Participation of children and youth in mental health policymaking

Participation of Children and Youth in Mental Health Policymaking: A Scoping Review [Part I]

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Abstract (max 250 words)

Purpose Although youth participation is oft-acknowledged as underpinning mental health policy and service reform, little robust evidence exists about the participation of children and youth in mental health policymaking.

Method A scoping review based on Arksey and O'Malley's framework was conducted to identify and synthesize available information on children and youth's participation in mental health policymaking. Published studies up to November 30, 2020 were searched in Medline (OVID), PsycINFO (OVID), Scopus, and Applied Social Sciences Index and Abstracts (PROQUEST). Unpublished studies were identified through Google Scholar and targeted web searches October to December, 2020. Three reviewers performed screening and data extraction relevant to the review objective, followed by an online consultation.

Results From 2,981 records, 25 publications were included. A lack of diversity among the youth involved was found. Youth were often involved in situational analysis and policy design, but seldom in policy implementation and evaluation. Both the facilitators of and barriers to participation were multifaceted and interconnected. Despite a range of expected outcomes of participation for youth, adults, organizations, and communities, perceived and actual effects were neither substantially explored nor reported.

Conclusions: Our recommendations for mental health policymaking highlight the

inclusion of children and youth from diverse groups, and the creation of relational spaces that ensure safety, inclusiveness, and diversity. Identified future research directions are: the outcomes of youth participation in mental health policymaking, the role of adults, and more generally, how the mental health of children and youth shapes and is shaped by the policymaking process.

Background

Youth mental health is a growing priority in the global health agenda. Indeed, there is growing recognition that investing in children's and youth's mental health is crucial to their wellbeing and their ability to actively participate in society now and as adults (Rose et al., 2017). Three quarters of all mental health challenges start by the mid-20s (Kessler et al., 2007) and about 10-20 percent of children and adolescents worldwide experience diagnosed mental health conditions (Kieling et al., 2011).

The participation of children and youth in service delivery planning, research, and policymaking has been shown to improve the mental and physical health outcomes of the children and youth who participate (CYCC Network, 2013; Jenkins, Bungay, Patterson, Saewyc, & Johnson, 2018; Oliver, Collin, Burns, & Nicholsa, 2006; Price & Feely, 2017). Moreover, participation provides youth with a sense of power and control of their own identity (Ungar & Teram, 2000). The involvement of children and youth in decision-making is enshrined in Article 12 of the *Convention on the Rights of the Child* (UNGA, 1989). It stipulates that children (i.e., people under the age of 18 years) have the right to express their views freely in all matters that affect them. This includes judicial and administrative proceedings and policymaking processes at all levels of government. Public participation rights have also been recognized for individuals 18 years of age and older in other treaties such as the *International Covenant on Civil and Political Rights* (UNGA, 1966), which highlights the crucial role that people play in promoting governance through equal access to public services (Art. 25).

Initiatives to engage children and youth in mental health policy are gaining momentum, notably in Australia, Canada, and the United Kingdom (UK) (Government of Canada, 2018, 2020; Orygen, 2020; United Nations, 2010; Young Minds, 2017). These initiatives are aligned with a positive youth development approach that views children and youth as active contributors to their own development and to their communities (Iwasaki, 2016). Yet, participation of children and youth is seen more often in service planning, implementation, evaluation, and research than in policymaking (Jenkins, Haines-Saah, et al., 2020). On the other hand, little is known about what has been done to facilitate the consistent and meaningful inclusion of children and youth as actors/agents in policymaking in the field of mental health (Jenkins, McGuinness, et al., 2020). Indeed, some marginalized groups — such as teenage parents, youth living or spending time on the street , racialized, unemployed, and Indigenous children and youth, and those in the criminal-legal system— are often left out of decisions that affect their lives (Mohajer & Earnest, 2010). At the same time, a range of social determinants such as gender, poverty, and racism disproportionately affect mental health of these marginalized groups.

In this context, a scoping review of publications describing the current state of child and youth participation in mental health policymaking is needed to guide and sustain future research and decision-making in this field. In our review, policymaking is broadly defined in a spectrum where participation can be found at different stages of a policy cycle, including research participation and dissemination of knowledge aiming to inform policies (Macauley et al., 2022; OECD, 2017).

Method

We conducted this scoping review in accordance with established frameworks and methodology guides (Arksey & O'Malley, 2005; Peters, Godfrey, et al., 2020; Peters, Marnie, et al., 2020). The review was structured in six stages: (1) defining the review question; (2) identifying relevant studies and searching the academic and grey literature; (3) selecting relevant studies; (4) extracting data relevant to research questions; (5) analyzing and reporting data that respond to the review questions; and (6) conducting stakeholder consultations with children and youth, policymakers, and adult facilitators of child and youth participation. A preliminary search of PROSPERO, MEDLINE, the Campbell Collaboration Library, the Cochrane Database of Systematic Reviews, and the Joanna Briggs Institute Database of Systematic Reviews and Implementation Reports was conducted and no existing or underway scoping reviews or systematic reviews on the topic were identified. The scoping review protocol was registered in Open Science Framework (OSF) on November 30, 2020 (10.17605/OSF.IO/H5ERX).

Identifying the review question

The main review question, developed after considering the purpose of the review (Arksey & O'Malley, 2005), was: What information is available on child and youth participation in mental health policymaking? We subsequently came up with the following sub-questions: (1) What are the socio-demographic characteristics of the children and youth participating in mental health policymaking? (2) In what geographical and substantive contexts have children and youth participated in

policymaking? (3) What is the extent and nature of child and youth participation? (4) What facilitators of, barriers to, and effects (expected or documented, individual or collective) of the participation of child and youth in mental health policymaking have been reported?

Identifying relevant literature

Inclusion and exclusion criteria

We included literature examining the participation of children and youth in mental health policymaking. Children under the age of 18 years according to the United Nations Convention on the Rights of the Child (UNGA, 1989) and youth between 15 and 24 years of age according to the United Nations definitions of youth (UNDESA, n/d) were considered. Other common terms (i.e., child, adolescent, youth, young adults, and emerging adults) were used in the literature search. The search strategy is included in Appendix I (Supplementary Material).

In terms of content, we included sources that explored the active participation of children or youth in mental health policymaking or evaluated interventions to support child and/or youth participation in mental health policymaking. Participation in policymaking can range along a continuum of levels and take place at different points in the policymaking process. A broad definition of policymaking was thus applied; both formal and informal participation processes where youth are engaged in information sharing, consulting (e.g., public meeting, youth council), or collaborating (e.g., youth advisory group, participatory research) to directly or indirectly influence policy agenda, directions or decisions within a policy cycle in government, school, and community

settings We included studies that: took place in any geographic location (i.e., including high-, middle-, and low-income countries); involved any subgroup of the population; and pertained to any type of public mental health policy, any phase of the policymaking process, and level of government. We included a comprehensive definition of mental health policymaking, encompassing a range of interventions, from the promotion of wellbeing to the prevention of mental illnesses (Stewart-Brown, 2017; Weijers & Jarden, 2017).

In this scoping review, we considered published primary sources of evidence and grey literature and reviews if they included not only an evidence synthesis but also consultations. Studies could be of any type of design (i.e., quantitative, qualitative, and mixed methods), policy documents, agency reports, etc., available in English. In order to minimize the risk of omitting relevant sources, no specific criteria were applied for heterogeneous types of data presented in retained publications. We excluded documents focusing on policymaking that were not related to mental health or that addressed adults only or that addressed the entire general population, without any specific focus on children and youth. Also, bibliometric analyses, book chapters, reviews that did not include consultations, protocols, conference/seminar proceedings, editorials, letters to the editor, and introductions to issues and special issues were excluded.

Search strategy

A research librarian conducted the main search using key/text words and subject headings identified from existing knowledge and the titles, abstracts, and index terms of relevant articles on the topic based on the results of an initial limited search in Medline

(Appendix 1). This search strategy was independently validated by another research librarian. Four bibliographic databases were searched on November 30, 2020: Medline (OVID interface), PsycINFO (OVID interface), Scopus, and Applied Social Sciences Index and Abstracts (PROQUEST interface). We did not apply any date or language restrictions. The grey literature was searched in English through Google Advanced Search for published materials that met the inclusion criteria between October and December 2020. The keywords used to search for grey literature include: child; children; youth; adolescents; young adults; emerging adults; mental health; mental illness; mental disorder; wellness; well(-)being; ill(-)being; mental health policy; mental health policy development; mental health policy making; policy making; policy development; participation; inclusion; engagement; consultation; co-creation; co-production; co-design; decision-making; shared decision-making; input; experiential; advocacy; well(-)being promotion; mental illness prevention; and, mental health promotion. We further identified other sources through team members' existing networks of researchers and relevant organizations working in the field globally. Relevant grey literature sources were identified by examining the context, precision, and quality of key concepts used in the references and how these potentially related to the research questions.

