

Mental disorders and self-harm among Brazilian children, adolescents, and young adults: prevalence, disability, and mortality estimates from the Global Burden of Disease Study



Claudia Buchweitz,^{a,b} Arthur Caye,^{c,d,e} Jader Piccin,^{a,b} Igor Duarte,^{d,e} Guilherme V. Polanczyk,^e Luis Augusto Rohde,^{f,g,h} Giovanni A. Salum,^{i,j,k} Peter Szatmari,^l and Christian Kieling^{a,b,*}



^aDepartment of Psychiatry, Universidade Federal do Rio Grande do Sul & Hospital de Clínicas de Porto Alegre, Rua Ramiro Barcelos 2400, 90035-002, Porto Alegre, RS, Brazil

^bInstituto de Pesquisa, Hospital Moinhos de Vento, Rua Ramiro Barcelos 910, 90560-032, Porto Alegre, RS, Brazil

^cDepartment of Psychiatry, Universidade Federal do Rio Grande do Sul, Rua Ramiro Barcelos 2400, 90035-002, Porto Alegre, RS, Brazil

^dMental Health Research and Innovation Center (CISM), Universidade de São Paulo, Rua Dr. Ovídio Pires de Campos 785, Cerqueira César, São Paulo, SP, Brazil

^eDivision of Child & Adolescent Psychiatry, Department & Institute of Psychiatry, Faculdade de Medicina FMUSP, Universidade de São Paulo, Rua Dr. Ovídio Pires de Campos 785, Cerqueira César, 05403-010, São Paulo, SP, Brazil

^fADHD Outpatient Program & Developmental Psychiatry Program, Hospital de Clínicas de Porto Alegre, Federal University of Rio Grande do Sul, Rua Ramiro Barcelos 2400, 90035-002, Porto Alegre, RS, Brazil

^gMedical Council UNIFAJ & UNIMAX, Brazil

^hNational Institute of Developmental Psychiatry & National Center for Innovation and Research in Mental Health, Rua Dr. Ovídio Pires de Campos 785, Cerqueira César, São Paulo, SP, Brazil

ⁱChild Mind Institute, 215 E 50th St, New York, NY, 10022, USA

^jUniversidade Federal do Rio Grande do Sul, Rua Ramiro Barcelos 2400, 90035-002, Porto Alegre, RS, Brazil

^kNational Institute of Developmental Psychiatry for Children and Adolescents (INCT-CNPq), Rua Dr. Ovídio Pires de Campos 785, Cerqueira César, São Paulo, SP, Brazil

^lCundill Centre for Child and Youth Depression, Centre for Addiction and Mental Health, University of Toronto, 80 Workman Way, Toronto, ON, M5S 1A1, Canada

Summary

Background The period from childhood to young adulthood involves heightened susceptibility to mental health problems, requiring specific health policies. We present the prevalence and burden associated with mental disorders, substance use disorders (SUDs), and self-harm in Brazilian children, adolescents, and young adults.

Methods Using Global Burden of Disease Study (GBD) data, prevalence and years lived with disability (YLDs) were described for mental disorders and SUDs in ages 5–29 years. Self-harm mortality and years of life lost (YLLs) were described for 10–29 years (reflecting GBD modeling). Analysis was carried out disaggregated by sex. Race/ethnicity data were not available.

Findings Sixty-six unique sources from Brazil were used in GBD 2023 to model prevalence of mental disorders and SUDs. Mortality was derived from Brazil's Mortality Information System. At least one mental disorder was diagnosable in 15.6 million (20.91%) youths (6.9 million males, 8.7 million females); 2.5 million (3.36%) met criteria for at least one SUD (1.6 million males, 0.9 million females). Mental disorders and SUDs together accounted for over one third of the disability from all GBD causes in this age range. Self-harm accounted for 5402 annual deaths (4149 males, 1253 females) and 361,631 YLLs in 10 to 29-year-olds; annual mortality rate per 100,000 population ranged from 1.24 (95% UI: 1.06–1.46) at 10–14 years to 13.43 (95% UI: 12.29–14.92) at 25–29 years.

Interpretation The available sources indicate high prevalence and burden, underscoring the need for urgent action to safeguard the mental health of young Brazilians.

Funding None.

Copyright © 2026 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

The Lancet Regional Health - Americas 2026;61: 101583

Published Online 5 August 2026

<https://doi.org/10.1016/j.lana.2026.101583>

1016/j.lana.2026.101583

*Corresponding author. Instituto de Pesquisa, Hospital Moinhos de Vento, Rua Ramiro Barcelos 910, 90560-032, Porto Alegre, RS, Brazil.

E-mail address: christian.kieling@hmv.org.br (C. Kieling).

Keywords: Global Burden of Disease; Mental disorders; Drug use disorders; Self-harm; Child; Adolescent; Epidemiology

Research in context

Evidence before this study

Young age is a period of heightened susceptibility to the onset of mental health conditions, including substance use disorders, which may be linked to self-harm and could translate into a chronic course. This early developmental period therefore also provides important opportunities for prevention that could substantially reduce burden for individuals, communities, and healthcare systems. We reviewed the available evidence on the burden of mental disorders in Brazil, searching PubMed, Google Scholar, and SciELO, without language restrictions. The search was performed between October and December 2025 using as search terms burden AND self-harm AND mental disorders AND youth AND adolesc* AND child* AND Brazil. Estimates for prevalence, mortality, and burden expressed as disability-adjusted life years (DALYs) have been produced regularly by the Global Burden of Disease Study (GBD), while other studies have focused on the prevalence of specific disorders (such as anxiety or depression) or specific mental health-related constructs (such as substance use or bullying), covering broad age ranges often encompassing distinct developmental periods (such as 11–19 years or 18–35 years). Conversely, our search did not yield previous literature providing a developmental perspective addressing the combined scenario of mental disorders, substance use disorders, and self-harm as a function of age in Brazil, which implies an important gap in the information needed for the design and implementation of health policies in this country.

Added value of this study

The developmental focus on five age groups (ages 5–9; 10–14; 15–19; 20–24; and 25–29 years) revealed a high

prevalence (12.06%) of the aggregate of mental disorders modeled by GBD in 5–9 year-old Brazilians, as well as a steady increase in prevalence in the second and third decades of life, reaching 24.95% in 24–29 year-olds. Anxiety was ranked as the first cause of disability across all 375 causes modeled in GBD in these five age groups, while mortality from self-harm represented an important contribution to premature death already at 10–14 years, with a sharp increase in the subsequent age groups. While gaps were noted in the epidemiological research output relating to child and youth mental health in the country, with evidence lacking for several disorders and concentration of research in specific cities in the South and Southeast of Brazil, the available evidence clearly indicates an elevated prevalence and burden of mental disorders early in life.

Implications of all the available evidence

Health policies must incorporate mental health as an integral aspect of the healthcare provided to children, adolescents, and young adults in Brazil. This effort should include not only the provision of treatment and care proportionate to demand, but also a strong preventive perspective, considering the potential benefits across the life course. The current social and economic challenges faced by youth, together with the available data on fatal and non-fatal burden, provide sufficient evidence to justify urgent action focused on this age group. Strengthening surveillance systems and improving the incorporation of mental health indicators into nationwide surveys are essential steps to support evidence-informed policymaking.

Introduction

The country in which young Brazilians are growing up and living at present has come a fairly long way in designing policies that recognize their specific needs: a child and adolescent legal framework was enacted in 1990, accounting for the protection of individuals until 18 years of age,¹ and extended over two decades later to also cover the ages of 19–29 years.² These legal provisions, which are also reflected in the structure of Brazil's community-oriented public mental health network,^{3,4} include the right to health and emotional wellbeing, acknowledging that more than a period of transition into adulthood, youth encompasses developmental milestones of its own, involving specific processes that are linked to correspondingly specific strengths and vulnerabilities.⁵

In that sense, while young age is often equated with good physical health, it is also recognized as a period of

heightened susceptibility to the onset of mental health conditions,⁶ with biological, social and economic factors playing an important role.⁷ From this perspective, Brazil—the largest country in Latin America in terms of both population and territory⁸—has just tipped the balance of population growth, with the first recorded drop in the percentage of the younger age groups at the base of the population pyramid.⁹ Even though the current cohort of about 75 million people aged 5–29 years is still quite large in global terms, the shift has major implications for the future of these young people—who, having recently faced the COVID-19 pandemic and repeated extreme climate events with important economic consequences,^{10,11} are also particularly vulnerable to violence leading to death and death by suicide.^{12,13} This is the cohort who will face the challenge of a demographic transition (i.e., a shift in reproductive

behavior from a state of high birth and death rates to a state of low birth and death rates),¹⁴ including a shrinking working-age population to support societal needs¹⁵; and, by the time the expected decline in population in Brazil begins,¹⁶ this group will have reached the ages of 21–45 years and thus will be entering, or will be fully engaged in a fast-changing work and job market, simultaneously characterized by increasingly precarious and informal work arrangements and demands for skilled or highly skilled workers.⁵

