JNAMUN 2026

WORLD HEALTH ORGANIZATION

WHO

AGENDA ITEM:

Improving mental health and emotional well-being for young people

USG: Bilge Ankıtcı
Chair: Nur Beren Şen
Co-Chair: Ece Kul
Rapporteur: İpek Nur Aykaç

TABLE OF CONTENTS

World Health Organization

Letter from the Secretary General

Most honourable participants of Junior Nesibe Aydın Model United Nations 2026 (JNAMUN'26),

It is my great pleasure to welcome you all to JNAMUN'26, which is organized by the hardworking and talented middle school students of Nesibe Aydın Gölbaşı Campus. I extend my sincere thanks to our academic team, who have researched every detail with great care to ensure that you enjoy such a prestigious and diplomatic conference. I also offer my appreciation to our organisation team for planning activities that will allow you to build friendships and collaborate with fellow delegates while having an enjoyable and memorable experience.

As the JNAMUN'26 team, our mission is to support our delegates in every respect, to help you gain insight into diplomacy, to develop your public speaking abilities, and to strengthen your language skills. Another valued aspect of attending JNAMUN'26 is the opportunity to form lasting friendships and create memories that will stay with you. Both our academic and organisation teams have worked with dedication to offer you the most enriching Model United Nations experience possible.

*This year in JNAMUN'26 we are hosting nine committees which are **UNHCR** (United Nations High Commissioner for Refugees), **FAO** (Food and Agriculture Organization), **WHO** (World Health Organization), **UNESCO** (United Nations Educational, Scientific and Cultural Organization), **CSW** (The Commission on the Status of Women), **UNICEF** (The United Nations International Children's Emergency Fund), **DISEC** (Disarmament & International Security Committee), **ECOSOC** (Economic and Social Council), and **SPECPOL** (Special Political and Decolonization Committee). The agenda items for each committee have been selected in line with the policies of their respective United Nations bodies.*

We wish you an exceptional Junior Nesibe Aydın Model United Nations experience. As the JNAMUN'26 team, we look forward to meeting you and supporting you as you achieve your goals to the very best of your ability.

Best of luck,

Mustafa COŞKUN

Secretary General of JNAMUN'26

1. Introduction to the Committee

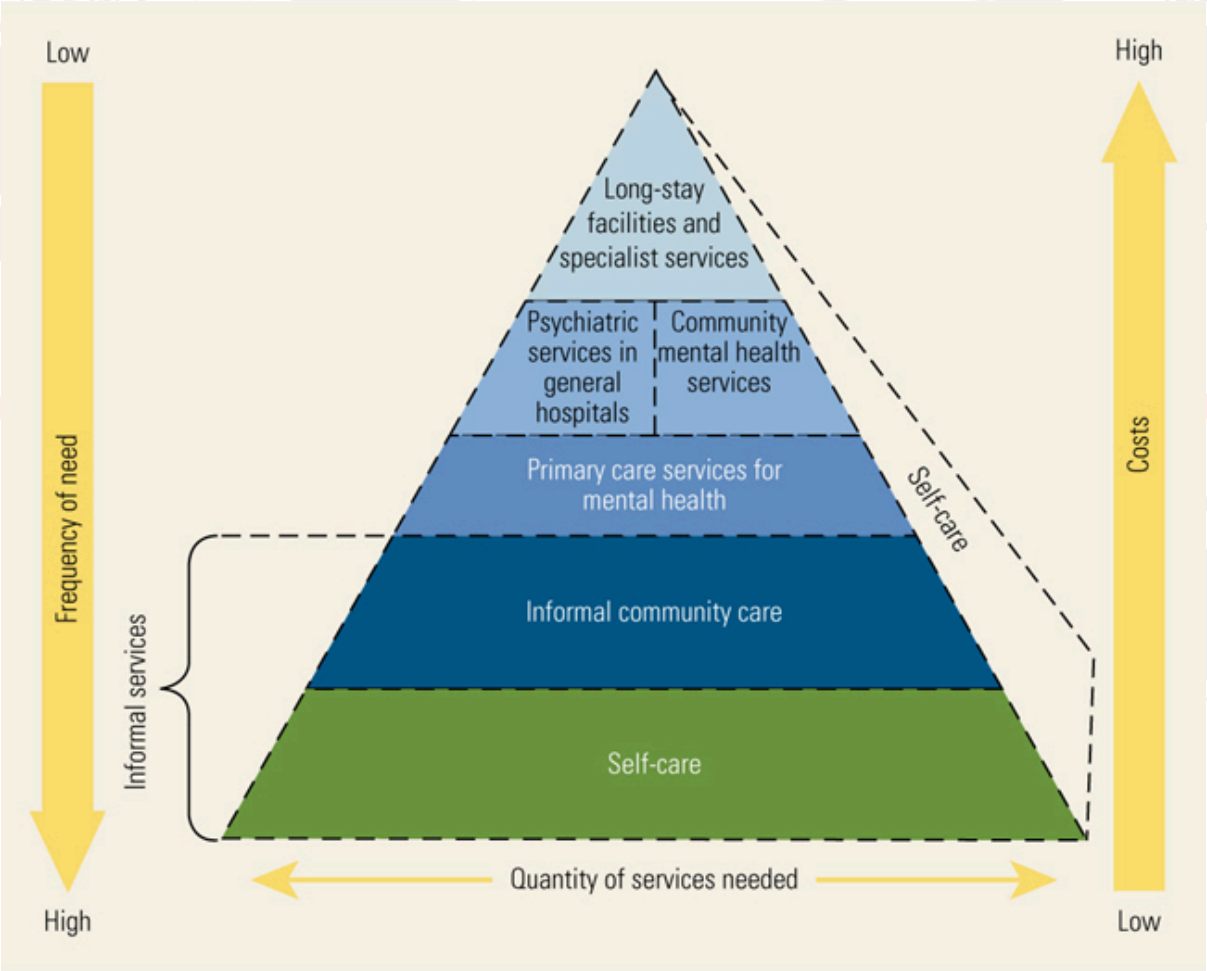
The World Health Organization (WHO) is the United Nations' specialized agency for health. Its core mission is to promote health, keep the world safe, and serve the vulnerable by helping countries prevent disease, strengthen health systems, and respond to emergencies. WHO sets global health standards and guidelines, tracks health trends, supports research and data systems, and provides technical assistance so governments can translate evidence into real services.

