from stakeholders and institutions in countries such as the USA, Australia, Canada, and across Europe.

Some programmes already incorporate internal referral pathways, directing children to different interventions within the same programme depending on their mental health needs. While there are also occasional referrals across programmes, particularly for children requiring greater support or specialised attention, there is a need for stronger collaboration. Programmes would benefit from a clearer understanding of one another's offerings, referral pathways for specific needs, and a shared vision of how Singapore's children's mental health and wellbeing ecosystem can work together as an interconnected network rather than in isolation.

## 2.1 Mental health promotion

Through this landscape mapping, 30 programmes were identified that focused on mental health promotion. Such programmes are characterised by a holistic, strengths-based approach focused on fostering children's overall wellbeing, resilience, and life skills, proactively. Some of these initiatives are informed by evidence-based frameworks such as the CASEL model for social and emotional learning and Yale's RULER approach, helping to structure programming around emotional intelligence principles. These initiatives are implemented in diverse settings, including schools, community centres, family service centres, enrichment academies, and arts organisations.

Needs are not "one-size-fits-all"; different children face distinct emotional, social, and developmental challenges. These needs also evolve over time, meaning that what supports a child at one stage may not be sufficient at another. To address this, programmes must be able to recognise and adapt to children's changing circumstances, whether it is helping younger children learn to regulate emotions or supporting neurodivergent children with safe and inclusive spaces. Recognising this diversity of needs, the mental health promotion programmes for children in Singapore aim to develop social-emotional skills (recognising and expressing emotions, empathy, communication, conflict resolution), strengthen life skills (coping strategies, resilience, navigating online-offline environments, and independence for children with disabilities), and improve mental health and wellbeing through normalised conversations that encourage help-seeking. They also respond to the need for building safe and supportive spaces that foster resilience, enable early identification of distress, and provide accessible, non-verbal modalities of support.

These programmes address the need to equip caregivers and educators with the skills required to detect early challenges, guide children effectively, and prevent the escalation of symptoms or developmental concerns. One initiative explicitly designs sensory and nature-based programming for children with ADHD, dyslexia, and neurodivergence, addressing both regulation skills and a lack of safe "play" spaces that many academic-focused schools and high-density neighbourhoods fail to provide.

While these programmes target younger children, some are open to families or older children. Some even flexibly include older children with intellectual or developmental disabilities whose needs don't line up neatly with chronological age.

***"Giving children the tools and ability to enhance their self-awareness and attention abilities."***

## Settings

Out of 30 interventions focusing on mental health promotion, almost half (47%) take place in schools, classrooms, and kindergartens. Additional non-clinical settings for interventions include community spaces, such as homes, recreational outdoor spaces, and community arts/education hubs (n=7), or online platforms (n=9).

## Activities

Programmes blend movement, sensory play, arts, guided skill practice, and parent/teacher engagement. As seen in Figure 3, the most common mental health promotion activity is life skills development and mindfulness, covered by 26 out of 30 programmes.

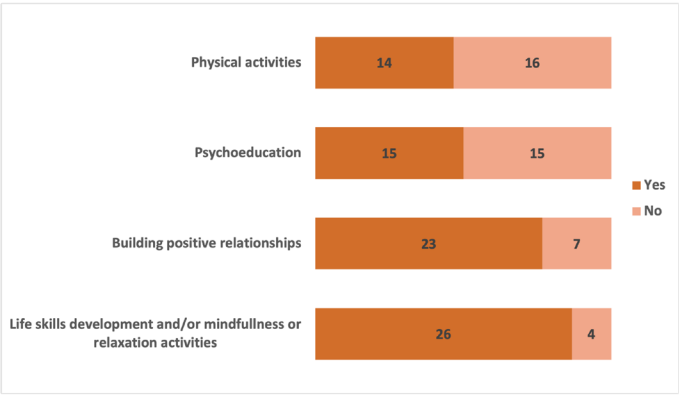


*Figure 3: Programme activities used to promote wellbeing and/or mental health*

Programme activities used to promote wellbeing and/or mental health span from physical activities to psychoeducation, life skills development and positive relationships building.

Below are examples of the activities used in these programmes, as described by our interviewees and as categorised in Figure 3[1]

## Physical activity

Movement and sensory-based approaches to help children regulate emotions and cope in a fun, holistic way. Examples:

- To support and empower children with disabilities, one programme has established creative labs where children can explore and express themselves through music, visual arts, and sports. These labs provide a safe and stimulating environment that encourages self-expression, builds confidence, and fosters social and emotional development.
- Combining sports, music, and storytelling offers a holistic approach to support social-emotional learning and enhancing children's mental wellbeing by helping to alleviate stress and academic pressure. This engaging method allows children to have fun while gaining insights into different emotions and learning how others manage them through the stories they hear.

## Psychoeducation

Sessions that talk about mental health and wellbeing, raise awareness of emotions and promote healthier responses to stress and negative feelings. Examples:

- Workshops run on a cohort level for children to be more aware of their emotions and how to manage them. They focus on increasing understanding of emotions, being aware of negative emotions, the effect these emotions have

1. The classification of programmes is derived from self-reported identification under mental health promotion.

on them, and the "constructive actions they could take to manage those negative emotions".
- Art serves as a powerful medium for children to express themselves and develop key skills such as social-emotional learning, self-awareness, self-regulation, confidence, and critical thinking. For children who may struggle to articulate their feelings verbally, creative expression offers an accessible and meaningful way to communicate their emotions.

## Workshop insight:

Meditation has been proposed as a tool to support mental wellness in children, though it faces scepticism due to perceived spiritual associations. Organisations offering school-based programmes have demonstrated that techniques are non-sectarian to gain approval. While pilot programmes outside of schools have engaged hundreds of students, integration into the curriculum has been limited due to concerns about teacher workload.

Early childhood settings have also explored calming techniques, such as meditation and value-driven activities, to help young children regulate emotions. International examples suggest that such programmes can effectively support mental wellbeing.

### *Building positive relationships*

Initiatives that foster stronger family and community support systems through social skills training and peer support activities. Examples:
- Parents are actively informed about their children's physical, social, and emotional wellbeing, and how to continue supporting them at home. Through these children's mental health and wellbeing programmes, parents can observe positive changes in their children and learn strategies to support them, especially for children who regulate differently.
- A school-based mental health initiative adopts a systems-level approach by equipping teachers, principals, and parents to support children's emotional wellbeing. This is achieved through workshops, coaching sessions, and co-developed lesson plans rooted in frameworks such as growth mindset and positive psychology.

## Workshop insight:

Participants shared that the prevention and management of adverse childhood experiences hinged on two key factors: (1) parents prioritising their own wellbeing, and (2) parents understanding the crucial impact of early childhood experiences on their child's development. The participant stressed that recognising both their own and their child's wellbeing is essential for safeguarding the child's overall health and resilience.

One participant shared that facilitators in their programme encourage parents to adopt respectful parenting approaches when supporting their children.

### *Life skills development*

Practical exercises that build coping skills, problem-solving, self-awareness, and self-regulation, while empowering children to express themselves. Examples:
- "Risky play" and "messy play" through activities such as woodworking, whittling, setting up fires, and urban gardening to encourage children to express themselves and become more confident and willing to take risks.

- To ensure continuity and sustainability of programmes, some programmes train

teachers to create and adapt mindfulness content into daily classroom practices.

## *Common features of mental health promotion programmes*

- **Multi-modal, experiential activities**: These programmes employ sports, nature-based play, art therapy, meditation, creative expression, and mindfulness-based programmes to build self-awareness, self-regulation, social-emotional skills, and coping strategies.
- **Systems and ecosystem orientation**: These programmes situate children within family, school, and community networks, recognising the importance of parent-child dynamics and equipping adults to reinforce healthy behaviours in children.
- **Flexible, inclusive design**: Our survey indicates that most programmes are adapted to meet children's specific needs, including considerations for neurodiverse learners and children with disabilities (n=10), family circumstances (n=10), and age-appropriateness (n=34). The organisations consciously review language complexity and cultural fit, often eschewing "clinical" labels in favour of child-friendly- engaging framings. They also take additional measures to consider logistics (location, timing, food) to accommodate low-income families, non-English speakers, or those with limited transportation.
- **Iterative and responsive development**: Curricula are frequently updated in response to observed needs, teacher feedback, parental input, and, where feasible, children's expressed interests. For instance, some programmes adapt content to suit diverse language/cultural contexts, involve children in co-designing activities, or solicit coach/teacher input to calibrate difficulty and appropriateness.

## *How programme appropriateness is addressed*

- Programmes simultaneously balance global frameworks (e.g., mindfulness, positive psychology) with local realities: one programme drew from positive psychology literature and initiatives, while collaboratively adapting the content with students and teachers to ground it in local experiences.
- Appropriateness is also managed via feedback cycles: parents report positively on children "using their voice" or on changed "home dynamics," reinforcing programme fit and need.

## Highlighted organisation:

A community- and family-focused organisation supporting children and individuals with disabilities, primarily those with mild to moderate needs. Their programme enhances cognitive development, life skills, and independence, while their creative labs offer avenues for self-expression through arts, music, and sports. Adopting an ecosystem approach, they work closely with participants and families, reaching over 250 beneficiaries, and have expanded from a therapy-focused model to broader, inclusive programmes. Programmes are highly personalised, using small teacher-to-student ratios or group learning to foster social interaction, and are offered as after-school enrichment.

They prioritise low-resource families and employ an inclusive workforce (30% with special needs or caregivers). Their programmes currently serve 130 families and have engaged over 32,000 people through their events and outreach. Programmes are guided by a Theory of Change framework,

with data-informed approaches to measuring impact, using metrics such as engagement reach, beneficiaries served, partnerships formed, events held, and caregiver feedback, while maintaining alignment with organisational goals.

## 2.2 Mental health prevention

Mental health prevention initiatives (n=30) target at-risk children or those at early stages of distress, intervening before the onset of clinical disorders. These programmes are mostly school- or healthcare-embedded, focusing on early detection, short-term psychoeducation, and skill-building to prevent escalation.

Many of these programmes are focused on "quiet" at-risk children, such as those who internalise distress (e.g., psychosomatic stomach aches linked to academic pressure), prevention aims to intervene before crises. Prevention programmes support those with emerging psycho-emotional or developmental needs through early detection, assessment, and intervention. Programmes work to reduce unnecessary healthcare utilisation, provide community-based support, and equip educators with skills to identify and manage early signs of distress. One programme was created in response to hospitals noticing that children referred for stomach pains were cycling through multiple specialties without access to psychosocial help, which often led to worse outcomes.

Programmes are crafted for high-risk windows; one specifically targets upper primary (P5/P6) where risk of self-harm spikes during transition to adolescence. Another intervention includes children as young as 6 who have stabilised post-crisis. For children facing challenges with emotional dysregulation, one programme applies Dialectical Behaviour Therapy (DBT) techniques, delivered by DBT-certified trainers and volunteers. The intervention covers four core modules: emotional regulation, distress tolerance, interpersonal effectiveness, and mindfulness.

***"What we saw were patients who were being referred to different medical specialties, maybe waiting for a long period to address their difficulties in a psychosomatic lens... Our experience was that these kids were harder to treat. They were more likely to drop out of treatment. They were quite demoralised by their presentation. They had missed a lot of school, or they were going really sporadically. So, there's a real impact in seeing kids who were presenting and not getting intervention early enough."***

### *Settings*

These programmes are often conducted in accessible community spaces (n=13) like family service centres, in healthcare settings (n=8) such as hospitals, polyclinics, or in school settings (n=9) with interventions delivered both individually and in groups, coordinating with community resources for sustained effects post-intervention.

### *Activities*

Programmes range from hospital-based non-specialist screening to art trucks. Out of 30 programmes, awareness efforts are included in 27 preventive programmes, highlighting the strong educational and awareness-raising dimension of these initiatives. Parental involvement is present in most early intervention and prevention programmes (n=34).