Source of evidence selection

All identified records (n=2,981) were merged into EndNote X9 (Clarivate Analytics, PA, USA) and duplicates (n=514) were removed (Figure 1). Three independent reviewers (AH, PM, SY) conducted a pilot screening of titles and abstracts

of 20 records (randomly selected) against the inclusion criteria for the review and continued the same process until 80% interrater reliability was established. Then, these three independent reviewers assessed the full text of the potentially relevant records against the inclusion criteria. Disagreements at any stage were resolved through discussion or by a senior team member.

Data extraction/charting

The data were extracted from 25 sources retained by three independent reviewers (AH, PM, SY) into an Excel spreadsheet. By adapting the JBI template source of evidence details, characteristics and results extraction instrument (Peters, Godfrey, et al., 2020), we extracted general information about the source as well as specific details about the participating population, study design, and key findings relevant to the review objectives. Due to a range of retained publications, three reviewers met after the initial charting process and becoming familiar with the study data in order to ensure consistency of the data that each reviewer was extracting with review questions. Disagreements at any stage were resolved through discussion or by an independent researcher (NB/MRC). We did not conduct a quality assessment of retained studies following the principles of scoping review methodology (Arksey & O'Malley, 2005).

Consultation

We conducted online individual and group interviews to validate the findings, inform future research, and develop knowledge dissemination strategies (Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010). 44 participants with direct

experience in policy processes in mental health were recruited from 16 countries in three categories: (a) youth aged 14-24 years, (b) policymakers, and (c) adult facilitators of child and youth participation in mental health policymaking. Preliminary review findings were shared with participants and they were then invited to comment on them and identify what was missing from the findings (Hawke et al., 2019). The findings of these consultations are presented in a separate publication [Part II] of the current series.

Results

General information about evidence sources

As shown in Figure 1, a total of 2,981 publications were identified from the database and manual search, and 25 publications were retained for full extraction. As shown in Table 1, these included 11 peer-reviewed studies, 10 agency reports, three policy documents, and one doctorate thesis. Nineteen employed qualitative methods, while one used mixed methods. Nine publications had an objective of directly influencing youth mental health policymakers through child and youth participation. Other objectives included: better understanding of child and youth perspectives and experiences; advancing participatory research/models; synthesizing evidence/current programs; and evaluating child and youth engagement and participation strategies and mechanisms.

Socio-demographic characteristics of participating children and youth

Whenever the ages of child and youth participants were specified in the publications (n = 15), they fell between 10 and 26 years. Eleven publications clearly stated the ethnicity of children and youth participants, including Indigenous (n = 6),

Pacific Islanders (n = 4), African American and/or Latino (n = 3), and Asian (n = 3) people. The World Economic Forum and Orygen (2020) also reported participation of children and youth from 50 countries from all six inhabited continents. Eight publications reported the gender-ratio among children and youth participants, which ranged from more women (n = 5), equal women and men (n = 1), and more men (n = 2). Among three publications that reported on the sexual orientation of participants, non-binary youth participation ranged from 1.9% to 3.0%. While socio-economic status (SES) of participants was similarly not mentioned in 18 retained publications, the rest (n = 7) reported inclusion of participants with low or low-to-middle SES. The lived experiences of mental illness among children and youth participants, as reported in 14 publications, included those of mental health problems in general (n = 11), substance use (n = 2), psychosis (n = 1), and depression (n = 1). In addition, one publication described a small number of youth participants going through grief and loss issues due to suicide by close friend or family member.

Educational attainment and disabilities of participants, which were not initially considered for extraction, were later extracted based on input from the consultations. Among the seven publications that reported the educational attainment of youth participants, the majority of participants in four publications were enrolled at schools (middle school, high school, university, etc.), and three publications also included child and youth participants who were not in formal education or had trouble at school. Only three publications reported that children and youth with unspecified disabilities participated, with the proportion of those with disabilities among total participants

ranging from 6% (Howe, Batchelor, & Bochynska, 2011) to 24% (Research and Training Center on Family Support and Children's Mental Health, 2009).

Contexts of child and youth participation: Policy type, content, and scope

The retained publications focused on different types of policies/instruments. Six publications focused on mental health (Australian Infant Child Adolescent and Family Mental Health Association, 2008; Braddick, Carral, Jenkins, & Jané-Llopis, 2009; Mental Health Commission of Canada, 2015; Research and Training Center on Family Support and Children's Mental Health, 2009; Rodarmel, 2013; Simmons et al., 2020), four on youth health more broadly (New Zealand Ministry of Health, 2002; Ott, Rosenberger, McBride, & Woodcox, 2011; Percy-Smith, 2007; Sheridan et al., 2014), and one on youth policy broadly (Victoria State Government, 2016). Other types of policies included frameworks, guidance manuals/toolkits/guides, acts, and a sustainable development agenda. Nineteen publications had a general focus on mental health, and two focused on both physical and mental health (New Zealand Ministry of Health, 2002; Sheridan et al., 2014). Other specific foci were on stress (n = 3) (Ott et al., 2011; Percy-Smith, 2007; Soleimanpour, Brindis, Geierstanger, Kandawalla, & Kurlaender, 2008) and psychosis (n = 1) (Jones, 2015). Indigenous holistic perspectives of health were considered in three publications (Aboriginal Life in Vancouver Enhancement Society, 2020; Mental Health Commission of Canada, 2015; New Zealand Ministry of Health, 2002); and two publications, focused on general youth policies, also considered housing and employment (Aboriginal Life in Vancouver Enhancement Society, 2020; Victoria State Government, 2016).

While the scope of two publications was at the global level, 12 publications had a national scope, which was limited to Canada, Australia, New Zealand, US, UK, Vanuatu, and 15 European countries. Additionally, seven publications described work at the state/provincial level, and four publications focused on municipal/county-level policies.

Extent and nature of participation of children and youth

Roles of children and youth participants

As shown in Table 2, children and youth played different roles in mental health policymaking, including: (a) informants who provided feedback on mental health frameworks, policies, and services (n = 14); (b) co-creators with adults in the design of mental health services, policies, and tangible products (e.g., leaflets and websites) (n = 12); (c) advocates who disseminated their perspectives and knowledge to the general public, researchers, and policymakers in collaboration with organizations (n = 11); and (d) co-researchers who were often involved in participatory research (n = 7). They were provided training in research methods (Percy-Smith, 2007; Simmons et al., 2020; Soleimanpour et al., 2008), and were involved in adapting the data collection tools to be youth-friendly (Garcia, Minkler, Cardenas, Grills, & Porter, 2014; Rodarmel, 2013), conducting surveys (Garcia et al., 2014; Soleimanpour et al., 2008) and analysis (Garcia et al., 2014), supporting their peers (Jones, 2015; Simmons et al., 2020), and training staff (Young Minds, 2017).

Roles of adult participants

Adults also played different roles in mental health policymaking along with children and youth, including (a) informants who provided their views and feedback (n = 12); (b) trainers who helped children and youth participants develop a variety of skills such as communication skills and youth mental health first aid (n = 8); (c) supervisors who oversaw the implementation of projects (n = 6); (d) mentors (n = 4); (e) coordinators (n = 3); (f) experts who recommended actions from a process of discussion, debate, and feedback (n = 3); and (g) co-chairs who sat together with youth in a working group (n = 2) although the balances of power between children and youth and adults in group processes and decision-making varied.

Purpose and methods of child and youth participation

When the primary purpose of child and youth participation was to identify a policy gap, they were consulted through focus groups (n = 2) (Ott et al., 2011; Sheridan et al., 2014), surveys (n = 4) (Garcia et al., 2014; Rodarmel, 2013; Soleimanpour et al., 2008; Young Minds, 2017), and interviews (n = 1) (National Mental Health Commission of Australia, 2017). In particular, visual material such as videos and posters, was identified as an effective communication method for children and young people, to share their key health issues in their daily lives (Percy-Smith, 2007). When children and youth were consulted about the content of policy and frameworks, they were consulted through interviews (n = 1) (World Economic Forum and Orygen, 2020), group discussions (n = 4) (Australian Infant Child Adolescent and Family Mental Health Association, 2008; Mental Health Commission of Canada, 2015; Percy-Smith, 2007; World Economic Forum and Orygen, 2020), and surveys (n = 5) (Australian

Infant Child Adolescent and Family Mental Health Association, 2008; Kutcher & McLuckie, 2013; New Zealand Ministry of Health, 2002; Victoria State Government, 2016; World Economic Forum and Orygen, 2020). In addition, children and youth often joined working groups such as a Youth Reference Group and a Youth Council, to participate in iterative brainstorming, feedback, and reflection processes.

