



# **Parental and carer mental health: the impact on the child.**

**A narrative synthesis of existing evidence and opportunities.**



The Bernard van Leer Foundation commissioned this report as a means to identify the current trends in parental and carer mental health and its impact on children with a view to informing future policy, advocacy and program development to improve childhood early development.

An effort has been made to document findings from high-income countries (HICs) and to also address burden of mental illness and opportunities and innovations in low- and middle-income countries (LMICs). The lead authors of this report have a long-standing commitment and interest in maternal and child mental health and parental mental health strengthening in community and specialist care settings. Following a narrative review, summary findings are presented and recommendations for supporting scaling up action and future research work are offered.

### **Acknowledgements**

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## Abbreviations

ACE - Adverse Childhood Experiences  
CCD - Care for Child Development  
CETA - Common Elements Therapeutic Approach  
CHW - Community Health Workers  
CMDs - Common Mental Disorders  
CRC - Convention on the Rights of the Child  
CRPD - Convention for the Rights of Persons with Disabilities  
DALYs - Disability Adjusted Life Years  
DAMH\_CA - Development Assistance for Child and Adolescent Mental Health  
EBF - Exclusive Breastfeeding  
ECD - Early Childhood Development  
GBD - Global Burden of Diseases  
GBV - Gender Based Violence  
G-IPT - Group Interpersonal Psychotherapy  
HIC - High-Income Country  
IPV - Intimate Partner Violence  
IVR - Interactive Voice Response  
LMIC- Low- and Middle-Income Country  
MDGs - Millennium Development Goals  
MFG - Multiple Family Groups  
mhGAP - Mental Health Gap Action Program  
MIC - Middle-Income Country  
MNS - Mental Neurological and Substance Use  
MRC - UK Medical Research Council  
NGO - Non-Government Organization  
PPD - Post Partum Depression  
RCT - Randomized Controlled Trials  
SDGs - Sustainable Development Goals  
SDH - Social Determinants of Health  
SRH - Sexual and Reproductive Health  
SSA - Sub-Saharan Africa  
SSM - Supported Self-Management  
THP - Thinking Healthy Program  
THPP - Thinking Healthy Program Peer-delivered  
UHC - Universal Health Coverage  
UNESCO - United Nations Educational, Social and Cultural Organization  
UNFPA - United National Population Fund  
UNHCR - United Nations High Commissioner for Refugees  
UNICEF - United Nations International Children Emergency Fund  
WHO - World Health Organization



## Definitions

**ECD** - Early Childhood Development (ECD) refers to the physical, cognitive, linguistic, and socio-emotional development of a child from the prenatal stage up to age eight.

**mhGAP** – the acronym stands for mental health gap action program which proposes scale up services for mental, neurological and substance use disorders for countries especially in low and lower middle incomes. It has development treatment guidelines, assessment tools, low intensity interventions and generated evidence around available interventions.

**Return on investment** - is a form of economic evaluation that values the financial return, or benefits, of a health intervention against the total costs of its delivery.

**Adolescent pregnancy** - teenage or adolescent girls within the ages of 13-19, becoming pregnant. The term in everyday speech usually refers to girls who have not reached legal adulthood, which varies across the world, who become pregnant.

**Morbidity** - refers to having a disease or a symptom of disease, or to the amount of disease within a population.

**Mortality** - this could be a death rate, or the number of deaths in a certain group of people in a certain period of time.

**DALYS** - one DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

**Meta-Analysis** - refers to a statistical procedure for combining data from multiple studies.

**Systematic Review** - summarizes the results of available carefully designed healthcare studies (controlled trials) and provides a high level of evidence on the effectiveness of healthcare interventions. Judgments may be made about the evidence and inform recommendations for healthcare.

**Life course approach** - An approach that aims at increasing the effectiveness of interventions throughout a person's life. It focuses on a healthy start to life and targets the needs of people at critical periods throughout their lifetime.

**Social Determinants of Health** - The social determinants of mental health, according to WHO, are the conditions in which we 'are born, grow, live, work and age,' which are generated by economic status, social power, and access to resources such as education, health, and safe environments.

## Executive Summary

Mental health is a human right and yet current trends demonstrate a great and growing need to improve mental health policy and practice given both the disease burden and treatment gap. This is particularly the case for the mental health of parents, carers and crucially children. This report outlines the key trends around the importance of investing at an early stage of life – focusing on the impact of the mental health of parents and carers on early childhood development. It demonstrates why it is important to empower parents and carers with the necessary skills and competencies and ensure there is the necessary medical, psychosocial and policy related support for the management of mental disorders.

There is enormous wealth of information that has been generated in last two decades of global mental health research and advocacy targeting parent and caregiver needs across the lifespan, and its impact on early childhood development. This report documents evidence that points to the compelling need to strengthen existing research, programming and advocacy work in parental, carer and child mental health and it provides examples of past and current interventions to improve parental, carer and child mental health.

### Mental health over the life course

*It's estimated that 970 million people worldwide had a mental or substance use disorder in 2017.*

Anxiety disorders are estimated to be the leading cause of disability adjusted life years (DALYS) associated with mental disorders.

The susceptibility to mental, neurological and substance use disorders is spread out over the life course. *Worldwide 10-20% of children and adolescents experience mental health disorders.* Half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s. Neuropsychiatric conditions (mental disorders attributable to diseases of the nervous system) are the leading cause of disability in young people in all regions. The incidence of mental health disorders rises when young adults are transitioning and becoming parents, i.e. from adolescent years onward with mental health conditions peaking in early 20s. The figures vary from one cultural context to another as early parenthood, especially motherhood, is more common in some regions than others. It begins to rise again towards the end of the lifespan.

As human beings evolve and grow, transition from one role to another, mental health needs change and therefore interventions too need to incorporate prevention, treatment and advocacy components that respond to the individual's context. *This is significant given that both parents/carers and children need ongoing support as their roles and life trajectories evolve.* While parents would be the main biological carers, the broad category of carers includes grandparents, and extended family members including older siblings who play an important role in child development in many parts of the world.

### The mental health of parents and carers

*Worldwide about 10% of pregnant women (15.6% in LMICs) and 13% of women (19.8% in LMICs) who have just given birth experience a mental disorder, primarily depression. In adolescent mothers, post-partum depression is estimated to be between 26-50%.* Furthermore, depression is not the only condition affecting vulnerable women. Many more peripartum women experience symptoms of anxiety, trauma, stress, low self-esteem and a loss of confidence as individuals and this impacts their role as carers.



Lack of mental health services and resources is a huge concern in high, middle and low income countries. Of greatest concern are vulnerable populations including pregnant adolescents and adolescent motherhood, peripartum women, parents with disabilities and the support required for parenting and parental mental health amidst humanitarian settings and conflicts. Providing mental health care to mothers of low birth weight infants or pre-term births, and timely identification and treatment of peripartum depression have been identified as critical pathways to reduce maternal morbidity.

### **The impact of parental and carer mental health on the child**

*It is estimated that globally between 15-23% of children live with a parent with mental illness and parental ill-health predisposes these children to mental illness.* Additionally, children can be affected by the suicide of a parent or carer and by the average reduction in life expectancy of someone with a mental health condition. Parental mental health directly impacts early childhood development and in high burden households, adverse social determinants such as poor environment and poverty affect both caregivers and their offspring.

Single parenthood is a particular risk factor for optimal child development. In many parts of the world, single motherhood brings added responsibilities and constraints. However, in recent studies, single fatherhood has been associated with the worst self-rated health and mental health and partnered fathers with poor self-rated health and mental health. There are some studies that report on the mental health of fathers on child development: existing evidence suggests it is important to look at fathers and male carers in relation their mental health and its impact on children.

### **Policy gaps for parental, carer and child mental health**

*Approximately 25% of countries have no mental health legislation, more than 40% of countries have no mental health policy and over 30% have no national mental health programme.* The responsibility to provide adequate and timely support for parents, carers and children lies with national governments yet many are failing in their duties. The legislation and policy in HICs have targeted access to evidence-based psychotherapies and access to psychotropic medication. Despite this, mental health services in many resource rich countries remain inaccessible and insensitive. While there is an effort to include families in mental health programming, there is variable inclusion of consideration of parent and carer mental health on child development.

In LMICs, even though countries may have enacted an updated mental health policy they have not necessarily changed the system to conform to the WHO's recommendations or to evidence-based guidelines. The investment in building community health structures is critically missing as most funding support goes in sustaining psychiatric facilities and institutions and building managerial capacity in primary care and specialist institutional contexts. A focus on institutions often means ignoring the need to keep parents and carers with the children for whom they are responsible.

### **Successful interventions are available**

*A number of successful community-, school- and health facility- based maternal and parental mental health interventions have been tested worldwide, including in LMICs.* Large numbers of innovative interventions and programs have been tested on parental mental health including interventions combining both caregiver and child mental health outcomes in different income settings.



This report has selected successful community mental health interventions according to those that were marked by simplicity of intervention, ease of their acceptability into the community and low effort from specialized or community health institutions. However, the impact of positive parenting on child mental health in humanitarian context still needs refinement and scaling up. Further, there are few studies on child and adolescent sexual and reproductive health, adolescent pregnancy and vulnerable mothers in humanitarian contexts.

## The case for investment

*Lack of investment in mental health across all countries is striking. Evidence shows governments spend an average of only 3-4 percent of their health care budgets on mental health, ranging from less than 1 percent in low-income countries, to 5-8 percent in high-income countries.*

The low national budgets for mental health are a cause for deep concern. If mental health is a human right then the global community needs to do much more to invest and promote mental health. To build the case for national and global support there needs to be the data and arguments to demonstrate cost-effectiveness, return on investment and cost of inaction. However at least some of this data exists and yet investment has not substantially increased. There needs to be a concerted effort to strengthen political buy-in for the delivery of services that address the mental health needs of parents, carers and children. This will contribute to national and international efforts to achieve the SDGs.

## Summary of Recommendations

1. Mental health is a human right. Parents, children and families need strong mental health. Improving maternal mental health is the area for which there is greatest evidence of a positive impact on child development. BvLF's work in support of early childhood development and its ongoing work in partnership with others, places it in a unique position to draw on different sources of evidence and to advocate for mental health for all, particularly as it relates to child development.
2. Specific attention needs to be paid to pregnant and parenting adolescents and their offspring in LMICs and to fathers in all countries. BvLF can help draw attention to, and advocate for, greater support for mothers, young parents and for fathers.
3. There is an important opportunity to increase mental health care under SDGs target 3.8 to achieve Universal Health Coverage. BvLF can use its experience of advocacy and influencing to ensure mental health is advanced as part of the SDG and UHC agenda.
4. Greater innovation and integration with ECD are essential to successful parent and carer mental health interventions if they are to lead to enhanced child outcomes. Given the history and role of BvLF on ECD it has a unique opportunity to help advocate for, and invest in, greater integration.
5. Generating further knowledge by more research including implementation effectiveness is important to inform future programming. BvLF can help make the case not only for sharing lessons from HICs in LMICs but for greater research and innovations direction for LMICs.
6. Greater political and financial support from national governments, key international donors and policy makers for parental and carer mental health is necessary, to positively impact child development. BvLF can help to bring international donors and NGOs on board to address the cost of inaction by developing a convincing economic case and advocating for greater political and financial action.