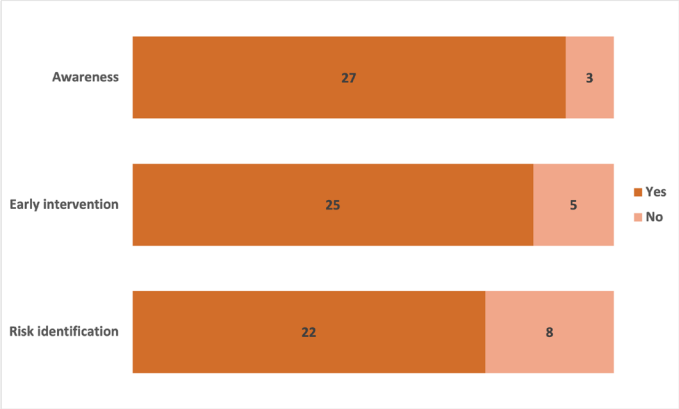


*Figure 4: Preventive strategies used by survey respondents' programmes (n=30)*

Programme activities aimed at preventing worsening mental health or wellbeing range from raising awareness to early intervention and risk identification.

Below are examples of the activities used in these programmes, as described by our interviewees and as categorised in Figure 4 [2]

## *Awareness*

Efforts within mental health prevention that focus on building understanding of specific conditions such as depression, anxiety, and related disorders. These interventions aim to increase recognition that such illnesses exist, how they manifest, and the importance of early support, thereby reducing stigma and encouraging timely help-seeking. Examples:

- Children showing early signs of distress are enrolled in a three-session programme at a psychosomatic paediatric clinic, which facilitates a more detailed exploration of their psychosocial background and offers structured mental health education.
- Parents of children with anxiety participate in sessions that equip them with strategies to support their child's emotional needs, manage anxious behaviours, and lower the risk of anxiety disorders during the preschool years, thereby easing the transition to primary school. The programme intentionally avoids medical terminology, framing concepts in everyday language for increased accessibility.

## Workshop insight:

Students with special needs are often targeted for bullying due to perceived vulnerability, while perpetrators' behaviour may stem from underlying psychosocial issues. Schools typically respond with disciplinary measures, which can limit access to external support for the perpetrators and focus attention on the victims. In contrast, the Norwegian approach emphasises the role of bystanders in preventing and addressing bullying.

## *Early intervention*

Collaboration with healthcare and social services, peer support programmes, and other support systems to reach and assist at-risk children early. Examples:

- Group-based support is provided to children identified as having early signs of behavioural issues or needs that extend beyond standard classroom settings. These group settings are typically facilitated by a formally trained professional. Some programmes have a multidisciplinary team of facilitators made up of social workers and counsellors. This support can span 6 to 8 sessions. During these sessions, topics such as "enhancing self-worth, self-confidence, and communication skills" are covered.
- For children exposed to domestic violence and experiencing significant emotional and psychological trauma, mental health support is provided through a combination of group-based interventions, play therapy, and peer support.
- One-on-one sessions are offered to children who may need more individual attention and support.
- Creative art therapy offers non-verbal avenues of support for children through

2. The classification of programmes is derived from self-reported identification under mental health prevention.

visual arts, music, dance, and movement, extending beyond traditional counselling approaches. It has proven effective in addressing trauma, anxiety, and depression, particularly for children who are more withdrawn or find it difficult to express themselves verbally.
- A hospital-based paediatric mental health initiative in Singapore focuses on early intervention for children aged 3-11 showing emerging psychosomatic symptoms, offering brief, structured psychoeducational support tailored to symptom severity and onset.

## *Risk identification*

Spotting early symptoms or warning signs (e.g., anxiety, behavioural changes), training teachers and caregivers to recognise risks, and using screening tools or assessments such as validated questionnaires or mental health checklists. Examples:

- A programme has expanded beyond the hospital setting to include primary care and emergency settings, adopt a flexible, needs-based model, and invest in training community providers to identify and manage psychosomatic distress early.
- An anonymous platform offers children a safe space to talk about their mental health, normalising help-seeking while enabling early detection of distress and facilitating warm referrals through professional guidance.

## *Common features of mental health prevention programmes*

- **Targeted, tiered intervention**: Hospital- and school-based interventions serve children who show early emotional, psychosomatic, or behavioural signs, often in upper primary or transition years (P5/P6).
- **Trauma- and play-based supports**: Interventions for children exposed to family violence include arts-based therapy for children to verbalise trauma through more creative, play-based, and empirically grounded prevention strategies.
- **Integrated parent and school involvement**: Prevention programmes routinely involve parents and caregivers, in assessments and as co-participants, with continuous collaboration with school staff.
- **Screening and right-matching**: Intake processes stratify children by risk and ensure appropriate referral, minimising stigma and maximising fit. One programme offers lighter psychoeducation to children with shorter symptom duration.
- **Adaptive, context-specific & culturally sensitive design**: All these efforts emphasise ongoing calibration to children's developmental stage, family context, cultural background, and school environment.
- **Early identification and tailored support**: Programmes include mechanisms for recognising students who may require additional support, whether through teacher observations, informal assessments, or self-reports. These students are then provided with targeted preventive interventions or referred to specialised services as appropriate.

## *How programme appropriateness is addressed*

- Programmes include flexible formats: small group, individual sessions, after-school or during holidays, attuned to the busy schedules and often difficult lives of at-risk families.
- Trauma-informed approaches and adaptive screening ensure programming is not only developmentally but emotionally appropriate, play therapy accommodates children who struggle with verbalisation, using art and movement instead.

## Highlighted organisation:

The programme supports children exposed to domestic violence by prioritising their psychological and emotional wellbeing within the family system. Targeting families where immediate safety risks have stabilised, the programme enhances resilience and coping through synergetic play therapy, group-based therapeutic interventions, peer support, and creative expression. Caregivers are included through pre- and post-programme sessions to set family goals and sustain progress.

Run in small groups of 8-10 over 8 sessions conducted during school holidays, the programme reduces barriers for low-income families by providing meals and transportation support, while remaining inclusive of children with special needs including those with ADHD or mild intellectual disabilities. Children are recruited via Family Service Centres and assessed to ensure suitability for group participation.

Evaluation is embedded through observations, family feedback, and the Strengths and Difficulties Questionnaire, capturing outcomes at short-, mid-, and long-term intervals. Early findings indicate reduced emotional and behavioural difficulties and improved pro-social behaviours. By combining play-based therapy, family involvement, and structured evaluation, the programme offers a holistic, culturally adapted intervention that fosters healing, resilience, and family restoration for children affected by domestic violence.

## 2.3 Mental health literacy

Mental health literacy programming (n=24) raises awareness, encourages help-seeking, and reduces stigma, equipping children, parents, and educators to recognise, articulate, and address mental health issues. These initiatives focus on knowledge transfer, myth-busting, and normalising conversations around emotions and mental wellness. They are reported to be flexible, offering either one-off or recurrent activities depending on the needs of their stakeholders.

Children's mental health programmes in Singapore address low levels of mental health literacy by providing child-friendly information that raises awareness, normalises help-seeking, and reduces stigma and misinformation before problems become acute. They emphasise the importance of recognising emotions, understanding psychosomatic symptoms, and knowing where to seek help, for both children and teachers. At the same time, programmes build social-emotional strengths, particularly for children from low-income backgrounds, and equip parents and caregivers with the knowledge and skills to better support their children's wellbeing.

Importantly, literacy initiatives place strong emphasis on engaging teachers and parents, with 18 programmes reporting such efforts through survey responses. Recognising their critical role in shaping children's attitudes toward mental health, these initiatives address adult misconceptions and reduce stigma among caregivers and educators, thereby creating a more supportive environment that enables children to seek help more confidently and earlier.

*"We are going to bring you this project about mental health, I think the children will have a big question mark. They don't know... What is that? Maybe they hear the words many times before, but they may not be able to relate that to their day-to-day life... we wanted to create the awareness of the importance of these healthy habits around these areas, and how these healthy habits actually relate to your mental wellness as a result of that."*

## Settings

The landscape mapping highlights that Mental Health literacy activities and programmes are carried out mostly in school environments (n=8), community spaces (n=8) with other being delivered through digital platforms or in healthcare settings (n=8).

## Activities

Mental health literacy is delivered through interactive workshops, games, storytelling, structured sessions, and educational materials. Parents and teachers are also trained and supported through digital resources, handbooks, and targeted caregiver-focused interventions. The most commonly used approaches are interactive games and workshops (n=17) and educational materials (n=16). Below are examples of activities used in these programmes.

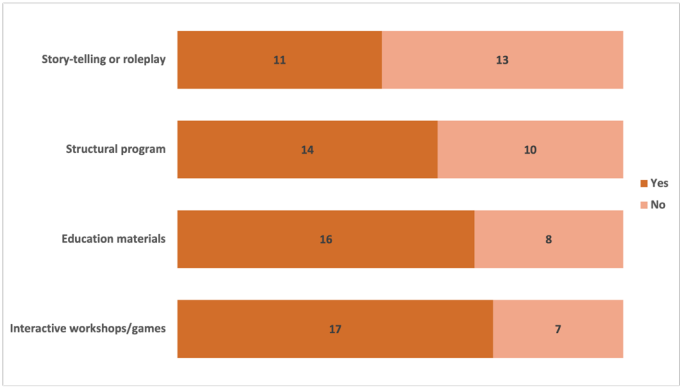


*Figure 5: Methods used to improve mental health literacy (n=24)*

Activities designed to enhance mental health and wellbeing literacy include storytelling and roleplay, structured programmes, educational materials, and interactive workshops or games.

Below are examples of the activities used in these programmes, as described by our interviewees and as categorised in Figure 5[3]

## Interactive workshops/games

Engaging activities in schools and community spaces to build emotional awareness and mental health literacy. Examples:

- Activities range from school assemblies and classroom sessions to public events, including the use of simple emotion cards in lower primary classes, interactive talks, and community art exhibitions.
- Teachers/parents are routinely trained, with digital resources and repeated workshops available outside school hours.

## Education materials

This includes handbooks, videos, posters, and e-magazines that provide child-friendly content and practical guidance for children and parents on mental health, digital literacy, and overall well-being. Examples:

- Parents play a crucial role in fostering healthy habits. To support the

3. The classification of programmes is derived from self-reported identification under mental health literacy.

development of digital literacy, they are provided with handbooks, video series, and posters that outline recommended screen time for children, suggest ways to use devices productively, and offer guidance on setting appropriate boundaries around device use.
- E-magazines serve as a platform to promote mental health literacy, offering child-friendly content alongside dedicated sections for parents on how to support their children's wellbeing.

## *Storytelling or roleplay*

These activities can help children express emotions, build social-emotional skills, and develop agency, while framing mental health as a proactive and universal practice. Examples:
- The use of art can help students process emotions by connecting personal experiences with narratives in artworks, framing mental health as a proactive and universal practice rather than a response to problems.
- Movie-making is a creative activity that allows children to express their ideas and perspectives through storytelling and roleplay, fostering social-emotional skills, agency, and 21st-century competencies.

## *Structured programme*

Structured programmes delivered within a defined timeframe to improve mental health literacy for children and parents. Examples:
- One programme, adapted from Paula Barrett's Australian cognitive behavioural therapy frameworks, is delivered over 8–12 weeks in small, play-based groups, using interactive activities, roleplay, videos, and books to teach children, parents, and facilitators about stress, anxiety, and emotional wellbeing.
- A time-limited, structured trauma response programme provides immediate support for children aged 6-18, teaching coping skills and guiding caregivers to manage their own responses while supporting the child.

## *Common features of mental health literacy programmes*

- **Targeted education and campaigns**: Organisations run targeted initiatives for mental health literacy including school-based talks, campaigns on cyber wellness and art-based myth-busting activities which communicate crucial messages about emotion recognition, stress, support services, and digital wellbeing.
- **Whole-school and community focus**: Programmes engage not just children, but parents, teachers, school leaders, and even older youth who mentor or share lived experience.
- **Diverse, accessible delivery methods**: Video series, interactive roadshows, emotion cards, sticker boards, myth-buster games, digital content, family workshops, and take-home activities address children and adults in schools, homes, community spaces, and online.
- **Participatory, empowering, feedback-rich approaches**: Programmes integrate child and parent feedback cycles, interactive boards, surveys, story-sharing, and informal dialogue to make content relevant and engaging. Further, peer-driven approaches break down trust barriers and make content relatable.
- **Upstream and field-wide impact**: Increasingly, literacy is positioned not only as school-based but as a social movement, with organisations running community/digital outreach, and many providers partnering with MOE, MSF, and other public, philanthropic and private agencies.