WHO works through its World Health Assembly (where all Member States make decisions), its Executive Board, and its Secretariat led by the Director General, with six regional offices and country teams that support national ministries of health. It produces key norms and tools such as clinical and public health guidelines, the International Classification of Diseases (ICD), emergency risk management support, and health system strengthening frameworks. In mental health specifically, WHO helps countries design policies and laws, integrate mental health into primary care, train health workers using practical packages such as mhGAP, and measure progress through indicators and reporting. Because mental health is shaped by education, employment, safety, housing, online environments, and social protection, WHO also coordinates with other UN bodies and partners to push "health in all policies" approaches, especially for children and adolescents.

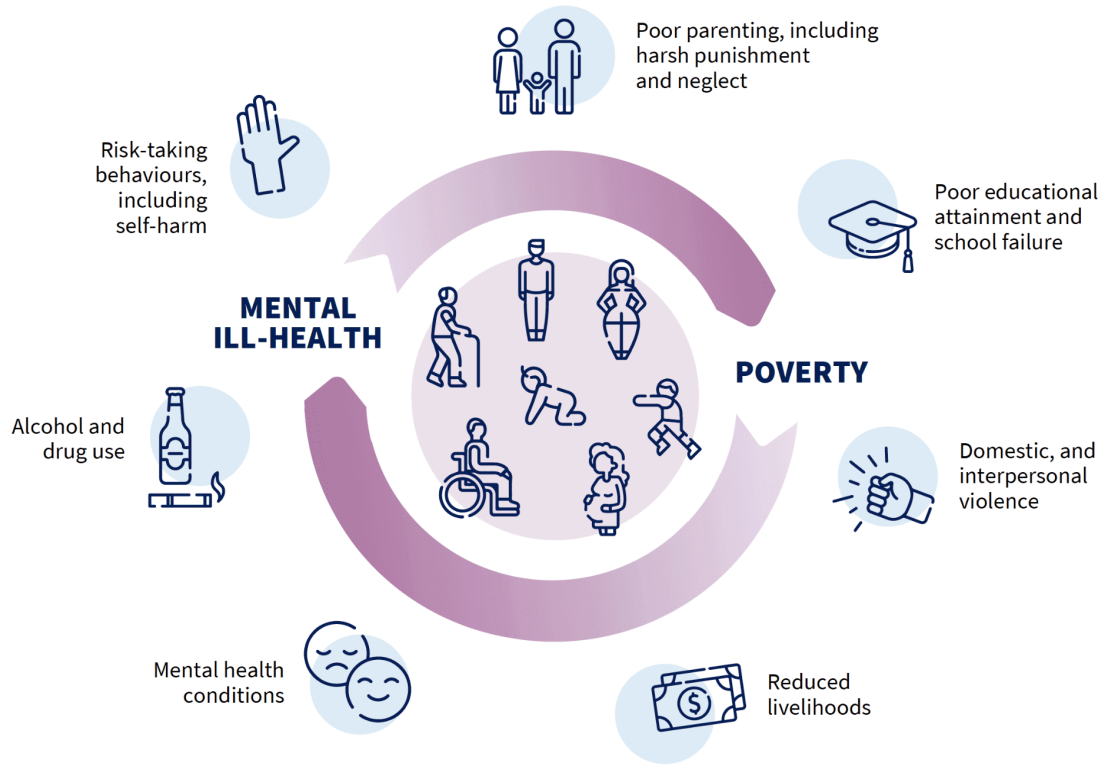
WHO's mandate connects directly to the 2030 Agenda, especially SDG 3 (Good Health and Well Being), including targets on non communicable diseases, universal health coverage, and strengthening prevention and treatment of substance abuse and mental health conditions. For this committee's agenda, "Improving mental health and emotional well being for young people (SDG 3)," delegates will focus on how countries can prevent mental health risks early, expand access to youth friendly services, and build supportive environments across schools, families, communities, and digital spaces. The goal is to design realistic, scalable public health policies that reduce stigma, improve early identification and care, protect vulnerable groups, and make mental health support accessible, affordable, and safe for adolescents and young adults.