Although this signals an urgent need to act now to prevent the onset, as well as avoid recurrence and chronicity from mental disorders,¹⁷ only scattered information is available on the mental health status of children and youths in Brazil, complicating an effective synthesis of knowledge and translation into policy and practice.¹⁸ To address this gap, publicly available data from the Global Burden of Disease (GBD) study may be explored. The GBD aims to provide a comprehensive perspective on the epidemiology and burden associated with health conditions through cross-sectional estimates of prevalence and mortality, as well as fatal and non-fatal burden for a broad range of conditions that are recognized as having special importance in youth, including a group of mental disorders, substance use disorders (SUDs), and self-harm. One special strength of the GBD is that it allows data analysis by fairly granular age brackets. As previously shown by our group, there are marked differences in the prevalence and disability burden from mental disorders globally in 5–9, 10–14, 15–19, 20–24-year groups.¹⁹ In addition to shedding light on developmental aspects that can guide policies and interventions, knowledge regarding these separate age groups can also provide insights into the particular life events that impact the trajectory from childhood to adulthood, and which entail different health care expectations and needs.⁵ Considering these aspects, in the present study we used data from the most recent GBD iteration to depict the burden associated with mental disorders, SUDs, and self-harm in five age groups contemplated by legal frameworks (5–9, 10–14, 15–19, 20–24, and 25–29 years) in Brazil, while also synthesizing aspects of the availability and coverage of the data used to produce these estimates and linking the findings to specific needs in the Brazilian context.

Methods

The GBD is an ongoing study that combines an extensive data collection effort with robust data modeling to appraise the burden of disease and injuries according to age, sex, location, and socio-demographic group. Data on race/ethnicity were not available and thus not considered in our analysis. The GBD 2023 iteration covers 204 countries and territories, providing estimates for 292 causes of death²⁰ as well as 375 diseases and injuries.²¹

In GBD, the aggregate of all causes is categorized into a hierarchy. Level 1 includes three groups: communicable, maternal, neonatal, and nutritional diseases; noncommunicable diseases; and injuries. Of interest to the present article, mental disorders and substance use disorders appear as Level 2 causes descending from non-communicable diseases. Mental disorders are further divided into the following Level 3 causes: attention-deficit/hyperactivity disorder (ADHD), anxiety disorders, depressive disorders, autism spectrum disorders, bipolar disorder, conduct disorder, eating disorders, idiopathic developmental intellectual disability, schizophrenia, and other mental disorders. Depressive disorders are further divided into Level 4 dysthymia and major depressive disorder; and eating disorders are divided into Level 4 anorexia and bulimia. Substance use disorders encompass the following Level 3 causes: alcohol use disorder and drug use disorders. Drug use disorders split into Level 4 cannabis use disorder, amphetamine use disorder, cocaine use disorder, opioid use disorder, and other drug use disorder. Self-harm is a Level 3 cause nested under injuries and is broken down into two Level 4 causes, self-harm by firearm and self-harm by other specified means. Details of the GBD hierarchy are also available in [Supplementary Table S1](#) of the GBD Causes of Death capstone Appendix.²⁰ The definition and cataloging system codes (ICD-9, ICD-10, and Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision, DSM-IV-TR) for each condition of interest appear in [Supplementary Table S1](#) of the present study.

Data sources

GBD derives epidemiological datasets from systematic reviews of published studies, national health surveys, disease registers, notification data, hospital inpatient data, household surveys, government and international organization websites, published reports, primary data sources, and contributions by GBD collaborators. These sources are routinely updated, although the literature is not reviewed at every iteration. For mental disorders, gray literature searches and expert consultation were performed in 2023, with systematic review updates conducted for eating disorders (combining anorexia and bulimia); anxiety disorders; mood disorders (combining depressive disorders and bipolar disorder); schizophrenia; developmental intellectual disability; and a combined review of ADHD and conduct disorder. Regarding SUDs, updates involved re-evaluation of data quality, with information re-extracted from several country sources and exclusion of some sources for cannabis and alcohol use disorders.²¹ For injury-related mortality, which covers self-harm, estimates are derived from vital registration, verbal autopsy, mortality surveillance, censuses, surveys, and police record data. If no sources are available, a best estimate is modeled based on available data from other locations around the

world.²² The limitations related to the quality of cause-of-death certification reported in vital registration systems are also addressed in the GBD study through the redistribution of causes of death associated with codes that are too vague, implausible as an underlying cause, or represent intermediate causes of death (garbage codes).²³

Data sources for each cause and geographical location are available for download from the GBD Sources Tool.²⁴ For each cause, the tool provides a .csv file with bibliographic citations of studies or datasets used to derive estimates, as well as a second .csv file with metadata including details of the samples analyzed in these studies (for example, the youngest and oldest ages). For mortality, all information was derived from Brazil's Mortality Information System (*Sistema de Informação sobre Mortalidade*, SIM) for the period ranging from 1980 to 2023. For the prevalence of mental disorders and SUDs, the 2023 iteration of the GBD study included a total of 77 unique sources for Brazil across all ages. No sources were available for schizophrenia and for the category of other mental disorders ([Supplementary Table S2](#)).

For mental disorders and SUDs, we examined each individual source from the literature to ascertain coverage of the 5 to 29-year range. Following this step, the selected sources were analyzed to derive the number of participants aged 5 to 29-years-old. When data were not available for the specific age intervals within this range, or were grouped into a broader range, we assumed an even distribution of individuals across all the years in that broader range. If that was not possible, we searched for additional publications referring to the same study or sample, or attempted to contact corresponding authors for clarification.

Data modeling and presentation

GBD estimation methods are continuously updated and details are always described in the most recent GBD iteration, with full details provided in the capstone publications and their methods appendices.^{20,21} A summary is provided below for the measures explored in this study.

In GBD, burden is modeled considering a non-fatal component (years lived with disability, YLDs), a premature mortality component (years of life lost, YLLs), and a combined measure, disability-adjusted life years, or DALYs, representing the sum of YLDs and YLLs. However, specifically for mental disorders, YLLs are only attributed to anorexia; as a result, DALYs are exactly the same as YLDs for most conditions ([Supplementary Table S3](#)). Therefore, as previously described,¹⁹ in the present study we will report on non-fatal burden expressed as YLDs as well as prevalence for mental disorders. Also, to keep in line with the International Classification of Diseases (in which disorders due to substance use are classified under Mental, behavioral or neurodevelopmental disorders), only YLD estimates will be presented for SUDs. Mortality and YLLs will be presented for self-harm.

Prevalence rates are estimated using the DisMod-MR 2.1 or DisMod-AT (specifically for anxiety disorders, major depressive disorder, and autism spectrum disorder) tools. DisMod-AT was implemented for the first time in GBD 2023 to address disease progression that takes place over age and time (AT) simultaneously. Thus, age and time are not modeled independently but instead are introduced in the model simultaneously. In addition, for dysthymia, a past-year crosswalk (i.e., the process of adjusting data for known biases) was added to the model for the first time, with the aim of addressing heterogeneity in prevalence estimates and ensure alignment with data reflecting current episodes of dysthymia.

Prior to estimation, the data extracted from available sources are adjusted for biases, for example, survey instrument (diagnostic or symptom scale), survey interviewer (clinician or lay), and recall type (point, 12-month, or lifetime prevalence). For mental disorders, adjusted prevalence rates reflect point prevalence for all causes except bipolar disorder, for which 1-year prevalence is considered. The overall prevalence for each disorder is distributed according to severity categories (e.g., asymptomatic, mild, moderate, and severe) to which a disability weight is assigned ([Supplementary Table S1](#)). Disability weights are predefined values (i.e., disability weights do not vary with each GBD iteration) ranging from 0 (full health) to 1 (death); they were originally derived from multicountry household or web-based surveys in which individuals aged 18 years or older were asked to compare two hypothetical individuals with different functional limitations and indicate which person was healthier. To calculate YLDs, the prevalence estimated for each severity category is multiplied by the disability weight assigned to the severity category. YLDs then undergo a comorbidity correction that accounts for the effect of an individual experiencing more than one sequela simultaneously.

