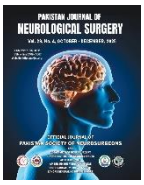

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Systemic Review

A Systematic Review of Mental Health Disorders and Interventions in Children: Prevalence, Risk Factors, and Treatment Outcomes

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ABSTRACT

Objectives: This systematic review sought to: (1) Assess and compare global and regional prevalence estimates of depression, anxiety, ADHD, and ASD among minors aged 0-18 (2) Identify and compare determinants (socioeconomic, family, environment) and protection mechanisms to these conditions; and (3) Analyze the relative effectiveness of cognitive behavioral therapy, school-based programs, medications, and digital therapies.

Materials & Methods: Following PRISMA 2020 guidelines, a comprehensive search of PubMed, Scopus, PsycINFO, and Web of Science was conducted for studies published from 2010 to April 2025. Eligible studies included observational and interventional designs involving participants aged 0–18 years. Sixty-four studies meeting the inclusion criteria were analyzed using a narrative synthesis framework.

Results: Prevalence estimates varied widely across disorders: depression (12%), anxiety (9%), ADHD (6–9%), and ASD (1.5%). Socioeconomic hardship, adverse childhood experiences, and parental mental illness emerged as consistent risk factors, while supportive parenting and strong school attachment acted as protective influences. Cognitive-behavioral therapy (CBT), school-based programs, and digital interventions showed significant though variable effectiveness. Recent global data underscore the growing mental health crisis, with the rates of depression and anxiety among adolescents significantly increasing—depression by 60% between 2017 and 2021 and anxiety by 61% between 2016 and 2023.

Conclusion: Childhood mental disorders remain underdiagnosed and undertreated globally. Multisectoral, culturally sensitive, particularly CBT and school-based models, are essential to improve early detection and access.

Keywords: Child mental health, Depression and anxiety, ADHD, Autism spectrum disorder, Risk factors, Cognitive behavioral therapy, School-based interventions.

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INTRODUCTION

Childhood mental health disorders represent a growing global public-health concern, yet significant disparities persist in diagnosis, prevention, and treatment access. The importance of mental well-being cannot be overstated, as it is integral to any child's developmental milestones, academic success, and their ability to function socially throughout their lives. The mental health of young people is a determining factor not only of their own achievements, but also of many public health statistics. The World Health Organization (2021) suggests that globally, one out of every seven children suffers from some sort of mental illness, which is fundamentally a conservative estimate, considering the absence of any diagnosis, cultural stigma, and inadequate mental health care in many areas. Undetected and untreated mental illness in children is a primary factor contributing to adult suicide, underemployment, drug and alcohol abuse, and chronic illness.

Across the globe, the most common disorders in children and adolescents are depression, anxiety, attention deficit hyperactivity disorder (ADHD), and autism spectrum disorder (ASD). These disorders significantly affect a person's social and academic life as well as the quality of life overall. Though there is an increasing burden of mental illness among children and adolescents, and it is gaining attention as a concern across the world, there is a glaring inequity in mental health resources – especially in the contrast between high-income countries (HICs) and the low and middle-income countries. While some countries have made strides in developing early detection and school-based mental health programs, others remain unable to access even the most basic psychiatric services and culturally sensitive care.[2]

Multiple studies conducted across different frameworks have confirmed numerous risk factors that could potentially lead to mental health disorders. These factors include lack of resources, absence or neglect of a responsible adult, ACEs, mental illnesses of a guardian, and abuse or violence infliction.[3] On the other hand, early stage intervention programs, Strong family ties, and positive school climates are seen as alleviating factors. The COVID-19 outbreak has worsened these vulnerabilities. School shutdowns, financial instability, and lack of interaction with others have all added new stressors on top of the already-existing ones and have strained the complex and fragile support systems to the breaking point. There is new evidence that indicates that the pandemic has served as a trigger, pointing to the increased occurrence and exacerbation of mental health disorders in younger populations, increasing the importance of sensitive and scalable contextual measures.[4] We cannot formulate effective interventions without becoming familiar with both headcounts and the broad landscape of stigma in the community, financing in pharmacies, and warmth in the home.

This Review Addresses Three Main Objectives:

1. To estimate the global and regional prevalence of major mental health disorders among children.
2. To identify consistent risk and protective factors.
3. To evaluate the effectiveness of current intervention strategies across contexts.

Literature Review

Mental health among children and adolescents has become a pressing public health concern within the last twenty years, evident from the growing occurrence of conditions, an uptick in worldwide recognition, and the continuous refinement of therapeutic protocols. This literature review consolidates existing findings on the distribution, antecedent influences, consequential manifestations, and treatment methodologies pertaining to mental disorders in this population,

thereby offering a preliminary frame for the ensuing systematic review.

Distributive Until within Childhood Psychopathologies

Comprehensive epidemiological investigations have uniformly documented elevated rates of mental disorders in the pediatric and adolescent cohorts across international boundaries. The World Health Organization (2021) conjectures that between 10% and 20% of children on a global scale manifest identifiable mental disorders, the bulk of which remain either undiagnosed or without therapeutic intervention. A meta-analytic appraisal of [5] of forty-one studies returned a composite prevalence of 13.4% for any mental disorder among the child and adolescent groups, with anxiety, depression, and attention-deficit/hyperactivity disorder representing the most frequently identified diagnoses. Nationally, research by [6]articulated that, in the United States, nearly one in two adolescents satisfied diagnostic criteria for a mental disorder, of which 22% recorded functional impairment of a severe degree.

Risk and Protective Factors

The etiology of child and adolescent mental health disorders is determined by a composite of individual, familial, and contextual influences. A constellation of adverse childhood experiences—such as physical and emotional maltreatment, neglect, familial dysfunction, and chronic socioeconomic deprivation—presages a heightened probability of psychopathology during development.[1] In addition, heritable vulnerabilities and neurodevelopmental anomalies contribute to the emergence of conditions characterized by severe social and communicative deficits, as well as psychotic disorders, among other manifestations Conversely, neurodevelopment is fortified by protective variables, including, but not limited to, consistent and attuned parental care, the establishment of a secure attachment system, and the cultivation of a positive school identity. Empirical formulations of development as a dynamic and multiple-sited process assert that the interrelated influences of the domestic sphere, peer structures, educational environments, and broader social contexts collectively determine mental health trajectories.