## Workshop insight:

One participant highlighted the use of social media to share bite-sized content on mental health and social-emotional learning for both children and parents. Emphasising that parents' own SEL is often overlooked, he noted that recognising triggers in children's behaviour can help parents respond more constructively, preventing negative patterns from being passed down. Rather than relying on formal websites, the organisation leverages social media as the primary platform to engage parents, provide practical guidance, and promote positive parenting behaviours.

### *How programme appropriateness is addressed*

- Iterative process for linguistic and cultural review: text and visuals are modified after feedback from non-English-speaking or low-literacy children and their families and teachers.

## Highlighted organisation:

The programme offers workshops for parents to enhance their mental health literacy. Targeting parents of children aged 7-12, the programme addresses challenges such as academic and peer stress, while aligning closely with the MOE curriculum to ensure consistency between home and school guidance.

Workshops, offered both virtually and in-person, typically run for 1–1.5 hours and cover a range of topics tailored to the age of the child. For parents of preschoolers, the focus is on social-emotional skills, while for primary school parents, the emphasis shifts to building resilience and managing stress. Content is regularly updated based on ongoing feedback from parents, and programme effectiveness is measured through pre- and post-workshop surveys to assess knowledge gained. Additionally, the programme includes a feedback mechanism that encourages parents to reflect on how they can apply the workshop topics at home, fostering a practical connection between the sessions and real-life parenting.

# 3

# Programme Domains

*At the heart of children's mental health and wellbeing programmes should lie human rights, participation, community connection, accessibility, equity, and inclusion. These principles ensure initiatives are not just effective, but also just, empowering, and sustainable.*

Based on the WHO-UNICEF Service Guidance on the mental health of children and young people, this chapter examines specific programme domains that serve as benchmarks for ethical and inclusive child mental health initiatives. It considers human rights-based approaches, where programmes are designed to respect, protect, and fulfil the rights of children and young people, including their rights to information, privacy, non-discrimination, respect, and protection from harm. The chapter also discusses the importance of a participatory approach, which ensures that children are not only beneficiaries but active contributors to programme design, implementation, and evaluation.

The mapping highlights community-embedded efforts, which emphasise meaningful partnerships with civil society actors such as schools, primary care providers, social service agencies, and community groups, as well as the value of co-design and community-led delivery. In addition, the chapter addresses accessibility, examining how programmes mitigate structural and social barriers whether financial, geographic, environmental, linguistic, or related to mental health literacy that may limit participation. Finally, the chapter analyses whether programmes are equitable and inclusive, ensuring that services are offered fairly across demographic groups and extend to populations who have historically faced barriers in accessing mental healthcare.

Collectively, these domains provide a framework to assess whether programmes are not only effective, but also rights-based, inclusive, and sustainable in their impact.

## *Human rights-based approaches*

Not many organisations actively consider how children's human rights can be placed at the centre of their programmes. Among those that do, the dominant framing of a rights-based approach remains limited to ethical service delivery, ensuring safety, and maintaining confidentiality. During the interviews, several (n=17) programmes reported efforts to safeguard children's wellbeing and safety, embed confidentiality protocols into their data management processes and train staff, volunteers, and implementers in ethics.

For example, one programme underscored trauma-informed training for volunteers, emphasising safety above all else:

***"The volunteers that come in learn about trauma-informed care. We discuss youth profiles, humility, and understanding. They are trained in ethics, understanding what's okay and what's not okay, with safety above all else."***

However, these measures, while important, reflect a lens of protection, where children are positioned primarily as vulnerable recipients of programmes.

By contrast, fewer programmes embedded practices that uphold children's agency and autonomy in a substantive way. Only four organisations explicitly described efforts to respect and recognise children's autonomy, whereas six reported efforts to inform children of their rights. This imbalance highlights that most implementers interpret children's rights through the narrower lenses of safety, confidentiality, and ethics rather than through

fostering voice, choice, and decision-making power. The current landscape therefore reflects a critical gap. While protection is rightly prioritised, children's capacity to exercise agency within mental health and wellbeing initiatives remains under-recognised and underutilised.

## *Participatory*

Although there was evidence that children were occasionally involved in programme design, implementation, and evaluation, central to a participatory approach that emphasises their active role in shaping and assessing programmes, children's contribution was comparatively limited, with other stakeholders playing a far more active role. Our survey findings indicate that, mental health professionals, such as psychiatrists and psychologists, as well as social workers (n=24), played the most active role, contributing expertise on intervention design, clinical appropriateness, and evidence-based practices. In the planning and development of child mental health and wellbeing programmes, parents and caregivers (n=19) were also involved, providing insights into children's needs at home and helping to shape family-focused components. Children (n=18) themselves contributed feedback on content and delivery to ensure activities were engaging, relatable, and meaningful. Academic experts and teachers participated by reviewing programme frameworks, aligning activities with developmental and educational goals, and providing practical perspectives on implementation in school settings. School counsellors offered guidance on strategies for integrating support within existing school services. Other contributors, such as representatives from hospitals, community partners, philanthropic organisations, art therapists, implementation research experts, and government or educational bodies, were involved based on the nature of the programme, its delivery, and funder objectives.

Interviewees consistently highlighted the importance of user testing and feedback loops to ensure relevance and effectiveness. One participant described how their team conducted a user-testing study to refine the design and layout of their website, while also gathering feedback from parents on the clarity, usefulness, and appropriateness of its content. This process not only improved usability but also grounded the programme in the real needs and perspectives of its intended audience.

The concept of co-designing interventions with children and communities emerged as both promising and challenging. While still relatively new to many organisations, it marks a shift away from traditional top-down approaches. As one participant reflected, their earlier programme design had relied largely on professional expertise in psychoeducation and conventional cognitive behavioural therapy (CBT) delivery, without significant input from children or caregivers. Such reflections highlight the growing recognition of participatory approaches as a way to make interventions more responsive and empowering.

However, interview respondents also noted that meaningful co-design, particularly with younger children, presents unique challenges. Limited access to children's perspectives, along with the difficulty of identifying engaging and age-appropriate methods for feedback collection, often constrain participation. As a result, there is a pressing need for more creative, child-friendly consultation methods that not only capture children's voices but also ensure they have a tangible influence on programme design.

## *Community-embedded*

Many children's mental health and wellbeing programmes are strongly community-embedded, with 24 out of 43 participating programmes featuring community-based

sessions such as public awareness campaigns or support groups in local centres, building partnerships and engaging a wide range of stakeholders beyond mental health professionals. Local organisations often take a central role, collaborating with one another to expand reach and strengthen impact. These partnerships allow programmes to expand their reach, tap into existing community networks, and leverage the expertise and resources of multiple organisations.

Schools and teachers serve as crucial partners, acting as hosts and facilitators for programme delivery. Several initiatives work directly with schools to involve teachers, counsellors, and support staff in designing and implementing activities, while also engaging parents to maintain continuity of support outside the classroom. As one programme noted:

***"Parents and caregivers are kept informed of their child's progress through a report… Parents have expressed that through these reports they see their children in a different light as they recognise that the child may have an unmet need."***

Volunteers and university students play an active role in programme delivery, supporting logistics, assisting with activities, and contributing to co-design processes. Engaging non-mental health professionals in meaningful ways helps programmes extend their reach while fostering community ownership and shared responsibility.

Mental health professionals remain essential for ensuring clinical appropriateness and supervision, with referrals to specialists such as psychiatrists, psychologists, or upstream community programmes when required. Additional contributors such as play therapists, speech therapists, and teachers from various disciplines highlight the multidisciplinary support network that underpins effective programme delivery.

Government agencies, hospitals, and corporations provide further support through funding, alignment with national initiatives, and partnerships for event-based activities. Agencies such as MOH, MOE, and NCSS may provide financial support, technical expertise, or resources for programme implementation, as well as frameworks for monitoring and evaluation. In some cases, government bodies collaborate directly with hospitals and schools to co-lead initiatives. By keeping programmes aligned with broader national initiatives, it can foster multi-sector coordination and bridge the gaps between schools, healthcare providers, and local communities.

## *Accessibility*

Accessibility is a critical dimension of child mental health programmes, as it determines whether intended beneficiaries can meaningfully engage with and benefit from the interventions offered. Across the 43 programmes reviewed, 34 incorporated age-appropriate content and activities, 13 specifically adapted content for different languages, 26 used culturally sensitive approaches, and 10 made deliberate accommodations for children with disabilities.

Several interviewees emphasised the importance of real-time responsiveness, where facilitators dynamically adapt content and pacing to children's cues or emerging needs. Accessibility was also advanced through flexible delivery models, for example, embedding programmes in everyday settings like schools and clinics, shifting from fee-based to donation-supported formats, or piloting digital content tailored to underserved linguistic groups. Service gaps for certain language groups, such as Tamil speakers, motivated some organisations to create new offerings like Tamil mindfulness sessions. Importantly, these were not designed to

target a particular socioeconomic group but rather to reach communities historically underserved. Similarly, other organisations supplemented English-language delivery with Mandarin, thereby broadening accessibility while keeping English as the primary medium.

To overcome financial barriers, many initiatives were provided at little or no cost. One programme that did require fees actively sought to reduce exclusion by making its 8-week course eligible for SkillsFuture Credits, allowing participants facing financial hardship

***"Our programme is SkillsFuture Credit-eligible, so even if they are not that well-off, as long as they have the SkillsFuture Credit and would like to use them, they can."***

## *Equity and inclusion*

A strong emphasis on inclusion and equity was evident across programmes, with many organisations adapting their approaches to ensure that children with diverse needs could participate meaningfully. Out of the programmes reviewed, 26 incorporated culturally sensitive approaches, while 10 specifically addressed accessibility for children with disabilities. These commitments reflect a deliberate effort to move beyond one-size-fits-all models and design interventions that are equitable and responsive to children's varying contexts.

For programmes adapted from overseas models, careful localisation was essential. One example would be the way in which Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy were reworked into culturally responsive formats like Mindfulness-Based Wellbeing Enhancement, ensuring greater relevance to Asian contexts. Programme developers also tailored interventions to developmental stages, neurodiversity, and varying levels of risk. For example, children with special needs often received one-on-one sessions to reduce discomfort, while neurotypical children participated in groups. High-risk children received additional modifications to ensure both safety and therapeutic relevance.

Many programmes also embraced innovative delivery methods to respond to generational shifts. Interactive and play-based approaches, including art, storytelling, peer support, and expressive activities, were incorporated to reduce the emotional burden of conventional talk therapy and to create safe, engaging spaces for children to process difficult experiences. Facilitators noted that such methods were particularly important for children who had not yet developed the cognitive or emotional maturity to express themselves verbally or abstractly. Screening mechanisms further ensured that children whose behaviours might disrupt group sessions were offered individualised alternatives better suited to their needs.

Taken together, these strategies illustrate a strong commitment to responsiveness, inclusivity, and cultural adaptation in programme design. By addressing both systemic barriers and individual differences, organisations demonstrated the importance of tailoring interventions to the diverse realities of children and families.

# 4

# Monitoring & Evaluation of Programmes

*Programmes supporting children's wellbeing and mental health in Singapore employ a range of evaluation methods, varying in structure and complexity. Key outcomes include participants' engagement and participation levels, and participants' satisfaction levels. Collecting and evaluating these data plays an important role in understanding the level of success of the programmes, and how to identify key barriers to address and improve.*

Out of 41 programmes responding to this section of the survey, 66% of them have engaged in some monitoring and evaluation processes (n=27), while the remaining 14 (n=14) have yet to conduct an evaluation of their programmes.