In turn, most cause-specific death rates (including death by self-harm) are estimated using the Cause of Death Ensemble model (CODEm). CODEm is a GBD-specific modeling tool that is used to evaluate the out-of-sample predictive validity of different statistical models and covariate permutations (i.e., the available data are split into a training set and a validation set used to assess the model's performance). To estimate premature mortality, GBD predicts life expectancy considering two main components: a theoretical "best" life expectancy (that assumes that people in all countries around the world could have this life expectancy) and the average age of death derived from life tables for each location. These estimates are interpolated to predict the life expectancy in each location for each age group. YLLs are then calculated by multiplying the number of deaths from each cause by the predicted life expectancy (Section 6-3 in [Appendix 1](#) of the 2023 Capstone).²⁰

Estimates extracted from GBD are presented here as counts and percent or age-specific rates per 100,000

population, calculated using the GBD standard population estimates, obtained by selecting “population” in the “GBD Estimate” menu in the Results Tool.²⁵ A 95% uncertainty interval (95% UI) that reflects the uncertainty arising from the modeling of various data types and processes (including unpredictable variation in input data, age/sex splitting, bias corrections, data manipulations, application of statistical techniques) is provided for all results except the overall 5 to 29-year group, which is not a standard GBD aggregate age category. Figures were plotted using the ggplot package in R, except for Fig. 1 (Datawrapper and Figma).

Age restrictions

As shown in Supplementary Table S4, some restrictions on age are applied for data modeling based on the best available evidence (such as evidence indicating no incidence of a disorder before or after a certain age), including expert feedback.²¹ For example, no data are

modeled for bipolar disorder in the 5 to 9-year old group, whereas no data are modeled for conduct disorder after 18 years of age. SUDs and mortality from self-harm are only modeled for age 10 or older.

Ethics approval

GBD analyses adhered to the Guidelines for Accurate and Transparent Health Estimates Reporting (GATHER).²⁶ Ethics approval was not required for the present analysis because participant data are anonymized in the publicly available GBD database.

Role of the funding source

This study did not receive any funding.

Results

Data sources

Of the total of 77 unique sources on mental disorders and SUDs available for the 2023 GBD iteration in

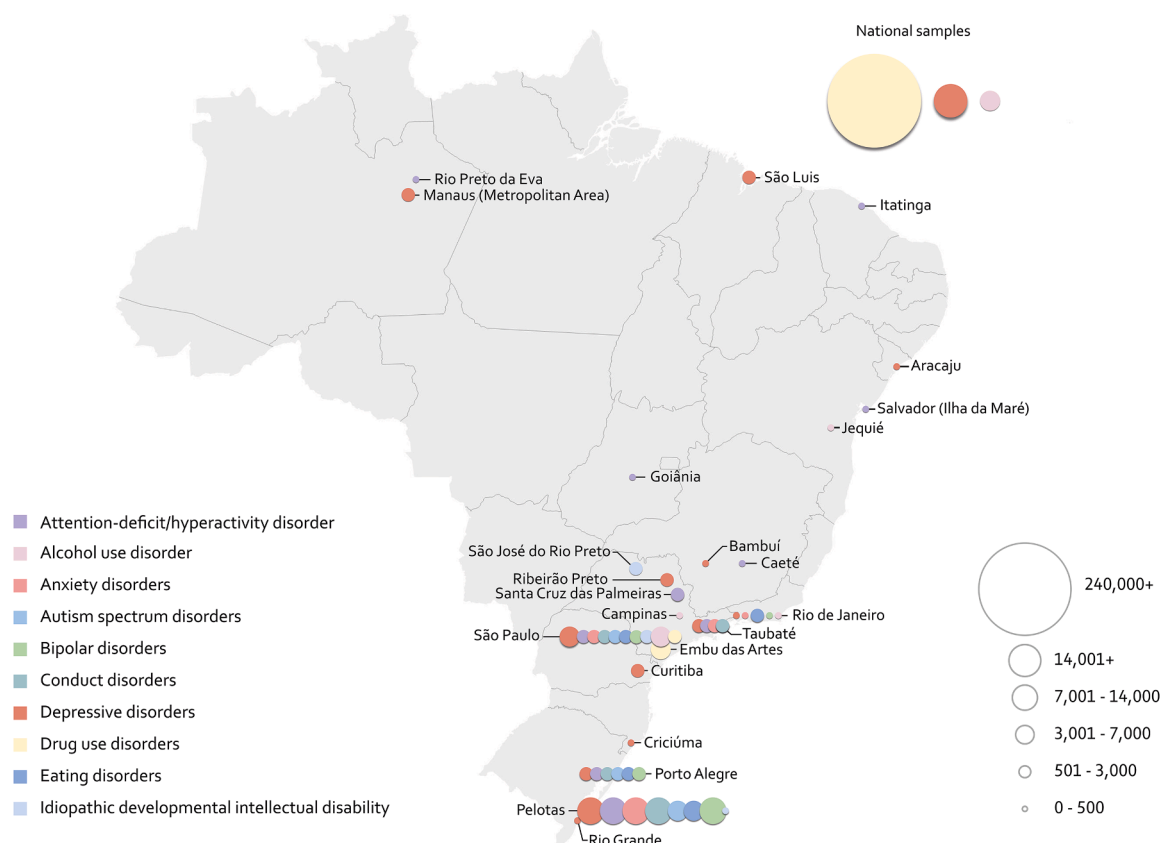


Fig. 1: Geographic distribution of samples included in the 2023 iteration of the Global Burden of Disease study to derive data for mental and substance disorders covering ages 5 to 29 years in Brazil. The color legend (squares) represents the disorders for which sources were available, while the size of the circle represents the sum of sample sizes within the 5 to 29-year-old range. National studies (Brazil World Health Survey; Brazil National Survey of Health; Brazilian National Alcohol/Drug Survey; Brazil Household Survey About the Use of Psychotropic Drugs; National Survey of School Health) are summarized in the upper right corner. For national studies, we were unable to determine the distribution of the samples within the 5 to 29-year range at the federative unit level. The number of individuals in the age range of interest could not be derived in one study on bipolar disorder reporting on 165 participants aged 18 years or older in Rio de Janeiro (Silva RA et al. Trends Psychiatry Psychother. 2013;3: 141–5). No sources were available for schizophrenia and for the category of other mental disorders.

Brazil, 66 unique sources covered the 5 to 29-year-old range. Fig. 1 and Supplementary Table S5 show the distribution of samples derived from available sources for the specific age groups of interest.

Specifically for the 5 to 29-year-old group, 28 sources were used to estimate the prevalence of depressive disorders (Supplementary Table S5); 12 were used for ADHD; 11 for anxiety disorders; eight for bipolar disorder; five for eating disorders; four for conduct disorder; two for autism spectrum disorder, and two sources were used to estimate the prevalence of idiopathic developmental intellectual disability. The youngest and oldest ages covered were 6 and 29 years, respectively, for depressive disorders, anxiety, bipolar disorder, and eating disorders; 5 and 29 for ADHD; 6 and 14 in conduct disorder and autism spectrum disorder; and 7 and 11 in idiopathic developmental intellectual disability (one source covering of idiopathic developmental intellectual disability in 4-year-olds was not considered in this study).²⁷ Alcohol use disorders covered ages 12 to 29, and drug use disorders covered ages 10 to 29.

Across disorders, samples from the state of São Paulo contributed to 41 studies (city of São Paulo samples represented 31 times, including 10 studies using data from the São Paulo Megacity Mental Health Survey; a sample from the city of Taubaté was represented four times; Campinas was represented twice; and samples from the cities of Ribeirão Preto, Santa Cruz das Palmeiras, São José do Rio Preto, and Embu das Artes were represented once each). Samples from Rio Grande do Sul contributed to 37 prevalence studies (with the Pelotas birth cohorts represented 21 times; seven additional studies relied on other samples from Pelotas). The capital Porto Alegre contributed samples to eight studies, of which seven were derived from the Brazilian High-Risk Cohort for Mental Health Conditions (BHRC); and the city of Rio Grande contributed one sample. Samples from the city of Rio de Janeiro contributed to nine studies. Samples from the states of Amazonas, Bahia, Minas Gerais, and Paraná appeared twice each. Ceará, Santa Catarina, Maranhão, Sergipe, and Goiás appeared once each. National samples (recorded as “Brazil”) contributed to 18 studies, including the Brazil National Health Surveys.