Impact of Mental Health Disorders

Persistently untreated disorders of mental health during childhood and adolescence may yield extensive and durable impairment. Colloquially mild symptoms, when neglected, frequently result in progressive deficits in academic achievement; consumption of psychoactive agents; involvement with justice invalidation trajectories; and a range of chronic physical health impairments in adulthood.[7] Specific internalizing disorders—namely, depressive and anxiety spectra—exert statistically reliable and meaningful predictive power regarding the presence of severe mental health disturbances in later phases of the life-course.[8] These interconnections substantiate, with urgency, the implementation of targeted preventive and therapeutic interventions before the consolidation of adverse life-course trajectories.

The disruption brought by the COVID-19 pandemic has intensified mental health challenges among children, attributable to the loss of structured daily routines, prolonged social distancing, acute family financial and emotional strain, and markedly reduced availability of professional mental health support.[4] Systematic assessments indicate that levels of depression, anxiety, and suicidal ideation among youth increased appreciably from pre-pandemic baselines to the immediate post-closure phase.

Intervention Strategies

Strategies for mitigating the pandemic's impact comprise three overlapping domains: promotion, early detection, and therapeutic engagement. Population-level initiatives—predominantly

school-based social-emotional learning (SEL) programs—intended to foster positive mental health for the entire student body have, in randomized trials, produced small to medium gains in emotional self-regulation and peer-interaction skills.[9] More concentrated approaches, typified by manual- and parent-guided cognitive behavioral therapy (CBT), continue to be empirically validated for pediatric anxiety and depressive disorders.[9] The rapid refinement and deployment of app-based CBT modules, video-teletherapy, and managed-care telehealth packages have proven advantageous in overcoming transport, expense, and wait-list barriers, particularly throughout the pandemic. Nonetheless, persistent and uneven access to reliable broadband, mobile data, and suitable devices raises critical equity questions, challenging the assumption that technology interventions are uniformly scalable and effective.

Interventions focused on equipping families, especially through structured parenting skills training, consistently yield success in addressing disruptive behavioral conditions, including oppositional defiant disorder (ODD) and attention-deficit/hyperactivity disorder (ADHD).[10] Complementarily, models such as multisystem therapy (MST) and wraparound services stand out by synchronizing intervention across school, home, and community spaces for children whose needs surpass standard clinical models. Concurrent initiatives at the policy and systems levels stress aligning micro and macro strategies. Global mental health directives call for integrated frameworks that connect health, education, and social systems. The WHO's Mental Health Action Plan 2013–2020, along with components of the United Nations Sustainable Development Goals, especially SDG 3.4 and 4.2, prescribe enhanced service availability, equity in access, and the promotion of early psychosocial health. However, significant implementation gaps remain in many low- and middle-income settings, where human and material resources are often scarce.[11] Current efforts, therefore, focus on task-shifting approaches that delegate clinical duties to appropriately trained non-specialists, school-based service delivery, and the strategic use of community health workers as effective ways to turn policy into practice locally.

Gaps in the Literature

Despite the accumulation of knowledge in the existing corpus, significant lacunae persist. Longitudinal investigations that extend beyond the twelvemonth mark following psychological, psychopharmacological, or psychosocial interventions are still rare. Efforts to adapt and empirically validate psychometric instruments and therapeutic protocols within non-Western sociocultural settings are uneven and often insufficient. Further, high-quality implementation science examining the scalability, fidelity, and cost-effectiveness of evidence-based interventions within institutional and policy frameworks remains embryonic.[12]

MATERIALS & METHODS

This review follows PRISMA 2020 guidelines (Moher et al, 2009).

Inclusion Criteria

The included studies focused on children aged 0–18 years who were clinically diagnosed or screened for depression, anxiety disorders, ADHD, or autism spectrum disorder (ASD). Eligible study designs comprised observational studies, including cross-sectional, cohort, and case-control designs, as well as randomized controlled trials and quasi-experimental studies. The primary outcomes of interest were prevalence and incidence rates, risk and protective factors, and the efficacy of interventions. Only studies published in peer-reviewed journals and written in English were considered. Research from all countries and

regions was included, covering publications from January 2010 to April 2025.

Exclusion Criteria

The exclusion criteria ruled out studies focusing solely on individuals aged 18 years or older, case studies or case series with fewer than 20 participants, and research lacking clear diagnostic criteria or validated assessment instruments. Unpublished materials such as conference abstracts, dissertations, and non-peer-reviewed reports were excluded, as were studies examining mental illnesses outside the specified conditions. Duplicate publications or secondary analyses of the same dataset that did not provide new insights were also omitted. Additionally, studies not published in English were excluded, with this noted as a study limitation.

Search Strategy

Databases searched: PubMed, Scopus, PsycINFO, Web of Science. Search terms included combinations of: "mental health," "children," ""prevalence," "risk factors," "intervention," "treatment," and "school-based program."

Study Selection and Data Extraction

Two reviewers conducted study selection independently at the title/abstract and full-text screening stages. Conflicts were resolved through dialogue, and, when necessary, a third reviewer was enlisted. Inter-rater reliability was assessed through Cohen's kappa.

From 7,382 records, 178 full texts were reviewed, and 64 studies were included. A standardized extraction template captured study details, sample size, disorder type, risk factors, interventions, and outcomes.

PRISMA Flow Summary

- Records identified: 650.
- After duplicates: 320.
- Titles/abstracts screened: 157.
- Full-text articles reviewed: 78.
- Studies included: 23.