2. Introduction to the Agenda Item

"Improving mental health and emotional well being for young people (SDG 3)" focuses on how countries can prevent psychological distress, reduce mental disorders, and help adolescents and young adults build resilience in a world that is faster, more connected, and more uncertain than previous generations experienced. Because most mental health conditions begin before adulthood, what happens in childhood and adolescence often sets the trajectory for lifelong health, education outcomes, relationships, and economic participation. This agenda is not only about treatment, it is about building environments where young people can develop safely, manage stress, and access help early without fear or stigma.



Prevention and promotion are the foundation. Promoting emotional well being means strengthening protective factors that make young people more resilient, such as supportive parenting, safe schools, stable routines, healthy sleep, physical activity, social connection, and skills like emotional regulation and problem solving. Prevention also means reducing exposure to major risk drivers: violence and bullying, discrimination, poverty and insecurity, harmful substance use, academic pressure without support, unsafe online experiences, and social isolation. Policies here include parenting support programs, anti bullying frameworks, school based life skills curricula, youth friendly community spaces, and social protection measures that reduce stress in vulnerable households.



Access to youth friendly services is the second pillar. Many countries have large gaps in mental health care because of workforce shortages, cost barriers, weak referral systems, and a lack of services designed for adolescents. “Youth friendly” means services that are confidential, non judgmental, affordable, culturally appropriate, and easy to reach through schools, primary health care clinics, community centers, and digital channels. Effective systems include early identification pathways, stepped care models (from low intensity support to specialist care), crisis response capacity, and continuity of care for severe conditions. Integrating mental health into primary care and school health services can massively expand reach, but it requires trained staff, supervision, safeguarding protocols, and clear referral mechanisms.

Digital life is now a major part of the agenda item. Online spaces can provide support communities and access to information, but they also create risks such as cyberbullying, harassment, exposure to harmful content, addictive design patterns, sleep disruption, and unrealistic social comparison. Governments and health systems can respond with digital literacy education, stronger child online safety standards, responsible platform regulation, and evidence based digital mental health tools that protect privacy. The aim is not "screen time panic," but practical policy that reduces harm while enabling safe, high quality support, especially for young people who cannot access in person care.

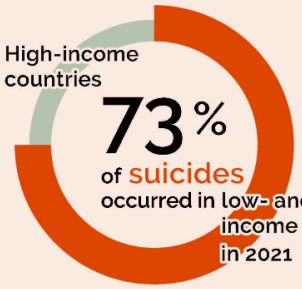
Equity and protection of vulnerable groups is essential. Mental health risks are not evenly distributed. Refugees and displaced youth, LGBTQ+ youth, young people with disabilities, survivors of abuse, those in conflict settings, and those living in extreme poverty often face higher exposure to trauma and fewer support options. Policies should address discrimination, strengthen safeguarding and child protection systems, ensure access regardless of legal or financial status, and build trauma informed services. This includes better coordination between health, education, social services, and justice sectors so young people do not fall through gaps.

Finally, measurement and stigma reduction determine whether policies work. If young people fear being labeled, punished, or excluded, they avoid care. Countries need public education strategies, school and workplace anti discrimination protections, and confidentiality rules that are actually enforced. They also need data systems to track prevalence, service access, quality, and outcomes, not just how many clinics exist. In this committee, delegates will design policy packages that combine prevention, service delivery, digital safety, equity protections, and measurable targets aligned with SDG 3, aiming for interventions that are scalable, ethical, and realistic for different income settings.

