Unlocking the Value of Adolescent Health in Saudi Arabia

Population Health Insights Series

Why Saudi Arabia Must Rethink Adolescent Health: Extending Life Expectancy, Realizing the Triple Dividend, and Unlocking ~SAR 77 Billion in Cumulative Savings Over the First 10 Years of Implementation, and SAR 11–14 Billion Annually Once Full Scale-Up Is Achieved.

Executive Summary

Investing in adolescent health is key to achieving the Kingdom of Saudi Arabia's Vision 2030 goals. Adolescence represents a critical life stage, during which the transition from pediatric to adult healthcare services must be developmentally informed to ensure that investments made in earlier stages of life are not lost. It supports the triple dividend by improving health and well-being among adolescents in the short term, strengthening future human capital and creating healthier families and communities over time.[1] Together, these benefits will contribute to longer life expectancy, stronger productivity, a vibrant society and sustainable economic growth.

This focus on adolescent health entails tailoring models of care to improve access and enhance care continuity and effectiveness to support adolescents in dealing with mental health disorders, obesity, asthma and diabetes.

Investing in adolescent health presents a significant economic opportunity. While the current system-level costs of adolescent health are not yet fully quantified, our estimates suggest that implementing a dedicated adolescent model of care could generate annual savings of SAR 11–14 billion once fully scaled, translating into cumulative savings of approximately SAR 63–77 billion over the first ten years as implementation gradually ramps up.[2]

These savings reflect both direct health system efficiencies and broader economic benefits. Beyond the financial impact, this investment would also improve health outcomes and contribute directly to the Kingdom's long-term development goals.

I. Introduction

Adolescence, spanning ages 10 to 19 as defined by the World Health Organization (WHO), is a decisive stage of life. While globally there is increasing recognition of adolescence as up to the age of 24, this paper adopts the WHO definition.[3] During these years, young people experience rapid physical, psychological and social changes that shape their health, learning and productivity as adults. In Saudi Arabia, addressing adolescent health matters now more than ever, due to the following:

- **Rapid population growth:** Adolescents aged 10–19 have grown by 8% since 2016,[2] the fastest increase among youth cohorts in Saudi Arabia.
- **Distinct disease burden:** Adolescents in the Kingdom face a unique and evolving health profile, increasingly dominated by mental health issues.
- **Escalating lifestyle risks:** Obesity, inactivity and excessive screen exposure are on the rise among teens, driving long-term health risks.
- **Fragmented care models:** While the current models of care specifically target pediatric and adult populations, they leave a gap in addressing the unique needs of adolescents.

In addition, reports show that 70% of preventable deaths from noncommunicable diseases in adults have been linked to risks encountered, and behaviors that started, during adolescence.[4]

If left unaddressed, these adolescent health challenges will not only have an impact on health outcomes but also contribute to increasing economic pressures on the Kingdom, directly through the cost of care, and indirectly through the impact on productivity.

Adolescent care should be designed to reflect the physical, emotional, and social transitions of this life stage, integrating preventive, behavioral and mental health services within accessible, confidential and adolescent-responsive settings that actively engage young people in their own health journey.

A national adolescent model of care can address these challenges and chart a new path.

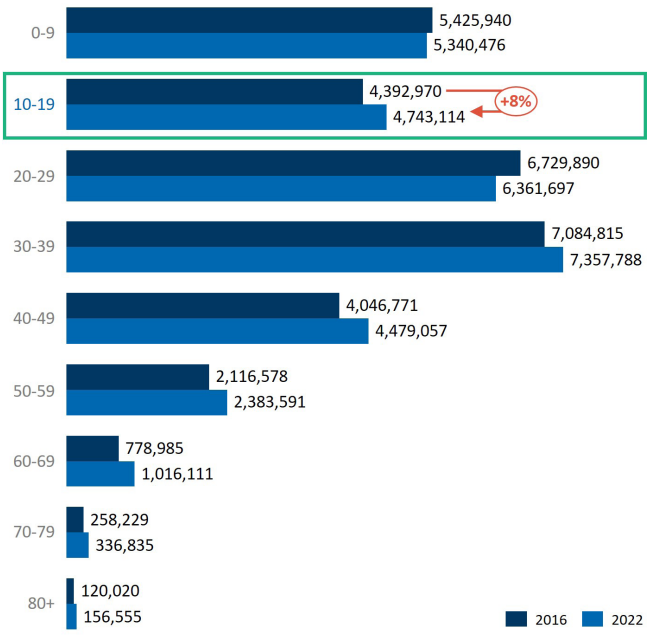
This report will now look at the scale of the challenge, the economic case for action and the design principles of an adolescent-responsive model of care that can deliver the triple dividend for Saudi Arabia.

II. The Unique Challenges of the Adolescent Population in KSA

A. Rapid population growth

Adolescents aged 10–19 in KSA have grown by 8% since 2016, the fastest increase among all youth cohorts including children and young adults.[5] This sharp growth highlights the rising need for health services tailored to address the specificities of this population cohort.