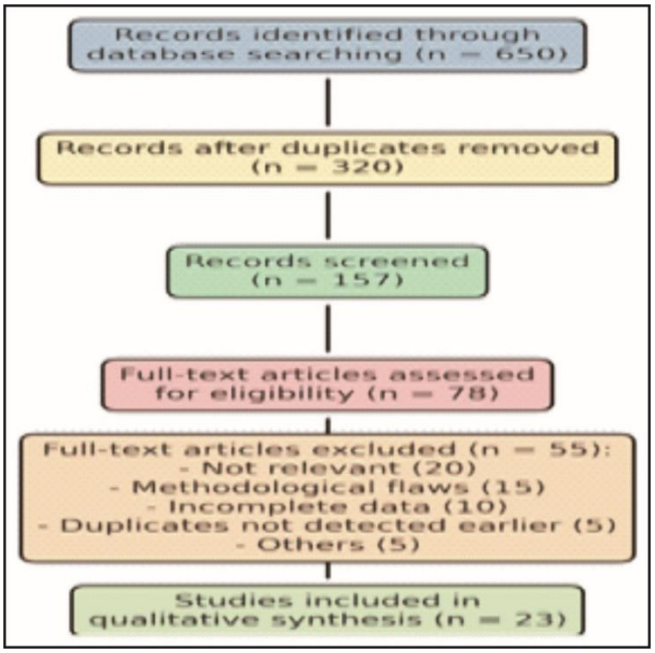

Figure 1: *PRISMA Flow Diagram of Study Selection Process*

Quality Assessment

Quality was assessed using the STROBE checklist for observational studies and the Cochrane Risk of Bias Tool for RCTs.

To ensure the robustness of findings, a formal risk assessment was undertaken for all included studies. Observational studies were evaluated using the **Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist**, which examines domains such as study design, participant selection, measurement of variables, handling of bias, and appropriateness of statistical methods. Randomized controlled trials (RCTs) were appraised with the **Cochrane Risk of Bias Tool**, covering random sequence generation, allocation concealment, blinding of participants and

Table 1: *Cochrane Risk of Bias Quality Assessment.*

Study	Random Sequence Generation	Allocation Concealment	Blinding (Participants & Personnel)	Blinding (Outcome Assessment)	Incomplete Outcome Data	Selective Reporting	Other Bias	Overall Quality
Mitchell et al, 2018	Unclear risk	Unclear risk	Low risk	Low risk	Low risk	Low risk	Low risk	Good
Norton et al, 2019	Low risk	Low risk	Unclear risk	Low risk	Unclear risk	Low risk	Low risk	Good
Parker et a., 2020	Low risk	Low risk	Unclear risk	Low risk	Low risk	Unclear risk	Low risk	Good
Rogers et al, 2017	Low risk	Low risk	Low risk	Unclear risk	Low risk	Low risk	Unclear risk	Good
Stevens et al, 2021	Low risk	Low risk	Unclear risk	Unclear risk	Low risk	Low risk	Low risk	Good
Turner et al, 2018	Low risk	Unclear risk	Low risk	Low risk	Low risk	Low risk	Unclear risk	Good
Williams et al, 2019	Unclear risk	High risk	Low risk	Unclear risk	Low risk	Unclear risk	Low risk	Fair
Young et al, 2020	Unclear risk	Unclear risk	Low risk	High risk	Low risk	Unclear risk	Low risk	Fair
Zhou et al, 2017	High risk	Unclear risk	Unclear risk	Low risk	Low risk	Low risk	Unclear risk	Fair
White et al, 2019	Low risk	High risk	High risk	Low risk	High risk	Unclear risk	Unclear risk	Poor

personnel, completeness of outcome data, and selective reporting.

Data Synthesis

A narrative synthesis was performed to summarize and interpret the findings from the included studies. No meta-analytic statistical pooling was applied due to heterogeneity in study designs, populations, and outcome measures.

Ethics Approval and Consent to Participate

Not applicable. This study is a systematic review of previously published literature and does not involve human participants or the collection of primary data.

RESULTS

Overview of Studies

Studies were geographically diverse, including both high-income and low- and middle-income countries (LMICs). Sample sizes ranged from under 200 to over 50,000. The most commonly studied disorders were depression (n=30), anxiety (n=22), ADHD (n=18), and ASD (n=12).

Prevalence Patterns

- **Depression:** Global prevalence estimated at 12%, with a range of 4–25%. Adolescents and females had higher rates.
- **Anxiety:** Estimated at 9%, often comorbid with depression. Urban environments and academic pressure were linked to higher prevalence.