## *Stakeholders involved in monitoring and evaluation*

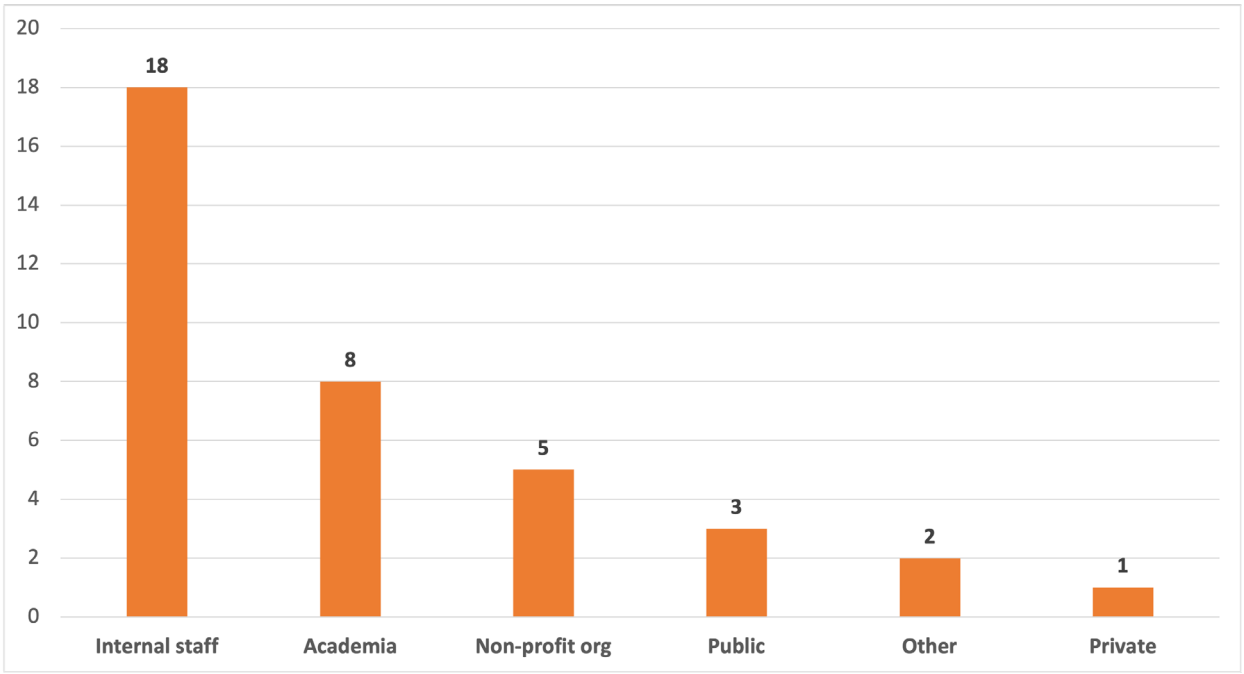


*Figure 6: Stakeholders involved in monitoring and evaluation processes (n=27)*

Out of the 27 initiatives that have engaged in monitoring and evaluation processes, two-thirds involved their internal staff in their impact measurement process (n=18), followed by academia (n=8) and non-profit organisations (n=5).

## *Most important outcomes to evaluate the initiatives' success*

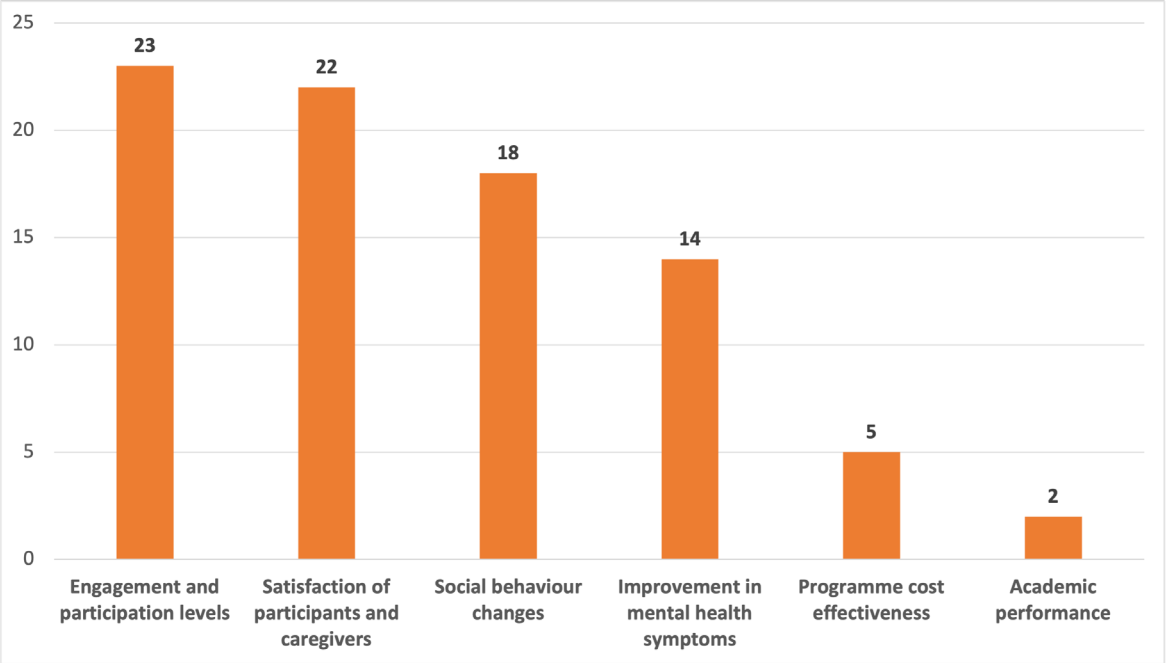


*Figure 7: Most important outcomes to evaluate the initiatives' success (n=27)*

Out of 27 initiatives that have engaged in monitoring and evaluation processes, almost all have found that participants' engagement and participation levels were the most important outcome for assessing the success of their initiatives (n=23), alongside participants' and caregivers' levels of satisfaction (n=22). Two-third of these initiatives have indicated social behaviour changes (n=18), while more than half of these initiatives have indicated participants' improvement in mental health symptoms (n=14) as the most important outcome to evaluate the success of their initiatives.

## *Method of outcome evaluation*

Out of 27 initiatives that have engaged in monitoring and evaluation processes, almost all sought feedback from the programme participants, including children, parents, and staff (n=26), and almost three quarters have conducted pre- and post-programme assessments (n=20). A few initiatives have also used focus groups or interviews (n=8) and scientific methodologies such as using control groups or randomisation (n=5) to evaluate the programme outcomes.

Additional types of questionnaires and tools used to collect data and measure outcomes include KIDSCREEN, KPI metric, Psychometric scales (YP-CORE, DASS-2, K-10, GAD-7), Strengths and Difficulties Questionnaire (SDQs), Five-Facet Mindfulness Questionnaire, Euro Quality of Life Five Dimensions, Children's Global Assessment Scale, Komodo survey, Children's Somatization Inventory, CASEL Evaluation Framework, in addition to questionnaires and session reports developed in-house. An interviewee describes how observations made during the programme correspond with feedback obtained through the SDQs, which were administered to both children and parents:

***"So the assessment tool we use actually use the Strength and Difficulties Questionnaires (SDQs), where we actually use it for both the caregivers and the children and I mean through the observations of the kids during the session. We know that they have gained some form of catharsis or some form of their needs met during the Programme during the sessions."***

## *Role of children and parents in evaluation*

Children's involvement in the evaluation process was highlighted by only a few programmes as a way for participants to advocate for themselves and ensure their voices are heard. One interviewee described how their programme values less structured participant input, noting that children's engagement and participation serve as important measure of the initiative's success.

***"Even when they are doing the activity, because we talk a lot about feelings, we get that sort of feedback from them. They are able to tell us clearly how they feel, and answer the questions that we're asking in the workshop setting. I would say that when we get all these responses, we see them interacting or actively participating in the programme. That is also feedback to us to tell us that the programme works, the effectiveness of the programme."***

Contrary to children's involvement, parental involvement was highlighted in various programmes. Addressing a child's needs requires not only support from the employee but also consideration of the family's broader circumstances, which may contribute to the child's difficulties or behaviour. Parental involvement took various forms, ranging from providing consent to actively participating in workshops and offering feedback during evaluation. Parents' involvement is important as they can play a crucial role in ensuring continuity and consistency of learnings from the programmes in community and home settings.

***"[We] evaluate [the programme] based on the progress of the children and the feedback from the parents. How are they regulating at home? Those are things that you cannot see. It's not just at the centre. How are they doing at school, at home, with their siblings, with their parents?"***

## Workshop insight:

Given the persistent stigma surrounding mental health, participants have found it effective to approach parents indirectly when seeking feedback about their children. Rather than framing questions around mental health explicitly, facilitators focus on observable aspects of the child's behaviour and emotional regulation. By discussing topics such as coping, social interactions, and daily challenges, parents are often more willing to share honest and candid insights.

### *Challenges in obtaining participants' formal, long-term feedback for sustainable changes*

Some programmes have highlighted the difficulty of obtaining formal feedback from some of the children due to developmental barriers.

***"In terms of programme evaluation, we focus a lot on self-reporting questionnaires. Now for children, obviously the questionnaires have to go to adults, although of course we do get the children's feedback so you know how they feel after but in terms of deeper and higher-level questions it usually goes to adults."***

While programmes recognised the need to incorporate formal evaluation methods, many of them faced difficulty in the process. Some programmes mentioned a lack of funding to perform these evaluations and obtain valid measures, difficulty evaluating and establishing impact with a lack of comparison groups, constant administration of surveys placings a burden on programme staff, and longer-term evaluations dealing with inaccurate data collection due to loss of follow-up. In addition, while short-term data such as satisfaction surveys are more readily available, obtaining long-term outcome data is more difficult. As a result, evaluations often centre on short-term outcomes from which assumptions are drawn about potential medium- and long-term impacts, making long-term sustainable outcome evaluation challenging.

***"[Long-term outcome evaluation] can be challenging as the entire funding cycle is around 4–5 years long. How can we evaluate [the outcomes] then? The need for evidence and data may inadvertently 'paralyse' programme development."***

### *Dissemination of outcome*

Out of 27 programmes, approximately half (n=13) disseminated their outcomes through targeted channels such as workshops, webinars, or meetings, or direct communication with stakeholders via newsletters and emails. One-third (n=9) shared their outcomes through open-access platforms, making reports publicly available and easily to accessible online. The remaining five programmes (n=5) used restricted-access platforms to disseminate their outcomes, which are not routinely shared or integrated into programme design.

# 5

# Funding

*Heavy dependence on external funding, mainly from government agencies, combined with short-term grants, high personnel costs, and challenges in maintaining free or low-cost services, imposes financial and scalability constraints and highlights the importance of securing long-term funding to achieve sustained impact rather than short-term results.*

Funding has been identified as a major challenge for programmes addressing child mental health, impacting their ability to sustain services, meet funders' expectations, and provide accessible support to those in need. Key issues include the prevalence of short-term funding, difficulties in maintaining free or low-cost services, and the high cost of skilled manpower.

A large majority of programmes (84%) reported receiving external funding, with government agencies serving as the primary funders (n=16). The figure below illustrates that private organisations are the second largest source of funding. This includes corporations that contribute through donations or venue sponsorships for events (e.g. Sentosa), as well as independent fundraisers organised by the programmes themselves.

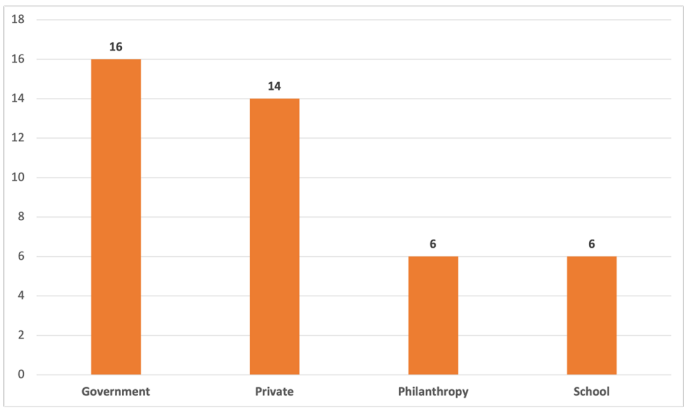


*Figure 8: Funding sectors of programmes (n=36)*

Funding for child mental health programmes in Singapore is diversified, with organisations seeking support from a variety of sources, including government, private, philanthropic, and school-based contributions.