World Health Organization

Suicide: facts and figures globally

More than **720 000** people died by suicide in **2021**



More than **1 in 100** (1.1%) were by suicide in 2021

Suicide is the **third** leading cause of death among **15-29** year-olds in 2021

56% of suicides happened before the age of **50** years in 2021

Implement LIVE LIFE to reach the target of reducing suicide rates by **1/3** by **2030** according to the UN Sustainable Development Goals 2030 and the WHO Mental Health Action Plan 2013-2030

LIVE
cross-cutting foundations

- Situation analysis
- Multisectoral collaboration
- Awareness raising
- Capacity building
- Financing
- Surveillance, monitoring, evaluation

Key effective evidence-based interventions

L Limit access to means of suicide

I Interact with the media on responsible reporting

F Foster life skills of young people

E Early identify and support everyone affected

Source: Suicide worldwide in 2021: global health estimates; World Health Organization, 2025
www.who.int/publications/i/item/9789240110069.

WHO/UCN/NMH/MHS/2025.10

3. Keywords & Definitions

1. **Mental Health**

   A state of well being in which a person can cope with normal stresses, learn and work effectively, and contribute to their community. In public health, it includes both prevention and access to care.

2. **Emotional Well Being**

   A person's ability to understand, express, and manage emotions, maintain relationships, and experience a sense of purpose and self worth, even during stress.

3. **Adolescents and Young People**

   A broad youth population often defined as ages 10 to 24 in policy discussions, capturing early adolescence through young adulthood when many mental health conditions first appear.

4. **Common Mental Disorders**

   High prevalence conditions such as anxiety and depressive disorders that can significantly reduce daily functioning but are often underdiagnosed and undertreated in youth.

5. **Severe Mental Disorders**

   Less common but high impact conditions such as psychosis and bipolar disorder that may require specialist care, long term support, and strong safeguarding.

6. **Psychosocial Support**

   Non medical support that helps people cope and function, including counseling, peer support, family support, and skills based interventions that improve coping and social connection.

7. **Psychological Distress**

   A state of emotional suffering often linked to stressors like conflict, academic pressure, violence, or economic hardship, which may or may not meet criteria for a diagnosable disorder.

8. **Risk Factors**

   Conditions that increase the likelihood of poor mental health, such as bullying, family conflict, trauma, discrimination, substance use, poverty, and unsafe online exposure.

9. **Protective Factors**

   Conditions that reduce risk and build resilience, such as supportive caregivers, safe schools, positive friendships, stable routines, physical activity, and access to trusted adults.

10. **Resilience**

    The capacity to adapt, recover, and keep functioning during adversity, built through skills, relationships, and supportive environments, not through willpower alone.

11. **Stigma**

    Negative beliefs and attitudes that label mental health problems as shameful or dangerous, leading to discrimination and preventing young people from seeking help.

12. **Discrimination**

    Unfair treatment based on mental health status or identity, including exclusion from school, employment, or services, and social punishment for seeking support.

13. **Early Identification**

    Recognizing warning signs early through screening or observation in schools, primary care, and communities so support can begin before problems worsen.

14. **Screening**

    Use of brief tools or structured questions to detect possible mental health difficulties. Screening is not diagnosis and must link to referral and support options.

15. **Diagnosis**

    A clinical determination that symptoms meet criteria for a specific condition. Overdiagnosis and underdiagnosis are both risks, especially when services are scarce.

16. **Suicidal Ideation**

    Thoughts about ending one's life. It requires urgent risk assessment, safety planning, and access to appropriate care, not punishment or moral judgment.

17. **Self Harm**

    Intentional injury to oneself, sometimes without suicidal intent. It signals distress and risk and should trigger supportive intervention and safeguarding.

18. **Substance Use Disorders**

    Patterns of alcohol or drug use causing harm, dependence, or impaired functioning. In youth, prevention, early intervention, and comorbidity with anxiety or depression are key issues.

19. **Trauma and Adverse Childhood Experiences**

Harmful events such as abuse, neglect, witnessing violence, or displacement that can affect brain development, stress responses, and long term mental and physical health.

20. **Trauma Informed Care**

An approach that assumes a person may have experienced trauma and designs services to avoid re-traumatization through safety, choice, trust, and empowerment.

21. **Youth Friendly Services**

Services that are accessible, confidential, affordable, non judgmental, culturally sensitive, and designed around adolescents' needs, including flexible hours and safe referral routes.

22. **Confidentiality**

Protection of personal information shared in care. For adolescents, confidentiality encourages help seeking but must be balanced with mandatory safeguarding when there is serious risk.