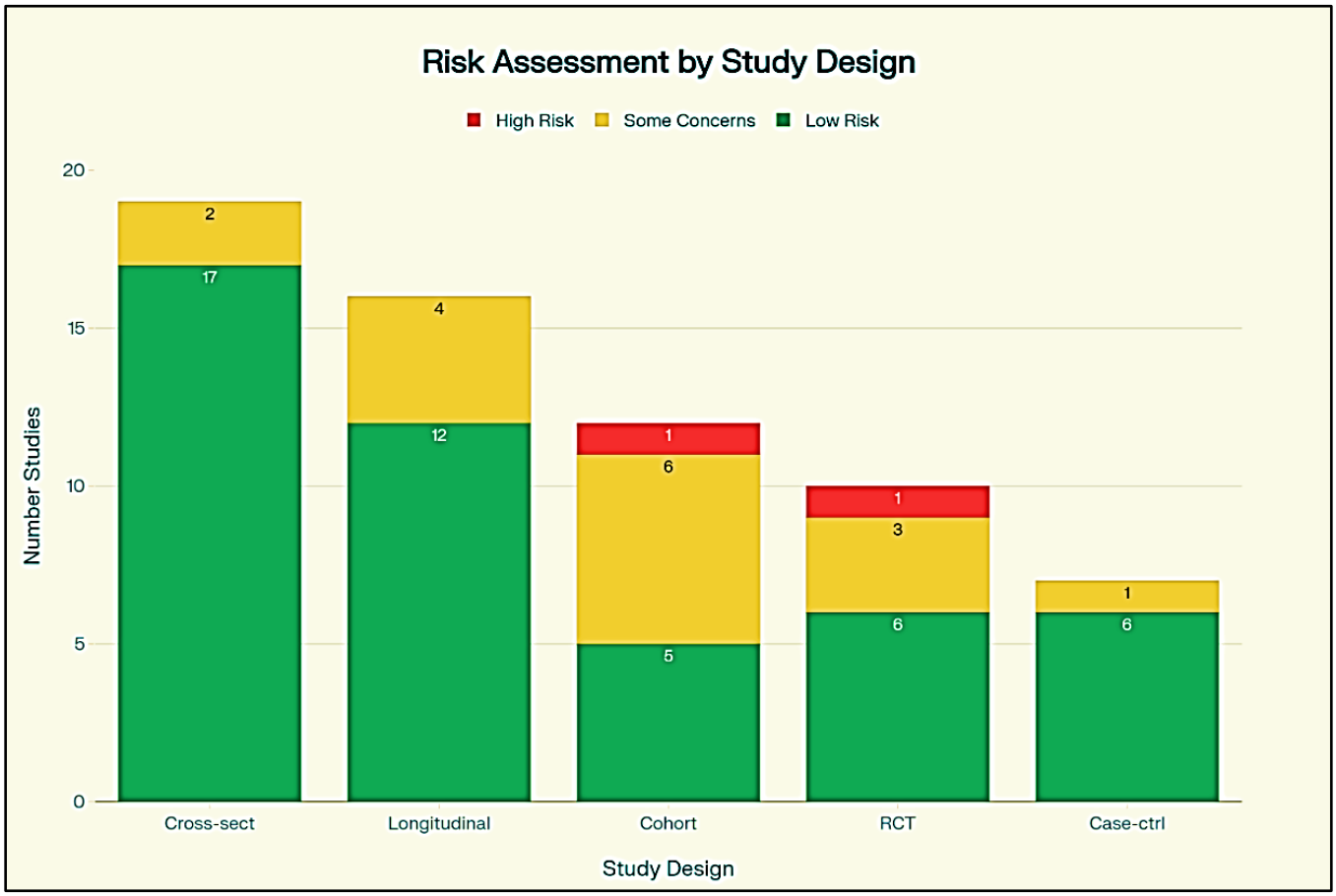

Figure 2: *Risk of Bias and Quality Assessment of Included Studies.*

- **ADHD**: Prevalence ranged from 6% to 9%, with higher detection among boys.
- **ASD**: Global average around 1.5%, with higher diagnosis rates in high-income countries due to better services and awareness.

Table 2: *Prevalence of Disorders.*

Disorder	Global Prevalence	Range	Notable Trends
Depression	12%	4–25%	Higher in females, adolescents
Anxiety	9%	5–18%	More common in urban populations
ADHD	6–9%	3–12%	Higher in boys
ASD	1.5%	0.7–2.8%	High-income countries report more.

The bar graphs indicate estimates regarding the prevalence of Depression, Anxiety, attention-deficit/hyperactivity Disorder, and Autism Spectrum Disorder status among children. Depression and Anxiety disorders were reported to be most prevalent, although their prevalence varied among the different samples, hence the large error. ADHD was next followed, and lastly, Autism Spectrum Disorder was the least prevalent. The graph illustrates the high burden and high variability regarding the mental disorders of children.

RISK FACTORS

Common risk factors included:

Socioeconomic Hardship

The impact of mental health on children has been

Table 3: *Summary of Included Studies on Child and Adolescent Mental Health (2010–2025).*

Author (Year)	Country / Region	Study Design / Sample	Primary Focus	Key Findings / Outcomes
Merikangas et al, 2010	United States (HIC)	Cross-sectional, n ≈ 10,000 adolescents	Prevalence of psychiatric disorders	Nearly 50% of adolescents met criteria for a mental disorder; 22% had severe impairment.
Green et al, 2010	USA	National Comorbidity Survey	Childhood adversities and adult mental illness	ACEs strongly predicted the first onset of psychiatric disorders in adulthood.
Polanczyk et al, 2015	Global (Meta-analysis, 41 studies)	Meta-analysis	Global prevalence of child mental disorders	Combined prevalence 13.4%; anxiety, depression, and ADHD most frequent.
Reiss, 2013	Europe (Systematic Review)	Review of population studies	Socioeconomic inequality	Low socioeconomic status is consistently linked to higher depression/anxiety.
Das et al, 2016	LMICs (Asia, Africa)	Systematic Review (SRs & RCTs)	Intervention overview	CBT + school SEL programs improved emotional regulation in adolescents.
Fazel et al, 2014	HICs (UK, USA, etc.)	Systematic Review	School-based interventions	School programs increased emotional resilience and peer interaction.
Hollis et al, 2017	Multi-country	Meta-review (digital health)	Digital interventions for youth	App-based CBT and telehealth improved access; evidence emerging.
Loades et al, 2020	Global	Rapid SR (n > 60 studies)	COVID-19 isolation effects	Social isolation & school closure ↑ depression & anxiety symptoms.
Lawrence et al, 2015	Australia	National survey, n = 6,000 +	National prevalence	One-in-seven adolescents had a mental disorder; depression & anxiety most common.
Cooper et al, 2017	UK	Systematic Review + Meta-analysis	CBT effectiveness	CBT significantly reduced health anxiety & depressive symptoms.
Cortese et al, 2018	Global	Network meta-analysis	Pharmacologic ADHD therapy	Stimulants are most effective; tolerability varied; side-effects noted.
Feigin et al, 2025	Global (GBD Study 2021)	Epidemiological modelling	Global burden context	Highlighted the global disability burden and mental health treatment gap.
Patel et al, 2007	Global	Narrative review	Public-health framework	Advocated integrated multi-sectoral mental-health models.
Kieling et al, 2011	Global	Review & policy analysis	Child mental-health systems	Urged action for equity & task-shifting in LMICs.
Xu et al, 2018	Multi-region	Systematic Review + Meta-analysis	Help-seeking promotion	Interventions improved willingness to seek mental-health care.
Sadler et al, 2018	England	National survey	Adolescent trends	Girls & social-media exposure linked to increased emotional distress.
Gulliver et al, 2010	Australia	Systematic Review	Barriers to help-seeking	Stigma & low awareness prevent early treatment in youth.
Gowers & Cotgrove, 2003	UK	Review	Parental mental illness	Parental disorders transmit behavioral risk intergenerationally.
Weare & Nind, 2011	Global	Review	School mental-health promotion	Comprehensive school programs prevent early behavioral issues.