## Government

Key government funders include the Ministry of Health (MOH), Ministry of Social and Family Development (MSF), Agency for Integrated Care (AIC), NCSS, MOE, HPB and the Tote Board. These government bodies provide financial support through grants and subsidies arrangements to programmes across hospitals, schools, and community settings. Notable funding schemes include the AIC Caregiver Training Grant which provides annual subsidies for caregivers to attend approved courses to better care for their loved ones, government co-funding through ComLink, and MOHT's Movement from Health initiative. One respondent suggested the use of the Singapore Grants Portal (https://oursggrants.gov.sg/) to identify potential government funding sources.

## Private

Private funding stems from a range of sources such as individual donations, corporate sponsorships, and direct payment from participants. Some organisations are self-funded or cover the programme costs directly, while others may receive grants from private entities. In community-based programmes, for example, parents may be paying the cost of the activities directly. Additionally, corporate sponsors like Dell have organised digital literacy workshops for children, the Sentosa Development Corporation provided operational support to one of the programmes, and Gardens by the Bay organised a "Sand Art" activity for families.

## *Philanthropy*

Philanthropic funders such as the Quantedge Foundation, Octava Foundation, Temasek Foundation, Templeton World Charity Foundation, Lien Foundation, and The Majurity Trust contribute grants that support the development and delivery of these programmes. These foundations play a crucial role in ensuring sustainability of these initiatives by providing targeted funding for services and projects not covered by government or private sources. For example, The Majurity Trust runs a mental health-specific fund, Musim Mas BlueStar, which supports programmes addressing the mental health needs of children and youth in Singapore. Similarly, the Quantedge Foundation and Lien Foundation have supported programmes focused on providing direct care and empowering parents from disadvantaged backgrounds to better support their children's physical, cognitive, social, and emotional development. This demonstrates a growing interest and potential for funding in this area.

## *Schools*

Schools play a significant role in funding or co-funding mental health programmes, either by paying for services directly or through training funds provided by MOE. Schools have access to financial resources or subsidies which allow them to offer mental health and emotional wellbeing workshops or services for students and their parents. They can also use available resources to deliver training sessions for teachers and school leaders, helping them build their mental health literacy. Training equips educators with the knowledge and tools to recognise signs of mental health challenges in students, allowing them to provide early support or make referrals to appropriate services. By integrating mental health awareness into the school culture, schools not only enhance their capacity to support students' emotional wellbeing but also foster a more inclusive and responsive learning environment.

## *Common funding challenges*

Several organisations noted challenges in managing funders' expectations, particularly as non-government funders often prefer to support short-term outcome measurements rather than sustained, long-term programme delivery and impact measurements. Short-term funding mechanisms complicate efforts to advocate for interventions whose benefits may only become apparent later in a child's life. As one programme representative explained:

***"Early interventions that might not show results quickly might show results later in someone's life… To articulate to funders that this is going to be long-term work. That's the hardest sell."***

- **Short-term funding**: Foundations typically provide short-term grants of one to three years, expecting organisations to develop their own strategies for sustainability and scale. Given that foundations generally do not view themselves as long-term funders, the responsibility for sustained investment in child mental health programmes ultimately falls to the government.
- **Continuation of low-to-no cost programmes**: One programme reported that their services are currently provided free of charge to families, prioritising accessibility for under-resourced children and families. However, maintaining this model depends largely on external funding, in-kind contributions, and volunteer support. Without stable, long-term financial backing, sustaining free or low-cost access remains a significant challenge.
- **Cost of skilled workforce**: Another programme highlighted that funding is directed toward hiring the skilled

professionals necessary to deliver their interventions, such as social workers and counsellors for group-based support. However, limited funding constrains their ability to maintain and scale their interventions to support more children who may need their programme.

- **School budget prioritisation**: Some programmes partner with schools to provide their services and rely on school budgets to fund their activities. One challenge shared would be how schools decide to prioritise their budget. As one interviewee shared, "it's not that there's no money, it's just a different level of prioritisation. Schools will tell you that, 'because of our budget, we can only do so much with it'."
- **Public fundraising and donations**: Programmes relying on donations and fundraising have expressed difficulties achieving long-term financial sustainability, sharing the instability of these income streams and the resulting challenges in scaling their activities. To address this, many have sought to diversify their funding sources to reduce reliance on fundraising or donations.

# 6

# Implementation Barriers

*The effectiveness and reach of child mental health programmes in Singapore are often constrained by a combination of workforce shortages, stigma, parental hesitancy, and logistical hurdles, highlighting the need for systemic support and collaborative action.*

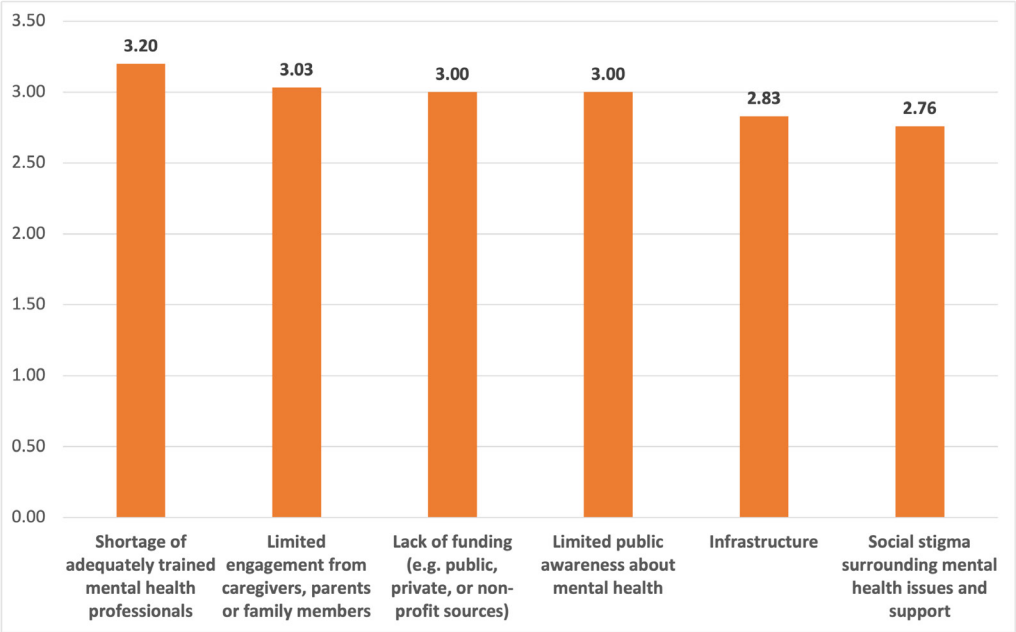


*Figure 9: Main barriers to implementing wellbeing and/or mental health programmes*

The survey identified several key barriers to implementing children's mental health and wellbeing programmes. Participants rated potential barriers to implementation on a five-point scale (1 = Not a barrier, 2 = Rarely a barrier, 3 = Sometimes a barrier, 4 = Often a barrier, 5 = Always a barrier). The most prominent barrier identified was the shortage of adequately trained professionals (mean=3.20), underscoring a critical gap in workforce capacity to deliver child mental health services effectively. This was followed by low levels of stakeholder engagement, insufficient funding, and limited public awareness of mental health issues.

Stakeholder interviews reinforced these findings, highlighting interconnected challenges specific to the Singapore context. A key obstacle is the limited pool of professionals equipped to address the complex mental health needs of children, a constraint further compounded by funding limitations that restrict scalability and long-term sustainability. Stigma surrounding mental health and limited awareness of its impact on children's learning and development also hinder schools and parents from fully engaging with programmes. Some parents and educators remain hesitant to participate or to allow children to access such services due to misconceptions about mental health more broadly. Additionally, logistical challenges, such as overcrowded school timetables and the high cost of external venues, further complicate the consistent delivery of accessible interventions.

Together, these findings suggest that tackling barriers to child mental health programming in Singapore will require a multi-pronged approach: raising public and parental awareness, reducing stigma, strengthening professional training, securing sustainable funding, and addressing structural and cultural obstacles to service delivery.

## Workforce

***"This is not something that we could just go off the street and say, "'Can I have some volunteers?" It is something that requires professionals or years of experience working with the kids, knowing a little bit about mental health challenges, how to do basic counselling, knowing about youth work."***

One of the primary barriers highlighted by interviewees was the shortage of adequately trained professionals to implement mental health programmes effectively. Due to the vulnerability of the target population and the need for multidisciplinary support, relying on one-off volunteers' training sessions is often insufficient. Programmes, particularly those focused on mental health prevention, require ongoing involvement of qualified mental health professionals. In Singapore, the limited availability of trained professionals is influenced both by funding constraints and an overall shortage of specialists in the field. This shortage poses a significant challenge to the quality, scalability, and sustainability of child-focused mental health initiatives. Closing the gap will be critical to ensuring these programmes can effectively meet the complex and evolving needs of the populations they serve.

## Stigma

***"If the child has mental health needs, it might mean that they are not the child is not resilient enough. Or if the child has mental health needs that it's a spiritual, religious explanation to it. So either it's like karma, they must pay for it or it's just something you have to pray through and then you get a miracle and breakthrough. Or if the child has mental health needs, then their potential might be compromised."***

Schools and parents' limited understanding of mental health and wellbeing can present significant barriers to the successful implementation of programmes, largely due to persistent negative or limited perceptions. Mental health is often viewed through an illness-centred lens, which can lead to discomfort or avoidance when engaging with related activities. Parents and educators may also be unfamiliar with therapeutic approaches such as play therapy or art therapy, leading to scepticism or hesitation about their effectiveness in supporting children's emotional and psychological development.

In the context of Singapore's education system, there are widespread concerns that participation in mental health programmes could detract from academic performance or hinder a child's prospects in future. This fear often stems from a cultural emphasis on academic success, which can overshadow the importance of mental wellbeing. One programme representative described the "parents' mentality" as a challenge that perpetuates a cycle of pressure with parents pressuring schools, schools pressuring teachers, and teachers ultimately pressuring students, resulting in an environment of heightened academic stress for children.

## Parental engagement

***"We work with quite a number of parents background who may be in lower literacy level, so they may not actually really understand... We do have a parenting workshop as well, because we hope that they can come in, that they also learn this together. That is where the challenge is, because they will say, "No. I don't have time. I'm busy"... So, the children go through their learning process not accompanied by the parents."***

Parents play a crucial role in shaping their children's overall wellbeing and mental health outcomes. While many programmes actively engage parents through outreach, literacy initiatives, and regular updates on their children's progress, some hesitancy remains. This is particularly significant for younger children, as parental consent is often required to access professional mental health support. Therefore, parents' perceptions and attitudes toward mental health are critical factors that can either facilitate or hinder their children's access to care.

Interviewees shared that some parents may not fully recognise the impact of mental health on learning, behaviour, and long-term wellbeing, which could affect their motivation to engage in related activities or seek support for their children. Additionally, concerns about stigma, cultural beliefs, or fears about the impact of mental health services on their child's future may further reduce willingness to engage. One participant highlighted the influence of a fear- and anxiety-driven culture, sharing:

***"In terms of community, everyone is still very fear and anxiety based. What if my kids don't do well for PSLE? No, then they cannot go. So, it's because of that fear and anxiety that is guiding their parenting."***

These anxieties are often reinforced by societal pressures around academics and achievement, resulting in "helicopter parenting" and a tendency to prioritise academic outcomes over social-emotional development. As another participant observed:

***"I think it's the mindset of the community sometimes, a lot of helicopter parenting… because we're so academic focused, we forget that play is very, very important. People see play as secondary, but play can actually reduce bullying in school because people start to have connection."***

## Workshop insight:

Participants observed that many of the households they support face basic financial struggles, which heavily impact mental health and family relationships. An experimental cash-transfer programme provided $300–500 monthly per family, improving parent-child interactions and easing financial stress, though the initiative has since ended.

Participants highlighted how financial pressures occupy significant "mental bandwidth," limiting families' capacity to focus on wellbeing. They also stressed the importance of tailoring support to diverse household needs.