## 1. The global mental health context

There are well-established findings in global mental health that help provide context for understanding the importance of parent and carer mental health:

- Overall mental health trends show that disability attributed due to mental disorders is rising globally and this trend is part of the surge of non-communicable diseases in both LMICs and HICs.<sup>1</sup>
- It's estimated that 970 million people worldwide had a mental or substance use disorder in 2017. Anxiety disorders are estimated to be the leading cause of disability adjusted life years (DALYs) associated with mental disorders.
- The susceptibility to mental, neurological and substance use disorders is spread out over life span. Current patterns show that children and young people are disproportionately affected due to the developmental and social challenges they have to navigate.
- Every phase of the lifespan includes well-documented risk factors and vulnerabilities to mental disorders; however, the global burden of mental illness demonstrates that this burden is highest in younger age groups from late adolescence to late thirties. (See figure 1 which maps mental, neurological and substance use morbidity drawn out from analysis of 2010 GBD data).
- Looking at age patterns across individual lifespan, the evidence points to greater vulnerability and risks for mental disorders closer to the time young adults are transitioning and becoming parents, i.e. from adolescent years onward, demonstrating that mental health conditions peak in early 20s (see figure 1). The figures might vary from one cultural context to another as early parenthood, especially motherhood, is more common in some regions than others.

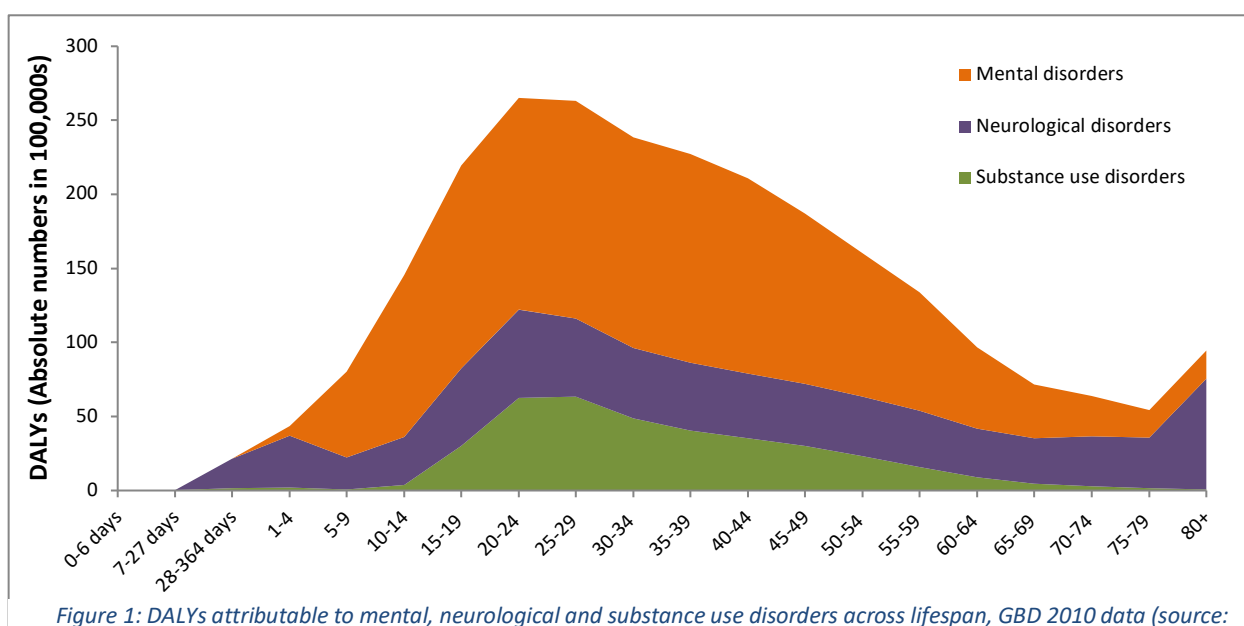


Figure 1: DALYs attributable to mental, neurological and substance use disorders across lifespan, GBD 2010 data (source: Whiteford et al 2015)

- Parenthood when combined with chronic stress including adverse social determinants of health paves way for ill-health. This environment is ripe for development of mental disorders or mental disorder related comorbidities combined with physical disease conditions. This requires early investment in a timely manner to address adversities, chronic stress and support vulnerable families and populations in time-responsive manner.
- Mental health interventions need to combine treatment along with prevention and promotion elements – the education of parents, communities and policy makers about the importance of mental health and addressing the behavioural risk factors underpinning well-being – to ensure greater impact and reach.

### 1.1. Mental health over the life course

- As human beings evolve and grow, transition from one role to another, mental health needs change and therefore interventions too need to incorporate treatment, prevention and advocacy components that respond to the individual’s context.
- Mental health should be seen as a continuum across the lifespan: a life course approach considers biological, environmental and social determinants of health and development.
- Early childhood and adolescence offer unique entry points to make a positive impact.

Child mental health is an ongoing developmental process that has beginnings with conception in pregnancy through to adolescence and young adulthood. It is, therefore, impossible to separate child and parental mental health as one shapes the other. People need treatment for mental disorders as well as life-skills, support structures and strategies to combat challenges throughout their life which will have an impact of the mental health of children in their care.

Donald Winnicott, a paediatrician and child psychoanalyst, who was known to be a prolific writer on family mental health, would say *‘there is no infant without the mother’* meaning that we cannot talk about child development without considering the caregivers whose own lives and ecosystem impacts the child’s well-being.<sup>ii</sup>

Healthy youth and positive parenting experiences are protective factors not only for the child but also for parents across their lifespan. Figure 2 offers a lifespan-based approach to development that factors in neurodevelopment, biological, social and genetic determinants of health. Some of the genetic or developmental disorders can be mitigated if chronic/toxic stress and high-risk behaviours are addressed at the right time.

Figure 2 also underscores the need to see how neurodevelopment is both a cause and consequence of biological and environmental influences. The caregiver’s attitudes towards health, level of health awareness and material resources available to them to make healthy choices in life, are critical to child development. Processes such as plasticity (the human brain’s ability to change throughout lifetime

especially more so in early years), pruning (the process of removing the irrelevant synapses during infancy and childhood period) and senescence (growth arrest at cellular level due to aging) are critically impacted by environmental exposure through parenting experiences and interface with social determinants of health.

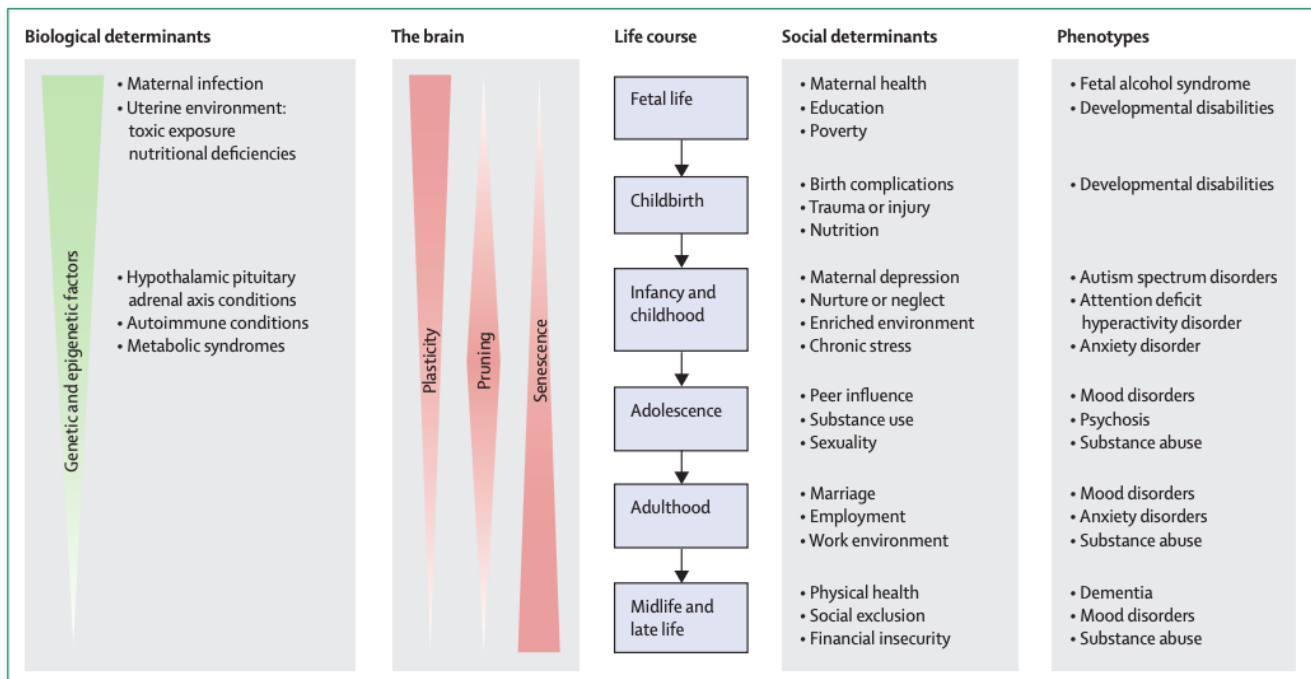


Figure 2: Biological and social determinants of neurodevelopment across life span. Source: Lancet Commission on global mental health and sustainable development 2018

As figure 2 shows, a phenotype refers to the observable physical properties of an organism; these include the organism's appearance, development, and behaviour. An organism's phenotype is determined by its genotype, which is the set of genes the organism carries, as well as by environmental influences upon these genes.<sup>iii</sup>

For example, in many parts of South America, South Asia, and Sub-Saharan Africa (SSA), adolescent girls and boys are known to develop severe substance use disorders; alongside with this, the rates of early and unintended pregnancy are also very high in these regions. The prevalence of fetal alcohol syndrome in LMIC settings has grown over the years and in principle this is a syndrome caused by environmental exposure that can be controlled. If young adolescents are provided with guidance on impact of substances, offered sexual and reproductive health (SRH) education and appropriate SRH services including community and health facility-based campaigns, and awareness interventions programs, fetal alcohol syndrome would be highly preventable.

## 1.2. Mental health of parents and carers

- Maternal depression is a leading cause of disability in mothers living in high adversity LMIC contexts. However, depression is not the only condition affecting vulnerable women. Many more peripartum women experience sub-clinical symptoms of anxiety, trauma, stress, somatization, low self-esteem and a loss of confidence as individuals and this impacts their role as carers.<sup>iv</sup>

- Access to medical care, including addressing intimate partner violence (IPV), timely dissemination of solutions for infant care during illnesses, mental health care of mothers of low birth weight infants or pre-term births, and timely identification and treatment of peripartum depression have been identified as critical pathways to reduce maternal morbidity.
- Given half of all mental health conditions develop before the age of 14 and three quarters before the age of 20, adolescent parents, especially mothers, require additional support for their mental health needs.
- Fatherhood and barriers experienced by men in providing emotional support to their families remains under-investigated but evidence gathered suggests fatherhood is a cause of mental ill health and should be more systematically addressed.
- Loss of education, opportunity and security are tied to family dysfunction, mental and physical health problems for parents, carers and children.