23. **Safeguarding**

Policies and actions that protect children and adolescents from abuse, exploitation, and harm, including clear reporting pathways and trained staff.

24. **Primary Health Care Integration**

Embedding mental health support into first contact services such as family doctors, community clinics, and nurses to increase access and reduce specialist bottlenecks.

25. **School Based Mental Health Programs**

Interventions delivered in schools, ranging from life skills education and anti bullying measures to counseling and referral systems.

26. **Social Determinants of Mental Health**

Non medical drivers that shape mental health, including income, housing, education quality, food security, neighborhood safety, discrimination, and access to social support.

27. **Digital Mental Health**

Use of apps, telehealth, chat based counseling, and online programs to deliver support. Quality, evidence, privacy, and crisis escalation pathways are critical.

28. **Cyberbullying**

Harassment or humiliation through digital platforms that can cause anxiety, depression, and school avoidance and increases risk when persistent or public.

29. **Content Moderation and Online Safety**

Measures that reduce exposure to harmful content and harassment. Effective policies combine platform accountability, reporting tools, age appropriate design, and user education.

30. **Stepped Care**

A service model that starts with the least intensive effective support and escalates to specialist care based on need, improving efficiency when resources are limited.

31. **Continuity of Care**

Consistent support over time, including follow up after crises, smooth referral between services, and support during transitions such as moving from child to adult services.

32. **Task Sharing**

Training non specialist workers such as nurses, teachers, community health workers, or counselors to deliver structured mental health interventions under supervision to close workforce gaps.

33. **Mental Health Literacy**

Knowledge and skills to recognize mental health problems, seek help, support peers, and avoid misinformation, delivered through schools, families, and public communication.

4. Historical Background

After World War II, health systems focused heavily on rebuilding and controlling infectious diseases, while mental health was often handled through large institutions and stigma driven social policies. Even so, WHO's founding vision already treated mental health as part of health, because its constitution defined health as complete physical, mental, and social well being. As countries industrialized and urbanized, new stressors appeared for families and adolescents, including displacement, poverty, changing social structures, and later the pressures of modern schooling and labor markets. These shifts made it clear that mental health is not only a medical issue, it is shaped by society, education, and economic security.

From the 1950s through the 1970s, psychiatry and public policy began moving away from long term institutionalization toward community based models. This period was driven by new medications, human rights debates, and evidence that isolating people often worsened outcomes. The idea of community mental health grew, along with the understanding that prevention and early support could reduce lifelong disability. At the same time, youth specific mental health needs were still frequently overlooked, with many systems treating children and adolescents as smaller versions of adults rather than as a group with distinct developmental risks and safeguards.

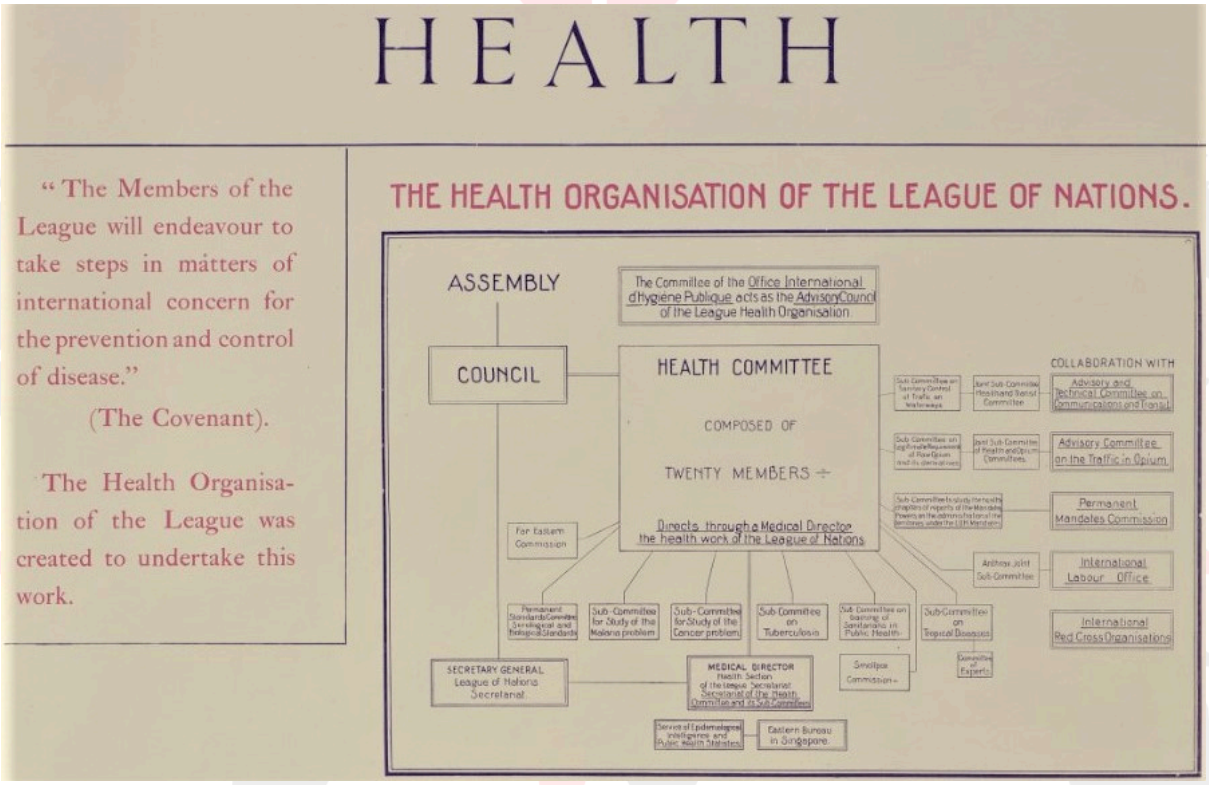
In the 1980s and 1990s, global health frameworks started to connect mental health to health promotion and human rights. The expansion of primary health care thinking made it more realistic to integrate mental health into everyday services rather than keeping it only in specialist hospitals. Youth protection norms also strengthened through international child rights standards, pushing governments to treat violence, neglect, exploitation, and discrimination as public health issues with direct mental health consequences. This era helped establish that schools, social services, and justice systems are part of the mental health ecosystem, not separate from it.