### *School logistics*

***"The school's timetable is very packed. So they say it's very hard to find time to do [the programme]. And I think that is also one of the main reasons why the sign-up rate is not high."***

Some programmes depend heavily on schools as the primary setting for delivering their activities. This reliance means that the programmes must operate within the constraints of the school's schedule and timetable, often competing with a variety of other school-related commitments

and extracurricular activities. As a result, student participation rates can be limited, as programmes must compete for attention and time alongside established priorities within the school environment.

In addition to scheduling challenges, many programmes face logistical hurdles related to venue availability. Those without dedicated or permanent spaces within schools often need to rent external venues to conduct their sessions. With the rising costs of rental spaces, these programmes are increasingly struggling to secure affordable locations, which in turn limits their capacity to deliver consistent and scalable interventions. The financial pressure from escalating venue expenses poses a significant barrier to sustaining and expanding these initiatives, particularly for organisations with limited funding.

# 7

# Recommendations

*Planning, implementing, and investing in children's mental health and wellbeing programmes requires moving beyond short-term, siloed interventions towards more integrated, inclusive, and sustainable approaches. The following recommendations outline priority actions for funders and implementers to build a coordinated system of support that can endure and evolve over time. These insights focus on ensuring programmes are impactful, adaptable, and equitable across the full continuum of needs. From broader mental health prevention, promotion, and literacy to targeted interventions. These recommendations aim to strengthen both the structural foundations and practical delivery of programmes while building the long-term viability necessary for lasting impact.*

## 7.1 For funders

### *Increase the funding base for children's mental health and wellbeing*

While important contributions have already been made by government agencies, philanthropic foundations, and private sector actors, the funding landscape for children's mental health and wellbeing in Singapore remains relatively limited. By encouraging greater participation from corporates, additional foundations, philanthropists, and new government-linked initiatives, it could help to broaden the pool of funders and reduce overreliance on the same few key players.

A more diverse funding base can also create additional opportunities for innovation, cross-sector collaboration, and long-term sustainability, with more available resources to support the overall ecosystem.

### *Increase support for long-term delivery and scale*

Several organisations highlighted that funding limitations significantly constrain their ability to sustain mental health and wellbeing programmes for children over the long term. Current funding structures are typically short-term, lasting one to three years, with the expectation that programmes demonstrate clear impact within that timeframe to secure government funding or greater integration into the health system. However, measurable impact on children's mental health and wellbeing often takes longer to manifest. While short-term funding and targeted project grants are valuable for sparking innovation and piloting new initiatives, additional avenues for long-term funding are essential to ensure programmes have the manpower, infrastructure, and agility to respond effectively to both current and emerging needs.

Many programmes also provide services at little or no cost, which, while enhancing accessibility, limits their ability to offer competitive salaries and retain skilled staff. This has direct implications for workforce stability and the long-term viability of service delivery. Addressing workforce sustainability therefore needs to be a core consideration in funding models.

Scaling up promising initiatives remains another challenge, particularly when organisations lack sufficient capacity for rigorous monitoring and evaluation to demonstrate impact and account for delivery at scale. Funders are therefore encouraged to consider not only how they support the direct delivery of services and programmes, but also how they invest in organisations' capacity and technical expertise to carry out robust programme evaluation, plan for scale, and transition toward sustainable long-term

delivery. By providing funding pathways and technical advisories that bridge pilots to scale, especially for programmes that demonstrate strong outcomes and high-quality service delivery, funders can help ensure that promising interventions reach more children and contribute to lasting improvements in Singapore's mental health and wellbeing ecosystem across the lifespan.

## Workshop insight:

Participants shared that current approaches to mental health programming in schools often prioritise quick results over longer-term, relationship-based support. Short-term funding for only a few sessions limits the ability to build trust with children, which is essential for meaningful outcomes. At the same time, stigma around mental health and special needs persists. A more constructive approach would shift the framing from problem-focused questions to goal-oriented dialogue, encouraging self-driven improvement while reducing stigma.

### *Adopt broad and flexible funding practices to foster equity*

Many organisations tailor their programmes to cater to the unique needs of the children and families they serve, including minority groups, underserved communities, or children with special needs. Meeting these needs often requires organisations to be flexible in programming and able to respond to evolving circumstance on the ground. At the same time, funders rightly value well-defined programme structure and clear deliverables to ensure accountability and measurable impact. Striking the right balance between these priorities is essential to ensure programmes are both impactful and equitable.

Funding models that can blend breadth, flexibility, and structure are particularly valuable. Broad-based funding enables programmes to direct resources toward underserved groups and strengthens accessibility for all children. Flexibility in funding, through means such as adaptive programming, responsive budget lines, or allowance for mid-course adjustments, empowers implementers to adapt to emerging needs. Meanwhile, encouraging programme structure ensures accountability to shared long-term goals, maintaining high standards of quality in programme delivery.

By embedding inclusivity, accessibility, and equity as explicit priorities within funding practices, funders can enable organisations to design and deliver programmes that are responsive to the diverse realities of children's lives. In doing so, funders play a critical role in strengthening the overall ecosystem by ensuring that services do not only reach those who are easiest to serve but also extend to those most at risk of being left behind.

### *Foster ecosystem collaboration and knowledge exchange*

Many programmes are tailored for specific communities or subgroups. At the same time, organisations expressed a strong desire to learn from others working in the children's mental health and wellbeing space. Several participants at the stakeholder validation workshop noted their surprise at the breadth and depth of programmes available in Singapore, along with a wish for more opportunities to learn from and collaborate with other organisations.

Funders have an opportunity to play a catalytic role by serving as intermediaries themselves or by supporting platforms and communities of practice that facilitate cross-sector knowledge exchange and collaboration. This includes fostering co-design among diverse stakeholders across healthcare, education, social services and policymaking, so that goals can be aligned and solutions developed

jointly. They can also strengthen linkages between policy and practice, ensuring that programme learnings contribute to broader system change.

By encouraging collaboration at the ecosystem level, funders can help reduce duplication of efforts and improve coordination of care. With a macro-level overview of the landscape, funders are uniquely positioned to identify and address gaps in care, enabling a more comprehensive and multi-pronged strategy for addressing children's mental health and wellbeing in Singapore.

### *Support comprehensive and multi-domain programmes*

Children's mental health and wellbeing are shaped by interconnected factors across socio-ecological levels, ranging from economic and social factors to individual skills and resilience, to family dynamics, school environments, and wider community support systems. Programmes that operate in only one domain risk overlooking opportunities for greater and more sustained impact.

Initiatives that integrate prevention, promotion, and literacy components across individuals, families, schools, and communities should be prioritised. This approach recognises that raising awareness, reducing risk factors, and strengthening protective factors work best in tandem. Flexible, cross-domain models also enable programmes to adapt to emerging needs and embed mental health and wellbeing across education, healthcare, social services, and community settings.

To achieve this, funding mechanisms should support the development and growth of a strong, skilled workforce. Investment in workforce training, upskilling, and cross-sector collaboration ensures organisations have the human resources needed to deliver high-quality, comprehensive programming. A well-supported workforce is essential for reinforcing positive outcomes across multiple environments and building a sustainable ecosystem for children's health and wellbeing over time.

## 7.2 For implementers & practitioners

### *Strengthen evaluation and sustainability in programme design*

While most programmes in Singapore have some form of evaluation plan, not all have been able to carry out formal or rigorous evaluations. Establishing more robust evaluation frameworks would allow programmes to better assess their impact, generate stronger evidence of effectiveness, and identify clearer areas for improvement over time. Ideally, the development of evaluation plans should be integrated into the design phase of interventions and programmes. Doing so enables programmes to clarify the most appropriate indicators, plan for the necessary data collection during implementation, and align evaluation goals with programme objectives from the outset.

Evaluation approaches should also consider moving towards mixed methods, combining structured quantitative data collection with semi-structured qualitative feedback mechanisms to provide a fuller understanding of the impact of the programme on mental health and wellbeing outcomes. Qualitative data can better capture the lived experiences of children and families, while quantitative data provides measurable evidence of change between and across time points.

Where reasonable, children themselves should be directly involved in the evaluation process. Particularly with older children, survey tools can be tailored to age-appropriate reading levels to better allow them to express their feelings and opinions on the design and implementation of programmes.

Beyond evaluation, sustainability planning should also be a priority from the design phase, even for early-stage initiatives such as pilots or proof-of-concepts. Considering sustainability early ensures that programmes are positioned for long-term viability, with the necessary workforce capacities in place, and resources allocated efficiently. Sustainability can be strengthened by building partnerships with government agencies, as well as by engaging volunteers, peer supporters, caregivers, and other community stakeholders. These collaborations not only broaden programme reach but also foster collective ownership and resilience in the system of care for children's mental health and wellbeing.

## *Effectively engage parents and other trusted adults*

Parental engagement emerged as an implementation barrier across several programmes. Addressing this challenge goes beyond simply improving parents' general mental health literacy; it requires fostering a deeper appreciation of how mental health shapes a child's development. Programmes are encouraged to consider ways to better integrate parents as active co-participants in supporting their child's mental health and wellbeing.

Beyond parents, other caregivers such as grandparents, domestic helpers, and educators in preschools, schools, and enrichment settings, also play important roles. While many programmes incorporate Social-Emotional Learning principles, these are often confined to the limited time children spend in structured activities. To maximise impact, it is crucial that trusted adults around the child also embody these same principles in daily life, especially since younger children learn a lot by observation and role modelling. For example, parents demonstrating self-awareness and self-management during stressful moments at home, or teachers showing social awareness in the classroom with difficult students, can reinforce the lessons children are learning in other structured activities.

Some programmes have been able to integrate structures like parent ambassadors or older youth mentorship to also introduce peer-level engagement. Initiatives such as these can also help to shift community-wide perceptions and increase engagement with mental health and wellbeing programmes.

By extending engagement beyond the child to include the wider ecosystem of adults and older youths, programmes can create more consistent touchpoints and opportunities for reinforcement, leading to more holistic and sustainable impacts on children's mental health and wellbeing.

### Workshop insight:

Parents are more receptive to mental health programmes when they participate alongside their children in engaging activities, rather than being asked to attend alone. Joint parent-child activities help normalise discussions about mental health and strengthen family bonds. To encourage participation, organisers have partnered with major organisations and aligned activities with large-scale events, such as collaborations with Gardens by the Bay and the National Family Festival. Offering multiple, family-friendly activities in the same space has proven effective in attracting parents and increasing openness to mental health initiatives.

## *Participate and collaborate in the ecosystem*

There is a significant need to foster greater collaboration across the entire ecosystem of stakeholders involved in child mental health and wellbeing. Active engagement from these stakeholders creates opportunities for

knowledge exchange, skills training, and the co-development of best practices. Such collaboration also helps identify service gaps, enables stakeholders to respond proactively to emerging trends and priorities, and ensures that resources are mobilised more effectively. It can also help bridge the gaps between policy, research, and on-the-ground implementation.

Interdisciplinary and multi-sectoral collaboration is particularly critical for building a strong and sustainable community of practice. No single stakeholder can fully shape or safeguard children's outcomes. By participating actively in this ecosystem, programmes can contribute to a more integrated and coordinated system of care, where children and their families experience seamless support across different stages and settings of their lives.

## Workshop Insight:

Participants highlighted the need for better communication and reflective dialogue among implementers, organisers, and mental health professionals to prevent burnout and support wellbeing. They suggested the creation of support groups as a potential space for constructive conversations about mental health, noting that such initiatives are largely absent in Singapore. They emphasised the importance of building meaningful, sustained relationships within professional communities, reflecting on past wellbeing initiatives and the potential to create similar support networks for working parents and professionals.

### *Embed children's human rights as a guiding principle*

In line with WHO's service guidance for the mental health of children and young people, a human rights-based approach is a key domain for strengthening systems of care and wellbeing. Children's human rights extend beyond access to services, they include the right to a supportive environment free from stigma, discrimination, and coercive practices, as well as respect for privacy, dignity, and confidentiality. A human rights-based approach also recognises children as active rights-holders whose voices and perspectives deserve to be heard and acted upon in decisions that affect them.

Despite its importance, the deliberate integration of children's rights is not yet a clear priority for many programmes. Implementers are therefore encouraged to be able to explicitly articulate how children's rights inform programme design, delivery, and evaluation. This could include ensuring that information is communicated in child-friendly ways, creating safe avenues for children to express their opinions about programmes, tailoring interventions to be developmentally appropriate, and protecting confidentiality at every stage of service delivery. By embedding children's rights as a guiding principle, programmes can not only strengthen trust and engagement but also contribute to more equitable and ethical systems of mental health support for children and young people.