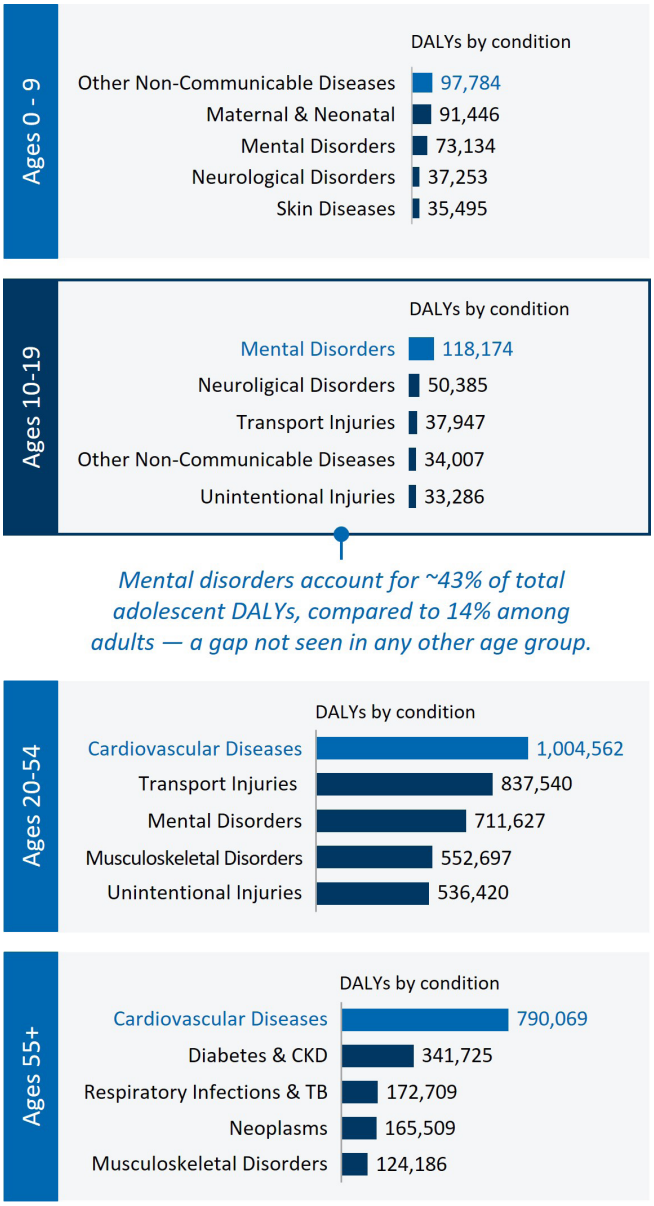
Figure 1 – Total KSA population by age group (2016, 2022)[5]



B. Distinct disease burden

Based on an analysis of Institute for Health Metrics and Evaluation (IHME) data, adolescents in Saudi Arabia exhibit a distinct health burden, differing qualitatively from both children and adults. Mental health conditions dominate in this population, contributing the highest share of Disability-Adjusted Life Years (DALYs) among other top causes.

Figure 2 – Top 5 Causes of Disability in KSA Measured by Disability-Adjusted Life Years (2021)[6]



Mental disorders account for ~43% of total adolescent DALYs, compared to 14% among adults — a gap not seen in any other age group.

The Rising Mental Health Burden Among Saudi Adolescents

The mental health landscape among adolescents in Saudi Arabia presents significant challenges and underscores an urgent need for strengthened support systems. In a large-scale national school-based study in KSA, known as "Jeeluna", involving over 12,500 adolescents aged 10-19, 14% reported symptoms suggestive of depression ("feeling so sad or hopeless" for ≥2 weeks in the past 12 months, to the extent of stopping usual activities). In the same survey, 6.7% reported symptoms suggestive of anxiety ("feeling so worried" in the past 12 months, to the extent of stopping usual activities). These symptoms were significantly more prevalent among females and older adolescents, highlighting particular subgroups at higher risk.[7]

These findings mirror global estimates, where anxiety and depression account for nearly 40% of all adolescent mental disorders, affecting an estimated 166 million adolescents worldwide.[8] Epidemiological evidence underscores adolescence as a critical window for mental health intervention: nearly 50% of mental health conditions begin by age 14, and 75% by age 24, with early detection offering the greatest opportunity to alter long-term trajectories.[9]

The high prevalence of mental health conditions makes this a critical policy area. Nevertheless, only 14.47% of Saudis with a mental disorder reported receiving any form of treatment in their lifetime.[10]

Addressing this treatment gap in the Kingdom will require mental health services that are both culturally sensitive and age-appropriate.

Key Insights

- The disability burden profile of the adolescent population in Saudi Arabia is distinct from that of the 0-9 and 20+ population groups. It is characterized by a unique mix of conditions, with mental health disorders as the leading condition, followed by neurological issues, and transport-related injuries.
- If left unaddressed, these challenges will persist into adulthood, driving lower productivity, higher chronic disease risk, and rising healthcare costs.[11]

C. Escalating lifestyle risks

The adolescent population in the Kingdom exhibits particular challenges, which, if unaddressed may hamper the Kingdom's ambitious development goals.