In the 2000s, mental health moved closer to the center of global health policy. WHO and partners emphasized that mental disorders are common, treatable, and major drivers of disability, while suicide prevention became a more explicit priority. A key operational shift was scaling practical care models in low and middle income countries through approaches like task sharing and integration into primary care, rather than waiting for enough specialists to exist. This period also saw growing attention to adolescent risk factors such as substance use, violence, and school dropout, alongside protective strategies such as life skills education and community support.

From 2013 onward, mental health was anchored more clearly in global targets and measurable planning. WHO's comprehensive action planning approach gave countries a structure to build governance, services, promotion, prevention, and surveillance, while the 2015 Sustainable Development Goals explicitly framed health as well being, not only survival. SDG 3 strengthened the political case for youth mental health by linking it to non communicable disease prevention, suicide reduction, universal health coverage, and equity. It also supported the logic that mental health investment improves education outcomes, employment, and long term physical health, making it a development issue, not a niche health topic.

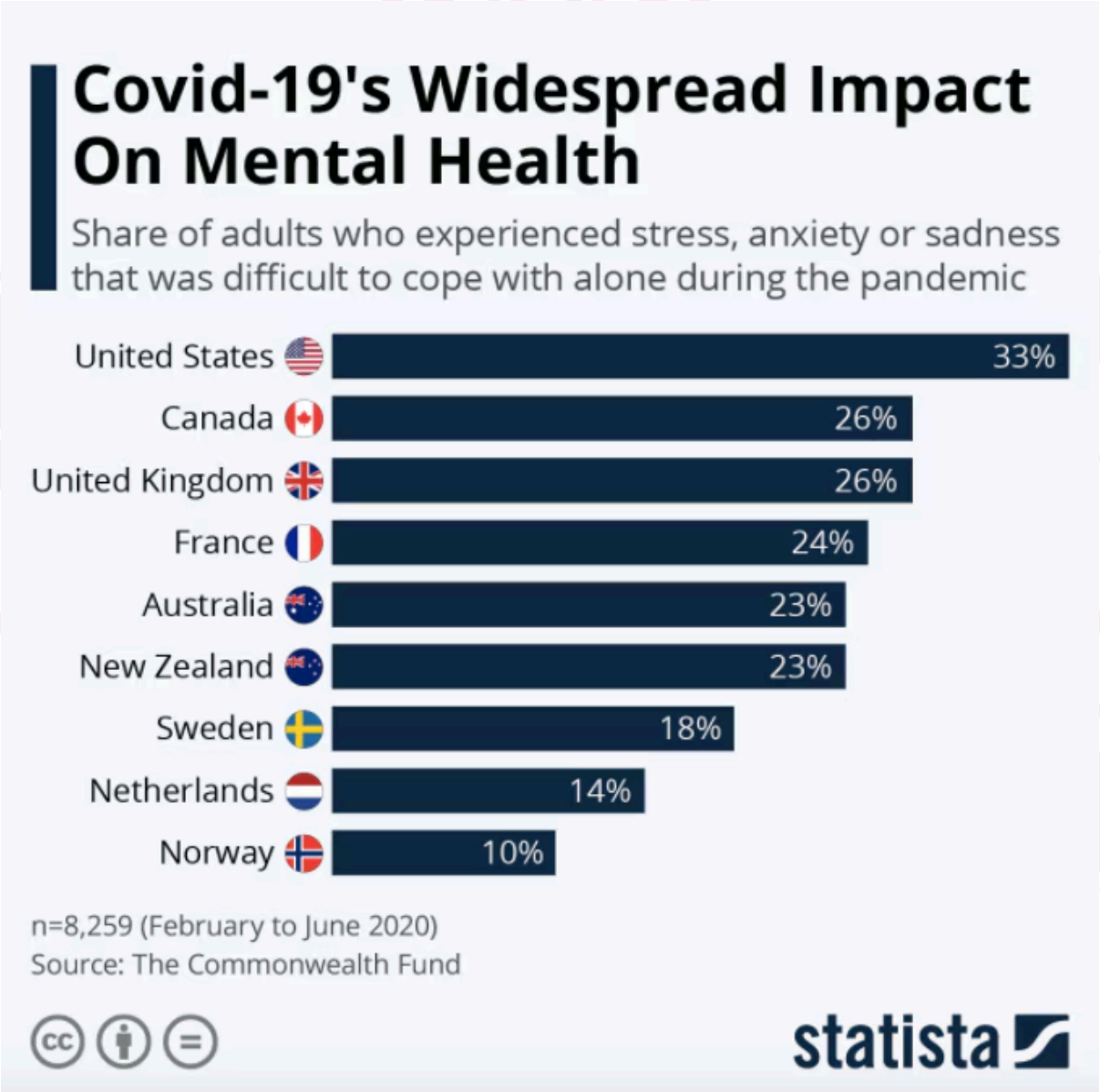
Over the last decade, youth mental health became more urgent because the risk environment changed faster than most health systems adapted. Digital life expanded peer connection and access to information, but also amplified cyberbullying, harassment, addictive design, sleep disruption, and harmful social comparison. At the same time, rising academic pressure, economic insecurity, conflict driven displacement, and climate related anxiety increased chronic stress for many young people. The COVID 19 period further exposed service gaps, especially the lack of early support and the fragility of school and community based safety nets, accelerating interest in telehealth and digital interventions while raising privacy and safeguarding concerns.