There are several considerations when it comes to understanding parental mental health needs. Mental and physical health of both parents (and carers) matters. Against the backdrop of a lifespan approach, this section offers specific evidence around parental mental and potential interventions.

### 1.2.1 Maternal Mental Health

Globally, depression is the leading cause of disease burden in women of reproductive age.<sup>v</sup> Estimate of the prevalence of depression during perinatal period is 11-18% worldwide, and 30-50% in LMICs.<sup>vii</sup> In LMICs, maternal and neonatal disorders continue to be the top five leading causes of disability and maternal mental disorders represent a big proportion of that total disability burden.<sup>viii</sup> With regards to maternal morbidity, maternal depression is known to be a key risk factor contributing to DALYS.<sup>x</sup>

In a meta-analysis, covering 200 plus studies focusing on 56 countries, the global prevalence of postpartum depression (PPD) was found to be approximately 17.7% (and higher rates were found in LMICs at approximately 19%).<sup>xi</sup> Loss of education, opportunity, and security was tied to family dysfunction, mental and physical health problems in several of these studies.

Suicide prevention, access to medical care especially with regards to timely dissemination of solutions for infant care during illnesses, interventions for low birth weight infants or pre-term births and timely identification and treatment of PPD have been identified as critical pathways to reduce maternal morbidity.<sup>xix</sup>

Mental disorders, especially depression, and Intimate Partner Violence (IPV) have been identified as critical risk factors leading to poor maternal health. IPV also increases the risk of depression and there is evidence that the longer the duration of the exposure to abuse, the more pronounced the impact on depressive symptoms; this applies to high-, middle- and low-income country settings.<sup>xiv</sup>

Figures 3a and 3b address the DALYS associated with all causes and behavioural risks in females ages 15-49 years in the Global Burden of Disease Study, 2017.

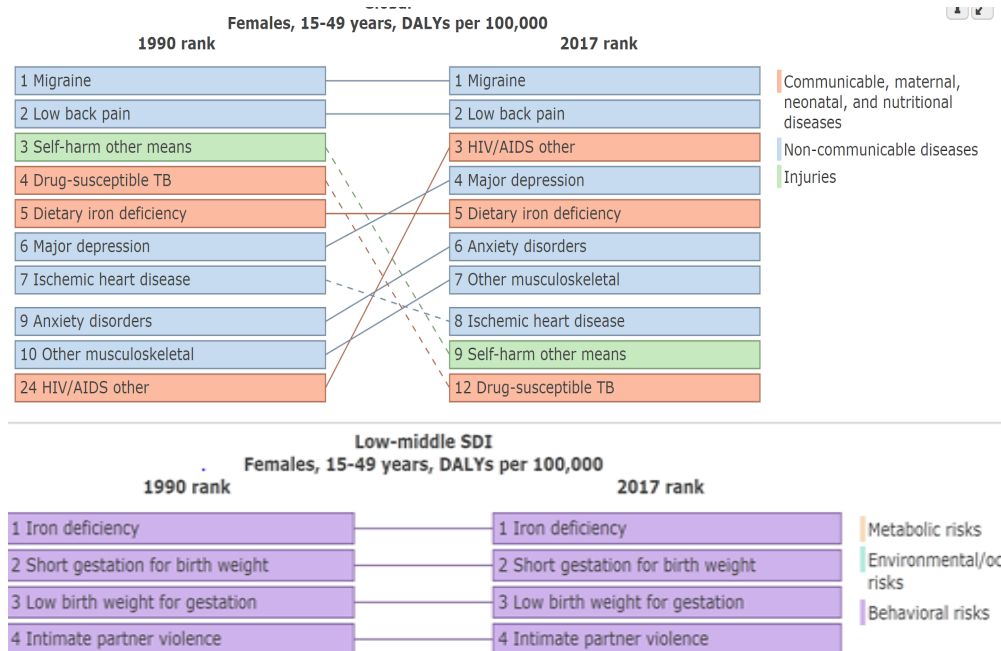


Figure 3: Global maternal and neonatal disorders associated with a) three GBD subset of risk factors b) behavioural risks associated with maternal and neonatal disorders in LMICs. (Source: GBD, 2017)

### 1.2.2 Adolescent pregnancy and adolescent motherhood and parenthood

UN figures estimate over 16 million girls worldwide give birth between ages 15-19 and around 1 million before the age of 15 in LMICs.<sup>xv</sup> Structural inequalities and social environments impact adolescent well-being including their reproductive, educational and long-term social development.<sup>xvi</sup> Psychosocially, adolescence is a critical stage linking childhood development to further growth in adulthood.

Adolescent pregnancy predisposes girls to poor physical health outcomes, and adverse mental health consequences, with depression and anxiety being the most common mental disorders.<sup>xvii</sup> Depression during motherhood impacts the infant and has been associated with negative child outcomes ranging from impaired physical health to poor neuro-cognitive development.<sup>xviii</sup>

It is well-documented that pregnant adolescents are 2-9 times more likely to develop perinatal depression and perinatal depression has a detrimental impact on parenting, family functioning, parent-child relationships, and children’s physical, social, behavioural health, and cognitive functioning.<sup>xix</sup> Higher estimates of PPD are also reported in adolescent mothers (26-50%).<sup>xxi xxii xxiii</sup>

High prevalence of adolescent pregnancies and perinatal depression in vulnerable adolescents and women in low income countries especially in SSA has resulted in a tremendous public health burden with further effects on the well-being of children and damaging impact on family, community health and the productivity of youth.<sup>xxiv</sup>

While there is research on perinatal depression, adolescent mental health and child development – with well-established evidence and remedial suggestions - the challenge often comes in trying to ‘implement’ these innovative research findings.



UNICEF has recently reported 115 million young boys have been married as children with one in five before the age of 15<sup>xxv</sup>. Therefore, it is not only young girls but also boys that struggle with mental health due to the pressures of early marriage, parenthood and the requirement to earn a livelihood (as they frequently do not continue their education).

Meanwhile it should be noted half of all mental health conditions develop before the age of 14 and three quarters before the age of 20 therefore beyond anxiety and depression (which affect an estimated 300 million people), young parents are at risk of other mental health conditions that have potentially life-long impacts on their children<sup>xxvi</sup>.

For example, schizophrenia typically begins in late adolescence or early adulthood. There are an estimated 23 million people living with schizophrenia, and while effective treatments for schizophrenia exist and people affected by it can lead a productive life, only 1 in 2 people globally have access to such treatment. Meanwhile suicide occurs throughout the lifespan but it is the second leading cause of death among 15-29 year olds globally. There are an estimated 800,000 deaths by suicide each year and many more attempts. These examples reinforce the need for support for young parents.

### 1.2.3 Paternal Mental Health

Single parenthood is a particular risk factor for optimal child development.<sup>xxvii</sup> In many parts of the world, single motherhood brings added responsibilities and constraints. However, in recent studies, single fatherhood has been associated with the worst self-rated health and mental health than partnered fathers with poor self-rated health and mental health.<sup>xxviii</sup>

Fathers with low levels of education and those with mental health conditions were more likely to exert a negative effect on the mental health of their children.<sup>xxix</sup> In a qualitative study carried out in the UK, it was found that fathers experienced psychological distress in the perinatal period but they questioned the legitimacy of their experiences. Darwin et al found that men may be reluctant to express their need for support lest it detract from their partner's needs.<sup>xxx</sup>

The recommendation of Darwin et al is to have resources tailored to men, framed around fatherhood, rather than mental health or mental illness per se. These authors suggest these focused interventions would help align men's self-care with their role as supporters to their female partners. Baldwin et al suggest that fathers would need more guidance and support around the preparation for fatherhood and partner relationship changes.<sup>xxxi</sup> These studies point to the need for greater male partner support during transition to parenthood. A Cochrane study reiterated similar limitations of group-based parenting interventions when it identified lack of studies focusing on fathers. It also found that very few studies reported outcomes on fathers.<sup>xxxii</sup>

Interventions targeting child mental health through paternal mental health are innovative ways of bolstering vulnerable families. A study funded by Grand Challenges Canada in Vietnam tried to mobilize fathers in parenting and involve them directly in the cognitive and emotional development of their infants. The study sought to indirectly enhance infants' nutritional status by having fathers encourage mother's breastfeeding exclusivity and duration.<sup>xxxiii</sup> Moreover, engagement of fathers and male caregivers can help not only strengthen the maternal and child mental health programming and but also address barriers to mental health care (such as resistance of male family members to seeking treatment) at the same time.

### 1.2.4 Extended Family Carer Mental Health

There is limited documented evidence around mental health interventions focusing on extended caregivers such as grandparents or even first-degree relatives. From our review findings, two set of studies have utilized extended caregivers. One set focuses on the mental health burden and behavioural aspects of HIV prevention and treatment adherence looking at family and community as a support base.<sup>xxxiv xxxv xxxvi</sup> In some of these studies, orphan-hood and adoption of children by other caregivers have been the reason to address larger family mental health support.

The second set of studies focuses on family and community strengthening to address psychiatric illness in adults by enabling the caregivers to address their stress and anxiety. This is addressed in the work of the EMERALD and PRIME consortium.<sup>xxxvii xxxviii</sup> However, understanding the mechanisms of change in interventions focusing on extended family remains limited. Most of the studies cited here were carried out in SSA and parts of South Asia including Nepal.

The premise of strengthening social support through the engagement of the family and community members is well-proven.<sup>xxxix xl</sup> However, this model has not been tested in terms of involving older siblings, grandparents or even neighbours in the context of offering ECD and parental mental health support. The community model and its focus on peer-support is somewhat similar to this model but no clear evidence has been demonstrated so far on its sustainability and long-term effectiveness on mental health outcomes.

## 1.3 Impact of Parental and Carer Mental Health on Early Childhood Development

- It is estimated that globally between 15-23% of children live with a parent with mental illness, and parental ill-health can impact both emotional and physical development of children and predispose these children to mental illness.
- Parental mental health conditions are linked to several negative outcomes in children, including low birth weight, higher rates of child diarrheal and respiratory diseases, stunting, increased hospital admissions, lower completion of recommended immunisation schedules and social and emotional difficulties among young children.
- Parental mental health directly impacts early childhood development and in high burden households' adverse social determinants affect both caregivers and their offspring.