OBESITY & UNHEALTHY DIETARY HABITS

Obesity and poor diet have become critical public health concerns among Saudi adolescents, with prevalence rates continuing to rise. The "Jeeluna" national adolescent health survey utilized objective clinical measurements to assess weight status among 12,575 Saudi adolescents, finding that only 54.8% had healthy weights while 30.0% were overweight or obese and 15.2% were underweight.[12]

Across the broader Middle East and North Africa (MENA) region, an estimated 55 million children and adolescents, roughly 1 in 3, are classified as overweight or obese.[13]

These worrying trends align with the global picture, where over 390 million children and adolescents (ages 5–19) were overweight in 2022, with 160 million categorized as obese.[14]

Compared with both regional and global averages, Saudi Arabia faces a disproportionately high burden, underscoring the urgent need for targeted prevention programs that promote healthy eating and active lifestyles among adolescents.

PHYSICAL INACTIVITY

Physical inactivity is another major risk. The "Jeeluna" national adolescent health survey yielded a stark finding: only 13.7% of these adolescents engaged in at least 30 minutes of physical activity daily.[15] Other Saudi studies align with these results and show that inactivity levels amongst adolescents range from 44% to 65%.

This is in line with global findings around widespread inactivity amongst adolescents; with an estimated 81% of adolescents failing to engage in sufficient physical activity.[16]

TOBACCO USE & RELATED RISKS

Tobacco use, including traditional cigarettes and emerging products like e-cigarettes, sheesha (waterpipe), nicotine pouches and other alternative nicotine delivery systems, remains a significant health risk for Saudi adolescents. The "Jeeluna" national survey found that 16% of adolescents had ever smoked cigarettes and 10.5% had ever smoked sheesha, alongside 16% reporting

solvent sniffing in the preceding month (with females reporting higher rates at 21.4% vs. 11.5% for males).[12]

While some sources report a decline in tobacco use among adolescents aged 13–15, from 15.9% in 2007 to 9.4% in 2022,[17] other national studies indicate that nearly 1 in 5 male adolescents in Saudi Arabia are either a current user of nicotine products or at risk of becoming one, with prevalence varying across regions and age groups (12%–30%).[18]

These figures point to an evolving pattern: rather than a simple reduction in use, there appears to be a shift from traditional cigarettes to newer products perceived as less harmful or more socially acceptable.

This transition in youth nicotine consumption underscores the need for proactive monitoring, awareness and regulatory action.

EXPOSURE TO VIOLENCE & BULLYING

The "Jeeluna" national survey found that 26% of adolescents reported exposure to bullying in the past 30 days, and one in three reported exposure to physical violence at school in the past year. Exposure was higher among males and older adolescents. Both bullying and physical violence were associated with higher odds of frequent symptoms of depression and anxiety, while exposure to physical violence was also linked to poorer academic performance.[19]

The above lifestyle-linked risks carry multifaceted consequences, extending beyond immediate health concerns to impact the long-term physical and mental health of Saudi adolescents.

To tackle these challenges, a holistic and adolescent-focused model of care must align closely with national public health priorities, such as tobacco control, nutrition programs and health promotion initiatives, to ensure a sustainable, system-wide impact.

D. Fragmented care models

Saudi Arabia's healthcare system, while undergoing major reforms, still lacks an adolescent-responsive service model with professionals trained to address adolescent needs. Without tailored care models, adolescents often fall into systemic and age-related transition gaps, limiting early intervention and continuity of care. When forced into inappropriate adult or pediatric settings, adolescents may experience discomfort, a sense of irrelevance, increased risk of patient safety issues and mistrust in the healthcare system, all of which discourage care-seeking and contribute to unmet health needs.

The "Jeeluna" study mentioned earlier revealed that one in four adolescents reported difficulties accessing health services,[20] with rates even higher among low-income families and those with existing mental or physical conditions, highlighting broader equity gaps in access and outcomes. Currently, there are few specialized adolescent health clinics in the Kingdom. The very first clinic was established in 2008 at the Department of Pediatrics at the King Abdulaziz Medical City (KAMC) in Riyadh, which is part of the Ministry of the National Guard Health Affairs.[21] This first clinic was a general specialized adolescent health clinic, followed by a second clinic focused on adolescent gynecology, led through a partnership between Adolescent Medicine and Obstetrics & Gynecology. Since then, only a few additional specialized clinics have been established, mostly in Riyadh. Healthcare transition clinics (HCT) are also important, and one notable model is the HCT clinic for adolescents with endocrinology conditions established in 2018 at the KAMC in Jeddah.[22]

The transition from pediatric to adult healthcare services is a critical phase for adolescents, must be developmentally-informed, and is essential to ensure that investments made in earlier stages of life are not lost.[23] This is often fraught with challenges in KSA, largely due to gaps in provider training and inconsistencies in age-related policies, including variability in the age at which adolescents are transferred from pediatric to adult services, which in most settings in KSA occurs as early as age 14, compared with a global average of 19 years.[24] A substantial proportion of healthcare providers (44%) reported not receiving any formal training on adolescent health during their undergraduate or postgraduate education, and only 53.9% felt they possessed adequate knowledge of adolescents' unique healthcare needs.[21]

Furthermore, activating primary care as part of the adolescent model of care is essential. It serves as the main gateway for coordinated, comprehensive adolescent services, supporting both complex or sensitive cases and providing basic and preventive care.