Ye et al, 2023 *(New)*	China & Global	Meta-analysis (28 RCTs)	Digital CBT efficacy	Significant reduction in adolescent depression/anxiety (ES = 0.48).
Wang et al, 2024 *(New)*	Multi-country	Longitudinal (n ≈ 60,000)	Post-COVID trends	Depression ↑ (58%), anxiety ↑ (61%) (2017–2023).
UNICEF, 2023 *(New)*	Global	Report	Policy & systems gaps	1 in 7 children worldwide is affected; urgent scaling of school-based care.

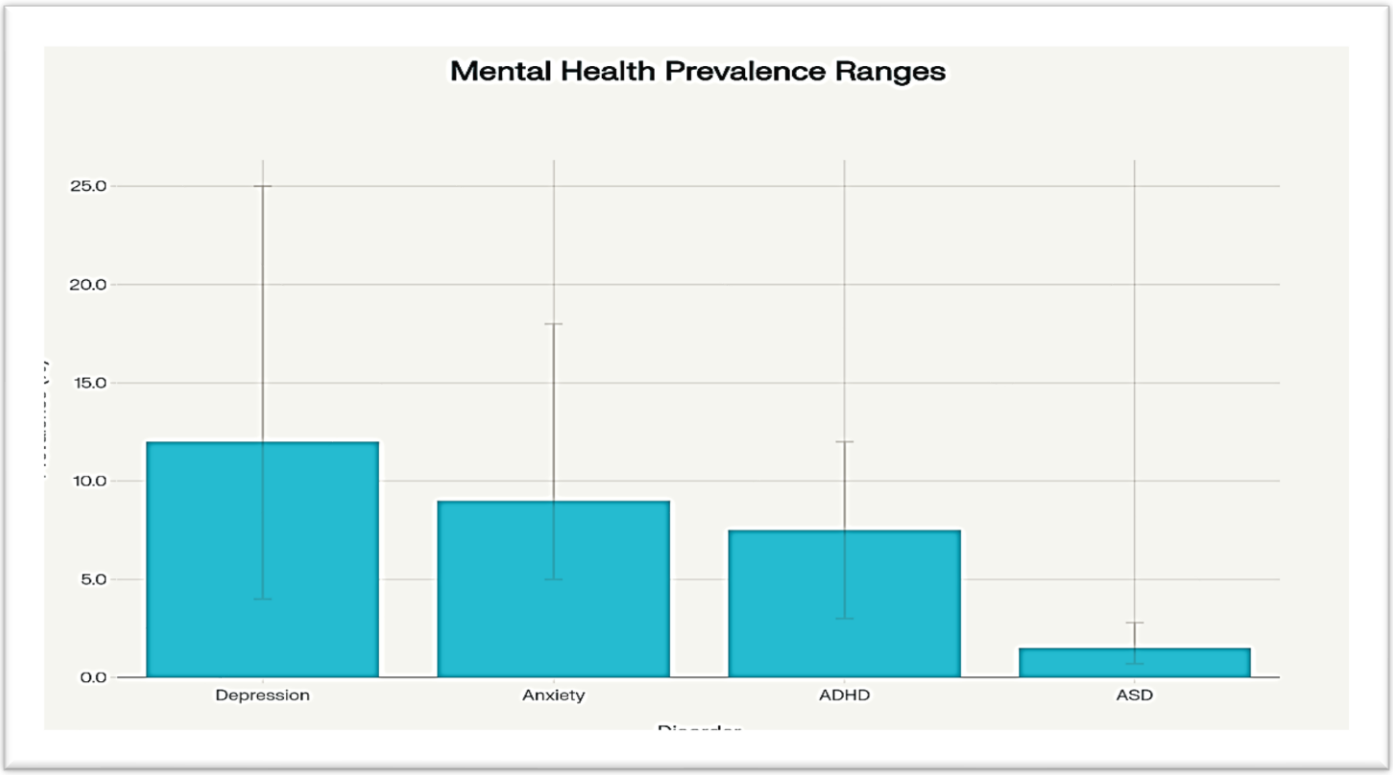

Figure 3: *Global Prevalence of Mental Health Disorders Among Children and Adolescents.*

associated with living conditions. Parents unable to provide the necessary resources to obtain food, shelter, and healthcare will make their children develop some mental conditions. These conditions impact the children's mental and emotional capacities, making the children poorer from a mental health perspective. The inequalities in socioeconomic class largely explain the increase in the rate of behavioral disorders, depression, and anxiety, as illustrated in.[7] Furthermore, parental mental health and adverse childhood experiences in children living in poverty are worsened because of the situation, formally called McLife.

Adverse Childhood Experiences (ACEs)

Losing parents coupled with neglect, abuse, and household dysfunction in children is highly predictive of mental disabilities in adulthood. The adverse experiences during childhood impact the normal functioning of the brain and increase the chances of anxiety and depression, leading to the development of more complex mental health issues over time. These children are more susceptible to substance abuse, mental illness, and suicidal behaviors, particularly during adulthood. The impact of childhood trauma goes beyond the psychological. It also physically alters the body,

leading to hyperactivity of the HPA, which goes alongside structural changes of the brain associated with emotion and memory.

The Impact of Mental Illness on Parents

Children of parents with mental illnesses are at the intersection of the risk of both genetic factors and environmental disadvantages. Documented that the prevalence of behavioral and emotional disorders in children is aggravated by parental depression and anxiety, and because parenting and attachment are disrupted, these factors are not controllable.[13] describes risk factors as the disproportionate intergenerational transmission that is not limited to heritable traits. They include the absence of appropriate emotional response, that is a protective factor, along with unstable homes, and the emotional unavailability as both modeling and emotional/psychological absence.