For the purpose of advocacy, children and youth shared their perspectives and experiences at various public forums (n = 6) (Aboriginal Life in Vancouver Enhancement Society, 2020; Australian Infant Child Adolescent and Family Mental Health Association, 2008; Garcia et al., 2014; Percy-Smith, 2007; Research and Training Center on Family Support and Children's Mental Health, 2009; Simmons et al., 2020) and research findings at academic conferences and journal publications (Canas, Lachance, Phipps, & Birchwood, 2019). For the evaluation of youth mental health programs and services, children and youth participated through focus groups (n = 3) (Bourke & MacDonald, 2018; Howe et al., 2011; Research and Training Center on Family Support and Children's Mental Health, 2009), questionnaires (n = 2) (Bourke & MacDonald, 2018; Howe et al., 2011), and interviews (n = 1) (Research and Training Center on Family Support and Children's Mental Health, 2009).

Policy stage of child and youth participation

The forms and levels of participation of children and youth can differ depending on the stages of the policy cycle: i) analysis of the situation; ii) policy design and planning; iii) implementation; iv) monitoring and evaluation; v) and advocacy and participatory debate that feeds back into ongoing situation analysis (OECD, 2017). As Table 1 shows,

child and youth participation was part of situation analysis that explored their views of health and health needs for future policy development in nine publications. Children and youth also participated in policy design and planning (n = 8). In Victoria State, Australia, a Youth Reference Group helped develop the new Youth Policy, leading to social and economic reforms to address the priority issues identified by youth, including mental health (Victoria State Government, 2016). No retained publications found child and youth participation at the implementation stage. In Garcia et al. (2014), despite the successful policy change through youth's participation and advocacy work, policy implementation faced challenges due to the complex political environment and the local realities of poverty, homelessness, and criminalization in Skid Row, Los Angeles. One publication reported youth participation in evaluation. Bourke and MacDonald (2018) conducted an evaluation of a school-based mental health program across Aotearoa New Zealand. The evaluation results were disseminated to policymakers. The participation of children and youth at the stage of advocacy and participatory debate was found in seven publications. For instance, the Youth Alliance played a key role as the 'public face' in over 35 community awareness activities, presentations, and workshops in the Central Coast region of New South Wales, Australia (Howe et al., 2011).

Duration of youth participation

Youth participation ranged in duration from less than a year (n = 3) (Australian Infant Child Adolescent and Family Mental Health Association, 2008; Rodarmel, 2013; Sheridan et al., 2014), 1-2 years (n = 4) (Aboriginal Life in Vancouver Enhancement Society, 2020; Orygen and World Economic Forum, 2020; Victoria State Government,

2016; World Economic Forum and Orygen, 2020), 2-3 years (n = 6) (Davidson, Wiens, & Anderson, 2010; Garcia et al., 2014; Howe et al., 2011; Mental Health Commission of Canada, 2015; Simmons et al., 2020; Soleimanpour et al., 2008), and more than 3 years (n = 1) (Canas et al., 2019).

Factors influencing child and youth participation

Facilitators of child and youth participation

Factors identified as facilitators of child and youth participation (accessibility, flexibility, practical support, training, safe environment, personal belief, accountability) appeared multifaceted and interconnected at different levels (individual, microsystem, mesosystem, macrosystem, and socio-political landscapes) when mapped onto an adaptation of the ecological model of participation of children and youth proposed by Gal (2017) (Table 3)..

At the individual level, identified facilitators included the individual beliefs in change of children and youth and their own capacity and commitment (n = 2); accessibility related to the internet/online platform (n = 6) and transportation (n = 2); and financial compensation (monetary or a voucher) or reimbursement (n = 5). A flexible schedule was key for children and youth with competing interests such as school or part-time work, and flexibility also meant accommodations when mental health conditions fluctuated (n = 4). At the mesosystem level, one major facilitator was practical support, including clear communication and mentoring/coaching from adult participants (n = 9); administrative support (n = 3); and peer support (n = 3). In addition,

a school credit system, which recognizes the participation of child and youth, was seen as particularly important to engage those at risk or who were tenuously engaged within their school setting (Australian Infant Child Adolescent and Family Mental Health Association, 2008). Furthermore, youth were encouraged and motivated by training for skills development as this could add value to their CVs (n = 7). Another major facilitator within the mesosystem was a safe environment characterized by cultural safety (n = 2); equitable decision-making (n = 5); diversity to support minority group participation (n = 3) and inclusiveness (n = 3); confidentiality (n = 1); and appropriate accountability through feedback to child and youth participants (n = 2). The media also played a role in promoting opportunities, updates, and outcomes of programs and initiatives (n = 2).

Barriers to child and youth participation

Barriers to child and youth participation also mapped onto different levels of the ecological model (Table 3). At an individual level, their availability was impacted by their lack of belief/confidence in the process of change (n = 3), their lack of time due to their multiple responsibilities and competing interests (n = 9), and the fluctuation of their mental health status (n = 4). Limited access to the internet and difficulty finding helpful information regarding opportunities and organizations to get involved in were seen as limiting participation (n = 3).

At the level of the microsystem where parents and families are involved, parents'/guardians' disapproval of participation in activities can limit child and youth participation (n=1).

At the level of the mesosystem where children and youth interact with adults, identified barriers were: lack of flexibility in planned activities and/or organizational structures that did not address the changing needs of youth (n = 4); and lack of practical support, including lack of financial compensation (n = 7), accommodation for special needs (n = 4), support and action from adults (n = 4), and training children and youth on research skills (n = 1).

Relational space with adults/peer youth participants affected youth participation. Lack of power sharing with adults (n = 10) and "tokenism" (n = 4) were often mentioned as barriers to participation. In addition, lack of diversity and discrimination could result in limiting participation of certain groups of children and youth such as those with communication difficulties, disabilities, behavioural problems, cultural barriers, younger children, youth no longer engaged in the educational systems, those from traveller communities (e.g., Roma Slovak), rural areas and low-SES backgrounds, and child and youth carers and/or parents (n = 3). Despite the adults' effort to increase diversity, when participants from diverse backgrounds (e.g., class, SES) worked together, group dynamics could be a challenge as those from lower-income families did not necessarily feel comfortable interacting with those from high-income families (n = 3).

Furthermore, lack of accountability and lack of clear communication of expected roles were identified as barriers to participation (n = 2). More broadly, lack of media attention (n = 2) and lack of political will/interest can undermine motivation to participate (n = 2).

Individual and collective outcomes of child and youth participation

Youth: Expected and Perceived/Actual Outcomes

Fifteen publications mentioned that children and youth were expected to increase their sense of empowerment, self-efficacy, and control over their decisions as a result of their participation in policymaking processes. Other expected outcomes in relation to policymaking found in the retained publications were: improved physical/mental health outcomes and wellbeing (n = 8); personal growth and skills development (n = 6); better access to more youth-informed and youth friendly mental health services and programs (n = 4); increased sense of community (n = 3); and increased participation in the workforce (n = 2); and reduced internalized stigma (n = 1).

The perceived/actual effects of participation on children and youth have not been fully explored or reported (n=10). Among the reported perceived/actual effects of child and youth participation in mental health policies and programs were, for the child and youth participants: the prevention of mental health problems (n = 13); having youth voice/needs being heard through dialogue (n = 10); positive feelings such as feelings of making progress, engagement, self-confidence, and inclusion (n = 6); and skills development and the fostering of professional aspirations (n = 4).

Adults: Expected and Perceived/Actual Outcomes

The reported expected outcomes for adults were: better understanding of child and youth perspectives and needs (n = 6); and adults being empowered in seeing youth's confidence in their competence and potential for change (n = 3).

As was the case for children and youth, 14 publications did not mention

actual/perceived benefits for adults. The reported actual/perceived benefits for adults included: adults learning about new and diverse perspectives and experiences of children and youth (n = 4); finding the gap between policies and practices (n = 3); and feeling empowered and inspired (n = 3).