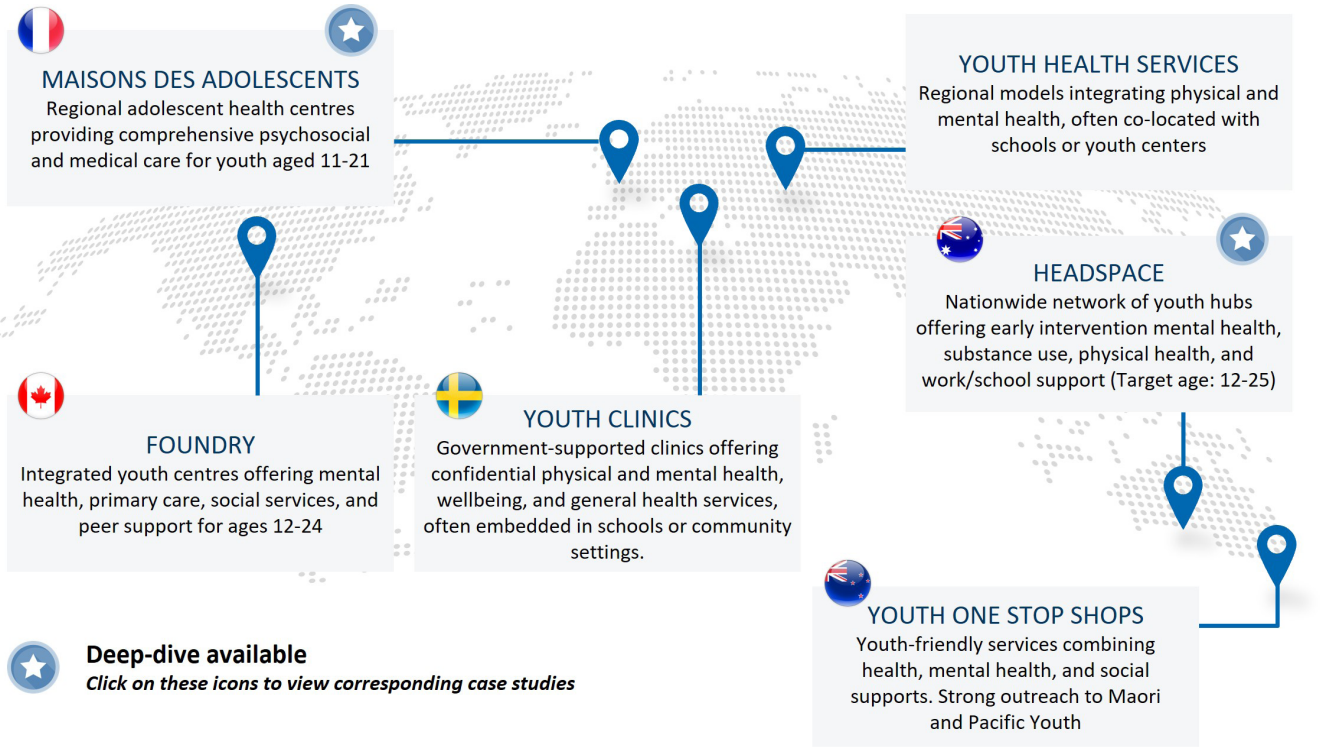
Beyond traditional clinical settings, adolescent care can be enhanced through tailored digital platforms such as adolescent-responsive teleconsultation portals, self-care applications and appointment reminders.

Finally, an adolescent model of care needs to be supported with clear policies on consent, privacy and confidentiality to reduce access barriers and empower adolescents to seek care independently.

III. Learning From Global Benchmarks in Adolescent Care

Globally, health systems are reimagining adolescent care through multidisciplinary, youth-responsive hubs that emphasize early intervention, care integration, and long-term well-being.

Figure 3 – Selected Global Models of Adolescent Health Care



Key Insights

- Global models are moving away from fragmented services toward integrated care centers that combine mental, physical, and social support under one roof.
- Services are increasingly community- and school-based, improving accessibility, reducing stigma and ensuring a more holistic approach to adolescent well-being.
- Youth-responsive environments that ensure confidentiality, cultural sensitivity and ease of access are essential for building adolescent trust and encouraging health-seeking behavior.
- Countries adopting these models report earlier detection of mental health issues, reduced care gaps and smoother transitions into adult services.

IV. Eight Design Principles for Value-Based Adolescent Care

Reimagining adolescent care requires shifting from fragmented, reactive delivery towards a proactive, population-based system that takes into consideration the complexity and maximizes health and societal value. Eight design principles establish the foundation for this transformation, guiding how health systems prioritize adolescent needs, organize care around what drives outcomes and align multisector resources to where they generate the greatest return.