There is a strong link between parental and carer mental ill health and the physical and mental development of children. As noted in previous sections, depression during motherhood impacts the infant and has been associated with negative child outcomes ranging from impaired physical health to poor neuro-cognitive development.<sup>xli</sup> Perinatal depression has a detrimental impact on parenting, family functioning, parent-child relationships, and children's physical, social, behavioural health, and cognitive functioning.<sup>xliixliiii</sup>

There is strong evidence in LMICs that perinatal mental health conditions are linked to various harmful outcomes in children, with the largest evidence pointing to lower birth weight in babies of women depressed both during pregnancy and/or after childbirth.<sup>xliiv</sup> Other outcomes for children born to mothers with depression include higher rates of child diarrheal and respiratory diseases, stunting, increased hospital admissions, lower completion of recommended immunisation schedules and social and emotional difficulties among young children.<sup>xliv</sup> Further studies have shown that maternal



depression and stress also can lead to early cessation of breastfeeding, which has further negative effects.<sup>xlvi</sup>

In regards to lower completion of recommended immunisations, parents struggling with mental health or overwhelmed by stress may be less likely to seek health services for their children, resulting in a lower completion of immunisation schedules. The Thinking Healthy Programme in Pakistan that targets the prevention and treatment of maternal mental health, for example, explicitly aims to improve immunisation rates as a measure of the success for the programme.<sup>xlvii</sup>

Maternal depression is also associated with increased prevalence of mental disorders amongst their children, including anxiety, attention deficit hyperactivity disorder (ADHD), and conduct disorders. A correlation has also been shown between parents experiencing posttraumatic stress disorder symptoms and psychological distress in their children.<sup>xlviii</sup>

Other mental illnesses, aside from depression, can also negatively affect early childhood development. For pregnant women, stress not only affects their ability to bond with their future child, but also can affect the fetus' neural development, both in the womb and after birth. Maternal anxiety and stress have an adverse effect on the attention span, reactivity and cognitive development of young children. One study conducted in rural China found that infants and toddlers of caregivers who had symptoms of at least moderate or severe anxiety had significantly lower language scores, and caregivers who showed symptoms of moderate or severe depression or anxiety were significantly more likely to have infants and toddlers with social-emotional delays.<sup>xlix</sup>

Caregivers who show signs of mental health problems are also significantly less likely to engage in interactive and positive parenting practices. Research has shown that maternal depression and stress often impairs the mother's sensitivity toward her child, depriving her of the energy, focus and patience necessary to have quality interactions and relationships, and decrease the quality of nurturing care.<sup>i</sup> A lack of a responsive relationship with a child may disrupt the developing architecture of the brain, and subsequent physical, mental, and emotional health may be impaired.<sup>ii</sup>

Parents and caregivers may negatively impact physical health through physical violence and abuse. An analysis of reviews shows parenting programmes have the potential to both prevent and reduce the risk of child maltreatment, but there remains a lack of evidence from LMICS where the risk of child maltreatment is greatest.<sup>iii</sup> The result of maltreatment and other adverse childhood experiences can have damaging effects on children's brain architecture, psychological functioning, mental health, behaviours around health risks (such as smoking, alcohol and drug abuse, unsafe sex, and violence), non-communicable diseases (such as cardiovascular disease and cancers) and communicable diseases (such as HIV and STDs).<sup>iiii</sup>

There is evidence to suggest behavioural disorders in children are closely associated with parents' psychological problems and there is good evidence that behavioural disorders can be seen as a child's reaction to family problems. A child's exposure to a mother's depression between five and seven years of age is a major factor in predicting the development of internalizing and externalizing symptoms in the child.<sup>lv</sup> Much less is known about paternal depression in LMICs, however depression amongst fathers has also been shown to negatively affect child development. Specifically, paternal depression during the postnatal period is associated with behavioural and emotional problems in children.<sup>lv lvi</sup>

In addition, there is also evidence of children’s reaction against numerous inappropriate environmental stimuli such as parental or social rejection of the child due to disability, illness, inadequate parental affection and support, family’s aimlessness and coldness, lack of maternal love and care, insecure childhood attachments, and parents’ stress.<sup>lvii</sup>

### 1.3.1 Social Determinants of Health

A number of social determinants of health including access to clean water, housing, medical and social services impact parental ability to provide care and protection. In some ways these are ‘causes of the causes of ill health and poor quality of life’.<sup>lviii</sup> Health disparities emanate from social contexts: there are differential consequences of ill health for more and less advantaged groups in socioeconomic, medical and mental health terms.<sup>lix</sup> Permanent poverty is related to levels and transitions into poor parental and child mental health.<sup>lx lxi lxii</sup> Parental and caregiver mental health is immediately impacted by structural and intermediary social determinants (see figure 5).

Stigma and poverty are described as the main barriers for parental and carer involvement in mental health service. The best documented social determinants of mental disorders include adverse childhood experiences, poor and unequal education, food insecurity, poor housing quality and housing instability, unemployment and underemployment, limited access to health care, poverty, and discrimination.<sup>lxiii</sup>

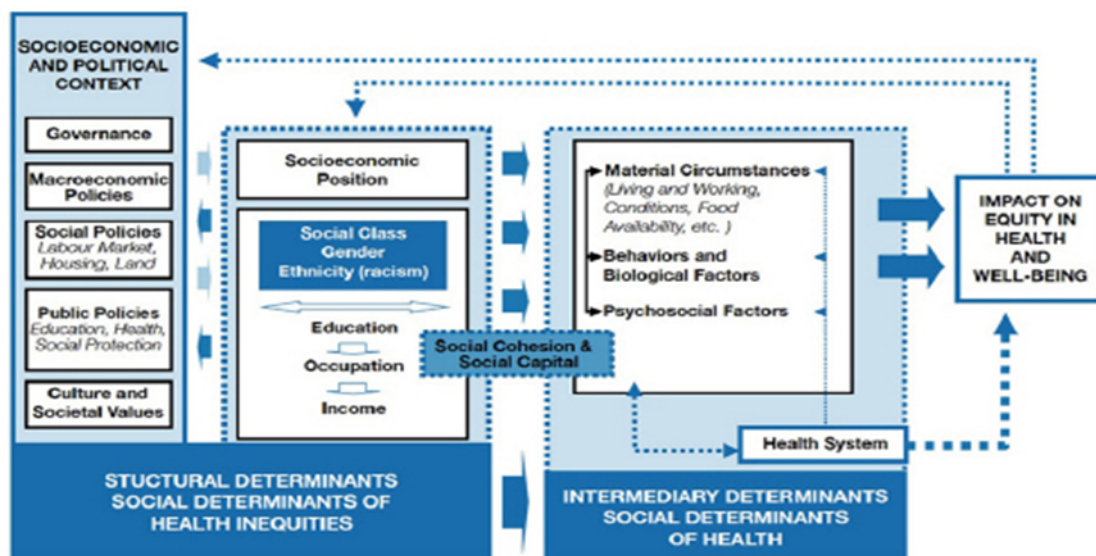


Figure 4: Social Determinants of Health. Source: WHO conceptual framework on social determinants of health National Academic Press, 2016

The WHO adverse childhood experiences (ACE) framework helps explain the combined impact of both family and society on children. ACEs are very common across cultures and social class contexts with higher vulnerability to some groups such as those in economic hardships or refugee contexts. Increasing levels of exposure are associated with either an increasing or a decreasing risk of the outcome. Toxic stress can impact both the caregiver’s mental health and have intergenerational implications for child health outcomes.<sup>lxiv</sup> Toxic stress is when the stress stops becoming a positive factor in emotional health and efficiency and becomes intolerable.

Figure 5 offers a multi-layered understanding of various risk factors that impact children and their caregivers across the lifespan. It offers a pathway for understanding trajectories of families with poor

and at-risk mental health and a contrast between mentally healthy carers and children. There are bidirectional influences on parental mental health – those that emanate from their own well-being and health related factors and others that may stem from child health conditions and outcomes.

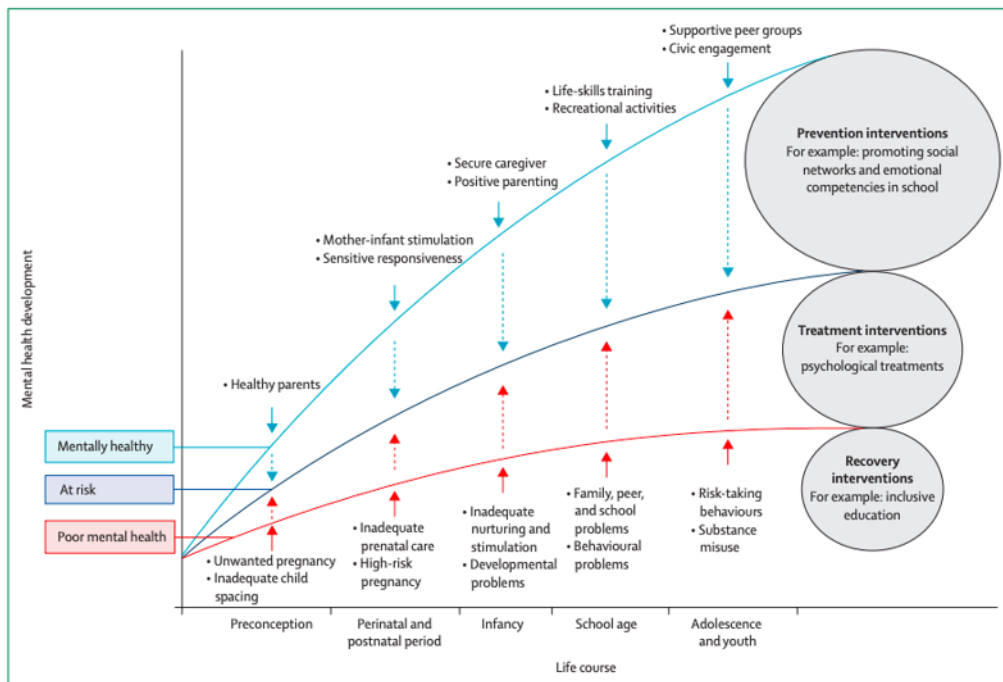


Figure 5: Protective and risk factors in the early life course. Source: Lancet Commission on global mental health and sustainable development 2018

Interventions would need to be modelled on needs. There are those with very poor mental health outcomes who need services to move from high risk to a more safe and secure trajectory, and those who are mentally healthy that need promotive and preventive strategies to continue on their journeys across the lifespan.

## 2. Policy gaps for parental, carer and child mental health

A mental health policy is a government statement specifying values, principles and objectives for mental health and it is usually implemented in the forms of mental health plans, programmes, strategies and legislation at multiple levels<sup>lxv</sup>.

There is considerable scholarship on parental, carer and child mental health with prevalence estimates, country level statistics and analyses of barriers and facilitators in providing care. The responsibility to provide mental health services and legal protection often lies with national governments yet approximately 25% of countries have no mental health legislation, more than 40% of countries have no mental health policy and over 30% have no national mental health programme.<sup>lxvi</sup>

It will not be possible to improve parent, carer or child mental health without mental health legislation, policies and programmes, that are well resourced and able to address the fundamental challenges outlined in the paper above.

### 2.1 Global level policy, conventions and frameworks, and what is missing

WHO is the UN agency global mental health policy lead. The WHO Comprehensive Mental Health Action Plan (2013-2020)<sup>lxvii</sup> was agreed by WHO member states as a means of clarifying what action needs to be taken to deliver good mental health for all. It covers six key areas: Universal Health Coverage (UHC), human rights, evidence-based interventions, the life course approach, the multisectoral approach and empowerment of individuals with mental disorders and psychosocial disabilities. It sets goals and targets for national action.