Organizations: Expected and Perceived/Actual Outcomes

Improved mental health services was the most mentioned expected outcome for organizations (n = 15). Other expected outcomes were: the transformation of organizations into youth-focused agencies (n = 8); the development of a youth engagement model (n = 2); and better understanding of the impact of implemented programs through youth participation (n = 1).

Fourteen publications did not mention actual/perceived effects of children and youth participation at an organizational level. Four publications reported that organizations became sites of sustainable youth engagement, while three reported organizational contributions to improving youth mental programs/services. Other stated outcomes included: strengthened youth-adult relationships (n = 3); improved quality of staff/overall organizational work (n = 3); and increasing networks (n = 3).

Communities: Expected and Perceived/Actual Outcomes

For this review, we broadly defined "community" as different environments/levels of society, to capture the effect of programs, policies, and associated changes on local, national, and/or international environments. The often-cited expected outcomes of youth participation are: more locally/culturally relevant and accessible mental health services and policies (n=18), and healthier and stronger communities (n=14). Participation of

children and youth, particularly those who are marginalized and disenfranchised in a community, was expected to generate a sense of community, connectedness, inclusion, and cohesiveness (n = 7), and also reduce stigma (n = 3). Child and youth participation in policy development was expected to narrow policy-practice gaps in the field of mental health (n = 5) and raise public awareness (n = 2).

Ten publications stated that child and youth needs and perspectives were identified for future policy/service development. Other outcomes included: the development of models, frameworks, or councils for youth-friendly policies and services (n = 5); youth-oriented policies (n = 5); and strengthening of youth-serving sectors by fostering existing and new networks with partner organizations (n = 4). Garcia et al. (Garcia et al., 2014) also reported that a community-based participatory research process strengthened social cohesion and created neighborhood wellness.

Consultation

Consultation, though being an optional stage of a scoping review, added methodological rigor to the current study (Levac et al., 2010). Consultation participants found the preliminary findings largely consistent with their own experiences and provided additional insights. We used their feedback to revisit some aspects of the preliminary findings and refine the analysis. In addition, the shared experiences and perspectives helped contextualize the review findings and identify research gaps in the existing literature. Findings from our consultation are presented in a separate publication [Part II].

Discussion

Who is and who is not participating in mental health policymaking?

The representation of young people with diverse backgrounds in terms of ethnicity, gender, SES, educational attainment, and disabilities was limited in the retained publications. In addition, only 56% of the retained publications explicitly stated involvement of people with living and lived experience in policymaking, while it is often unclear what counts as living and lived experience of mental illness (diagnosis versus subjective experience versus family members with mental illnesses). Ethnicity (n=11), gender (n=14), SES (n=16), and lived experiences (n=10) were "unspecified/unknown" in the retained publications. Since various adverse experiences, such as gender discrimination, racism, and poverty, affect mental health (Reiss, 2013; Vines, Ward, Cordoba, & Black, 2017; Wilson, Chen, Arayasirikul, Raymond, & McFarland, 2016), it is important to clarify what kind of experiences and perspectives are represented in policymaking processes.

The reviewed publications were mainly concentrated in Canada, Australia, New Zealand, UK, and US. There is thus a dearth of understanding about how the Western concept of "child participation" as a rights-based approach is implemented in low-and middle-income countries (LMICs), and how cultural values related to gender and family customs and socio-economic conditions of everyday life shape the way children and youth partake in mental health policymaking (Faedi Duramy, 2015; Faedi Duramy & Gal, 2020; Wyness, 2012).

How are children and youth participating?

The roles of children and youth and their level of participation are closely linked with the purpose and methods of participation as well as roles of adults. The role played by adults had bearing on the extent to which participation of young people as informants was passive versus involving more active collaborative roles such as "co-creators". The perspectives of young people presented in a few retained publications (Howe et al., 2011; Mental Health Commission of Canada, 2015) suggest that adults support children by providing guidance and assisting for their skills development, while ensuring child and youth participants could maintain the autonomy they desired. Furthermore, children and youth may have had negative experiences in the mental health system or have mistrust and feelings of discomfort around adults. It is noteworthy that how trust was built and how levels of influence and interdependence in adult-child relationships were negotiated and rebalanced in the whole participation process remain largely unexplored.

While two-to-three years of engagement was often found among the retained publications, temporal elements of policymaking processes (one-off, continuous, irregular, regular) can affect the extent to and the forms in which young people participate in decision-making processes (Gal, 2017; Tisdall, 2015). This temporal aspect of child and youth participation is also important to consider as it is related to the policy stage of participation. In this review, retained publications found child and youth participation in the stages of situational analysis, policy design and planning, and advocacy, yet none in the stage of policy implementation. To what extent child and youth participation leads to policy change that has an impact on their mental health

remains unanswered as well. Different temporal elements should be further explored for the meaningful and sustained participation of children and youth in policymaking processes.

What facilitates and hinders child and youth participation?

The mental health of child and youth participants emerged as a factor closely related to several facilitators and barriers. While flexibility to accommodate individual mental health needs can be a facilitator of participation, fluctuating mental health levels and/or inadequate attention to these or associated needs can limit child and youth participation (Jones, 2015). In addition, lack of financial compensation can affect participants' mental health as financial health influences mental health (Canas et al., 2019). Furthermore, empirical understandings of the dynamic ways in which the mental health of children and youth can affect as well as be affected by the process of their participation in policymaking, directly and indirectly, will provide practical insights into how to create safe and engaging spaces for child and youth participants with mental illness.

While various barriers and facilitators are interlinked at different system levels in an ecological model of child and youth participation, only one barrier at a family level, permission from guardian/parent, and one family level-facilitator, a family council, were reported in one publication each. This may indicate less attention being paid to the role of family in promoting or hindering child and youth participation (Muddiman, Taylor, Power, & Moles, 2019). Attention to potential positive and negative factors in the family environment that can support child and youth participation; and facilitate their

access to services, confidentiality, and privacy is also warranted.

What are the effects of youth participation?

The effects of child and youth participation are widely reported not only for children and youth but also for adults, organizations, and communities. However, there was a lack of evidence to know if aspired-to effects were or were not met, such as the extent to which participation can be therapeutic and lead to a long-term positive impact on participants' mental health and living conditions. Expected and perceived/actual effects for adults were also largely unreported. While adults may take on the role of "audience", who listen to the views of young people to influence policy and daily life practices (Lundy, 2007), child and youth participation processes involve relational experiences that are shaped by the power dynamics between young people and adults who have respective roles and positions (Wyness, 2012). Considering the interdependent relations between young people and adults (Wyness, 2012) and the evolving nature of children and youth's participation processes, an evaluation of multiple dimensional effects of their participation at different levels (young people, adults, organizations, and communities) is warranted to meet the changing needs and interests of children, youth, and other stakeholders (Simmons et al., 2020).

Limitations

Some relevant publications may not have been retrieved by our search strategy due to the broadness and complexity of concepts of participation, mental health (e.g., spiritual health) and policy. Despite the inclusion of grey literature, many relevant initiatives seem to be happening only on the ground and not reflected in websites or

publications, or are not described in English or French. On the other hand, a range of information presented in diverse types of publications made characterization and interpretation of the retained publications challenging and be subject to reviewer bias. In addition, generalizability may be limited due to lack of quality assessment of each publication. Although our extraction framework incorporated the perspectives of all team members, another limitation is that it was largely based on the perspectives of adult researchers. To address this limitation, we had adult researchers with extensive experience of participatory research involving children and youth as well as youth and young adult students in our team.

Conclusion

Our review highlights concrete recommendations for mental health policymaking around the inclusion of children and youth from diverse groups, and the creation of relational spaces that ensure safety, inclusiveness, and diversity. It also identifies future research directions such as the outcomes of youth participation in mental health policymaking, the role of adults, and more generally, how the mental health of children and youth shapes and is shaped by the policymaking process.

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Figure 1: Search results and article selection and inclusion process

Flow Diagram for the scoping review process adapted from the PRISMA statement by Moher and colleagues (2009).