Together, these principles move adolescent health from a service delivery lens to a holistic system stewardship role, embedding co-creation, equity, prevention, accountability and continuous learning into the core of how adolescent health is designed, financed, governed and improved over time.

1.Segment adolescents into population sub-groups with similar care needs to enable a population health management approach

A key design principle in building a **sustainable adolescent Model of Care** is **segmenting adolescents based on the factors that most influence their long-term health outcomes**. By recognizing that different adolescent groups have fundamentally different physical, mental, social and developmental drivers of risk, systems can **direct resources where they create the biggest impact**. Appreciation of these differences enables **Population Health Management approaches:** targeting prevention earlier, tailoring interventions and driving better outcomes over time.

The proposed segmentation categorizes the adolescent population into **seven distinct groups, based on the "Bridges to Health" model**,[25] but adapted to capture the complexity of adolescent health needs and ensure more comprehensive and targeted care provision.

Figure 4 – A foundation for adolescent model of care design

Segmented Adolescent Population Groups	Description/Service Needs	Design Considerations
Healthy Adolescents	No current conditions; primarily require preventive and health promotion services	How can they system keep adolescents mentally, socially, and physically well?
Adolescents with acute, non-emergency conditions	Episodic care for mild conditions not requiring urgent intervention	How do we ensure care is adolescent-responsive in terms of communication, privacy, and convenience?
Adolescents with acute, emergency conditions	Immediate, potentially life-threatening conditions requiring urgent attention	How can the system quickly and effectively treat adolescents who require urgent or planned care?
Adolescents with chronic physical conditions	Adolescents with long-term medical conditions needing continuous care	How can the system support adolescents manage their chronic conditions to prevent or delay complications?
Adolescents with mental health needs	Adolescents requiring mental or behavioral health support	How can we normalize mental health discussions among adolescents and reduce stigma?
Adolescents with developmental or physical disabilities	Adolescents with developmental, physical, or cognitive disabilities	How do we ensure adolescents with disabilities have equitable access to health?
Adolescents with maternity-related needs	Limited but relevant for late adolescents nearing adulthood or in specific at-risk groups	How do we manage at-risk pregnancies among older adolescents sensitively and supportively?

2. Engage adolescents, families and stakeholders throughout all design and implementation phases to maintain an understanding of the real-world challenges associated with change and maximize value-based care.

Engage the various adolescent segments, alongside their families, schools and communities, to co-create the adolescent health approach, understand how current services perform in practice, and ensure that, only by putting the beneficiaries at the center of the system design, value in healthcare is maximized.[26] Doing so ensures that every aspect of the model, from design to delivery, reflects adolescents' priorities, cultural realities, lived experience, social pressures, privacy concerns, and other barriers they face when seeking care.

This participatory approach strengthens **ownership and trust, while revealing both structural and experiential gaps in the system** that data alone cannot capture. These gaps may relate to uneven service availability, weak referral mechanisms, limited awareness or inconsistent quality standards. It also helps assess how current practices align with core-adolescent specific dimensions such as accessibility, confidentiality of services, extent of adolescent involvement in care decisions, availability of age-appropriate settings and the readiness of providers to address behavioral and psychosocial needs.

Through workshops, focus groups and adolescent advisory panels, health authorities can integrate adolescent voices into policy, service design and communication strategies. **This integration ensures the model is not only evidence-based but also experience-driven and reflective of adolescent voices.**

3. Define clear health outcomes that enable the system to focus its efforts and prioritize initiatives for each population segment

Maintaining a clear set of target outcomes for each population segment will help ensure resources within the system are channeled towards achieving them and that efforts are not diluted. These outcomes should then be cascaded into a structured indicator framework.

Establishing a structured indicator framework allows systems to **measure progress consistently, set a baseline against defined outcomes and identify the factors that constrain improvement**. The result of this understanding is a foundation for designing targeted interventions that accelerate performance change, while ensuring alignment with broader Population Health Management (PHM) goals for equity, access and impact.

ADOLESCENT HEALTH & WELL-BEING FRAMEWORK

Leading health systems link indicators to outcomes they want to achieve. For adolescents, this means going beyond generic health metrics to track issues like mental wellbeing, risk behaviors and more. A focused outcome framework ensures targeted services can be evaluated, improved and held accountable for delivering better results.