# 8

# Concluding Remarks

In Singapore, much of the focus on young people's mental health and wellbeing has traditionally centred on youth and adolescents. Increasingly, however, there is recognition of the importance of intervening earlier, with more deliberate attention being paid to supporting children's mental health from the earliest stages of development. While still relatively nascent, the mental health and wellbeing landscape in Singapore contains many promising elements to address the needs of children, with many programmes being developed and led by truly passionate individuals across many sectors and disciplines. Barriers, however, do still exist that hinder growth, scale, and seamless coordination across the ecosystem of these programmes. Limitations in skilled manpower, parental engagement, stigma, and funding remain key challenges for stakeholders to address.

Several key emerging trends were identified as additional focal points for children's mental health and wellbeing programming. Interviewees highlighted a rise in maladaptive behaviours and anxiety disorders among children, particularly in the post-pandemic period. Programmes working closely with families also noted rising concerns around family dysfunction, such as domestic violence or parental incarceration. These observations align with a 2024 report noting an increase in low-to-moderate risk family violence cases in Singapore (Ministry of Social and Family Development, 2024).

Excessive screen time and social media use also emerged as significant areas of concern. As children spend more time in digital spaces, risks include reduced interpersonal engagement, exposure to harmful or inappropriate content, and unhealthy peer comparisons. The rise of cyberbullying further underscores the need for robust online safeguards and has prompted ongoing discussions about whether additional regulations or protective measures are required to create safer digital environments for children.

The rise of Artificial Intelligence (AI) tools is another emerging area of concern for the mental health and wellbeing of children. Though not enough is known yet about how AI tools will eventually impact the social and cognitive abilities of its younger users over time. Other international organisations have made recommendations to policymakers and industry around generative AI technologies for children, emphasising increasing AI literacy and responsible use cases (The Alan Turing Institute, 2025).

Other priorities include the need for a broader community mindset shift around children's mental health and wellbeing. Greater public awareness is required to recognise mental health as a public health issue and to emphasise the importance of early intervention. Workforce capacity was also highlighted as a pressing concern, as demand for services continues to grow. Questions remain about whether the current workforce has sufficient competencies to meet this need, particularly as approaches such as task-shifting and task-sharing are still in early stages of exploration in Singapore.

This report has sought to provide an overview of the programmes currently available for children in Singapore, highlighting where they shine as well as where opportunities for improvement remain. By taking stock of the existing landscape, the authors hope it not only serves as a resource for practitioners, policymakers, and funders but also helps to lay the foundation for future innovations, partnerships, and investments to strengthen the ecosystem of care in Singapore for children's mental health and wellbeing.

# Appendix A

## Methodology

This project used a multi-phase approach to assess the current landscape of mental health and wellbeing programmes for children aged 3–11 in Singapore. The aim was to map existing interventions and identify gaps, strengths, and opportunities for policy and practice over a period of 6 months from February-July 2025. The mapping included public, private, NGO and civil society organisations involved in programmes for prevention, promotion and literacy of children's mental health and wellbeing.

The research design was composed of two primary activities:

1. A comprehensive landscape mapping of promotion, prevention, and literacy programmes that aligns with Tier 1 and Tier 2 of the Singapore Tiered Care Model for Mental Health Care Delivery


2. A supplementary expert stakeholder workshop to validate the findings and deliberate on identified barriers and enablers

The study received an exemption from the NUS Institutional Review Board (NUS-IRB) review, with the reference code NUS-IRB-2024-1117.

The landscape mapping exercise followed a mixed-methods approach, including a semi-structured survey and in-depth interviews with key informants from relevant organisations designed to systematically map the current programmatic domain. To ensure analytical rigour, the mapping of interventions was structurally guided by evidence-based frameworks of internationally recognised standards. The World Health Organization's 2022 Network of Community-Based Mental Health Services for children and young people's mental health was utilised to systematically categorise the diverse services and programmes identified (World Health Organization, 2022). Additionally, the qualitative components were developed in accordance with the Mental health of children and young people - Service guidance document that delineates the Standards for Mental Health Care (World Health Organization & United Nations Children's Fund (UNICEF), 2024).

### *Survey*

A self-administered online survey was disseminated and captured 42 programmes that address children's mental health and wellbeing in Singapore, with focus on promotion, prevention, and literacy among children aged 3-11 (See Appendix B). Potential respondents were identified using personal connections, collaborators of the SingHealth Duke-NUS Academic Medical Centre, a snowball sampling approach, as well as a search engine, social media outreach (LinkedIn) and potential stakeholders identified at relevant conferences. The survey contained 25 questions and took approximately 20 minutes to complete. It was developed to capture details about the organisation, an overview of relevant programme/s, and specific mental health strategies used. The survey instrument was co-designed with professionals with different expertise in mental health, public health, innovations, and evaluation. The four main categories included in the survey were:

- **Section 1**: Respondent, organisation and programme overview, which gathered data on the organisation's name and sector, the respondent's role, and a description of their flagship mental health programme for children aged 3-11.
- **Section 2**: Mental health promotion, prevention, and literacy, which delved into the specific strategies, activities, and settings used for mental health promotion, prevention, and literacy.
- **Section 3**: Programme evaluation, which enquired whether the programme has measured results, stakeholders involved in measuring, method of outcome collection, method of outcome dissemination.
- **Section 4**: Barriers, Gaps, and Feedback, which focused on identifying main barriers to implementation, such as funding and stigma, and sought suggestions for additional support or partnerships

This questionnaire was designed to capture comprehensive data across multiple domains, including project team composition, collaborative partnerships, intervention scope (thematic area, target population, geographical coverage), operational environment, implementation enablers and barriers (e.g., funding, regulation, manpower, stigma), and critically, the level of evidence supporting the innovation's impact and evaluation.

Participation was voluntary and no reimbursement or incentive was provided. Informed consent was taken prior to answering questions through the Qualtrics platform. At the end of the survey, participants were invited to indicate their willingness to take part in follow-up interviews and the stakeholder validation workshop.

### *In-depth interviews*

The mapping survey was supplemented by 39 in-depth interviews with 52 respondents from participating organisations, which were conducted to elicit deeper contextual insights into implementation experiences, challenges, and strategic priorities. Out of these 39 interviews, 32 were used for deeper analyses about specific programme domains while all were utilised to understand challenges and draw recommendations.

Interviews were conducted by two researchers through the video conferencing platform, e.g., Zoom. Verbal consent was obtained and recorded from stakeholders partaking in the interviews. The interviews lasted about 40 to 60 minutes and were conducted in English. A qualitative semi-structured interview guide was used during the interviews (See Appendix C). Interviews were

recorded (audio and visual) and transcribed. The transcriptions were checked against the original recordings for accuracy. Participants were advised to skip questions if they felt uncomfortable in answering them. No reimbursement or incentive was provided for participation in the interviews.

Data was analysed using the Rapid Qualitative Analysis (RQA) approach, following the Planning for and Assessing Rigor in Rapid Qualitative Analysis (PARRQA) consensus-based framework for designing conducting and reporting. This approach was employed to efficiently extract meaningful themes from the data based on (but not limited to) the domains delineated in the Standards of mental health care chapter of the Service Guidance document by the WHO and UNICEF.

| Domains used for RQA | | | |
|---|---|---|---|
| Programme Description & Design | Participatory | Accessible | Appropriate |
| Community embedded | Equitable and inclusive | Human-rights based | Continuously improving |
| Implementation barriers | Funding | Organisational priorities | Country-level priorities |

## *Stakeholder validation workshop*

Following the initial analysis, a half-day stakeholder validation workshop was held on 9th July 2025. This event brought together 47 local experts from across the public, private, and non-profit sectors. The agenda included a presentation of the preliminary findings from the landscape mapping, which highlighted key trends, gaps, and enablers in mental health promotion, prevention, and literacy for children aged 3-11 (See Appendix D). Through interactive Q&A sessions and immersive roundtables, participants were able to validate the findings and provide additional insights from their unique perspectives as programme implementers, policymakers, educators, parents and mental health professionals.

The outputs of this research are designed to provide a foundational understanding of Singapore's children's mental health ecosystem considering social impact investment and/or the strategic scaling of effective interventions. This methodology, while not intended to generate efficacy data, provides a thorough and overarching understanding of the current state of children's mental health programmes in Singapore.

As a descriptive landscape analysis, this study is subject to some methodological limitations that warrant consideration. This study was unable to capture data from MOE schools, thereby limiting programmes and further insights from the delivery of mental health curriculum within schools, a crucial touchpoint for children's mental health and wellbeing. Additionally, the reliance on a purposive and snowball sampling approach potentially underrepresents smaller, less connected, or more specialised programmes. The team also encountered difficulties in matching the survey respondents with the interview participants (due to lack of consent or opportunity or time of the

respondents) resulting in a differential number of participants for each of the two methods used in the landscape mapping exercise. The use of self-administered survey data may contribute to misunderstandings of specific terminology used in the survey. The use of self-report throughout the mapping study may also contribute to bias in how programme leaders, implementers, and organisation representatives represent their own work.

# Appendix B

## Survey Questionnaire

# Section 1: Respondent, organisation and programme overview

1. What is the name of your organisation?
   *(Short text response)*

2. What is your role in the organisation?
   *(Short text response)*

3. How many people work in your organisation
   - Less than 5
   - Between 5 to 10
   - More than 10

4. Which sector does your organisation belong to?
   - Public
   - Private
   - Academic
   - Community/NGO/Non-profit
   - Civil society
   - Other (please specify): _____

   *(Select all that apply)*

5. Please briefly describe the nature/work of your organisation.
   *(Short text response)*

For the following set of questions, we invite you to focus on a flagship mental health programme or service from your organisation designed for children aged 3-11 years old. This should be a programme that is still ongoing, pending future iteration, or recently concluded (within last 6 months).

6. What age group does your programme primarily target?
   - 3-5 years
   - 6-8 years
   - 9-11 years
   - All of the above

   *(Select all that apply)*

7. What is the main focus of your programme?
   - Mental health promotion
   - Mental health prevention
   - Mental health literacy

   *(Select all that apply) (skip logic will apply for Section 2 based on this response)*

8. Briefly describe the objectives and key activities of your programme.
   *(Short text response)*

9. Which of the following methods are used in your programme delivery?
   - School-based sessions (e.g., classroom interventions, teacher-led programs)
   - Community-based sessions (e.g., public awareness campaigns, support groups in local centres)

- Parent or caregiver workshops (e.g., training sessions, family-focused interventions)
- Digital/online platforms (e.g., apps, telehealth)
- One-on-one counselling or support (e.g., in-person or virtual therapy)
- Group interventions (e.g., peer-led support groups, psychoeducation workshops)
- Outreach programmes or mobile services (e.g., home visits, pop-up clinics)
- Other (please specify): _____

*(Select all that apply)*

10. When was your programme first implemented?
*(Short text response)*

11. What is the perceived need/gap that your programme is seeking to address?
*(Short text response)*

## Section 2: Mental Health Promotion, Prevention, and Literacy

### *Mental Health Promotion*

12. Which strategies or activities does your programme use to promote mental health?
- Life skills development (e.g., emotional regulation, problem-solving, resilience)
- Mindfulness or relaxation activities (e.g., meditation, breathing exercises)
- Physical activity and recreation (e.g., exercise programs)
- Building positive relationships (e.g., social skills training, peer support initiatives)
- Psychoeducation (e.g., workshops or seminars on mental health literacy)
- Other (please specify): _____

*(Select all that apply)*

13. What settings are used for mental health promotion?
- Schools
- Homes (family-based)
- Community spaces
- Healthcare facilities (e.g., clinics, hospitals, counselling centres)
- Online or digital platforms (e.g., apps, websites)
- Recreational spaces (e.g., parks, sports centres)
- Correctional or rehabilitation facilities (e.g., juvenile centres, prisons)
- Other (please specify): _____