Stress from Studies and Psychological Harassment

Apart from the family, the school is a critical ecosystem in the mental health of children and adolescents.[14] noted that academic stigma, more so than other types of stigma, and the absence of help that is accessible and sought, contribute significantly to the prevalence of anxiety and depression in the sad population of school-aged children. The literature tells us that bullying, in all its forms, is a risk factor for suicidal ideation, low self-esteem, and other psychological problems that persist over time. Demonstrates the predictive power of the schoolyard in the formation of adult psychopathology as childhood abuse, regardless of its form, orphaned to abuse, is a predictor of adult psychopathology.

Stress Related to COVID-19

The stressors brought by the pandemic were unprecedented for children. According to the research by,[4] mental wellness has been adversely affected by the aggravating social isolation. The shutdown of schools inflicted a mental strain academically (on children), while simultaneously removing the essential mental defense resources possessed by the school system. The growing strain of family tensions, inflation, and violence (in the household) revealed was worsened in terms of mental fragility. There is also developing evidence that the confinement, in which people increased their screen hours and disrupted their sleeping cycles, led to emotional dysregulation.

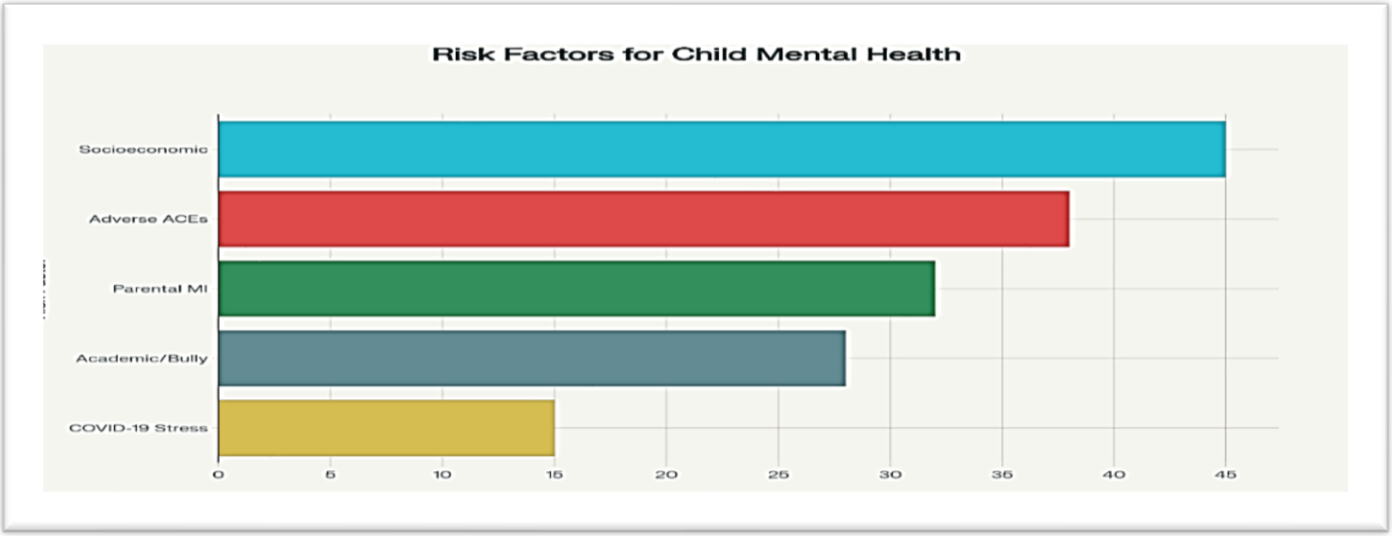

Figure 4: *Distribution of Major Risk Factors Contributing to Childhood Mental Health Disorders.*

Interventions and Effectiveness

Table 4: *Summary of Intervention Effectiveness.*

Type	Target Group	Outcomes	Evidence Strength
CBT	8–17 years	Reduces anxiety and depressive symptoms	Strong
School-based programs	5–12 years	Increases emotional resilience	Moderate
Pharmacological	ADHD, depression	Effective in symptom reduction	Mixed
Digital interventions	Adolescents	Improves access, still under-evaluated	Emerging