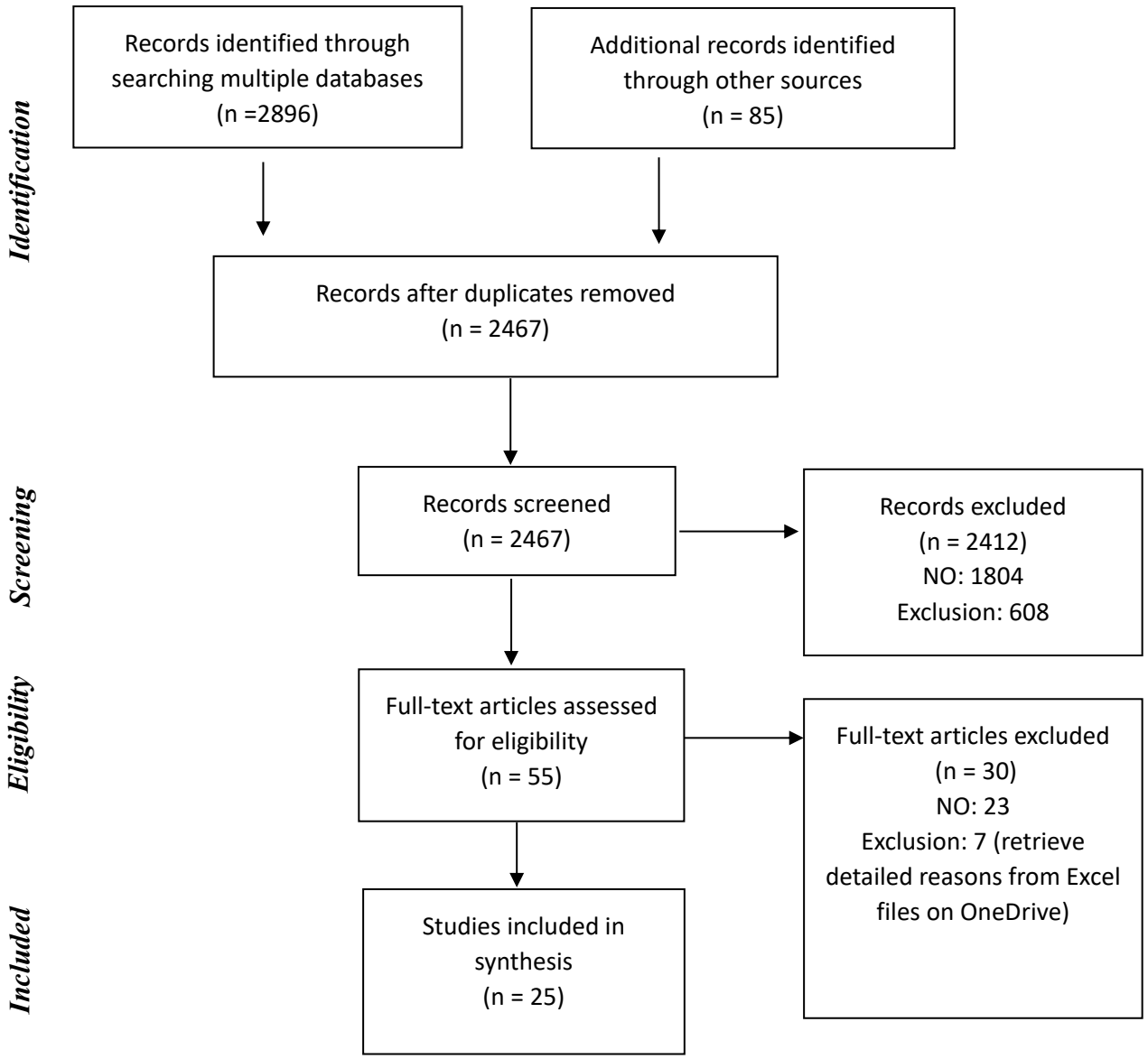

Table 1. Bibliographic overview of the included studies

Authors	Year	Geographic scope of policy	Objectives	Type of evidence	Methods (tools & techniques)	Policy stage of youth participation
Aboriginal Life in Vancouver Enhancement Society	2020	Local (Canada)	Directly influence policy makers for youth mental health policy development	Agency report	Narrative	Advocacy and participatory debate
Australian Infant Child Adolescent and Family Mental Health Association	2008	National (Australia)	Directly influence policy makers for youth mental health policy development	Agency report	Mixed methods (Literature review, surveys, consultations)	Policy design and planning
Bourke, R et al.	2018	National (New Zealand)	Understand youth views and experience	Peer-reviewed article	Mixed methods (Qualitative-interviews, observations and document analysis and quantitative-national surveys)	Monitoring and evaluation
Braddick, F et al.	2009	National (Europe 15 countries)	Synthesize evidence/current programs	Agency report (country profile)	Qualitative (Document review, survey, consultations)	Situation analysis
Canas, E et al.	2019	National (Canada)	Evaluate youth engagement strategy	Peer-reviewed article	Qualitative (Document review, interviews, consultations)	Advocacy and participatory debate
Davidson, J et al.	2010	Province (Canada)	Directly influence policy makers for youth mental health policy development	Peer-reviewed article	Narrative	Advocacy and participatory debate
Garcia, A P et al.	2014	Local (US)	Advance participatory research/model to inform policy	Peer-reviewed article	Qualitative (Focus group, interviews, participant observation, document review)	Situation analysis Policy design and planning Advocacy and participatory debate
Howe, D et al.	2011	Province (Australia)	Advance participatory research/model to inform policy	Peer-reviewed article	Qualitative (Survey, interviews)	Advocacy and participatory debate
Jones, N.	2015	National (US)	Improve services	Agency report (guidance manual)	Not applicable	Not applicable

Authors	Year	Geographic scope of policy	Objectives	Type of evidence	Methods (tools & techniques)	Policy stage of youth participation
Kutcher, S et al.	2013	National (Canada)	Directly influence policy makers for youth mental health policy development	Peer-reviewed article	Qualitative (Consultations)	Policy design and planning
Mental Health Commission of Canada.	2015	National (Canada)	Directly influence policy makers for youth mental health policy development	Policy document	Qualitative (Consultations)	Policy design and planning
National Mental Health Commission of Australia.	2017	National (Australia)	Improve services	Agency report	Qualitative (Literature review, interviews)	Situation analysis
New Zealand Ministry of Health.	2002	National (New Zealand)	Directly influence policy makers for youth mental health policy development	Policy document	Qualitative (Literature review, survey, consultations)	Policy design and planning
Orygen & World Economic Forum.	2020	Global	Directly influence policy makers for youth mental health policy development	Agency report (Tool kit)	Not applicable	Advocacy and participatory debate
Ott, M. A. et al.	2011	Province (US)	Understand youth views and experience	Peer-reviewed article	Qualitative (Focus group)	Situation analysis
Percy-Smith, B.	2007	Local (UK)	Advance participatory research/model to inform policy	Peer-reviewed article	Qualitative (Consultations, discussions)	Situation analysis
Pereira, N.	2007	Province (Canada)	Synthesize evidence/current programs	Agency report (Evidence synthesis)	Qualitative (Literature review, interviews)	Not applicable
Research and Training Center on Family Support and Children's Mental Health	2009	Province (US)	Synthesize evidence/current programs	Agency report	Qualitative (Focus group)	Advocacy and participatory debate
Rodarmel, S.	2013	Province (US)	Understand youth views and experience	Thesis	Qualitative (survey)	Situation analysis
Sheridan, S. A. et al.	2014	National (Vanuatu)	Understand youth views and experience	Peer-reviewed article	Qualitative (focus group)	Situation analysis

Authors	Year	Geographic scope of policy	Objectives	Type of evidence	Methods (tools & techniques)	Policy stage of youth participation
Sheridan, S. A. et al.	2014	National (Vanuatu)	Understand youth views and experience	Peer-reviewed article	Qualitative (focus group)	Situation analysis
Simmons, M. B. et al.	2020	National (Australia)	Evaluate youth engagement strategy	Peer-reviewed article	Narrative	Policy design and planning
Soleimanpour, S. et al.	2008	Local (US)	Advance participatory research/model to inform policy	Peer-reviewed article	Qualitative (survey)	Situation analysis
Victoria State Government.	2016	Province (Australia)	Directly influence policy makers for youth mental health policy development	Policy document	Qualitative (consultations)	Policy design and planning
World Economic Forum & Orygen.	2020	Global	Directly influence policy makers for youth mental health policy development	Agency report (global framework)	Qualitative (Literature review, consultations, survey)	Policy design and planning
Young Minds.	2017	National (UK)	Understand youth views and experience	Agency report	Qualitative (survey)	Situation analysis

Note: * "Other": These publications are descriptive of input from youth within policy development process rather than research per se.