In each of these areas some progress has been made but there are significant gaps in equity and access at national and regional level with regards to scaling up services and interventions in both HICs and LMICs<sup>lxviii</sup>. The World Health Assembly recently approved the proposal that the goals and targets are updated and the plan extended from 2021 to 2030. Therefore, the period from now to May 2021 will be critical to efforts to strengthen the ambition of the international community to make progress in improving the mental health of all – men, women and children.

Meanwhile the WHO Quality Rights Toolkit<sup>lxix</sup> developed by WHO to guide member states requires the establishment of community-based, recovery-oriented mental health services in accordance with Article 19 of United Nations Convention on the Rights of Persons with Disabilities which asserts that persons with disabilities, including psychosocial disabilities, should be provided with support to live independently in the community<sup>lxx</sup>.

The current international momentum to encourage national governments to develop plans to achieve Universal health Coverage (UHC) is a significant policy moment for mental health. The concept of UHC emerged in response to a growing awareness of the worldwide problems of low access to health services, low quality of care, and high levels of financial risk.<sup>lxxi</sup> UHC is now a core tenet of UN SDG 3. UHC was preceded by the aspirational notion of a minimum standard of health for all, enshrined in the Universal Declaration of Human Rights (adopted by the UN General Assembly in 1948) and the declaration of Alma-Ata in 1978, and many HICs have provided universal coverage for decades. The World Health Assembly endorsed the modern concept of UHC as an aspiration for all countries in 2005.



Subsequent World Health Reports by the WHO expanded on various technical aspects of UHC, and in 2015, UHC was adopted as a sub-goal (target 3.8) of SDG 3.<sup>lxxii</sup>

The SDGs, especially through the UHC movement, is driving global policy around integrated health care at all levels of services. The social determinants of health framework targets health access issues that impact those affected with mental disorders. UHC is intended to break the vicious cycle in which low socioeconomic status (SES) contributes to poor mental health, which in turn lowers SES. UHC aims to improve access to and use of basic health and social services, especially among the most disadvantaged.

Despite the current civil society and UN agency enthusiasm around UHC, integrated mental health at various service levels is still missing in large parts of the world. An effective health system is one that meets these UHC objectives by providing equitable access to affordable, high-quality health care—including treatment and curative services as well as health promotion, prevention, and rehabilitation services—to the entire population. Mental health is far behind physical health in UHC.

In 2019 there are a series of political events and moments at which UHC is being highlighted with a view to accelerating progress at national and international levels. Countries are setting out their UHC plans to 2030, yet frequently these only focus on physical health. Now is a critical time to advocate for mental and physical health parity – and for that to be enshrined in national UHC policies and in international frameworks and funding support for the achievement of UHC.

## 2.2 Trends in legislation and policy in high-income countries

Global mental health advocacy tends to target health disparities, promoting task-sharing and the development of a community health models in line with the WHO recommendations<sup>lxxiii</sup>. Deinstitutionalization continues to be a priority<sup>lxxiv</sup>. The Lancet Commission on Global Mental Health and Sustainable Develop recommended that a concerted effort be made in HICs to strengthen community, primary care, secondary and tertiary care in terms of coverage, degrees of specialization and a full spectrum of interventions that are evidence based<sup>lxxv</sup>.

The mental health legislation and policies in HICs have targeted access to evidence-based psychotherapies and access to psychotropic medication. Despite this, mental health services in many resource rich countries remain inaccessible and insensitive<sup>lxxvi</sup>. It has been reported that in the UK mental health spending increased to a record £11.6 billion in 2016–17<sup>lxxvii</sup> and other countries, most recently New Zealand, have also sought to increase expenditure. The paucity of trained specialists and health workers is not as great as in LMICs however the mental health workforce is insufficient and over stretched in many countries.

There are also limited resources and funding to carry out evidence-based research rigorously testing interventions. Organisations such as Wellcome are investing in addressing such gaps: The Wellcome Trust has announced £200 million for a program focused on strengthening the evidence base on teenage anxiety and depression. For the most part, the best funded research into interventions remains focused in HICs with a longer term objective of transporting these to LMICs (rather than begin with a focus on LMIC settings).

Interpersonal psychotherapy for individuals with depression and interpersonal psychotherapy for adolescents were both developed in the US and transported to LMICs due to interest in adapting this model for group interventions with vulnerable women. Similarly, stepped care models have been

adopted for use from UK and European health systems as a way of strengthening primary care services and enhancing specialist care for those who are most needy and in distress. From Netherlands, Italy, Germany, Australia and New Zealand, models on youth mental health and engagement with diverse youth populations on mental health stigma, engagement and integration within social contexts have been championed and offer unique opportunities to strengthen integration of immigrant and stigmatized youth populations.

Psychotherapies, which is a well-developed field in UK, Europe and North America, needs legislation and greater promotion (with the necessary funding to sustain it) to best serve the most disadvantaged: it continues to be an area that needs prioritization.

### 2.3 Trends in legislation and policy in low- and middle-income countries

The most pertinent critique in LMICs is that even though countries may have enacted a mental health policy they have not necessarily changed the system to conform to the WHO's recommendations or to evidence-based guidelines. The investment in building community health structures is critically missing as most funding support goes to sustaining psychiatric facilities and institutions and building managerial capacity in LMIC contexts in primary care and specialist institutional contexts<sup>lxxviii</sup>.

Under UHC, essentially most LMICs are focusing on integrating mental health care and systems in line with the broad health priorities. However, availability of timely and appropriate financial and human resources presents a challenge.

The African and South East Asia regions have the lowest percentage of updated mental health legislation of the 111 countries who participated in the WHO Mental Health 2017 Atlas<sup>lxxix</sup>. According to the Atlas, 66 countries or 40% of responding countries have updated their mental health legislation in the previous 5 years (since 2013), most commonly in the European region, however the proportion of countries that have updated their laws in the African region has more than doubled since 2014 to 21%<sup>lxxx</sup>. Out of the 64 countries stating that they do not have a stand-alone mental health law for mental health, 34 have mental health legislation that is integrated into general health or disability law<sup>lxxxii</sup>.

There is policy and programmatic action in LMICs, and legislative reforms are also taking place from revamping the mental health policy to developing a brand new one (for example the new mental health legislation in Liberia in 2017 and in India in 2018). The challenge remains in actioning these policies and agendas given the lack of resources, political will, health systems capacity and human resources deficits. These require not only a multisectoral response but also a dedicated financial and political commitment.

As a result, locally based CSO advocates have been working to help improve and reform mental health legislation, policies and practice. This ranges from helping to write the legislation and policies themselves (e.g. in India and Tonga) to campaigning for specific elements of the law or policies to be amended (e.g. stopping the practice of shackling in Indonesia and Ghana). In some cases these CSOs have been assisted by international NGOs and other stakeholders e.g. the Human Rights Watch work with local CSOs on stopping shackling; and the work of the Carter Centre in supporting action on the ground in Liberia. In May 2019 the Speak Your Mind campaign was launched to advocate for improved policies and practice and the necessary resources to sustain them. It is a CSO-led campaign bringing together advocates in over 15 countries (high, middle and low income countries) to call for change at national and global level.

### 3. Early Childhood Development and Mental Health

- Worldwide 10-20% of children and adolescents experience mental health disorders.
- Half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s.
- Neuropsychiatric conditions (mental disorders attributable to diseases of the nervous system) are the leading cause of disability in young people in all regions.
- In a number of aspects of health policy and practice the link between child and adult mental health is not sufficiently well made. Similarly, between developmental disabilities and mental health.
- Ideally ECD and mental health programmes will be developed and implemented together to improve parent and carer mental health and promote ECD.

The table in figure 6 provides the leading causes of mental illness in children under five years of age. Parents and carers supporting children with such mental illnesses are themselves put under further strain on their own mental health as a result.

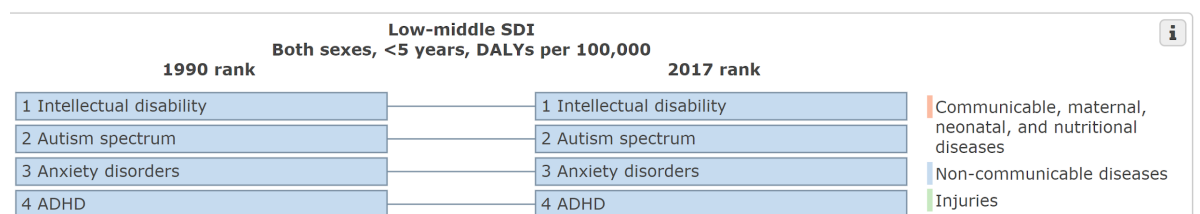


Figure 6 Mental disorders associated DALYs of under 5 children from low- and middle-income SDI Source: GBD, 2017

Few studies globally have integrated intellectual impairment, ADHD, and parental depressive and anxiety disorders in the early childhood development programs or targeted these conditions in mainstream parenting interventions. In LMICs in particular, these conditions cause significant disability and poor quality of life for the caregivers and children. Governments can resort to locking up young children as the only means of managing disabilities and parents struggle to secure financial support to keep children with them in their communities<sup>xxxii</sup>. Yet with appropriate management of these conditions, it is possible to retain children in their communities and minimize development of comorbid mental disorders and other physical conditions that can easily aggravate disability in these children. Digital and information technology is increasingly being used to provide training and services in LMICS where there is a shortage of psychiatric resources. The design and scale up of these services need further cost-effectiveness and social benefits analyses to further a case for return on investment.

The Nurturing Care Framework developed by WHO offers a dense and comprehensive agenda to incorporate child development in timely and thoughtful manner. In terms of very specific components of community-based parenting and ECD interventions, the evidence gathered in this paper shows while psychosocial intervention programs are effective in improving cognitive outcomes of impoverished groups, the evidence was poor for malnourished or stunted children. Strong evidence exists for combined treatments, especially incorporation of psychosocial stimulation and parenting interventions into ongoing ECD programming. Exclusive breastfeeding and maternal psychosocial support interventions improve cognitive and development outcomes. Emotional and social development are critical components to child development. Early intervention in these areas are well-known to reduce both internalizing (such as depression, anxiety) and externalizing disorders (conduct and other high-risk behaviours).

The effects of parenting programs on care practices via antenatal programs and through community-based approach were mixed. Results from interventions evaluated in various reviews we came across suggested that more frequent exposure to educational messages through a wide range of channels may lead to greater changes in mothers' care-seeking behaviour during the antenatal period. In terms of physical abuse prevention, group-based interventions were found to be effective. Therefore there is a need to combine efforts in parental and child mental health to deliver improved child development outcomes.

Parental mental health interventions that incorporate ECD elements by actively involving children could be a key to a successful program rather than focusing on parental health alone. Incorporation of cognitive and emotional development in ECD programs would strengthen the ECD package overall and particularly in emergency or humanitarian contexts. Combining ECD packages with psychosocial programs such as Intimate Partner Violence (IPV) prevention and promotion of paternal engagement in parenting would strengthen existing treatment services. Peer-led programs are effective but require a level of social mobilization first to encourage advocates to come forward. Development of interventions that combine parental mental health with child mental health including fathers and extended family help improve social acceptance and participation.