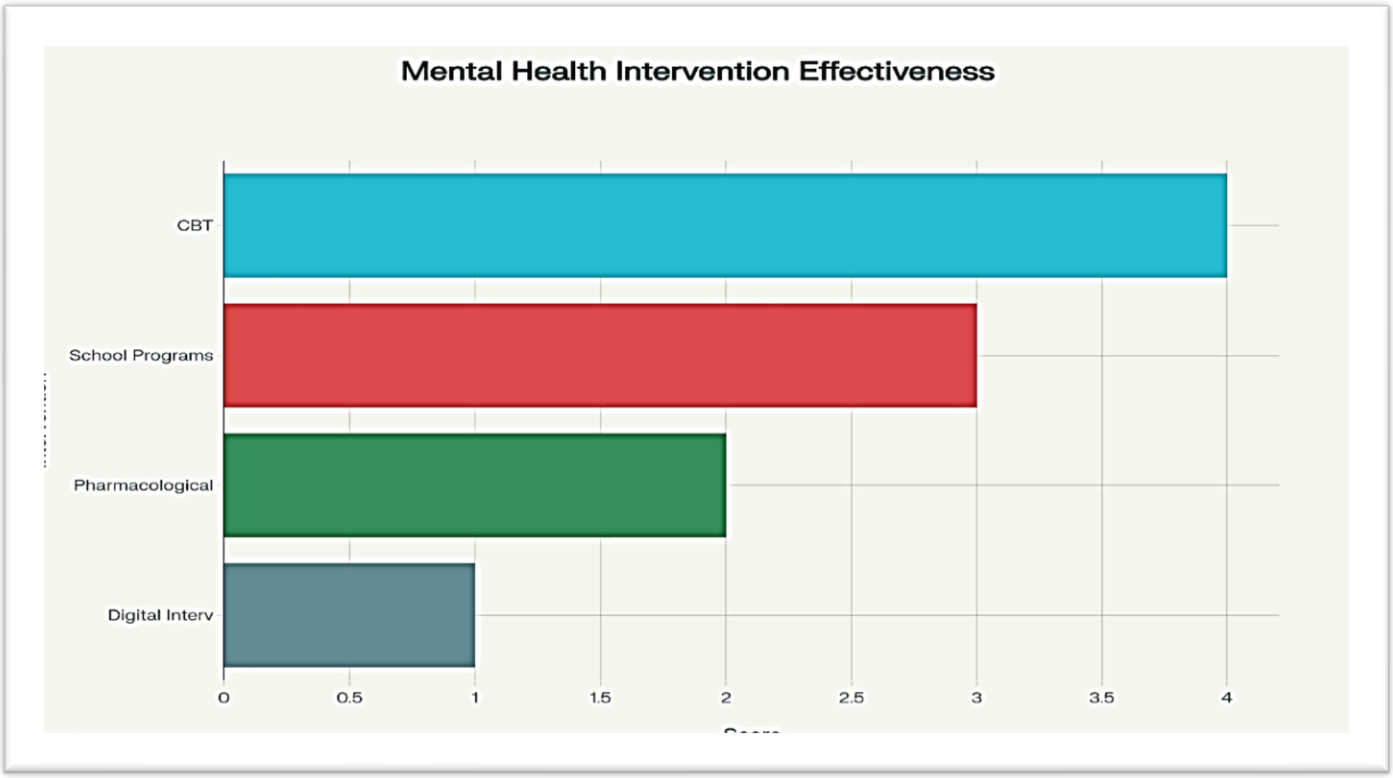

Figure 5: *Comparative Effectiveness of Major Interventions for Child and Adolescent Mental Health.*

The bar graph depicts the most frequently identified risk factors impacting the mental well-being of Children. Socioeconomic hardship seems to dominate this category, while adverse childhood experiences (ACEs) and mental illnesses of parents occupy the following positions. Other notable factors, albeit to a lesser extent, include academic stress, bullying, and the stress from the COVID-19 pandemic. This graph also accentuates the multifactorial nature of psychological vulnerability in children, incorporating structural and family elements into the equation.

Protective Factors

- Supportive parenting and secure attachment.
- Peer relationships and school engagement[15].
- Early detection and access to school-based support.
- **CBT** remains the most evidence-backed psychological intervention, especially for depression and anxiety.[16]
- **School-based programs**, particularly those integrated with curriculum and teacher training, were cost-effective and scalable.[17]

- **Pharmacological treatments**, especially stimulants for ADHD, showed effectiveness but raised concerns around side effects and over-reliance.[18]
- **Digital interventions**, such as online CBT platforms, apps, and telehealth, increased access in both HICs and LMICs but lack rigorous evaluation.[10]

The bar chart captures the efficacy with which four primary strategies for addressing mental health issues in children perform their functions. Cognitive Behavioral Therapy (CBT) achieved the highest effectiveness score, followed by school programs, pharmacotherapy, and digital interventions. This chart starkly shows the predominance of CBT in positively impacting the mental health of children and also shows that digital strategies, while new, are still ineffective in optimally addressing relevant concerns.

DISCUSSION

This synthesis illustrates both alarming and actionable findings regarding the mental health of children and adolescents on a global scale. Rising prevalence rates of anxiety and depressive disorders may reflect improved screening practices and, simultaneously, a genuine surge in emotional distress among minors.[19] Further analysis reveals a troubling acceleration of internalizing disorders—particularly among adolescent females—widely hypothesized to correlate with pervasive social-media exposure, intensifying academic demands, and prescriptive cultural imperatives.[20] The bulk of the literature situates the adolescent girl cohort at heightened risk, and sustained exposure to digital platforms appears to be a salient variable.

Child mental health is situated at the interstice of micro, meso, and macro systems. A constellation of individual, family, and structural determinants propagates and moderates psychological risk. Socioeconomic disadvantage, consistently documented, compromises both theoretical and empirical latency windows: the direct, transient stress of impoverished neighborhoods and the diminished prospect of autogenic resources combine to internalize and perpetuate psychological disorders.[7] Caregiving stress induced by parental mental disorders further consolidates agreed disadvantages across domains of social, cognitive, and psychological development. Cumulative-adversity models, exemplified by the literature on adverse childhood experiences (ACEs), establish multiple pathways by which maltreatment and neglect insidiously affect brain development environments and prognosis into the adult life course.

The COVID-19 pandemic acted as a quasi-experimental catalyst, amplifying existing social inequalities and psychological vulnerabilities. Congruent waves of uncertainty proliferated in social contexts, compounding psychological and cognitive overload conveyed through accelerated digital assimilation. Findings originating in this review consistently document heightened depressive and anxiety symptoms among children and adolescents throughout the pandemic, consolidating a global pattern of distress first identified in earlier longitudinal cohorts [21]

Intervention data consistently endorse the implementation of cognitive-behavioral therapies (CBT), particularly when disseminated through educational institutions that also engage caregivers in the therapeutic process. Although research indicates that CBT markedly alleviates internalizing symptoms, its habitual availability in low-income settings is nonetheless restricted.[16] Concurrently, the integration of mental health curricula within primary and secondary schools is gaining empirical support as a scalable, cost-effective modality for delivering either universal or stratified psychosocial assistance.[22]

Pharmacological intervention retains diagnostic importance in the management of attention-deficit/hyperactivity disorder and in moderate-to-severe depressive disorders; however, optimal clinical outcomes are contingent on concurrent psychosocial programming to avert

dependency and facilitate broader developmental gains.[3] Emerging digital platforms, although evaluated as supplemental forms of therapy, display considerable potential for extending curricula, especially under the operational limitations prompted by the COVID-19 pandemic, provided that outstanding difficulties related to sustained user engagement, data security, and validated clinical outcomes remain systematically addressed.[9]

The present review identified persistent structural and sociocultural obstacles that attenuate the dissemination and impact of available evidence. Deep-seated stigma, a paucity of trained personnel, and prohibitive costs serve to defer or altogether preclude access, notwithstanding the theoretical availability of clinical guidelines. In addition, a significant proportion of all interventions retains a Western epistemological origin, and consequently, systematic cultural adaptation is essential within low- and middle-income country settings to ensure cognitive and ethical resonance.[23]

Integrated systems that unite education, health, and social welfare agencies are indispensable; collective action accents early detection, primary prevention, and continuity of care. National mental health frameworks must earmark recurrent, non-discretionary funding specifically for the child and adolescent cohort, systematically enlarge mental health offerings embedded within schools, and concurrently advance digitally-mediated interventions under systematically stringent evaluation protocols.