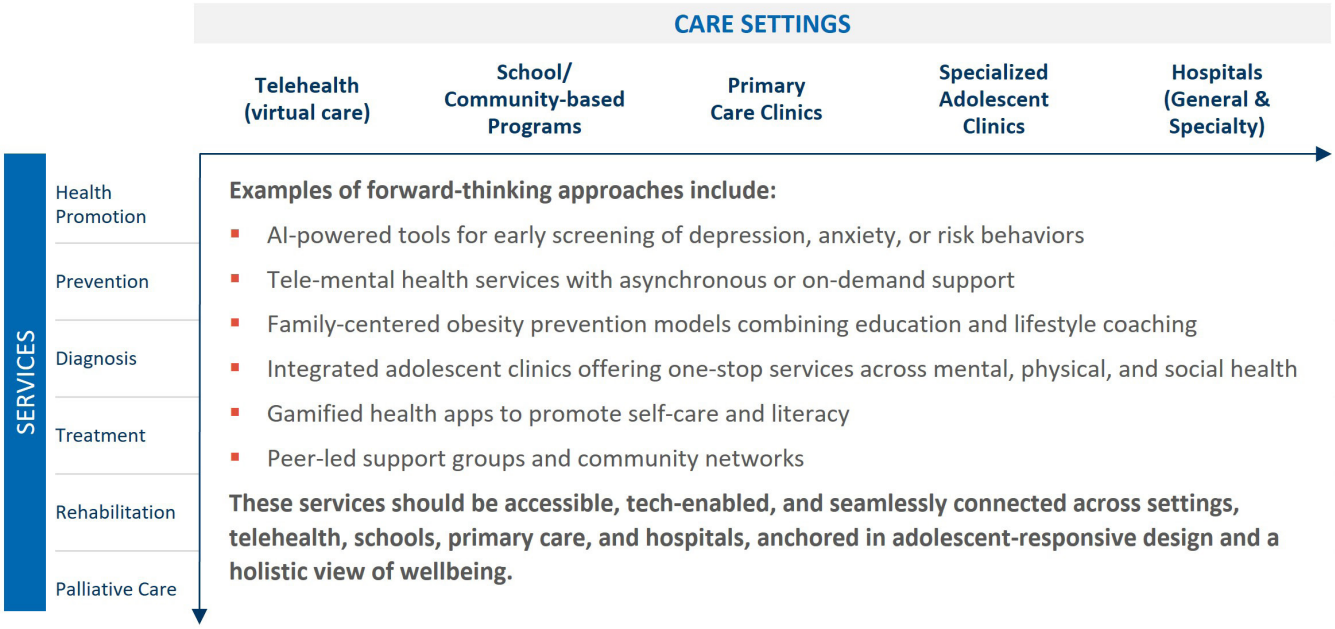
The global adolescent wellbeing framework developed by WHO and UN partners defines five core domains that together describe what it means for adolescents to thrive: health and nutrition; connectedness and positive values; safety and supportive environments; learning and skills; and agency and resilience.[27]

Global standards, such as the WHO's Global Action for Measurement of Adolescent Health (GAMA), translate this wellbeing framework into 47 core indicators across six domains: health behaviors, outcomes, systems and determinants, providing a comprehensive lens for outcome tracking.[28] Localizing such frameworks to national contexts ensures alignment with local health priorities and adolescent realities.

4. Design integrated care pathways that aim to drive the target outcomes while optimizing resources needed for delivery to drive a left shift

With a clear view of the current service landscape, **design optimized integrated care pathways** that address the **needs within each adolescent population segment**. Each pathway should be directly **anchored to the desired outcomes** and **structured to ensure adolescent-centered, accessible and equitable, proactive and preventive, multidisciplinary, and digitally-enabled care.**

Value-based adolescent care must extend beyond traditional clinical settings. Schools, digital platforms, and community spaces should serve as trusted entry points for early identification, prevention and support. Embedding psychosocial, family and educational components within each pathway ensures that interventions are holistic, accessible and developmentally appropriate.



5. Strengthen system capacity and workforce capability to enable value-driven adolescent care delivery

Enabling an adolescent model of care requires **deliberate investment in both system capacity and workforce capability**, to ensure services are responsive to the distinct needs of each adolescent segment. To deliver value, **resources must be allocated based on where they have the greatest impact**, enabling Population Health Management to focus effort and investment on the highest-priority needs and segments.

Infrastructure and system readiness form the backbone of effective adolescent care delivery. Strengthening service networks, digital infrastructure and referral mechanisms is critical to expanding access, improving coordination and ensuring equitable service quality across regions.