This history matters for your agenda because it shows a clear evolution: mental health moved from being treated mainly as an institutional and specialist issue to being recognized as a rights based, community focused, prevention oriented public health priority tied to development goals. WHO's role is to convert that shift into systems that actually work, meaning youth friendly access pathways, early identification and low intensity support at scale, safe escalation for severe risk, and coordinated action across health, education, social protection, and digital governance.



5. Examples of the Topic

Countries use different approaches to prevent mental health problems, improve emotional well being, and expand access to care for adolescents and young adults, combining school systems, primary care, community services, and crisis support.



In Australia, the headspace model created dedicated youth mental health centers focused on early intervention for ages roughly 12 to 25, bringing mental health, physical health, substance use support, and social help into one youth friendly entry point. The lesson is that young people are more likely to seek help when services are walk-in, low stigma, and designed around youth behavior rather than hospital routines.

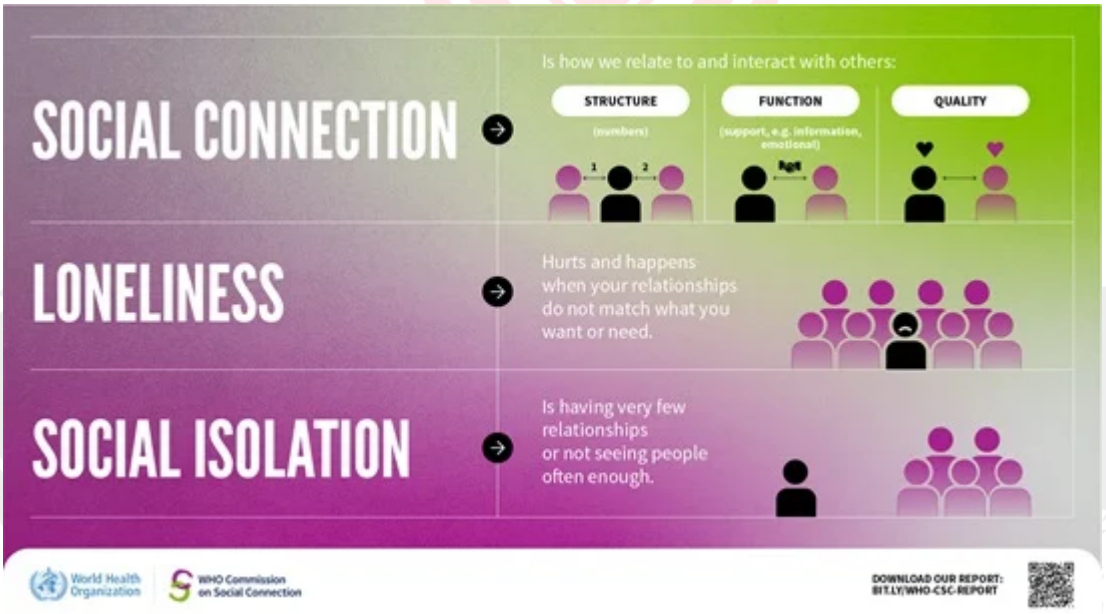
In England, Mental Health Support Teams have been rolled out in schools and colleges to provide early help for mild to moderate issues and create clearer pathways between education and NHS services. The lesson is that schools can function as a practical access layer, but only if there is a defined model for staffing, supervision, referral, and coverage targets.