Prevalence

In 2023, 15.6 million individuals (6.9 million males and 8.7 million females), or 20.91% of the population aged 5–29 years in Brazil, were estimated to meet criteria for at least one diagnosable mental disorder according to the GBD study. In turn, 2.5 million (1.6 million males, 0.9 million females), or 3.36%, were estimated to meet criteria for an SUD in this age range. For the aggregate of mental disorders, the point prevalence for each specific age range was 12.06% (95% UI: 7.99–20.42) for 5 to 9-year-olds; 18.81% (14.55–26.61%) for 10 to 14-year-olds; 23.58% (19.20–31.15) for 15 to 19-year-olds;

24.27% (19.70–30.53) for 20 to 24-year-olds; and 24.95% (20.83–30.71) for 25 to 29-year-olds. For SUDs, modeled for age 10 years or older, age-specific prevalence was 0.22% (95% UI: 0.13–0.32) at 10–14 years; 3.18% (2.42–4.02) at 15–19 years; 5.82% (4.83–7.13) at 20–24 years; and 6.91% (5.72–8.18) at 25–29 years (Supplementary Table S6). To provide context, Supplementary Figure S1 shows the prevalence of mental disorders and SUDs for both sexes in Brazil and globally.

Regarding the sex-specific prevalence of mental disorders and SUDs, non-overlapping 95%UIs indicated higher prevalence of depressive and eating disorders in females starting at 10 years of age; of anxiety at 25–29 years; and of the aggregated mental disorders at 20 to 24 and 25 to 29 years. In males, non-overlapping 95% UIs indicated higher prevalence of alcohol use, drug use, and the aggregated substance use disorders at 20 to 24 and 25 to 29 years (Fig. 2, Supplementary Table S6).

Years lived with disability

Among all GBD causes, mental disorders were the leading source of YLDs in Brazilians aged 5–29 years in 2023, accounting for 2.16 million YLDs. SUDs accounted for 265.8 thousand YLDs. For the aggregate of mental disorders, the number of YLDs in males surpassed that of females in the 5 to 9 and 10 to 14 years brackets; after that, females surpassed males in all groups, with the number of YLDs more than doubling from 10 to 14 years to 25 to 29 years (Fig. 3, Supplementary Table S7). Nevertheless, even in the presence of large absolute differences in the number of YLDs between females and males (e.g., 198,287.94 vs. 89,555.27 at 25 to 29 years for anxiety), all 95% UIs overlapped for most comparisons, except for eating disorders at 20 to 24 and 25 to 29 years and alcohol use disorders at 25 to 29 years (Supplementary Table S7).

Considering the distribution of YLDs from mental disorders across the life course, 33.41% of the total 6,531,563.91 YLDs occurred between age 5 and 29 years (Supplementary Table S3). Likewise, mental disorders and SUDs represented together 36.52% of the 6,704,995 YLDs corresponding to the sum of all causes in GBD in 5 to 29-year-olds. The high contribution of mental disorders and SUDs to disability is reflected in the YLD ranking across the five age groups examined here (Fig. 4).

As shown in Fig. 4, for all the age ranges addressed here, the group of anxiety disorders appears as the first contributor to non-fatal burden among all diseases covered in GBD. In the five age brackets, four mental or substance use disorders are among the top 10 contributors to non-fatal burden.

Death by self-harm: mortality and years of life lost

In GBD, the modeling of mortality from self-harm starts at 10 years of age. In total, 5402 annual deaths by

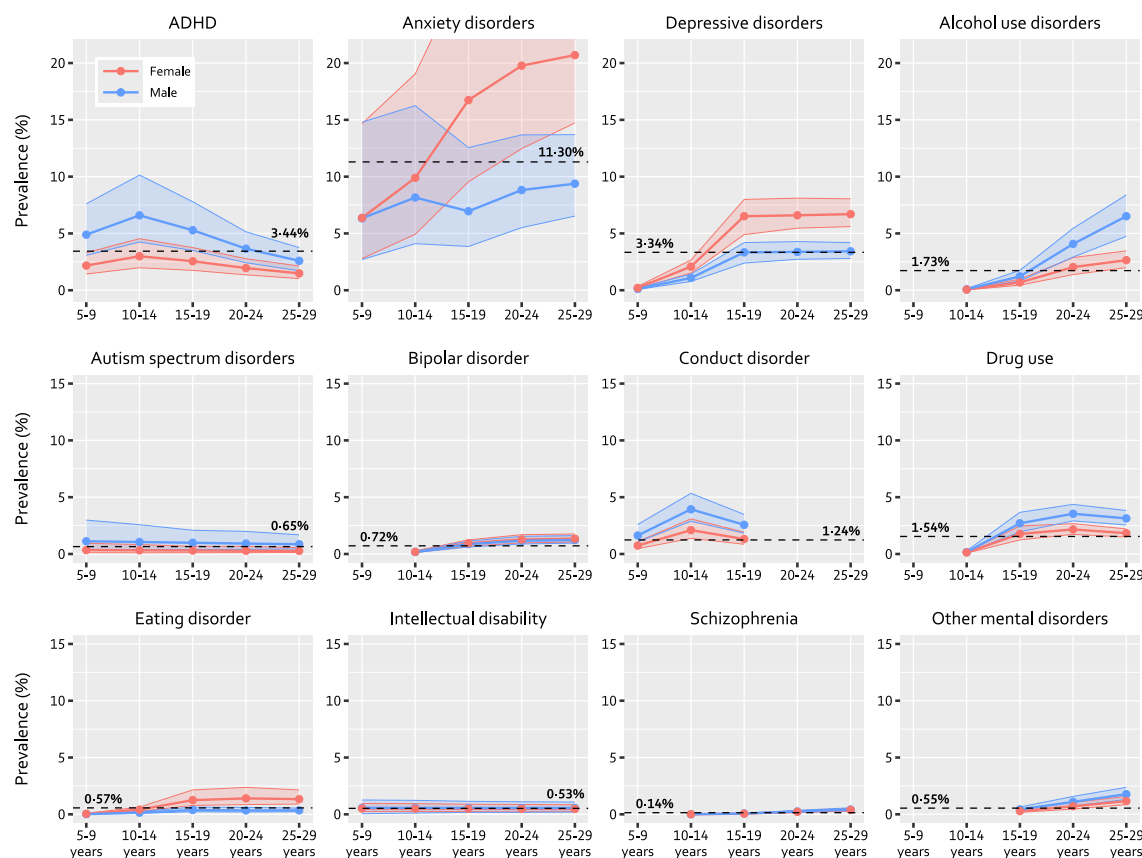


Fig. 2: Prevalence of mental and substance use disorders derived from the 2023 iteration of the Global Burden of Disease study for females and males in Brazil. Dotted lines indicate the mean combined prevalence for females and males across all age groups. Shaded areas represent 95% uncertainty intervals (95% UI). The upper limit of the 95% UI for anxiety in females was trimmed for presentation (actual values available in [Supplementary Table S6](#)). ADHD: Attention-deficit/hyperactivity disorder. Data were not modeled by the Global Burden of Disease study before age 10 years for bipolar disorder, schizophrenia, alcohol use disorders and drug use disorders; and before age 15 for other mental disorders. For conduct disorder, only cases prior to age 18 years are modeled. For attention-deficit/hyperactivity disorder, no incidence is assumed in GBD from age 12 years onward.

self-harm were recorded in 10 to 29-year-olds (4149 males, 1253 females), for a total of 361,631 years of life lost (YLLs) for both sexes combined. Self-harm was the 8th contributor to premature death expressed as YLLs in 10 to 14-year-olds, climbing to the 3rd position in all subsequent age groups (15 to 19, 20 to 24, and 25 to 29-year-olds).

The mortality rate per 100,000 population was 1.24 (95% UI: 1.06–1.46) in 10 to 14-year-olds; 7.78 (95% UI: 6.98–8.78) in 15 to 19-year-olds; 12.37 (95% UI: 11.32–13.58) in 20 to 24-year-olds; and 13.43 (95% UI: 12.29–14.92) in 25 to 29-year-olds. [Fig. 5](#) and [Supplementary Table S8](#) show the mortality rates in each age group for females and males.