## 4. Innovations and examples of interventions to address parental and carer mental health to improve childhood development outcomes

There are ongoing global efforts to offer prevention and promotion of mental disorders by focusing on parents and caregivers in both community, clinical and school settings. Several general mental health awareness and targeted interventions focusing on vulnerable populations have been tested in HICs and LMICs in last two decades.<sup>lxxxiii</sup> This section reviews the regional and country level progress of innovative scale up efforts assessing cost-effectiveness, comparative effectiveness and the development of new implementation strategies in the fields of parental mental health and early childhood development.

A number of successful community-, school- and health facility- based maternal and parental mental health interventions have been tested worldwide, including in LMICs. Despite the large number of innovative interventions and programs that have been tested on parental mental health, interventions combining both caregiver and child mental health outcomes in LMIC settings, and the impact of positive parenting on child mental health in humanitarian context still needs refinement and scaling up. Further, there are few studies on child and adolescent sexual and reproductive health, adolescent pregnancy and vulnerable mothers in humanitarian contexts.

### ***Annex 1 documents a range of interventions.***

Some of the interventions selected for this report were because they fulfilled a big gap, such as those offering school, community and adolescent focused interventions all in one; others have built robust evidence for a common elements therapeutic approach called Common Elements Treatment Approach (CETA) that uses different mental health techniques in different doses for different mental health conditions. The training of lay and non-specialized health workers in communities, health facilities and schools is also a highlight of these intervention examples.

Special implementation strategies and targeted interventions for certain age groups are included e.g. addressing suicides in adolescents. Other similar interventions exist but several of those are not well-documented or their effectiveness not fully tested, especially in real life settings and in terms of costs involved. Innovations are needed to integrate mental health within existing structures and connect parental and child mental health interventions.

### **4.1 Task-sharing and integrating mental health in the community settings**

Successful community mental health interventions were selected by simplicity of intervention, ease of their acceptability into the community and low effort from specialized or community health institutions. In these interventions there was a strong component of peer-advocacy and use of peer and lay health workers as additional capacity to tackle adversity and mental illness. For a full list see Annex 1.

Some of the most well-known regarding task sharing and integration into community settings are the Friendship Bench project that originated in Zimbabwe and the Thinking Healthy Project that originated in Pakistan. The Friendship Bench project has trained mainly grandmothers in CBT so that they can offer counselling to people seeking support at health centres (the women sit on benches outside the centres). It has subsequently been expanded to New York and is currently expanding to other African countries with an online component aimed at adolescents also in development. The Thinking Healthy Project was adopted and scaled up in different countries through WHO.

**Panel 1: Case Study of Maternal depression and parenting support scale up in Pakistan**

Thinking Healthy Program (THP) is the first low intensity psychological intervention endorsed by the WHO for the treatment of perinatal depression in LMICs<sup>lxxxiv</sup>. THP was originally based on cognitive behaviour therapy and delivered by Community Health Workers. It was recently adapted to enable delivery by lay health care providers (Thinking Healthy Program Peer-delivered - THPP, evaluated in India and Pakistan)<sup>lxxxv</sup>. THPP produced better outcomes than enhanced usual care alone, and led to moderate effects on clinical, social and functional outcomes over six months post-natal<sup>lxxxvi</sup>. THPP was delivered in 6 to-14 individual sessions in four phases (prenatal phase, baby's arrival, prenatal, early infancy, middle infancy) until the baby was 6 months old, with sessions lasting between 30-45 minutes.

In 40 district clusters of Rawalpindi, Pakistan women between ages 16-45 who were in their third trimester and manifested perinatal depression were recruited for the study. The primary outcomes measured were infant weight and height at 6 months and 12 months, and the secondary outcome was rates of maternal depression. Around 40 female health workers were trained in a brief two days long training that was followed by regular once in a month supervision and every four-month refresher course. The infant outcomes improved and it was found that there was an increased rate of immunization and uptake of contraception in affected women. Mothers in the intervention group had lower depression and disability scores and better perception of social support and better overall functioning.

## 4.2 Testing novel mental health delivery strategies

**Stepped care intervention delivery** has been recently suggested as a way of addressing the mental health treatment gap. It is not per se one set of interventions but it is promoted as a health service and implementation strategy aimed at utilizing lay health workers to deliver more nuanced mental health care. It uses an internal stepped care model that allows for the same non-professional service provider (or number of providers) to navigate between different intervention based on the severity and type of problems of the person affected<sup>lxxxvii</sup>.

**Transdiagnostic models** could address a wide range of comorbidity problems across the life span while reducing the number of treatments needed with the ability to only deliver the dosage needed, potentially reducing cost and resources<sup>lxxxviii</sup>. The goal is to create a simplified approach with a limited number of elements such as simple language, a short manual with practical step-sheets, and decision rules giving providers and their supervisors flexible choices in element selection, sequencing, and dose. The decision rules help the provider use the client's initial assessment (e.g., primary presenting problem; comorbidity) and ongoing presentation (e.g., symptom changes during treatment) to plan and adjust treatment as needed. It has been tested in Ukraine, Kenya, Thailand, Tanzania and other countries like Myanmar, Iraq and Zambia in trauma and high adversity contexts with both adults and children with good clinical effectiveness.

**Community platforms** were identified in one systematic review<sup>lxxxix</sup> as a strong alternative to primary health care support. They had the potential to reduce stigma, mobilize a wider set of individuals, focus on family needs holistically, promote social inclusion and provide additional benefits including medical adherence and prosocial parenting. This review also suggested that community platforms had the potential to enhance primary care service engagement and improve uptake of specialty care<sup>xc</sup>. In this review, arguments favouring community care were drawn from three brief case studies, including one

case study on suicide prevention in Sri Lanka using community engagement which led to enhanced follow up. Similarly supporting men and women with psychoses worked better in a community support program than facility-based treatment alone.

**Home or community-based support** by lay health workers was identified as a successful way to manage the peripartum period (such as those offered by THP). Provision of adequate antenatal care and centre-based pre-school services were identified as key considerations for strengthening parental mental health<sup>xci</sup>.

**Learning to play combined with CBT** for parents was the subject of a study funded by Grand Challenges Canada<sup>xcii</sup>. It led to enhanced parental awareness of developmental milestones and improvements in school readiness in Pakistan.

**A Supported Self-Management (SSM)** approach was used by the Mental Health in Adults & Children's Frugal Innovations (MAC-FI) program - focusing on training community health and social workers to identify and provide support to primary care users suffering from depression. Following this telemedicine coaches deliver weekly counselling sessions to parents of children with behavioural disorders<sup>xciii</sup>. The study demonstrated the potential to provide interrelated solutions for parental and child mental health support.

### 4.3 Multilevel interventions targeting children and adults for scaling up

Targeting both children and adults in a joint project is increasingly being implemented in different countries. Below is a case study on a psychosocial intervention focusing on carers of children with intellectual disabilities from Malawi. It is an example of targeting children who are suffering from poor mental health outcomes and aims to provide support and strength to the caregivers. Other examples are included in Annex 1.

***Panel 2: Psycho-social intervention for reducing psychological distress among parents of children with intellectual disabilities in Malawi***

Masulani-Mwale et al (2016, 2018, 2019) have used the framework designed by the UK Medical Research Council (MRC) to address psychological distress in parents and caregivers of children with intellectual disabilities in Malawi through a rigorous community-based intervention<sup>xciv</sup>.

The authors of the study found four objectives and research activities were critical:

- (a) use a systematic literature review to create a theory of how psychological interventions help to alleviate psychosocial problems in parents of children with disabilities;
- (b) conduct interviews with parents of children with disabilities in order to understand how best to address the psychological needs of parents;
- (c) use an expert panel of professionals to identify which themes and subjects would be most effective to address in a Malawian setting and;
- (d) pilot and pre-test the intervention according to levels of practicability, the ability to recruit and retain participants and the participants perceptions and acceptability by the parents.

This led to development of the Titukulane intervention that focuses on several training modules outlining human development, intellectual disabilities, different types and psychosocial support, self-care and management guidelines for caregivers and their families. The parents and other caregivers reported the intervention was highly acceptable and feasible. While the work is still

ongoing, the study uses a complex setting, integrates treatment, mental health promotion and care for a neglected age group of children and simultaneously addresses the caregiver well-being. Such an approach is a means of tackling parental, carer and child mental health.

#### 4.4 Government-led interventions

**Research-practice-policy dialogues** use knowledge transfer to facilitate uptake of mental health interventions and innovations. Several developments have taken place in different countries responding to their unique needs and development priorities. For examples the UK has used Improving Access to Psychological Therapies (IAPT) to strengthen delivery and access to psychotherapies by different providers at different settings. The European Union is prioritizing youth mental health and youth participation in the development agenda as a way of strengthening their capacities and in the US, the focus is on substance use particularly opioid addictions in young mothers with low incomes.

A study published in 2017, surveys integrated (one-stop shop) youth health care across a range of different HICs<sup>xcv</sup>. The study focused on adolescent mental health services but includes at least some services that integrate youth mental health within wider family health and education services. The study provides a useful overview of 18 integrated services across 5 countries (Ireland, Australia, France, New Zealand and Canada) with details on evaluations and impact. It also identified 10 single-service providers in six countries (Australia, New Zealand, Singapore, Israel, the US and the UK). It identifies a major flaw in many HICs that provide mental health services: the lack of coordination between services focussed on children and adolescents and those focussed on adults. This impacts the continuity of care with a potential impact not only on children and adolescents using the services, but those same individuals as they become young parents in equal need of support.

Annex 1 includes examples of individual initiatives and approaches from a wide range of countries including Chile, Uganda, Chile and the US. A separate paper for BvLF documents the government and international agency led interventions in conflict and humanitarian settings.

#### 4.5 Which interventions should be recommended for scale up?

Very few interventions can be scaled up without adaption given that health, social services and educational systems vary between and within countries and the population needs might vary depending on differential social determinants of health. We would suggest interventions need to meet the following criteria to be selected:

1. Tied to efforts towards UHC achievement therefore integration in primary health care and other priority platforms;
2. Use multilevel strategies that integrate school, community and or health sector;
3. Demonstrate effective multiple engagement strategies to improve mental health literacy and promotion at individual level and capacity building at health systems/population levels;
4. Connect mental health risks to social determinants of health and using social policies to promote mental health;
5. Use cross-country validation of measures, policies and strategies for greater learning around implementation challenges;
6. Incorporate rigorous monitoring and evaluation including cost-benefit analysis.

The Disease Control Priorities report that specifically looks at maternal mental health includes seven recommendations outlined in the table below<sup>x cvi</sup>. Their recommendation is that the impact on the health

and well-being of scaling up these seven interventions as part of Universal Health Coverage (UHC) will be substantial and costs would be affordable given that the investment required to improve women's health is modest.