Table 2. Profile & Role of Participants

Author	Year	Age	Ethnicity	Gender	Socioeconomic status (SES)	Lived experience		Disability	Education attainment	Role: Youth	Role: Adult
Aboriginal Life in Vancouver Enhancement Society	2020	NM [*]	Indigenous, Canadians	NM	Low	NM		NM [5]	NM	Advocator	NM
Australian Infant Child Adolescent and Family Mental Health Association	2008	12-26 years old for online survey	3% indigenous 1% culturally and linguistically diverse	NM Same sex attraction 17%	Low (14% = currently homeless 2% = guardianship of the Minister 7% =rural (living in an isolated community) out of 89)	Mental health (general)/grief and loss	40% with significant and serious mental health issues/ 3% with grief and loss issues (e.g., suicide by close friends/family member)	None	NM	Co-creator Co-researcher	Trainer Expert
Bourke, R et al.	2018	13-14 years old	55% NZ European 22% Maori 6.5% Pasifika 7% Asian 9.5% other ethnicity	59% female, 41% male for interview 62% female, 38%male, 0.7% Not mentioned for survey	NM	NM		NM	Year 9 and Year 10 students	Informant	Informant
Braddick, F et al.	2009	NM	NM	NM	NM	Mental health (general)		NM [6]	NM	Informant Co-creator Advocator	Expert

Author	Year	Age	Ethnicity	Gender	SES		Lived experience		Disability	Education attainment	Role: Youth	Role: Adult
Canas, E et al.	2019	NM	NM	NM	NM		NM		NM	NM	Advocator Co-researcher	Trainer Supervisor Mentor
Davidson, J et al.	2010	17-25 years old.	NM	NM	NM		Mental health (general)		NM	NM	Co-creator	Informant Co-chair
Garcia, A. P. et al.	2014	11-19 years old	African American and Latino	NM	Low		NM		NM	Fully half of the youth who participated in the survey (N=96) had been “in trouble at school” for not having proper or clean clothes or uniforms.	Co-creator Co-researcher	Informant Trainer Mentor
Howe, D et al.	2011	15-25 years old	young people from indigenous and other culturally and linguistically diverse backgrounds in Australia included	62.5% female, 37.5% male	Low	56% resided from a town of low SES	Mental health (general)	37.5%	Young people with disability (N=1)	University/TAFE student (37.5%) High school (18.8%) Not in education (43.8%)	Co-creator Advocator	Trainer Supervisor Coordinator
Author	**Year**	**Age**	**Ethnicity**	**Gender**	**SES**		**Lived experience**		**Disability**	**Education attainment**	**Role: Youth**	**Role: Adult**

Jones, N.	2015	NM	NM	NM	NM	Psychosis		Psychosis described as "psychiatric disabilities"	NM	Co-creator	Not applicable
Kutcher, S et al.	2013	NM	NM	NM	NM	Mental health (general)	68% indicated they have lived experience of mental health	NM	NM	Informant	Informant Co-chair
Mental Health Commission of Canada.	2015	NM	First Nations, Inuit, or Métis background/linguistic background included	NM	NM	Addictions	Including those with siblings or family members of persons with mental illness, experience with the child welfare system, or youth at risk with issues in housing, addictions, and/or the justice system/No number available	NM [7]	NM	Co-creator	Supervisor
Author	Year	Age	Ethnicity	Gender	SES	Lived experience		Disability	Education attainment	Role: Youth	Role: Adult

National Mental Health Commission of Australia	2017	NM	NM [3]	NM	NM	Mental health (general)	NM	NM	Informant	Informant
New Zealand Ministry of Health	2002	The Guide targets youth 12-24 year old	NM [4]	NM	NM	NM	NM [8]	NM	Informant	Expert
Orygen & World Economic Forum	2020	10-24 years old [1]	NM	NM	NM	NM	NM	NM	Advocator	Not applicable
Ott, M. A et al.	2011	15-24 years old.	71% White 19% Black 10% Latino	50% female 50%male	NM	NM	NM	Some participants were from a rural alternative high school, a university freshmen class, a private high school.	Informant	Researcher

Author	**Year**	**Age**	**Ethnicity**	**Gender**	**SES**	**Lived experience**	**Disability**	**Education attainment**	**Role: Youth**	**Role: Adult**

Percy-Smith, B.	2007	14-19 and 13-21	100% youth peer leaders were from minority ethnic groups (mainly young Asians) for peer leaders 75% minority ethnic (largely Asian) groups for poster presentation event	82% female, 18% male for Peer leaders 67% female, 33% male for Poster presentation event	NM	Mental health (general)	NM	NM	Informant Advocator Co-researcher	Informant Trainer
Pereira, N.	2007	13-25 years old but no mental health policy development	NM	NM	NM	NM	NM	NM	Informant Co-creator	Informant

Author	**Year**	**Age**	**Ethnicity**	**Gender**	**SES**	**Lived experience**	**Disability**	**Education attainment**	**Role: Youth**	**Role: Adult**

Research and Training Center on Family Support and Children's Mental Health	2009	15-25 years old	NM	NM	Low (Some participants reported to be low SES)	Substance use, neglect, use, depression	24% of respondents self-identified or having being diagnosed with learning disabilities	Among 33 participants in focus group, 63% are in high school, 10% graduated high school, 17% dropped out, 3% in community college and 7% other	Co-creator Advocator	Informant Trainer Mentor Supervisor
Rodarmel, S.	2013	12-21 years old	NM	NM	NM	Mental health (general)	NM	NM	Informant Co-researcher	Researcher
Sheridan, S. et al.	2014	17 years old	Pacific islanders	48% female 52% male	Middle to low	NM	NM	All were in final year of high school	Informant	Researcher
Simmons, M. B. et al.	2020	12-25 years old	NM	NM	NM	Mental health (general)	NM	NM	Co-creator Advocator Co-researcher	Trainer Supervisor Coordinator Mentor
Author	**Year**	**Age**	**Ethnicity**	**Gender**	**SES**	**Lived experience**	**Disability**	**Education attainment**	**Role: Youth**	**Role: Adult**

Soleimanpoul, S. et al.	2008	Eight through eleventh grade [2]	African American, Asian/Pacific Islander, Caucasian, and Latino included	75% female [2]	Low	NM	NM	Middle school/high school students	Informant Advocator Co-researcher	Trainer Supervisor Coordinator
Victoria State Government.	2016	12-24 years for participating in the online survey	Aboriginal & from culturally diverse communities included for Youth Reference Group; 7.4% Aboriginal or Torres Strait Islander, 12.9% born overseas, 2% international students for online survey	lesbian, gay, bisexual, transgender and intersex (LGBTI) included for Youth Reference Group;67.9% female, 30.2% male, 1.9% other for online survey	NM	NM	Youth with disability 13.5% among 1,000 young people who responded to survey	NM	Informant Co-creator	Informant

Author	**Year**	**Age**	**Ethnicity**	**Gender**	**SES**	**Lived experience**	**Disability**	**Education attainment**	**Role: Youth**	**Role: Adult**

World Economic Forum & Orygen.	2020	NM	50 countries from all six of the inhabited continents	NM	SES not specified but sample from low, middle, and high-income countries	Mental health (general)	NM	NM	Informant	Informant
Young Minds.	2017	11-25 years old	NM	39% female, 56% male, 3% non-binary, 3% other, 4% trans [Sexual orientation] 61% Heterosexual, 13% Bi, 2% Gay, 4% Lesbian 10% Other 10% Prefer not to say	NM	Mental health (general)	NM	NM	Informant Co-creator Staff trainer	Informant

Notes: [*] NM=Not mentioned. [1] There is no specific age description of youth participants, however, in general, the document is talking about youth from 10 to 24 (or sometimes 25) years old. [2] This information is extracted from the overview of the entire participatory research where the selected case study is included. [3] In an example of the headspace Youth National Reference Group (hY NRG), four out of 20 hY NRG is reported to be indigenous (20%). [4] Not mentioned in terms of youth participants in development of the Guide, however, the plan has a specific section focusing on ethnic youth group such as Rangatahi (Maori), Pacific, other minorities such as Asian. [5] Not mentioned about participants who attended the Policy Conference; however, the recommendations have emphasized the need of focus on issues of housing and poverty for youth with disabilities. [6] Not mentioned among participations who participated in the process of the document (Country Profile); however, some countries report disability-related statistics and policies. [7] Not mentioned among participants, however, Strategic Direction includes "respect and protect the rights of people living with mental health issues based on the UN Convention on the Rights of Persons with Disabilities. [8] Not mentioned among participants, however, the Guide of youth health action plan is part of the New Zealand Health Strategy and Disability Strategy.