Discussion

In the present study, we used data from GBD to gain insights into the status of mental disorders, SUDs, and mortality from self-harm in young Brazilians aged 5 to

29 years, corresponding to the groups covered by specific policies that establish the rights to a healthy and harmonious development as well as comprehensive health care as fundamental principles, with emphasis on the prevention and care of the most prevalent conditions in this age group.^{1,2} While these frameworks explicitly highlight priorities including vaccination, substance use, and early pregnancy, there is no explicit mention of mental disorders, even though, according to the present estimates, almost one in five individuals aged 5 to 29 years met criteria for a diagnosable mental disorder in Brazil. Furthermore, mental disorders and SUDs accounted together for more than one-third of the disability from all GBD causes in this age group, while mortality from self-harm represented an important contribution to premature death already at 10 to 14 years, with a sharp increase in the later age groups. The evidence showing the early presence along the life course of mental disorders, SUDs, and fatal

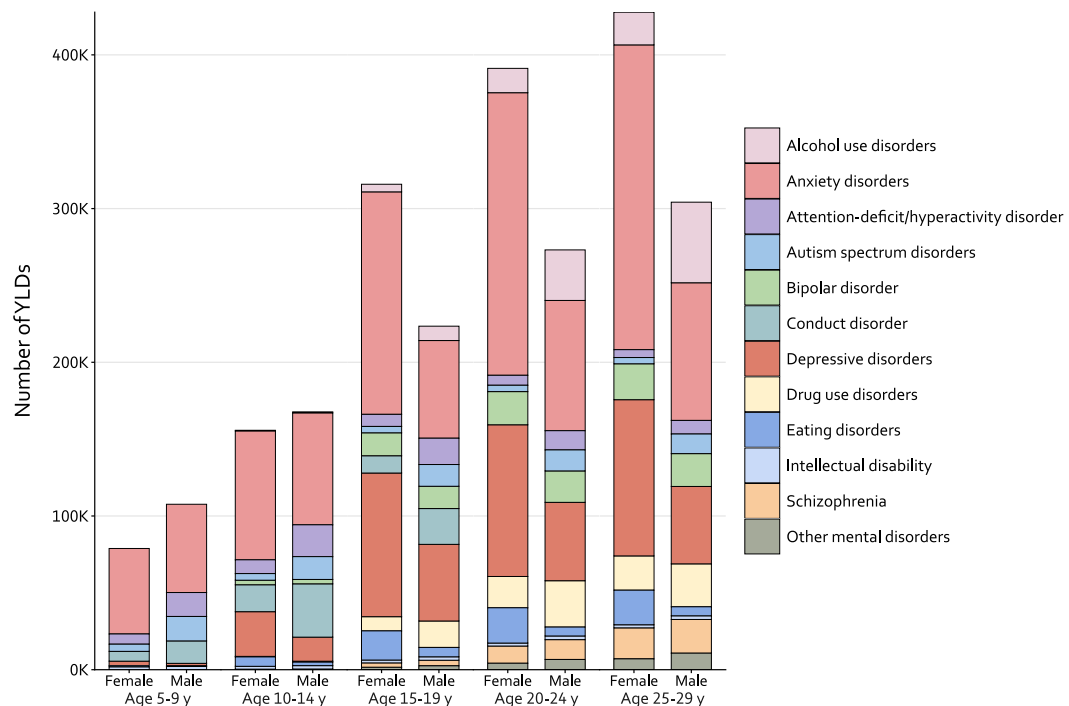


Fig. 3: Contribution of mental disorders and SUDs to non-fatal burden expressed as the number of YLDs derived from the 2023 iteration of the Global Burden of Disease study according to age and sex in Brazil. The number of YLDs is age specific rather than cumulative, i.e., YLDs from the older age groups do not incorporate the YLDs recorded for the younger age groups. Data were not modeled by the Global Burden of Disease study before age 10 years for schizophrenia, bipolar disorder, drug use disorders, and other mental disorders; for conduct disorder, only cases prior to age 18 years are modeled. For attention-deficit/hyperactivity disorder, no incidence is assumed in GBD from age 12 years onward.

self-harm is a non-trivial finding and a major contribution of the present study, with important consequences for prevention, service planning, and policy.

A crucial first message for successfully reducing the population burden imposed by mental disorders is the need to implement interventions early in the course of life. We have recently argued²⁸ that a transdiagnostic staged perspective is an advantageous framework for public mental health, incorporating opportunities for prevention and intervention. According to this perspective, mental disorders progress along a path involving overlapping symptoms and comorbid disease trajectories, beginning with stages that precede the emergence of a full-threshold condition—involving higher risk for the onset of mental health conditions or characterized by mixed symptoms not meeting criteria for full-threshold disorders—up to a stage in which severe, unremitting illness does not respond to adequate care. The transdiagnostic staging perspective proposes that each of these stages can be prevented, but strongly emphasizes early intervention,²⁹ with attention to initial presentations associated with distress and disability, which are typical of youth and often dismissed by healthcare services.³⁰ Preventing the onset of mental disorders early in both the course of life and the course of disease will

spare individuals and society from the possibility of life-long burden, and the healthcare system from increased demands for complex treatments and care.

For service planning, the emphasis on early life or disease course entails the expansion of “system entry points,” beyond primary care in the healthcare system and even beyond the healthcare system itself, identifying and preparing existing structures or initiatives, or creating new spaces, to contextualize and handle mental health needs that fall outside a formal diagnosis and which may be entangled with broader socioeconomic needs. The school system, which by definition is organized around a life course perspective and provides frequent, longitudinal contact with individuals and, to a certain extent, their families, could be an initial setting for expansion. Nevertheless, for integration of the health and education systems, policies must be reviewed to frame schools as community-oriented spaces that promote wellbeing.^{31,32}

In addition, other “soft entry” opportunities for care should be created, involving self-referral or drop-in services spread in the community, with attention to sex or gender-specific needs especially during adolescence and young adulthood.³³ A practical example is provided by Australia’s National Youth Mental Health

5-9 years	10-14 years	15-19 years	20-24 years	25-29 years
1 Anxiety disorders	1 Anxiety disorders	1 Anxiety disorders	1 Anxiety disorders	1 Anxiety disorders
8 ADHD	4 Conduct disorder	2 Depressive disorders	2 Depressive disorders	2 Depressive disorders
9 Conduct disorder	7 Depressive disorders	7 Conduct disorder	7 Drug use disorders	7 Alcohol use disorders
10 Autism spectrum disorder	10 ADHD	8 Bipolar disorder	8 Alcohol use disorders	10 Drug use disorders
29 Depressive disorders	12 Autism spectrum disorder	12 Drug use disorders	12 Bipolar disorder	14 Bipolar disorder
31 Intellectual disability	25 Eating disorders	14 Eating disorders	17 Eating disorders	15 Schizophrenia
51 Eating disorders	28 Bipolar disorder	15 ADHD	19 Schizophrenia	19 Eating disorders
N/A Alcohol use disorders	34 Intellectual disability	19 Autism spectrum disorder	22 ADHD	24 Other mental disorders
N/A Bipolar disorder	59 Alcohol use disorders	21 Alcohol use disorders	24 Autism spectrum disorder	27 Autism spectrum disorder
N/A Other mental disorders	61 Drug use disorders	32 Schizophrenia	30 Other mental disorders	29 ADHD
N/A Schizophrenia	64 Schizophrenia	45 Intellectual disability	46 Intellectual disability	50 Intellectual disability
N/A Drug use disorders	N/A Other mental disorders	46 Other mental disorders	N/A Conduct disorder	N/A Conduct disorder

Fig. 4: Disability ranking of mental disorders and SUDs among all disorders covered in the 2023 iteration of the Global Burden of Disease Study according to YLDs by age group in Brazil, both sexes combined. In each age group, the column order reflects the rank within the group of mental disorders, while the number inside each cell reflects the overall rank among all causes within the 2023 Global Burden of Disease study. Gray cells marked with not applicable (NA) show disorders for which burden was not modeled within the age group according to the GBD Methods Appendix. Anxiety disorders included the combined estimate of all subtypes of International Classification of Diseases anxiety disorders; depressive disorders, major depressive disorder and dysthymia; eating disorders, anorexia nervosa and bulimia nervosa; intellectual disability, idiopathic developmental intellectual disability, comprising intellectual disability from any unknown source after all other sources of intellectual disability are accounted for; and other mental disorders, residual category corresponding to an aggregate group of personality disorders. ADHD indicates attention-deficit/hyperactivity disorder.