Target Group	Priority Interventions
Young Children and Adolescents	<ul style="list-style-type: none"> <li>• Psychological treatment for mood, anxiety, ADHD, and disruptive behavior disorders in adolescents</li> </ul>
Adults and Older Women	<ul style="list-style-type: none"> <li>• Management of depression and anxiety disorders with psychological and generic antidepressant therapy;</li> <li>• Self-managed treatment of migraine;</li> <li>• Management of schizophrenia using generic anti-psychotic medications and psychosocial treatment and management of bipolar disorder using generic mood-stabilizing medications and psychosocial treatment; Interventions to support caregivers of patients with severe mental disorders</li> </ul>
All Ages	<ul style="list-style-type: none"> <li>• Post- gender-based violence care, including counseling, provision of emergency contraception, and rape-response referral (medical and judicial)</li> <li>• Long-term care services for patients with severe mental disorders</li> </ul>

#### 4.6 Which countries already demonstrate positive examples of work to improve parental mental health?

The table below summarises our findings on progress made at country level and in what areas.

Country	OECD ranking	Nature of interventions	Positive impact
Uganda	LIC	Group IPT for caregivers of nodding syndrome, maternal depression. Economic empowerment and asset building in HIV affected communities, in schools and communities with HIV orphans /affected children	Improved mental health and health outcomes, improved quality of life and livelihood options  Those offered economic empowerment opportunities with mental health support improved outcomes
Uganda Also Kenya, Tanzania	LIC LICs	Integration of mental health in primary care, adoption of mhGAP, scaling up of G-IPT as evidence based intervention for maternal mental health in community health care	Improvement in maternal mental and physical health, improved child health outcomes, increased community awareness, increase in trained staff at primary health care, successful adoption of task-sharing and task-shifting
Malawi	LIC	Psychosocial intervention for parents of children with developmental disabilities	Increased support for caregivers, stigma reduction, reduction of caregiver burden
Malawi, Canada, Nicaragua and Tanzania	Low LICs and HIC	Treatment of depression and suicide prevention in schools	Use of multiple modalities - combined interactive radio programs for youth, secondary school curriculum materials for teaching of mental health literacy, school-based radio listening clubs and training for primary health care providers in the diagnoses and treatment of adolescent depression. improved mental health and school related outcomes.
India and Pakistan	High LIC	Thinking healthy to improve maternal mental health outcomes especially depression in community settings	The intervention improved women's mental health and literacy, improved child health and parenting outcomes, women's financial empowerment, increasing their control over household spending as well as increased investment on parents and girlchild
Brazil, Peru, Chile, Guatemala	HIC to LIC	Stepped care intervention to address perinatal depression and common mental disorders	Improved patient outcomes, case identification and capacity building at primary care settings
US, Uganda, SA	HIC, LIC, MIC	Multiple family groups interventions	Improved family functioning, reduction in externalizing and internalizing disorders in children, improved parenting and parent-child communication

## 5. Financing for Mental Health: Existing and Potential Future funding

- While mental health costs the world trillions of dollars each year, the international community is investing less than 1% of development assistance for health on mental health; and national governments often less than 1% of health budgets.
- Spending specifically targeting parent, carer and/or child mental health is hard to track internationally and nationally. The available data suggests very low levels of investment with the focus of international assistance primarily on humanitarian programmes.
- Large numbers of people have to pay for mental health care themselves and often go without any care at all due to lack of funding and lack of trained health workers or lay persons to provide services and support.

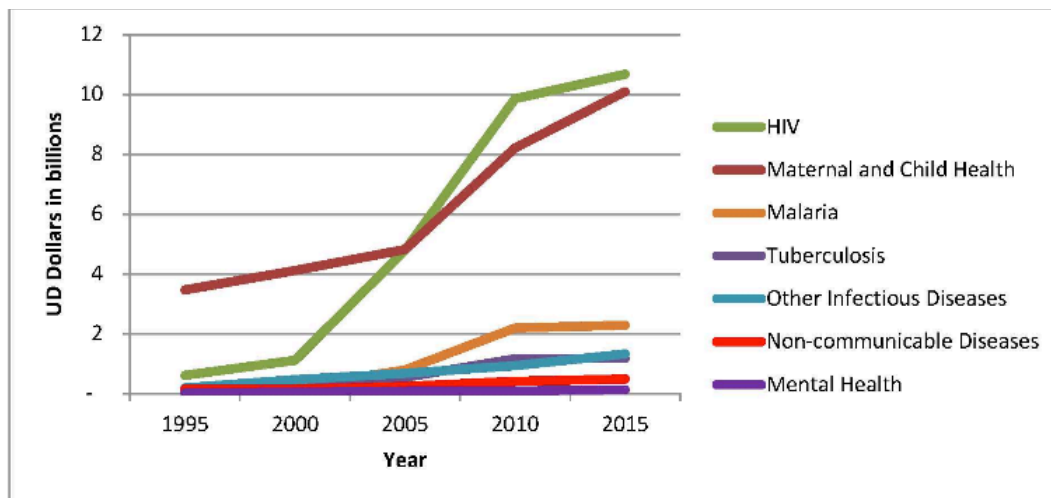
### 5.1 Mental Health Funding Inadequate

Total poor mental health cost the world economy trillions in lost output each year: in 2010, the cost was estimated to be US\$2.5–8.5 trillion in lost output due to mental, neurological and substance use disorders, depending on the method of assessment used. This sum is expected to nearly double by 2030 if a concerted response is not mounted<sup>xcvii</sup>. This is alongside the contribution to poverty, homelessness and crime<sup>xcviii</sup>.

However, both international and national funding fail to provide even a fraction of the funds required. The report of the Lancet Commission on Mental Health and Sustainable Development recommended all countries should commit to increase their mental health spending allocation to at least 5% in low middle income countries (LMICs) and at least 10% in high-income countries (HICs) of the total health budget to achieve mental health parity with physical health by 2030.<sup>xcix</sup> Few countries are meeting these targets.

The 2017 WHO Mental Health Atlas reported governments spend an average of 3-4 percent of their health care budgets on mental health, ranging from less than 1 percent in LICs, to 5-8 percent in HICs. In LICs the median government mental health expenditure is at US\$0.02 pppa; in lower middle-income countries it is US\$1.05 pppa, with more than 80% of that going directly towards institutions such as mental hospitals. Out-of-pocket payments for mental health treatment account for 40% of the total spend in Africa and 43% in South East Asia.

Moreover, global mental health is chronically underfunded from international sources (see figure 7). It represents just 0.4% of overall Development Assistance for Health (DAH).

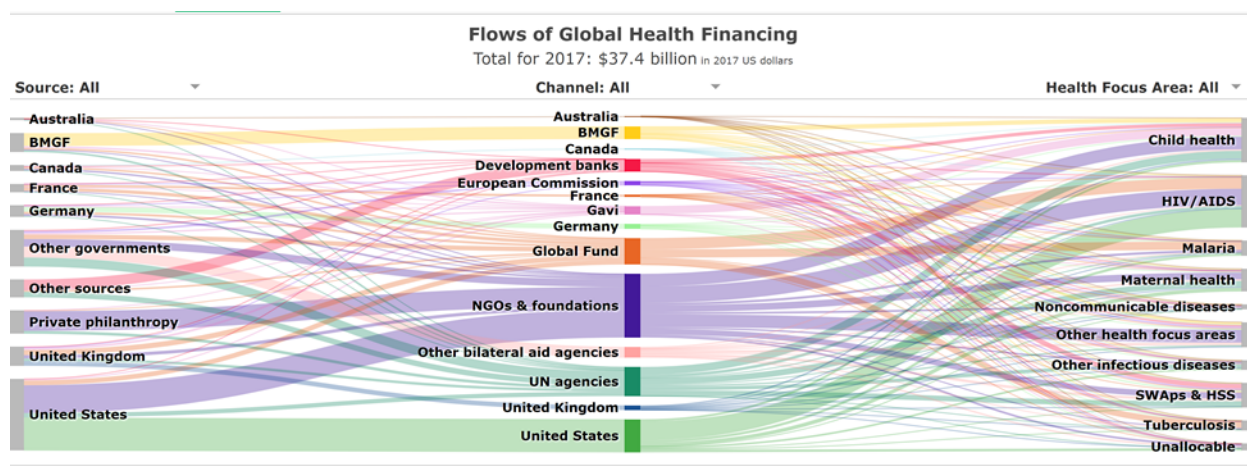


**Fig 1. DAH by health focus, 1995 to 2015.**

*Figure 7: Development Assistance for Health by Health Focus 1995-2015<sup>c</sup>*

International funding for mental health originates from a variety of Government and private sources and flows through various channels before reaching those in need.

The schematic presented in Figure 8 from the Global Burden of Disease visualization tool shows that very little global health financing at the moment is being invested in mental health. Although a large amount of assistance goes to child health, HIV/AIDS, maternal health and NCDs, the evidence on how much mental health is incorporated into the programming of each of these sectors is unclear. If mental health is a key driver of long-term well-being and economic prosperity of members of a society, the current allocation is woefully insufficient.



*Figure 8 Schematic of Global Health Financing Source: GBD, 2017 Flows of Global Health Financing, GBD 2017*

However, despite these very low figures, development assistance for mental health (DAMH) has experienced a 6-fold increase, starting from a low base, from USD \$18 million in 1995 to USD \$132 million in 2015. This is still far below the levels of many other health concerns. DAMH is categorized as financial, and in-kind resources that are transferred from development agencies to low- and middle-income countries, with the primary purpose of maintaining or improving mental health. DAMH is disbursed to various sectors, ranging from health, education, government and civil services, and humanitarian aid. Figure 9 shows the fluctuations in amounts of funding and focus.



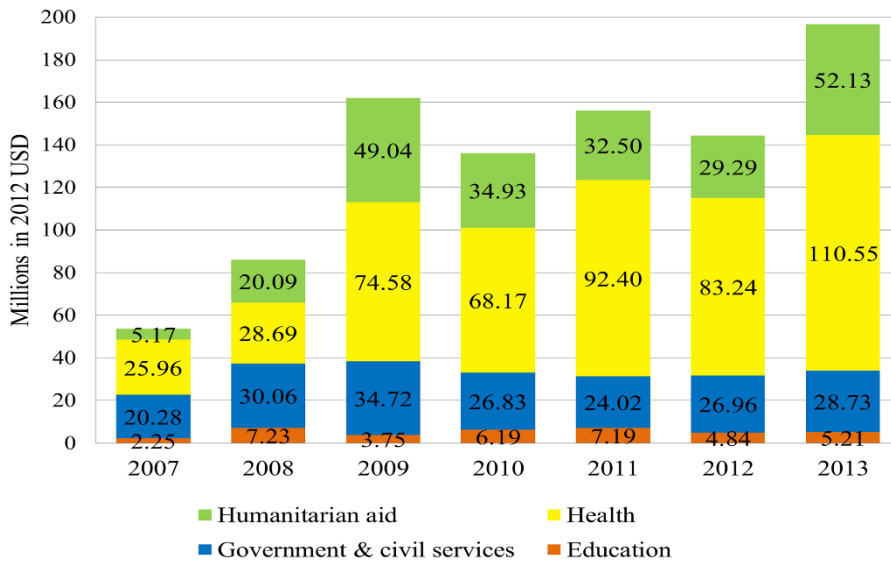


Figure 9: Annual DAMH by sector, 2007-2013<sup>ci</sup>

## 5.2 Existing international and national investments in parental and child mental health

One-quarter of DALYs for mental disorders and substance abuse is borne by those 24 years old or younger, the age group that account for more than 40% of the world’s population<sup>ci</sup>. However, aid levels do not reflect this concentration of mental health needs in young people. Donors invest little in child and adolescent mental health, in both absolute amount and fraction of overall health and other aid budgets.