Table 3. [Ecological Model of] Facilitators & Barriers of Youth Participation (Adapted from Gal 2017)

Category	Facilitators		Barriers	
	Sub-category	References	Sub-category	References
Process (interactions and activities children engage in)				
Flexibility	Activity (manner of engagement)	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Davidson et al., 2010 Percy-Smith, 2007 Rodarmel, 2013 Simmons et al., 2020	Activity/organizational structure not addressing the changing needs of youth	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Canas et al., 2019 Howe et al., 2011 Rodarmel, 2013
	Schedule	Canas et al., 2019 Davidson et al, 2010. New Zealand Ministry of Health, 2002 Simmons et al., 2020		
Practical support			Group dynamics	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Pereira, 2007 Soleimanpour, 2008
Resources+Forces				
Accessibility	Internet	Australian Infant Child Adolescent and Family Mental Health Association, 2008 National Mental Health Commission of Australia, 2017 Davidson et al., 2010 Kutcher & McLuckie, 2013 New Zealand Ministry of Health, 2002 World Economic Forum & Orygen, 2020	Limited access to internet	Research and Training Center on Family Support and Children's Mental Health, 2009
	Transportation	Davidson et al., 2010 New Zealand Ministry of Health, 2002	Difficult access to information about opportunity	Pereira, 2007 Rodarmel, 2013 Young Minds, 2017

Practical support	Financial compensation	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Canas et al., 2019 Jones 2015 Ott et al. 2011 Soleimanpour et al. 2008	Lack of financial compensation	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Howe et al., 2011 Jones, 2015 Pereira, 2007 Rodarmel, 2013 Simmons et al. 2020 Young Minds, 2017
Personal belief	Youth's own belief in change and capacity	Davidson et al., 2010 Young Minds, 2017	Lack of beliefs in change	Pereira, 2007 Rodarmel, 2013 Young Minds, 2017
Availability			Limited time	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Bourke & MacDonald, 2018 Howe et al., 2011 Percy-Smith, 2007 Pereira, 2007 Research and Training Center on Family Support and Children's Mental Health, 2009 Rodarmel, 2013 Soleimanpour, 2008 Young Minds, 2017
			Fluctuation of mental health status	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Canas et al., 2019 Howe et al., 2011 Young Minds, 2017
Microsystem: Parents, families				
Practical support			Permission from guardian/parent	Australian Infant Child Adolescent and Family Mental Health Association, 2008
Mesosystem: Professional practices				

Practical support	Clear communication with staff/mentoring	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Braddick et al. 2009 Canas et al., 2019 Davidson et al., 2010 New Zealand Ministry of Health, 2002 Ott et al., 2011 Rodarmel, 2013 Percy-Smith, 2007 Simmons et al., 2020 Soleimanpour, 2008	Lack of action/support from adults	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Pereira, 2007 Rodarmel, 2013 Young Minds, 2017
	Logistics/administrative support	Braddick et al., 2009 Davidson et al., 2010 Percy-Smith, 2007	Lack of accommodation of individual special needs	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Jones, 2015 Rodarmel, 2013 Young Minds, 2017
	Peer support	Howe et al., 2011 National Mental Health Commission of Australia, 2017 Simmons et al., 2020		
	School credit	Australian Infant Child Adolescent and Family Mental Health Association, 2008		
	Training	Australian Infant Child Adolescent and Family Mental Health Association, 2008 National Mental Health Commission of Australia, 2017 Braddick et al., 2009 Canas et al, 2019 Davidson et al., 2010 Jones, 2015 Percy-Smith, 2007 Simmons et al. 2020	Lack of training	Soleimanpour et al., 2008
Safe environment	Cultural safety	Bourke & MacDonald, 2018 Garcia et al., 2014	Tokenism	Jones, 2015 Pereira, 2007 Simmons et al., 2020

				Young Minds, 2017
	Shared/equal decision making	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Braddick et al., 2009 Jones 2015 New Zealand Ministry of Health, 2002 Pereira, 2007	Lack of equality/power-sharing	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Braddick et al., 2009 Canas et al., 2019 Jones, 2015 Kutcher & McLuckie, 2013 Ott et al., 2011 Pereira, 2007 Rodarmel, 2013 Simmons et al. 2020 Young Minds, 2017
	Inclusiveness	Jones, 2015 Mental Health Commission of Canada, 2015 Pereira, 2007	Lack of diversity/discrimination	Pereira, 2007 Simmons et al., 2020 Young Minds, 2017
	Diversity	National Mental Health Commission of Australia, 2017 Jones 2015 Research and Training Center on Family Support and Children's Mental Health, 2009		
	Confidentiality	Braddick et al., 2009		
Accountability	Feedback	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Simmons et al. 2020	Lack of feedback	Australian Infant Child Adolescent and Family Mental Health Association, 2008
			Lack of timely information sharing/clarity over expectations	Australian Infant Child Adolescent and Family Mental Health Association, 2008 Simmons et al. 2020
Meso-, Exo-, Macrosystems: Socio-political landscape				
Practical support	Media support	National Mental Health Commission of Australia, 2017	Lack of media support/representation	Garcia et al., 2014 Pereira, 2007

		Simmons et al., 2020		
Political			Lack of interest of policy makers	Braddick et al., 2009 Garcia et al., 2014
Accountability			Lack of change	Percy-Smith, 2007

Table 4 Individual and collective outcomes of child and youth participation

Level	Expected outcomes	References	Perceived/Actual outcomes	References
Youth	Increase in sense of empowerment, self-efficacy, and control over their decisions	Aboriginal Life in Vancouver Enhancement Society, 2020; Australian Infant Child Adolescent and Family Mental Health Association, 2008; Bourke & MacDonald, 2018; Braddick et al., 2009; Davidson et al., 2010; Jones, 2015; New Zealand Ministry of Health, 2002; Ott et al., 2011; Pereira, 2007; Research and Training Center on Family Support and Children's Mental Health, 2009; Rodarmel, 2013; Sheridan et al., 2014; Victoria State Government, 2016; World Economic Forum and Orygen, 2020; Young Minds, 2017	Prevention of mental health problems	Aboriginal Life in Vancouver Enhancement Society, 2020; Australian Infant Child Adolescent and Family Mental Health Association, 2008; Bourke & MacDonald, 2018; Braddick et al., 2009; Davidson et al., 2010; Garcia et al., 2014; Kutcher & McLuckie, 2013; Mental Health Commission of Canada, 2015; Ott et al., 2011; Simmons et al., 2020; Soleimanpour et al., 2008; Victoria State Government, 2016; World Economic Forum and Orygen, 2020
	Improved physical/mental health outcomes and wellbeing	Canas et al., 2019; Davidson et al., 2010; Garcia et al., 2014; Percy-Smith, 2007; Rodarmel, 2013; Soleimanpour et al., 2008; World Economic Forum and Orygen, 2020; Young Minds, 2017	Having youth voice/needs being heard through dialogue	Aboriginal Life in Vancouver Enhancement Society, 2020; Bourke & MacDonald, 2018; Braddick et al., 2009; Canas et al., 2019; Davidson et al., 2010; Mental Health Commission of Canada, 2015; Percy-Smith, 2007; Sheridan et al., 2014; Soleimanpour et al., 2008; Victoria State Government, 2016
	Personal growth and skills development	Canas et al., 2019; Howe et al., 2011; Jones, 2015; Pereira, 2007; Simmons et al., 2020; Soleimanpour et al., 2008	Positive feelings	Canas et al., 2019; Davidson et al., 2010; Ott et al., 2011; Research and Training Center on Family Support and Children's Mental Health, 2009; Soleimanpour et al., 2008; Victoria State Government, 2016
	Better access to more youth-informed and youth friendly mental health services and programs	Canas et al., 2019; Howe et al., 2011; Mental Health Commission of Canada, 2015; World Economic Forum and Orygen, 2020	Skills development and the fostering of professional aspirations	Canas et al., 2019; National Mental Health Commission of Australia, 2017; Research and Training Center on Family Support and Children's Mental Health, 2009; Soleimanpour et al., 2008
	Increased sense of community	Jones, 2015; Simmons et al., 2020; Soleimanpour et al., 2008		
	Increased participation in the workforce	Jones, 2015; World Economic Forum and Orygen, 2020		