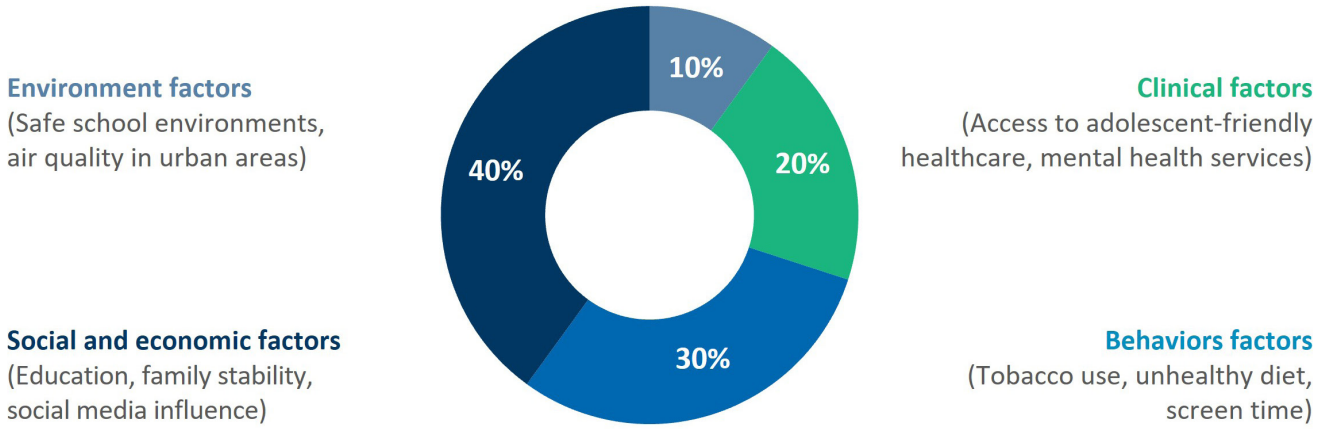
Workforce development is equally vital. Delivering adolescent care demands **multidisciplinary teams**, combining adolescent medicine specialists, pediatricians and family medicine physicians with the required adolescent-health competencies, mental-health professionals, school-based staff and social workers, supported by ongoing training, digital enablers and flexible delivery models. **Building this capacity is not merely a resource exercise; it is a strategic imperative for equity, quality and sustainability.**

6. Leverage population health analytics across determinants of health to guide a Health-in-all-Policies approach and provide support in improving outcomes

Delivering meaningful adolescent health outcomes requires a multisectoral mindset that goes beyond clinical care. Adolescent wellbeing is influenced by a wide range of environmental, behavioral, social, and economic factors, from air quality and safe school environments, to family stability, screen time, nutrition, stress and community context. Improving outcomes therefore demands collaboration across sectors, not only within healthcare, as illustrated in the accompanying diagram.

Effectively addressing these wider determinants requires a collaborative, multisectoral approach that extends beyond traditional health boundaries. National health authorities, education systems, youth and social development entities, municipalities, environment agencies, community organizations, and payers all have a role to play in shaping the environments where adolescents learn, live and grow.

Applying an adolescent Health-in-All-Policies lens enables integrated planning, better alignment of incentives and smarter resource allocation toward the drivers that matter most. Embedding this mindset across every component of the model, from segmentation to pathway design, system enablers and performance management, is critical to improving adolescent well-being and unlocking long-term societal value.



7. Ensure clear accountability across stakeholders by cascading roles, responsibilities, and KPIs to all regulators, providers, and payors

Translating an adolescent Model of Care into real impact requires **clear accountability and shared ownership** across all actors influencing adolescent health. Public authorities, social and education sectors, private providers and community organizations must operate through defined roles, aligned mandates and joint objectives.

Strong governance mechanisms, anchored in collaboration, transparent data exchange and performance monitoring, help ensure that all entities work toward a common set of outcomes. To reinforce this alignment, **target outcomes should be cascaded into measurable, short-term KPIs**, enabling each actor to monitor its contribution to system-wide goals. This shared accountability framework enables transparent performance monitoring and feeds directly into system-wide learning mechanisms.

8. Embed science in implementation to drive a learning health system by measuring fidelity to planned designs and the impact of the change

Applying an experimental mindset is essential to understand what drives improvement and value. By testing new models in controlled ways, and comparing them against baselines, health systems can attribute causality, identify which interventions work best for which segments and scale what delivers the highest impact.

Combining quantitative data, lived experience and iterative learning transforms monitoring from a compliance exercise into a continuous improvement engine. This enables the system to adapt in real time, close performance gaps faster and demonstrate measurable value for money while constantly improving adolescent well-being.

V. Quantifying the Impact of a Tailored Adolescent Model of Care

A value and population health-based approach to adolescent care can drive significant savings in the system. These savings can be achieved through prevention, early intervention, improved management of high-burden conditions, resource optimization and activation of broader community-based support.

Analysis suggest reveals that investing in adolescent care can pose significant benefits for the Kingdom: both, as healthcare cost savings and enhanced economic productivity as today's KSA adolescent population transitions into adulthood.

Using global effectiveness benchmarks and KSA-specific cost data, initial high-level analysis suggests that, once fully scaled, targeted adolescent interventions could yield annual savings of approximately SAR 11–14 billion. Assuming a gradual scale-up over the first ten years of implementation, this would translate into estimated cumulative savings of around SAR 63–77 billion.[29]

This projected impact reflects:

- A gradual, system-wide implementation of adolescent health interventions over a 10-year period.
- The realization of long-term direct health benefits from adolescent-specific interventions, consistent with published evidence demonstrating downstream improvements in adult health outcomes (e.g., reduced complications from diabetes, obesity, and other chronic conditions).
- The realization of long-term indirect economic benefits, as adolescent cohorts transition into adulthood and participate more fully in employment and the labor force, leading to reduced absenteeism and higher productivity, as a result of fewer long-term complications impacting workforce participation.

The estimated savings should therefore be interpreted as the level of recurring, steady-state impact achieved at system and population maturity.