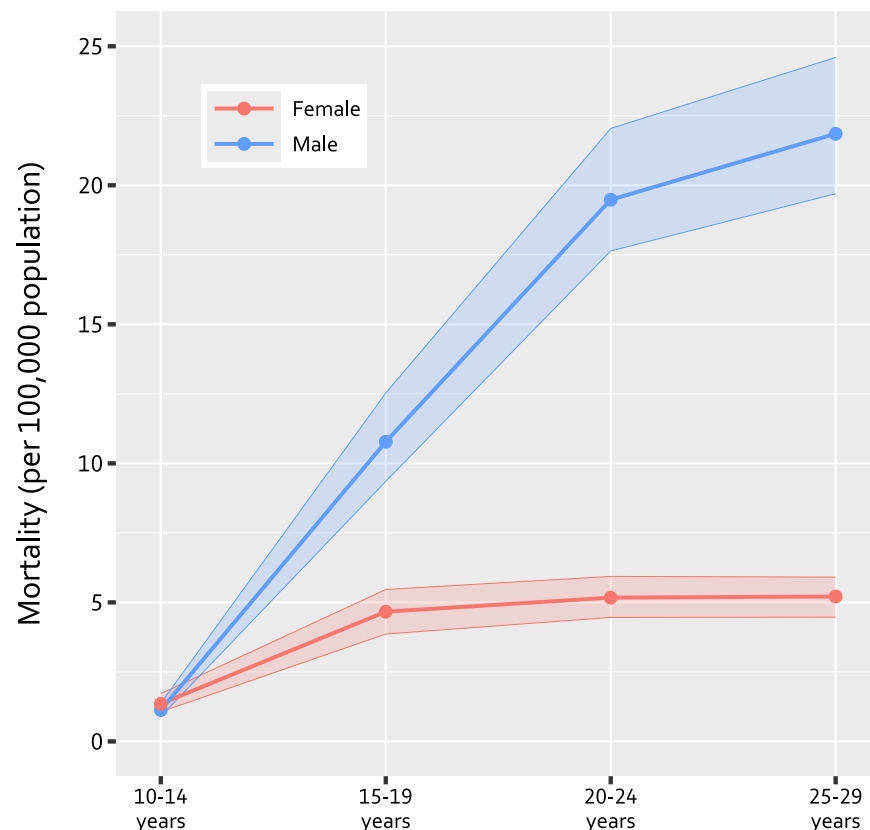


Fig. 5: Self-harm mortality estimates derived from the 2023 iteration of the Global Burden of Disease study in Brazilian females vs. males according to age group.

Foundation through its Headspace program,³⁴ which focuses on 12 to 25 year-olds, providing support for mental health, physical and sexual health, work and study, and alcohol and drug services in walk-in facilities and through online and phone counselling. These are important domains, considering the known association between not being involved in education, employment, or training (NEET) and mental health problems³⁵ and the transition to adult roles. In Brazil, the proportion of individuals with NEET status has been reported as around 30% in both 18 to 24-year-olds and 25 to 29-year-olds,⁵ whereas the proportion of individuals recognized as being in charge of the household affairs doubles among those aged 25–29 years (60%) as compared to individuals aged 18–24 years (30%). Individuals in this age range might be more likely to seek support from services framed with a broader scope. A meta-analysis³⁶ has also found that community-based interventions may be effective in reducing suicidal ideation and suicide attempts in individuals younger than 18 years, with results that support the integration of community-based (schools, community centers, or web-based programs) suicide prevention programs with mental health strategies. To design such initiatives,

meaningful engagement of youth with lived experience of mental disorders is key.²⁸

In Brazil, the Unified Healthcare System (SUS), relying on community health agents as a major strategy and including a Psychosocial Care Network covering primary and specialized mental health care, crisis management services, inpatient units, deinstitutionalization initiatives, and psychosocial rehabilitation programs, provides a strong basis for the expansion of early mental health intervention services. The system is supported by a legal framework and designed with consideration for special populations, such as indigenous peoples, and features a network of psychosocial centers (CAPS)^{3,17} that may constitute one of the largest community-based mental health strategies ever implemented outside high-income countries.⁸ In municipalities with a population larger than 70 thousand, the policy provides for psychosocial centers focusing on children and adolescents diagnosed with persistent and severe mental disorders (CAPSi) without restrictions in terms of diagnosis.³ However, difficulties have been reported in terms of coordination of care; vague or scattered guidelines may also hinder the delivery of care. For example, the National Policy for Comprehensive Child Health

Care³⁷ focuses strictly on children aged from 0 to 9 years and does not explicitly address mental health. An effort to harmonize policies, with the adoption of evidence-based guidelines integrating a staged model of mental and physical health and focusing on the life course (as exemplified by vaccination strategies³⁸) may facilitate coordination and is likely to benefit all age groups.⁸

Policy-wise, being able to monitor if and how financial resources are realized should be a priority, with transparency currently a major concern. For example, an important share of the resources destined to the SUS have been allocated through congressional earmarks for which no accountability mechanism is available.³⁹ As also pointed out in health indicator frameworks, including the Countdown 2030 Initiative,^{40–42} of particular relevance for mental health, the mere existence of a policy or plan is not sufficient, and thus accountability mechanisms must be created.

Traditional epidemiologic indicators used in public health include incidence, prevalence, mortality, and disability.²⁸ In mental health, determining incidence (that is, a first-ever episode of a mental disorder) is often complicated by barriers to identification of a first episode, including poor access to mental health services, stigma, difficulties in recognizing mental health conditions, and a focus on adult populations and the symptomatology that is typical of adulthood. Thus, prevalence (the number the proportion of all individuals in a population presenting a condition) is more frequently used to assess the burden of mental health conditions. The generation of informative prevalence estimates, however, is directly dependent not only on the measurement of cases, but also on the quality of measurements—which is especially complex in mental health. Among others, the lack of standardization in the diagnostic or screening instruments used to detect mental disorders poses a problem particularly for studies with children and adolescents given the use of proxy-reported rather than self-reported measures.⁴³ In the present study, considering the sources of information used by GBD to estimate MDD prevalence, we found that at least six instruments were used to detect the disorder—Composite International Diagnostic Interview, Children's Depression Inventory, Development and Well-being Assessment, Center for Epidemiologic Studies Depression Scale, Mini International Neuropsychiatric Interview, and the Patient Health Questionnaire (PHQ), a screening tool rather than a diagnostic instrument—whose ability to estimate depression prevalence has been questioned.⁴⁴ A previous meta-analysis of the worldwide prevalence of mental disorders identified diagnostic instruments as a significant moderator of prevalence estimates, with different instruments generating different prevalence estimates.⁴⁵

Anxiety disorders were ranked as the first cause of non-fatal burden among all disorders modeled in GBD 2023 for all the age brackets analyzed here, including 5

to 9-year olds. The historical GBD series shows that since 2010 (the initial year used to explore time trends in GBD 2023), anxiety disorders have been ranked among the five top causes of non-fatal burden among all causes in Brazil in the age groups we covered. For young people, the notion of megatrends⁴³ as drivers of mental ill-health has been proposed, including changes in social expectations regarding the transition to adulthood, technological and economic changes in society, the rise of artificial intelligence and its impacts on the job market, unregulated use of social media, and climate change, among others. Of note, the higher overall prevalence of mental disorders in Brazil compared with global estimates is largely driven by the elevated prevalence of anxiety disorders in 20 to 29-year-olds ([Supplementary Table S6](#)). This finding further underscores the need for prevention efforts targeting children and adolescents to reduce the substantial burden of disease in early adulthood.

Indicators of mortality and disability impose certain challenges in the context of mental health. Many studies provide evidence that mental disorders are associated with significantly increased risk of premature death from both natural causes and self-harm.⁴⁶ However, because mental disorders are not usually the direct cause of death, different indicators have been used, such as excess mortality—that is, the difference between the observed deaths in a certain group (for example, people with mental disorders) and the expected deaths based on the historical trends for people without that disorder. In Brazil, a retrospective cohort study with patients hospitalized in the SUS⁴⁷ showed that the mortality rate in individuals with severe mental disorders was more than twice that of non-psychiatric inpatients, with the highest excess mortality recorded for cardiovascular disease (ischaemic heart disease) and injuries (suicide, interpersonal violence, and road injuries). This supports the notion that the puzzle of mental disorders will not be completely understood without considering the prevalence of violence, also expressed for Brazilian youth in aspects such as the markedly higher mortality rate from external causes in individuals aged 15 to 29 years (and especially 20 to 24 years).⁴⁸

Disability from non-fatal self-harm is also not often accounted for. Among the major limitations of the GBD, the difficulty in estimating non-fatal self-harm likely translates in underestimation of the overall burden of suicidal behavior. Added to that, the fact that in GBD mental disorders are not modeled as contributors to self-harm mortality remains an important gap, acknowledged even by GBD investigators.⁴⁹ In our view, this is further compounded by the presentation of SUDs as separate from mental disorders, further increasing the difficulty in interpreting the burden of mental health conditions and contributing to the underestimation of this burden.