*(Select all that apply)*

### *Mental Health Prevention*

14. What types of mental health concerns does your programme address?
- Anxiety and stress (e.g., generalized anxiety, academic stress)
- Bullying (including peer, cyberbullying, and relational aggression)
- Behavioural challenges (e.g., conduct problems, attention difficulties)
- Emotional regulation difficulties (e.g., managing anger, mood swings)
- Trauma and adverse childhood experiences (e.g., abuse, neglect, exposure to violence)
- Depression and mood disorders
- Social isolation or relationship challenges (e.g., loneliness, peer rejection)
- Self-harm or suicidal ideation
- Substance use or addiction-related risks

- Attention Deficit Hyperactivity Disorder
- Autism
- Other (please specify): _____

*(Select all that apply)*

15. What preventive strategies does your programme use?
    - Early identification of symptoms or warning signs (e.g., anxiety, behavioural changes)
    - Teacher or caregiver training to spot risks
    - Support systems for at-risk children
    - Screening tools or assessments (e.g., validated questionnaires, mental health checklists)
    - Awareness campaigns (e.g., stigma reduction)
    - Promotion of social emotional learning (e.g., emotional regulation, resilience)
    - Inclusive school or community policies (e.g., anti-bullying programs)
    - Collaboration with healthcare or social services for early intervention
    - Peer support programmes
    - Other (please specify): _____

    *(Select all that apply)*

***Mental Health Literacy***

16. What mental health literacy components are covered in your programme?
    - Explaining what mental health is
    - Understanding emotions and mental wellbeing (e.g., emotional regulation, resilience building)
    - Awareness of mental health conditions (e.g., anxiety, depression)Reducing stigma related to mental health issues
    - Teaching children how to seek help when needed (e.g., from teachers, caregivers)
    - Teaching parents/caregivers about child mental health (e.g., early identification, seeking professional help)
    - Promotion of healthy child-parents relationship
    - Raising awareness of mental health in school settings (e.g., supportive school cultures, addressing bullying)
    - Other (please specify): _____

    *(Select all that apply)*

17. What tools or methods do you use to improve mental health literacy?
    - Storytelling or role-playing activities
    - Interactive workshops or games
    - Educational materials (e.g., videos, brochures)
    - Digital tools (e.g., apps, e-learning)
    - Structured programme (e.g. x number of sessions, manual, trained instructors)
    - Other (please specify): _____

    *(Select all that apply)*

# Section 3: Programme Assessment by WHO-UNICEF Service Guidance Domains

### *Accessible*

18. In which geographical areas does your programme operate?
    - Nationwide
    - Regional (e.g., specific districts or areas in Singapore) (Go to 18a)
    - Local (e.g., specific schools or communities) (Go to 18a)
    - Other (please specify): _____

    *(Select all that apply)*

    a. *(If "Regional" or "Local" in Q18)*
    Please specify which districts/areas/communities that your programme operates in
    *(Short text response)*

19. Does your programme offer include any of the following?
    - Subsidized or free services
    - Flexible programme locations/timings
    - Online or remote delivery options
    - Partnerships with schools or communities
    - Information campaigns
    - Other (please specify): _____

    *(Select all that apply)*

20. Does your programme include any of the following family-oriented components?
    - Caregiver education workshops
    - Caregiver-child joint activities
    - Caregiver support sessions
    - Specific information sessions for caregivers
    - Other (please specify):_____

    *(Select all that apply)*

### *Appropriate*

21. Does your programme include any of the following considerations?
    - Age-appropriate content and activities
    - Culturally sensitive approaches
    - Language adaptation (e.g., multilingual delivery)
    - Accessibility for persons with disabilities
    - Other (please specify): _____

    *(Select all that apply)*

### *Community-embedded*

22. Who are the key community stakeholders for your programme?
    - Parents/Grandparents/Caregivers
    - School teachers and counsellors
    - Grassroots/Community leaders

- Social Service Organisations
- Government Agencies (e.g. FSCs)
- Other (please specify):_____

*(Select all that apply)*

***Participatory and People-centred***

23. During the planning/development phase of your programme, which of the following groups were involved?
    - Children
    - Parents/caregivers
    - Teachers
    - School counsellors
    - Academic experts
    - Other mental health professionals
    - Other (please specify): _____

    *(Select all that apply)*

24. How were the groups in (previous question) involved in the planning of programme activities?
    - Feedback surveys
    - Focus groups
    - Peer-led activities
    - Other (please specify): _____

    *(Select all that apply)*

***Integrated***

25. Which sectors or services are involved in delivering or supporting your programme?
    - Education sector (schools)
    - Health sector (clinics, hospitals)
    - Social services (e.g., child protection)
    - Community organizations (e.g., peer support networks, community outreach programs)
    - Government agencies (e.g., Health Promotion Boards)
    - Local media (e.g., anti-stigma campaigns, mental health education)
    - None of the above
    - Other (please specify): _____

    *(Select all that apply)*

***Programme Delivery***

26. How does your organisation train staff/volunteers to deliver your programme (if any)? *(Short text response)*

***Continuously Improving / Evaluation***

27. How often do you measure the effectiveness/impact your programme?
    - Annually
    - Quarterly
    - Continuously/Ongoing

- Other (please specify):_____
- Never *(Skip section if selected)*

28. Which methods do you use to assess programme outcomes?
    - Pre- and post-assessments
    - Participant feedback (children, parents, staff)
    - Focus groups or interviews
    - Scientific methodologies (e.g. using control groups, randomisation)
    - Other (please specify): _____

    *(Select all that apply)*

29. What metrics or outcomes are most important when evaluating the success of the program?
    - Improvement in mental health symptoms
    - Engagement and participation levels
    - Academic performance
    - Social behaviour changes
    - Satisfaction of participants and caregivers
    - Programme cost effectiveness
    - Other (please specify): _____

30. Which of the following groups are involved in measuring programme effectiveness/ impact?
    - Academia (e.g., universities, research institutions)
    - Private company (e.g., consulting firms, evaluation specialists)
    - Public sector agency (e.g., government health or education departments)
    - Non-profit organizations or community groups
    - Internal staff (e.g., programme managers, in-house evaluators)
    - Other (please specify): _____

31. What metrics or outcomes are most important when evaluating the success of the program?
    - Improvement in mental health symptoms
    - Engagement and participation levels
    - Academic performance
    - Social behaviour changes
    - Satisfaction of participants and caregivers
    - Other (please specify): _____

32. How does your organisation disseminate the report about the programme's effectiveness/ impact?
    - Reports are publicly available and easy to access online.
    - Findings are summarized in user-friendly formats (e.g., infographics, briefs).
    - Regular dissemination through workshops, webinars, or meetings.
    - Findings are shared directly with stakeholders via newsletters or emails.
    - Limited access due to paywalls or restricted distribution.
    - Reports are available, but findings are highly technical and not easily interpretable.
    - Findings are not routinely shared or integrated into programme design

***Funding***

33. From which of the following sectors does funding for your programme come from?
    - Public
    - Private
    - Academic
    - Philanthropic
    - Multi-lateral
    - Other (please specify):_____

    *(Select all that apply)*

34. Can you name the funder(s) that support the programme?
*(Short text response)*

35. What amount of funding (in SGD) does your programme receive overall from these sources?
    - Less than $10000
    - $10001 - $15000
    - $15001 - $20000
    - $20001 - $25000
    - $25001 - $30000
    - More than $30000

## Section 4: Barriers, Gaps, and Feedback

36. What are the main barriers to implementing your mental health programme? Please rate each of the following option 1. Not a barrier, 2. Rarely a barrier, 3. Sometimes a barrier, 4. Often a barrier, 5. Always a barrier
    - Lack of funding (e.g. public, private, or non-profit sources)
    - Limited public awareness about mental health
    - Shortage of adequately trained mental health professionals
    - Social stigma surrounding mental health issues and support
    - Limited engagement from caregiver, parents, or family members
    - Infrastructure
    - Other (please specify): _____

    *(Select all that apply)*

37. What additional support or partnerships would help improve your programme?
*(Short text response)*

38. Any other feedback or suggestions?
*(Short text response)*

# Appendix C

## Semi-Structured Interview Guide

| Domains | Main Questions | Prompts |
|---|---|---|
| Introductory questions | • Could you introduce yourself, your organisation and its role in supporting children's mental health in Singapore?<br>• What are the key mental health needs your organisation aims to address? | • What are the range of programmes your organisation offers for children's mental health? |
| Programme design | • What inspired the development of your current mental health programme, and what core principles guide your approach?<br>• Who are the key stakeholders involved in designing and implementing your programme? | • Was the programme adapted from another context or made to Singapore's context?<br>• Which stakeholders were involved in developing the programme?<br>• What were the sources of inspirations to deliver this programme? |
| Participatory | • How do you involve children in your programmes?<br>• How do you incorporate their voices into programme planning? | • Are there structured feedback mechanisms in place for children?<br>• Can you share examples of meaningful participation by children? |
| Appropriate | • How do you ensure that your programme is culturally, socially, and economically and developmentally appropriate? | • Can you provide an example of how your programme has responded to changing mental health needs of children over time? |

| | | |
|---|---|---|
| Accessible | • What is the current uptake/participation in your programme?<br>• How do you ensure that your programme is discoverable and accessible by children and their families/caregivers?<br>• How do you address barriers related to physical access, language, and cultural differences? | • Are there specific outreach strategies and channels of communication used to promote your programme?<br>• What are the most common access challenges you encounter?<br>• Are there innovative tools or platforms you use to enhance accessibility (e.g., digital tools, helplines)? |
| Community-Embedded | • How do you engage with the community to design/implement/promote your programme?<br>• How do partnerships enhance your programme's reach and effectiveness? | • Who are your key partners, and what roles do they play?<br>• What existing partnerships do you have with local organisations, schools, or healthcare providers?<br>• What challenges do you face in building trust with communities?<br>• Are there specific community engagement strategies you've found particularly effective? |
| Equitable and Inclusive | • How do you address cultural or socio-economic barriers to inclusion?<br>• What measures are in place to prioritise support for marginalised or vulnerable children? | • Are there outreach efforts targeting specific underserved groups? |
| Continuously Improving / Evaluation | • What evaluation frameworks or methodologies do you use to evaluate your programme?<br>• How do you incorporate feedback from children, caregivers, and stakeholders? | • What processes are in place for continuous quality improvement in your programme?<br>• Can you share examples of programme changes driven by evaluation insights? |

| | | |
|---|---|---|
| Human Rights-Based | • What policies guide confidentiality, dignity, and non-discrimination in your programme? | • Are staff trained on children's rights and ethical considerations?<br>• Are children made aware of their rights in accessing your programme? |
| Funding | • How stable are your current funding sources and what measures do you take to ensure long-term financial sustainability? | • Are there innovative funding strategies you've explored?<br>• Are there areas where additional funding would have the most impact (e.g., training, resources, outreach, etc.)? |
| Implementation Barriers | • What are the key barriers you encountered in designing and delivering your programme?<br>• How do you address these barriers? | • Are there systemic challenges like stigma, policy gaps, or resource constraints? |

# Appendix D

## Stakeholder Validation Workshop

Stakeholder Validation Workshop Agenda

9th July 2025

The Foundry, 11 Prinsep Link, Singapore

| Time | Session |
|---|---|
| **09:15 – 09:30** | **Arrival and registration**<br>Coffee and tea refreshments available |
| **09:30 – 09:40** | **Welcome and overview** |
| **09:40 – 09:50** | **Participant introductions** |
| **09:50 – 10:10** | **Presentation of preliminary findings** |
| **10:10 – 10:30** | **Q&A and validation dialogue** |
| **10:30 – 10:50** | **Break and networking** |
| **10:50 – 11:50** | **Break-out roundtables**<br>Deep dive themes:<br>• Programme design, delivery, and evaluation<br>• Parenting and mental health<br>• School-based mental health interventions<br>• Skills/Assets and protective factors (moderated by Research for Impact) |
| **11:50 – 12:10** | **Roundtable reports**<br>**Plenary sharing**<br>*White Paper: Mental Health and Wellbeing in Children and Young Persons (4-25 years)*<br>Dr Sherria Ayuandini, Research for Impact |
| **12:10 – 12:30** | **Closing remarks and next steps** |

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