While this high-level analysis indicates significant potential saving opportunities, a subsequent paper will undertake a more in-depth economic assessment using tools such as Markov modeling. This will enable a more granular evaluation of individual interventions, supporting decision-makers in prioritizing the strategies with the greatest impact and value.

Beyond the Numbers: A Triple Dividend for KSA's Future

The value unlocked extends far beyond direct financial savings. Investing in adolescent health not only ensures that investments made in earlier stages of life are not lost, but also yields a "triple dividend", immediate improvements in well-being, enhanced future human capital and intergenerational benefits that strengthen the very fabric of society. A healthier adolescent population translates directly into:

IMMEDIATE WELL-BEING	FUTURE HUMAN CAPITAL	INTERGENERATIONAL PROSPERITY
Healthier, more resilient adolescents who are better able to succeed in school, avoid risky behaviors and engage in society	Stronger educational attainment, workforce readiness and long-term health, all critical for Vision 2030's productivity and innovation goals	Healthier adolescents become healthier parents, lifting entire families and communities, and breaking cycles of disadvantage

By investing now in a dedicated, adolescent-responsive and outcome-driven model of care, KSA can redefine adolescent health not as a cost center, but as one of the Kingdom's highest-yield investments.

Appendix

Deep Dive 1: Case Study on Headspace Model, Australia

Established in 2006, Headspace provides early-intervention services through a network of adolescent-responsive centers and online platforms. By 2023 it expanded to 154 centers nationwide, including many in regional areas.[30] Each center is a collaborative hub designed to make it easy for young people to get help for a variety of issues in one place.

Scope of services[31]

1. Mental health (counseling and therapy)
2. Physical and sexual health (onsite primary care for general health check ups, sexual and reproductive health services, health promotions, and basic preventive care)
3. Substance use support (e.g., education, referral)
4. Social and vocational support (e.g., vocational counseling to help with employment, education and social work support)

Target population: Beginning at age 12 and extending through age 25, patients are eligible for Headspace services, recognizing the transitional needs for this cohort.

Cohort size: Headspace services a large volume of patients - around 100,000 adolescents per year across Australia. In 1 year, over 80,000 visited centers and 35,000 used online support.

Care Settings & Providers: Care is delivered through dedicated Headspace centers located in the community – many centers serve as one-stop-shops, co-located with other youth services.

Multi-disciplinary team:

- Mental health professionals (e.g., psychologists, counselors, mental health social workers)
- Primary care clinicians (GPs, nurses)
- Social workers
- Vocational specialists

Success Measures: Over 70%[32] of clients showed significant improvement in at least one core outcome domain (reduced psychological distress, improved psychosocial functioning, or better quality of life) after utilizing Headspace services.

Deep Dive 2: Case Study on Maisons Des Adolescents (MDA), France[33]

The Maisons des Adolescents in France are integrated health and social care centers designed specifically for adolescents. First established in 1999, MDAs have expanded nationwide (over 100 centers by 2010) to improve access to care for young people with physical, mental or social difficulties. They provide a "one-stop" environment, a home-like, non-stigmatizing space, where adolescents (and their families) can receive holistic support for a wide range of issues, from medical to psychosocial.

Scope of services[26]

1. Health and prevention drop-in services emphasizing primary prevention
2. Multidisciplinary consultations including medical care, mental health care and social or legal guidance in one setting
3. Mobile outreach teams to extend care beyond the center
4. Creative and educational programs
5. Network meetings and case management
6. Family and parent support to help under-stand and cope with adolescent behavioral or mental health issues

Target population: The typical age range is 11 to 21 years. Many MDAs have extended this up to 25 years to cover the transition into adulthood.

Cohort size: Each MDA typically serves a sizeable cohort. On average, one MDA center welcomes about 700 to 1,000 young people per year, often with 2–3 visits each, and additionally supports 150 to 250 parents annually.

Care Settings & Providers: Centers are usually located in or near city centers or other easily accessible areas for adolescents. They are generally in standalone facilities (separate from hospitals) to avoid the stigma or anxiety that a hospital or psychiatric clinic might evoke.

Multi-disciplinary team:

- Pediatricians or general practitioners for physical health and development concerns
- Psychiatrists or clinical psychologists
- Nurses
- Social workers
- Legal advisors or liaison officers

Success Measures: Nationally, the network of MDAs has significantly increased youth access to care; by 2010 about 92% of the French adolescent population had reasonable access to an MDA in their region.

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[29] This report presents a high-level scenario analysis of adolescent health in Saudi Arabia, assessing the potential system-level impact of targeted interventions across key burden areas, including mental health conditions, obesity, diabetes, asthma, and conduct disorder. The analysis estimates recurring, steady-state savings once interventions are fully implemented and reach system and population maturity. Estimated impacts reflect both long-term direct health system benefits, driven by prevention and reduced downstream complications in adulthood, and indirect economic benefits, including improved productivity as healthier cohorts transition into the labor force. The model applies KSA-specific prevalence and cost data alongside global effectiveness benchmarks and published evidence. Results should be interpreted as indicative and directional, with more granular economic modelling required to support intervention-level prioritization and refine impact estimates.

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