Level	Expected outcomes	References	Perceived/Actual outcomes	References
Young	Reduced internalized stigma	Jones, 2015		
Adults	Better understanding of child and youth perspectives and needs	Bourke & MacDonald, 2018; Davidson et al., 2010; Ott et al., 2011; Percy-Smith, 2007; Pereira, 2007; Sheridan et al., 2014	Learning about new and diverse perspectives and experiences of children and youth	Bourke & MacDonald, 2018; Canas et al., 2019; Percy-Smith, 2007; Young Minds, 2017
	Adults being empowered in seeing youth's confidence in their competence and potential for change	Braddick et al., 2009; Pereira, 2007; World Economic Forum and Orygen, 2020	Finding the gap between policies and practices	Bourke & MacDonald, 2018; Percy-Smith, 2007; Sheridan et al., 2014
			Feeling empowered and inspired	Canas et al., 2019; Davidson et al., 2010; Garcia et al., 2014
Organizations	Improved mental health services	Aboriginal Life in Vancouver Enhancement Society, 2020; Davidson et al., 2010; Howe et al., 2011; Jones, 2015; Mental Health Commission of Canada, 2015; National Mental Health Commission of Australia, 2017; New Zealand Ministry of Health, 2002; Ott et al., 2011; Percy-Smith, 2007; Research and Training Center on Family Support and Children's Mental Health, 2009; Simmons et al., 2020; Soleimanpour et al., 2008; Victoria State Government, 2016; World Economic Forum and Orygen, 2020; Young Minds, 2017	Organizations became sites of sustainable youth engagement	Canas et al., 2019; Garcia et al., 2014; Howe et al., 2011; Pereira, 2007
	Transformation of organizations into youth-focused agencies	Canas et al., 2019; Jones, 2015; National Mental Health Commission of Australia, 2017; New Zealand Ministry of Health, 2002; Pereira, 2007; Rodarmel, 2013; Simmons et al., 2020; World Economic Forum and Orygen, 2020		
	Development of a youth engagement model	Australian Infant Child Adolescent and Family Mental Health Association, 2008; Canas et al., 2019	Organizational improvement in youth mental programs/services	Australian Infant Child Adolescent and Family Mental Health Association, 2008; Davidson et al., 2010; Soleimanpour et al., 2008

Level	Expected outcomes	References	Perceived/Actual outcomes	References
Organizations	Better understanding of the impact of implemented programs	Bourke & MacDonald, 2018	Strengthened youth-adult relationships	Garcia et al., 2014; Simmons et al., 2020; Young Minds, 2017
			Improved quality of staff/overall organizational work	Canas et al., 2019; Simmons et al., 2020; Young Minds, 2017
			Increasing networks	Canas et al., 2019; Pereira, 2007; Simmons et al., 2020
Communities	More locally/culturally relevant and accessible mental health services and policies become available	Aboriginal Life in Vancouver Enhancement Society, 2020; Davidson et al., 2010; Jones, 2015; Kutcher & McLuckie, 2013; Mental Health Commission of Canada, 2015; National Mental Health Commission of Australia, 2017; New Zealand Ministry of Health, 2002; Orygen and World Economic Forum, 2020; Ott et al., 2011; Percy-Smith, 2007; Research and Training Center on Family Support and Children's Mental Health, 2009; Rodarmel, 2013; Sheridan et al., 2014; Simmons et al., 2020; Soleimanpour et al., 2008; Victoria State Government, 2016; World Economic Forum and Orygen, 2020; Young Minds, 2017	Child and youth needs and perspectives identified for future policy/service development	Aboriginal Life in Vancouver Enhancement Society, 2020; Australian Infant Child Adolescent and Family Mental Health Association, 2008; Bourke & MacDonald, 2018; National Mental Health Commission of Australia, 2017; Ott et al., 2011; Percy-Smith, 2007; Rodarmel, 2013; Sheridan et al., 2014; Soleimanpour et al., 2008; Young Minds, 2017
	Creation of healthier and stronger communities	Aboriginal Life in Vancouver Enhancement Society, 2020; Canas et al., 2019; Garcia et al., 2014; Howe et al., 2011; Jones, 2015; Mental Health Commission of Canada, 2015; New Zealand Ministry of Health, 2002; Orygen and World Economic Forum, 2020; Pereira, 2007; Research and Training Center on Family Support and Children's Mental Health, 2009; Sheridan et al., 2014; Victoria State Government, 2016; World Economic Forum and Orygen, 2020; Young Minds, 2017	Development of models, frameworks, or councils for youth-friendly policies and services	Australian Infant Child Adolescent and Family Mental Health Association, 2008; Davidson et al., 2010; Howe et al., 2011; Kutcher & McLuckie, 2013; World Economic Forum and Orygen, 2020
	Sense of community	Aboriginal Life in Vancouver Enhancement Society, 2020; Davidson et al., 2010; Garcia et al., 2014; Jones, 2015; Pereira, 2007; Sheridan	Youth-oriented societies	Garcia et al., 2014; Mental Health Commission of Canada, 2015; New Zealand Ministry of Health, 2002;

		et al., 2014; Simmons et al., 2020		Simmons et al., 2020; Victoria State Government, 2016
	Narrow policy-practice gap	Aboriginal Life in Vancouver Enhancement Society, 2020; Australian Infant Child Adolescent and Family Mental Health Association, 2008; Bourke & MacDonald, 2018; Simmons et al., 2020; Soleimanpour et al., 2008	Strengthening of youth-serving sectors by fostering existing and new networks with partner organizations	Canas et al., 2019; Research and Training Center on Family Support and Children's Mental Health, 2009; Simmons et al., 2020; Young Minds, 2017
	Reduce stigma	Davidson et al., 2010; Jones, 2015; Young Minds, 2017		
	Raise public awareness	Mental Health Commission of Canada, 2015; Orygen and World Economic Forum, 2020		

Appendix I: Search strategy

MEDLINE (Ovid)
Citations and Daily <1946 to November 30, 2020>
1 exp Child/ (1930554)
2 exp Adolescent/ (2051714)
3 exp Young Adult/ (876253)
4 (child or children or adolescent* or student* or teen* or youth* or young people or young adult* or emerging adult*).ti,kf. (990533)
5 or/1-4 (3693140)
6 Community Participation/ (17386)
7 Patient Participation/ (26370)
8 exp Stakeholder Participation/ (1838)
9 (participation or participatory or experiential).ti,kf. (36553)
10 ((user* or consumer* or patient* or public) adj (input or involv*)).ti,ab,kf. (10605)
11 (co-design* or codesign* or co-produc* or coproduc*).ti,ab,kf. (6189)
12 ((child or children or adolescent* or student* or teen* or youth* or young people or young adult* or emerging adult*) adj2 (participat* or engage* or involv* or collab* or partnership*)).ti,ab,kf. (40397)
13 ((child or children or adolescent* or student* or teen* or youth* or young people or young adult* or emerging adult*) adj2 (voice* or view* or perspective*)).ti,ab,kf. (8884)
14 ((child or children or adolescent* or student* or teen* or youth* or young people or young adult* or emerging adult*) adj2 (advisory or advocacy or action or lobby* or council* or coalition* or group* or organi?ation* or decision making)).ti,ab,kf. (42944)
15 or/6-14 (175214)
16 exp Policy Making/ (26216)
17 exp Health Policy/ (107681)
18 exp Health Priorities/ (10928)
19 ((agenda* or priorit*) adj setting).ti,ab,kf. (3228)
20 (policy* or policies).ti,kf. (74331)
21 ((policy* or policies) adj2 (agenda* or analys?s or develop* or design* or guidance or instrument* or plan*)).ti,ab,kf. (21761)
22 (organi#ation* adj2 (strateg* or planning or decision*)).ti,ab,kf. (3642)
23 or/16-22 (202702)
24 exp Mental Health/ (40253)
25 exp Mental Health Services/ (96927)
26 Mental Disorders/ (164221)
27 mental health.ti,kf. (73675)
28 mental ill-health.ti,kf. (182)
29 (wellbeing or well-being or wellness).ti,kf. (25584)
30 depression/ or self-injurious behavior/ or stress, psychological/ (239102)
31 (depression or self-injur* or psychological stress or drug abus* or addiction*).ti,kf. (165445)
32 exp Health Promotion/ (78102)
33 health promotion.ti,kf. (14107)
34 or/24-33 (709648)
35 23 and 34 (18547)
36 (mental health adj2 (policy* or policies)).mp. (1650)
37 35 or 36 (19366)
38 5 and 15 and 37 (388)