In examining the sources used to derive GBD estimates for the 2023 cycle, we noted a paucity of primary datasets across disorders, especially for some conditions, such as schizophrenia.⁵⁰ Data gaps have also been recently highlighted regarding autism spectrum disorder⁵¹ and eating disorders.⁵² Also importantly, data are still lacking for a vast majority of the Brazilian territory. In the absence of data, providing a best estimate is a core principle of GBD, based on the perception that “no data” may be equated with the absence of a problem.²² In that sense, the modeling strategies that have been carefully designed and continuously improved by the GBD study to compensate for these data gaps can provide relevant information—if interpreted with care and a clear understanding of limitations. It should also be noted that the data used to estimate prevalence estimates (or lack thereof) may impact the calculation of YLDs, which, as described, are directly derived from prevalence measures in GBD.

Several additional limitations must be acknowledged. Still regarding GBD methodology, the disability weights used across all age groups were derived solely from surveys of adults. Considering that these disability weights reflect judgments about which functional limitations correspond to better or worse health, it is fair to question whether the views of children and adolescents on good or poor health align with those of adults. Also, and especially in mental health, the type of functional limitation considered to generate disability weights would likely benefit from some adaptation for the reality of young age groups. In that sense, the fact that GBD does not account for subthreshold manifestations of mental disorders, which are common in children and adolescents and associated with important disability and impairment, is an important gap. As already noted, the use not only of different instruments to produce prevalence measures, but also of different informants (e.g., parents, teachers, or self-reports), further underscores the challenges of case identification that are inherent to the field of youth mental health.

Beyond these methodological constraints, a major limitation shown here is the coverage of data sources in Brazil, with no specific information available for most federative units, for rural regions, for vulnerable groups such as Indigenous youths or other ethnic minorities and individuals living on the streets or in institutions. Rates of death by self-harm among Indigenous peoples in Brazil have been shown as more than twice the levels for the overall Brazilian population in 2020, with the highest rates recorded between 10 and 24 years of age — reaching 33.8 deaths/100,000 in 2015, and still around that level in 2020,⁵³ a stark contrast to the overall rate of 7.32 (95% UI: 6.72–8.08) death by self-harm/100,000 reported for this age group in Brazil by GBD in 2023. Likewise, the absence of studies including populations from the North, Central-West and Northeast regions of Brazil underscores the

imbalance between the representation of populations from the South, especially considering the weight of data from cohorts such as those established in São Paulo and Pelotas. However, rather than prompting action solely on the need to collect more data, these findings underscore the need for immediate action to provide mental health support for young Brazilians, at as early an age as possible.

In conclusion, the present study revealed a mental health landscape characterized by high prevalence and burden from mental disorders and SUDs and high mortality rate by self-harm among young Brazilians aged 5 to 29 years, threatening their wellbeing and productivity in the transition from childhood to adolescence and adulthood.³³ The study confirms the usefulness of focusing on granular age and national-level data to obtain relevant information for action, and shows that, in spite of some caveats, GBD is an important tool, and a starting point to provide insights for action in specific health scenarios. We argue that focusing early in the course of life and in the course of disease, with integration of physical and mental health and expansion of the early intervention network to provide pre-primary care entry points, should be priorities for immediate action.

Contributors

CB: conceptualization, data curation, formal analysis, project administration, figure/table development, writing—original draft, and writing—review & editing; AC: formal analysis, figure/table development, writing—original draft, and writing—review & editing; JP: formal analysis, writing—original draft, and writing—review & editing; ID: formal analysis, figure/table development, writing—original draft, and writing—review & editing; GVP: formal analysis, writing—original draft, and writing—review & editing; LAR: formal analysis, writing—original draft, and writing—review & editing; GAS: formal analysis, writing—original draft, and writing—review & editing; PS: formal analysis, writing—original draft, and writing—review & editing; CK: conceptualization, formal analysis, figure/table development, writing—original draft, and writing—review & editing. CB, AC, and CK verified the data. All authors had access to all data. CB and CK had the final responsibility for the decision to submit.

Data sharing statement

The study employed publicly available data accessible at <https://vizhub.healthdata.org/gbd-results/>, and data tables are provided in the [Supplemental Appendix](#).

Editor note

The Lancet Group takes a neutral position with respect to territorial claims in published maps and institutional affiliations.

Declaration of interests

AC received consulting fees from EMS Pharmaceuticals and Knight Therapeutics, outside the scope of this work.

GVP reports consulting fees from Apsen, EMS, Adium, and Libbs, and honoraria for lectures, presentations, speakers bureaus, manuscript writing, or educational events from Eurofarma and Medice.

LAR reports grant or research support from, served as a consultant to, and served on the speakers' bureau of Abdi Ibrahim, Abbott, Aché, Adium, Apsen, Bial, Celler, EMS, Hypera Pharma, Knight Therapeutics, Libbs, Medice, Novartis/Sandoz, Pfizer/Upjohn/Viatris, Shire/Takeda, and Torrent in the last three years. The ADHD and Juvenile Bipolar Disorder Outpatient Programs chaired by Dr Rohde have received unrestricted educational and research support from the

following pharmaceutical companies in the last three years: Novartis/Sandoz and Shire/Takeda. Dr Rohde has received authorship royalties from Oxford Press and ArtMed.

CK reports grants from the Wellcome Trust, the UK Academy of Medical Sciences, and Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq, Brazil); consulting fees from the Wellcome Trust and Child Mind Institute; and is a cofounder of Wida, a digital mental health platform.

CB, JP, ID, GAS, and PS report nothing to disclose.

Acknowledgements

The present work did not receive any funding. We thank Miguel de Loreto Neto for support with figure design, and Fernanda C. Rohretzer for review of the sample sizes extracted from mental health studies in 5 to 29-year-olds in an earlier version of this article.

Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.j.lana.2026.101583>.