In Finland, the KiVa anti bullying program targets peer dynamics and bystander behavior with structured school tools and has been scaled widely. The lesson is that reducing bullying is not a soft extra, it is a prevention intervention with measurable mental health impact because bullying drives anxiety, depression, school avoidance, and self harm risk.

In Iceland, the Icelandic Prevention Model uses community level data on risk and protective factors to coordinate parents, schools, sports and leisure programs, and local policy in order to shift the social environment around teenagers. The lesson is that youth mental health protection scales better when communities change norms and daily structures, not only when clinics add appointments.

In Canada, Foundry in British Columbia uses an integrated youth services model where young people can access multiple supports through one front door, including mental health, substance use, primary care, and social services, with physical centers plus virtual services. The lesson is that fragmented systems lose young people at handoffs, while integrated models reduce drop off by solving health and social needs together.

In the United States, the 988 Suicide and Crisis Lifeline created a simple national access point for crisis support via call, text, and chat, aiming to connect people to local crisis centers with national standards. The lesson is that crisis systems need a clear front door, but they must also be backed by mobile response, stabilization options, and follow up care or they become a revolving door.



At the global policy level, WHO and UNICEF developed the Helping Adolescents Thrive initiative and toolkit to guide countries on promotive and preventive strategies for adolescent mental health and reducing self harm and other risk behaviors across sectors. The lesson is that effective national plans treat adolescent mental health as a system design problem spanning schools, families, social services, and health, not as a single program owned by a ministry of health.

For service expansion in low resource settings, WHO's mhGAP tools support training and clinical decision support so non specialist providers in non specialized settings can identify and manage priority mental, neurological, and substance use conditions and refer when needed. The lesson is that workforce shortages can be reduced through task sharing and standard protocols, but only with supervision, referral pathways, and quality monitoring.

6. Questions to be Addressed

1. **How can countries build prevention first youth mental health strategies that strengthen protective factors in families, schools, and communities instead of relying mainly on clinical treatment?**
2. **What minimum package of school based support should every country aim to provide, and how should schools connect to health services without turning teachers into therapists?**
3. **How can governments reduce bullying, violence, and discrimination in ways that measurably improve youth mental health outcomes?**
4. **What policies best reduce academic stress while keeping education standards high, especially in exam heavy systems?**
5. **How can primary health care integrate early identification and low intensity mental health support for adolescents without overmedicalizing normal stress?**
6. **How can countries expand youth friendly services that are confidential and accessible while still meeting safeguarding duties for self harm, abuse, and severe risk?**
7. **How can countries ensure continuity of care during transitions, especially from child to adult services and from school to work?**
8. **What are the most effective strategies to reduce suicide and self harm in young people, including crisis lines, safety planning, restricting lethal means, and follow up care?**
9. **How should governments regulate and enforce online safety to reduce cyberbullying and harmful content exposure without blocking access to supportive communities?**
10. **What standards should be required for digital mental health apps and chat services on evidence, privacy, data retention, and crisis escalation?**
11. **How can countries reduce substance use harms among youth, especially where alcohol, vaping, or drugs are normalized, while avoiding punitive approaches that increase stigma?**
12. **How should mental health policy address trauma in conflict, displacement, and disaster settings, including trauma informed care and community based psychosocial support?**
13. **What legal and policy safeguards are needed to prevent discrimination against young people with mental health conditions in schools, universities, and workplaces?**
14. **What financing approaches can sustainably fund youth mental health, such as integrating into universal health coverage, school health budgets, insurance coverage, and results based funding?**
15. **How can governments coordinate across health, education, social protection, and justice ministries so young people do not fall through gaps between systems?**

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