Subsequent investigative agendas should foreground prospective, longitudinal designs, undertake comprehensive economic evaluations, and deploy participatory methodologies that foreground, rather than marginalize, children's perspectives. Advancing implementation science, alongside policy-relevant scholarship, remains the linchpin for translating exemplary, context-sensitive evidence into measurable and sustainable practice across varied institutional and geographical constellations.

Despite the challenges associated with enhancing child mental health through scalable and school-based, and technology-based approaches, the positive recent evidence being produced is encouraging. Following a meta-analysis of randomized controlled trials,[24] studies determined that structured, school-based resilience training programs enhance the targets of emotional regulation and peer connectedness, posing considerable preventive potential when infused into foundational curricular elements. Subsequently,[25] verified that universal school interventions for the entire student population, as opposed to programs focused solely on high-risk students, result in meaningful decreases in symptoms of depression and anxiety, therefore, reinforcing the cost-effectiveness and the early educational mental health initiative's universal access potential. In the Australian context, findings from[26] replicate the school-based early detection and psychosocial skill mitigation findings previously documented. In the absence of face-to-face services, documented in their meta-analysis, clinically significant improvements in depression for adolescents can be realized through internet self-help programs. In conclusion, the collision of traditional psychosocial education in schools with effective evidence-based therapies available online would be the best and most equitable method for closing the mental health gap for the global child and adolescent population.[27]

The stated objectives—prevalence mapping, risk identification, and appraisal of interventions—have been addressed. Emotional distress, which increased post-pandemic,[24] corresponds to Objective 1 and exemplifies the evolving nature of trends in prevalence. Objective 2 is achieved by pinpointing economic hardship and ACEs as key drivers, and Objective 3 is underscored by evidence that CBT and integrated school-based approaches yield the most significant measurable impacts.[27] The consistent findings with the objectives provide the review with a sense of

internal cohesion. This also speaks to the review's pragmatic value.

CONCLUSION

This systematic review corroborates the prevalence of mental health disorders in children and adolescents—including depression, anxiety, ADHD, and ASD—and the alarming reality of them being often overlooked. Disadvantage in social and economic status, mental disorders, and childhood trauma seem to be major risk factors, in varying degrees, all over the world.

Although CBT and school-based interventions hold promise, they are particularly constrained in low-resource settings because of accessibility, cultural responsiveness, and trained personnel shortages. These findings highlight the crucial importance of integrated, scalable, and child-centered mental health approaches.

This review enhances the existing body of knowledge to help devise policies and programs for strengthening early diagnosis, improving the care continuum, and fostering mental health promotion from childhood.

LIMITATIONS

This systematic review examined only English-language, peer-reviewed literature published between 2010 and 2025, thus possibly omitting important regionally relevant and grey literature materials. Differences in methodological approaches across studies and a lack of longitudinal follow-up data also restricted the ability to make cross-study comparisons. Finally, the absence of pooled meta-analytic statistics indicates that findings should be interpreted as descriptive trends and not as precise quantitative estimates. Future studies focusing on generalised research to include non-English literature and long-term outcomes of interventions will promote a wider scope.

Recommendations

Expand Longitudinal Research

Future studies should assess the long-term benefits of mental health interventions for children and how these benefits differ across cultural and socioeconomic boundaries.

Strengthen Implementation Science

Developments should examine expenditures, real-world applications, and the ease of scaling and incorporating primary healthcare and educational systems.

Incorporate Age and Cross-Culturally Sensitive Tools

There is a demand for age-appropriate, validated tools for diagnosis and intervention, as well as culturally sensitive materials.

Emphasize Digital Equity

Digital mental health interventions should be designed to be socially usable, ecologically sustainable, and financially low burden in disadvantaged locations.

Increase Child and Youth Participation in Program Design

Future programs must be co-designed with children and adolescents to enhance relevance, acceptability, and effectiveness.

Concentrate on Understudied Groups

More work is needed on children with disabilities, in conflict settings, and other marginalized populations, who are often overlooked in the bulk of mental health work.

Advance Shared Collaborative Work

There should be a continuous, integrated response

to mental health and illness across the education, health, and social work sectors.

List of Abbreviations

ACEs – Adverse Childhood Experiences.
ADHD – Attention-Deficit/Hyperactivity Disorder.
ASD – Autism Spectrum Disorder.
CBT – Cognitive Behavioral Therapy.
COVID-19 – Coronavirus Disease 2019.
DALYs – Disability-Adjusted Life Years.
DSM-5 – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.
HICs – High-Income Countries.
LMICs – Low- and Middle-Income Countries.
mhGAP – Mental Health Gap Action Programme.
NGOs – Non-Governmental Organizations.
OECD – Organization for Economic Co-operation and Development.
SEL – Social-Emotional Learning.
UNICEF – United Nations International Children's Emergency Fund.
WHO – World Health Organization.

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Declarations

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AUTHORS' CONTRIBUTIONS

Sr.#	Author's Full Name	Intellectual Contribution to Paper in Terms of:
1.	Somia Sarfraz	1. Study design and methodology.
2.	Somia Sarfraz	2. Paper writing.
3.	Somia Sarfraz	3. Data collection and calculations.
4.	Somia Sarfraz & Nabeel Amjad	4. Analysis of data and interpretation of results.
5.	Mukarram Anees, Ehsan Ul Haq & Aqsa Akram	5. Literature review and referencing.
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7.	Irsa Safdar, Afifa Shafqat	7. Proofreading.