References

- Brasil, Senado Federal. Estatuto da Criança e do Adolescente. Disposições constitucionais pertinentes, Lei nº 8.069, de 13 de julho de 1990, legislação correlata, atos internacionais, índice correlato; 2005. <https://www2.senado.leg.br/bdsf/bitstream/handle/id/70318/64.pdf>. Accessed February 19, 2026.
- Brasil, Senado Federal. Estatuto da Juventude: atos internacionais e normas correlatas. Brasília: Senado Federal; 2013.
- Marchionatti LE, Rocha KB, Becker N, Gosmann NP, Salum GA. Mental health care delivery and quality of service provision in Brazil. *SSM Mental Health*. 2023;3:100210.
- Sistema Único de Saúde, Conselho Nacional de Saúde, Comissão Organizadora da III CNSM. Relatório final da III Conferência Nacional de Saúde Mental. https://bvsms.saude.gov.br/bvs/publicacoes/mental_relatorio.pdf; 2002. Accessed February 19, 2026.
- Leandro B, Sobrinho A, Abramo H. Panorama da situação de saúde de jovens brasileiros, 2016 a 2022: interseções entre saúde, juventude e trabalho. Rio de Janeiro: EPSJV; 2024.
- Solmi M, Radua J, Olivola M, et al. Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. *Mol Psychiatry*. 2022;27:281–295.
- Committee on Fostering Healthy Mental, Emotional, and Behavioral Development Among Children and Youth, Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education, National Academies of Sciences, Engineering, and Medicine. Fostering healthy mental, emotional, and behavioral development in children and youth: a national agenda. Washington, D.C.: National Academies Press; 2019.
- Pimentel FG, Buchweitz C, Onocko Campos RT, Hallal PC, Massuda A, Kieling C. Realising the future: health challenges and achievements in Brazil. *SSM Mental Health*. 2023;4:100250.
- Instituto Brasileiro de Geografia e Estatística (IBGE). Panorama do Censo 2022; 2024. <https://censo2022.ibge.gov.br/panorama/>. Accessed February 19, 2026.
- Lazzari D, Garcez AB, Poltozi N, Pozzi G, Brito C. Extremos climáticos no Brasil: uma análise em paralelo de tendências históricas e impactos socioeconômicos. *Ciencia e Natura*. 2026;48:e90742.
- Global mutirão: uniting humanity in a global mobilization against climate change. https://unfccc.int/sites/default/files/resource/Mutir%C3%A3o_cop30.pdf; 2025. Accessed February 19, 2026.
- Cerqueira D, Bueno S. Atlas da violência. São Paulo: IPEA/FBSP; 2026. <https://forumseguranca.org.br/wp-content/uploads/2026/05/atlas-violencia-2026-relatorio-completo.pdf>. Accessed June 12, 2026.
- Ministério da Saúde, Secretaria de Vigilância em Saúde e Ambiente. Boletim epidemiológico: panorama dos suicídios e lesões autoprovocadas no Brasil de 2010 a 2021; 2024. <https://www.gov.br/saude/pt-br/centrais-de-contudo/publicacoes/boletins/epidemiologicos/edicoes/2024/boletim-epidemiologico-volume-55-no-04.pdf>. Accessed February 19, 2026.
- Chu CYC. Demographic transition and economic development. In: Chu CYC, ed. *Population dynamics*. Oxford: Oxford University Press; 1998:131–147.
- The European Commission. The impact of demographic change in a changing environment. Brussels: Office of the European Union; 2023.
- Agência Gov. Projeção do IBGE mostra que população do país vai parar de crescer em 2041; 2024. <https://agenciagov.ebc.com.br/noticias/202408/populacao-do-pais-vai-parar-de-crescer-em-2041#:~:text=%E2%80%A2,Segundo%20as%20Proje%C3%A7%C3%B5es%20de%20Popula%C3%A7%C3%A3o%20do%20IBGE%2C%20ap%C3%B3s%20atingir%20seu,199.228.708%20habitantes%20em%202070.&text=De%202000%20a%202023%2C%20taxa,1%2C57%20filho%20por%20mulher>. Accessed February 19, 2026.
- Kieling C, Salum GA, Pan PM, Bressan RA. Youth mental health services: the right time for a global reach. *World Psychiatry*. 2022;21:86–87.
- Marchionatti LE, Campello AC, Veronesi JA, et al. The science of child and adolescent mental health in Brazil: a nationwide systematic review and compendium of evidence-based resources. *BMJ Glob Health*. 2026;11(7):e018542.
- Kieling C, Buchweitz C, Caye A, et al. Worldwide Prevalence and disability from mental disorders across childhood and adolescence: evidence from the Global Burden of Disease Study. *JAMA Psychiatry*. 2024;81:347–356.
- Naghavi M, Kyu HH, Bhoomadevi A, et al. Global burden of 292 causes of death in 204 countries and territories and 660 subnational locations, 1990–2023: a systematic analysis for the Global Burden of Disease Study 2023. *Lancet*. 2025;406:1811–1872.
- Hay SI, Ong KL, Santomauro DF, et al. Burden of 375 diseases and injuries, risk-attributable burden of 88 risk factors, and healthy life expectancy in 204 countries and territories, including 660 subnational locations, 1990–2023: a systematic analysis for the Global Burden of Disease Study 2023. *Lancet*. 2025;406:1873–1922.
- Murray CJL. The Global Burden of Disease Study at 30 years. *Nat Med*. 2022;28:2019–2026.
- Brant L, Felisbino-Mendes M, Teixeira R, et al. Burden of disease and life expectancy decomposition in Brazil and its federated units, 1990–2023: an analysis based on the global burden of disease study 2023. *Lancet Reg Health Am*. 2026;57:101441.
- Institute for Health Metrics and Evaluation. Data sources. <https://sources.healthdata.org/>; 2026. Accessed February 19, 2026.
- Global burden of disease collaborative network. Results. <https://vizhub.healthdata.org/gbd-results/>; 2026. Accessed February 19, 2026.
- Stevens GA, Alkema L, Black RE, et al. Guidelines for accurate and transparent health estimates reporting: the GATHER statement. *Lancet*. 2016;388:e19–e23.
- Karam SM, Barros AJD, Matijasevich A, et al. Intellectual disability in a birth cohort: prevalence, etiology, and determinants at the age of 4 years. *Public Health Genom*. 2016;19:290–297.
- Buchweitz C, Viduani A, Herrman H, et al. Transdiagnostic stage-based monitoring of public mental health. *Nat Rev Psychol*. 2026;5:120–135.
- McGorry P, Nelson B. Why we need a transdiagnostic staging approach to emerging psychopathology, early diagnosis, and treatment. *JAMA Psychiatry*. 2016;73:191–192.
- Shah JL, Jones N, van Os J, McGorry PD, Gülöksüz S. Early intervention service systems for youth mental health: integrating pluripotentiality, clinical staging, and transdiagnostic lessons from early psychosis. *Lancet Psychiatry*. 2022;9:413–422.
- Leclerc G, Moll J. Políticas de educação integral em jornada ampliada. *Em Aberto*. 2012;88:1–214.
- Gunawardena H, Voukelatos A, Wilson R, Cross S, Hickie IB. Australian school based interventions addressing child and adolescent mental disorders: a systematic review. *J Ment Health Disord*. 2024;4:13–30.
- McGorry PD, Mei C, Dalal N, et al. The Lancet Psychiatry Commission on youth mental health. *Lancet Psychiatry*. 2024;11:731–774.
- National Youth Mental Health Foundation. Headspace. <https://www.healthdirect.gov.au/partners/headspace/>; 2026. Accessed February 19, 2026.
- O'Dea B, Glozier N, Purcell R, et al. A cross-sectional exploration of the clinical characteristics of disengaged (NEET) young people in primary mental healthcare. *BMJ Open*. 2014;4:e006378.
- Barker L, Wang SS, Huda MN, et al. Community-based mental health interventions for reducing youth suicidal thoughts and behaviours: a systematic review and meta-analysis. *BMC Psychiatry*. 2025;25(1):1041.
- Brasil. Ministério da Saúde. Portaria nº 1.130, de 5 de agosto de 2015. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt1130_05_08_2015.html; 2015. Accessed February 19, 2026.

- 38 Brasil. Ministério da Saúde. Vacinação. <https://www.gov.br/saude/pt-br/vacinacao>; 2025. Accessed February 19, 2026.
- 39 Instituto de Estudos para Políticas de Saúde (IEPS). *Orçamento do SUS cresceu 30% nos últimos 3 anos; quase metade da expansão foi apropriada por Emendas Parlamentares*; 2025. <https://ieps.org.br/orcamento-do-sus-cresceu-30-nos-ultimos-3-anos-quase-metade-da-expansao-foi-apropriada-por-emendas-parlamentares/>. Accessed February 19, 2026.
- 40 Saxena S, Kestel D, Sunkel C, et al. Countdown Global Mental Health 2030. *Lancet*. 2019;393:858–859.
- 41 United Nations Children's Fund (UNICEF). *Countdown Global Mental Health 2030: making mental health count*; 2023. <https://data.unicef.org/wp-content/uploads/2023/09/Countdown-Mental-Health-Report-2030-FINAL.pdf>. Accessed February 19, 2026.
- 42 United Nations Children's Fund (UNICEF). *Countdown for Global Mental Health 2030 dashboard*; 2023. <https://data.unicef.org/resources/countdown-for-global-mental-health-2030-dashboard/>. Accessed February 19, 2026.
- 43 Black L, Panayiotou M, Humphrey N. Estimating adolescent mental health in the general population: current challenges and opportunities. *Lancet Psychiatry*. 2025;12:153–160.
- 44 Levis B, Benedetti A, Ioannidis JPA, et al. Patient Health Questionnaire-9 scores do not accurately estimate depression prevalence: individual participant data meta-analysis. *J Clin Epidemiol*. 2020;122:115–128.e1.
- 45 Polanczyk GV, Salum GA, Sugaya LS, Caye A, Rohde LA. Annual research review: a meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *J Child Psychol Psychiatry*. 2015;56:345–365.
- 46 O'Connor RC, Worthman CM, Abanga M, et al. Gone too soon: priorities for action to prevent premature mortality associated with mental illness and mental distress. *Lancet Psychiatry*. 2023;10:452–464.
- 47 Melo APS, Dippenaar IN, Johnson SC, et al. All-cause and cause-specific mortality among people with severe mental illness in Brazil's public health system, 2000–15: a retrospective study. *Lancet Psychiatry*. 2022;9:771–781.
- 48 Fiocruz Informe I. *Violências e acidentes*. Rio de Janeiro: Agenda Jovem Fiocruz. 2025.
- 49 Ferrari AJ, Norman RE, Freedman G, et al. The burden attributable to mental and substance use disorders as risk factors for suicide: findings from the Global Burden of Disease Study 2010. *PLoS One*. 2014;9:e91936.
- 50 Matos G, Guarniero FB, Hallak JE, Bressan RA. Schizophrenia, the forgotten disorder: the scenario in Brazil. *Braz J Psychiatry*. 2015;37:269–270.
- 51 Dellazari L, De Bem ÉB, Falcão AB, et al. Mind the gap: the inconceivable void on the epidemiology of autism spectrum disorders in Brazil. *Braz J Psychiatry*. 2025;47:1–3.
- 52 De Oliveira J, Santos T, Ferro J, Stelmo I. Brazil has a problem: where is its research on eating disorders? *Braz J Psychiatry*. 2024;46:1–3.
- 53 Paiva De Araujo JA, Fialho É, Oliveira Alves FJ, et al. Suicide among Indigenous peoples in Brazil from 2000 to 2020: a descriptive study. *Lancet Reg Health Am*. 2023;26:100591.