Estimating the level of development assistance for child and adolescent mental health (DAMH\_CA) is complex. One study estimated DAMH\_CH in 132 developing countries between 2007 and 2015 using the creditor reporting systems. The study showed the largest investments in DAMH\_CA over this 8-year period were disbursed to the humanitarian assistance sector for children and adolescents in disasters or conflicts (41%), followed by the sector of government and civil services (31%), the health sector (20%), and the education sector (8%). The total amount of DAMH\_CA with a primary target on the mental health of children and adolescents was US\$190.3 million (12.5% of total DAMH and 0.1% of total DAH). Furthermore, aid was not necessarily concentrated in countries with greatest needs. Per capita, 90 developing countries received either 0 or less than US\$0.01 average DAMH\_CA, including 23 low-income countries (out of the 36 in total).

Figure ten shows the breakdown in sources of international funding for Development Assistance for Mental health with a focus on children and adolescents.

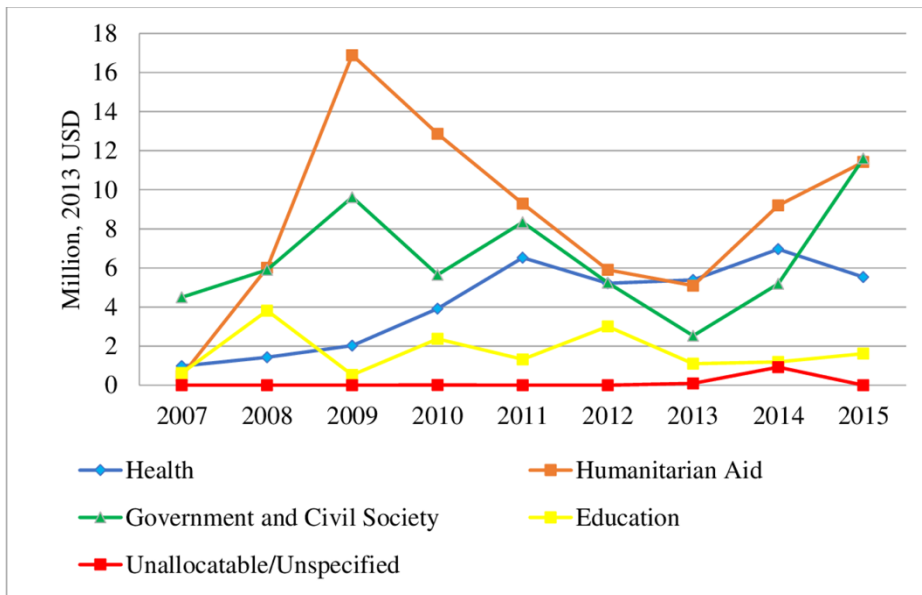


Figure 10: DAMH\_CA by sector 2007-2013<sup>ciii</sup>

In the short term at least, the quickest, low-cost way to increase mental health funding in LMICs would appear to be by integrating mental health and psychosocial support into existing humanitarian response and development programmes. The SDG indicators and targets for mental health include reducing the rate of suicides; doubling the coverage and treatment rates for substance abuse disorders by 2030; and ensuring mental health is a core part of the delivery of a national Universal Health Coverage plan.<sup>civ</sup> There are benefits to be gained towards achieving the UN SDGs by including a mental health component in other sectoral programmes, which could take advantage of larger funded programmes and uncommitted budgets. For example, in education, maternal and child health, and communicable as well as non-communicable disease budgets given the link between mental health and positive outcomes in these areas. One immediate example is the replenishment of the Global Fund where there is strong evidence that integration of mental health into HIV and TB programme improves outcomes in prevention, diagnosis and treatment (including adherence to treatment) for these diseases. Hence an investment in mental health will help deliver the Global Fund’s targets to end HIV/AIDS and TB. This is an issue currently being pursued by UnitedGMH in support of international experts on HIV/AIDS and TB and mental health, with support from national governments and international organisations including the WHO.

Meanwhile, spending by national governments is both hard to track and estimated to be very low. The WHO Child and Adolescent Mental Health Atlas<sup>cv</sup> observed child and adolescent mental health services funding is rarely identifiable in country budgets and in LMICs services are most often assumed to be delivered using private financing. The report strongly underscores how limited and unsatisfactory the government spending investment in child and adolescent mental health services by both HIC and LMICs.

The 2017 Mental Health Atlas<sup>cvi</sup> found a strong association between total government mental health spending per capita and gross national income (GNI) per capita. It also reiterated that the levels of public expenditure on mental health are very meagre in LMIC and more than 80% of these funds go to mental hospitals<sup>cvi</sup> rather than more efficiently using the resources to invest in low cost community-based care to both prevent and treat mental ill health.

The financial burden of mental health care frequently comes down to the individual - placing a heavy burden on limited household incomes especially in LMICs and therefore negatively impacting on the

family as a whole including children. The 2017 Mental Health Atlas noted 27% of countries reported mental health care and treatment is not included in national insurance or reimbursement schemes and 19% reported mental health disorders are explicitly excluded from national health insurance or reimbursement schemes. In some LMICs notably, in Africa and South East Asia, approximately 40% of people pay for their own mental health services - similarly in these regions people may be required to pay for psychotropic medications (45% in African region and 30% in the South East Asia region).

### 5.2.1 Human resources investment gap

Researchers have reported the lack of human resources for mental health over several years<sup>cviii</sup> including in the WHO Mental Health Atlas (2011) and the WHO Mental Health Atlas (2015)<sup>ciix</sup>. The latter reported that globally, nurses were the largest workforce category in the mental health system, with a median of 4.95 nurses per 100 000 population, followed by psychiatrists at 1.27 per 100 000 population. Mental health workers account for only 1% of the global health workforce and 45% of the world’s population live in a country with less than one psychiatrist per 100,000 people<sup>cx</sup>. The WHO Mental Health Atlas (2017) reports globally the median number of mental health workers is 9 per 100 000 population with a wide variation (from below 1 in LMICs to 72 in HICs)<sup>cx</sup>. Moreover, the attitudes of health workers towards mental health can hinder prevention and treatment given high levels of stigma among health workers: this also needs to be addressed if parents, particularly young parents, are to feel confident about seeking treatment.

The WHO care pyramid model demonstrates how a combination of primary health care (inclusive of lay health workers) and case managers could run evidence based low intensity mental health interventions, which are then overseen by more advanced level specialists. However, the lack of trained lay health workers including case managers worldwide is a potential challenge to the scale up of this model. Multisectoral collaboration and greater commitment to integration of mental health into both formal and informal services is essential to help fill the gap in services.

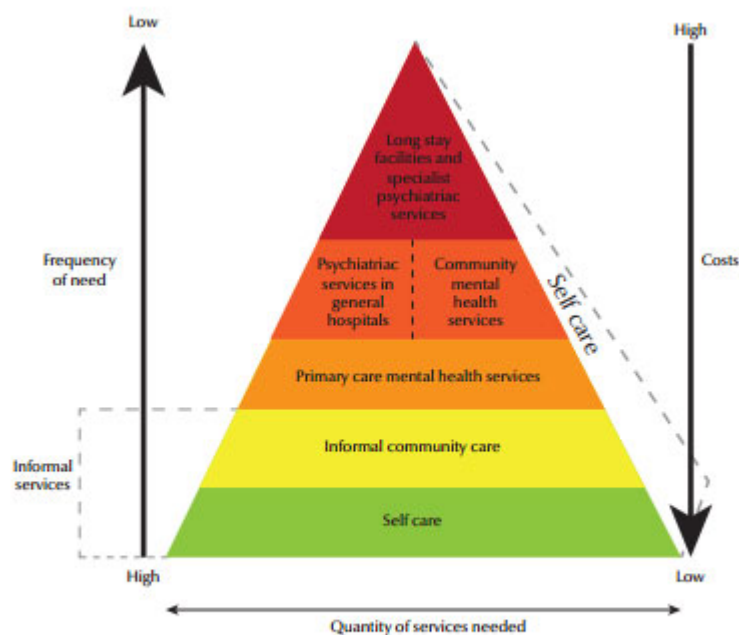


Figure 6: WHO Care Pyramid for LMICs (source: Integrating mental health into primary care, WHO, 2008)

## 6. The case for investment in parental and carer mental health to improve early childhood development

- Costings exercises have been undertaken to assess what funds are needed to improve parental and carer mental health.
- There is currently insufficient investment despite good evidence that community, primary health care facility and school based mental health interventions are cost-effective and with little investments multilevel benefits can be gained.
- Maternal mental health strengthening and empowerment is critical to receiving greater dividends on ECD programs. Enriching these programs with stress management, parenting and positive living strategies is a small price to pay for rich returns in terms of healthy, efficient and happy families.

### 6.1 Costings on Parental and Carer mental health

Costing studies, cataloguing the impact of mental health problems on service use and other domains in monetary terms, can be quite useful, but because they do not provide a measure of the outcomes of interventions they cannot be considered to be fully 'evaluative'<sup>cxii</sup>. Almost all costing and cost effectiveness evaluations underscore the same point.

#### 6.1.1 Adolescent mental health

A 2017 study found in their economic analysis of adolescent health interventions that school-based interventions did impact positively on SRH outcomes. However, with regards to mental health interventions alone cost effectiveness evidence is not so promising. School mental health programs are effective, but costs can be enormous<sup>cxiii</sup>.

A costing analyses undertaken in 2016 used the Resourceful Adolescent Program–Adolescent version (RAP-A) which used 11 hourly psychosocial sessions that led to short-term benefits to depression, hopelessness, coping skills, and self-esteem<sup>cxiv</sup>. Benefits to coping skills and self-esteem were sustained at follow-up after six months in Mauritius and to scale in countries such as Ethiopia, India and Mexico. The resulting cost of implementing this program at full scale (100 percent coverage) ranges from US\$0.03 per head of population in Ethiopia and India to US\$0.11 in Mexico and US\$0.24 in Mauritius, reflecting higher salary and other input costs. These findings indicate that school-based SEL interventions represent a low-cost strategy for promoting adolescent mental health.

#### 6.1.2 Adult maternal and parental mental health

A study by WHO in 2006 provides a comprehensive body of evidence examining cost effectiveness for the treatment of individual mental health conditions. It shows that proactive, maintenance depression treatment has one of the highest rates of returns particularly because a significant proportion of recurrent depressive episodes would be prevented. With regards to affordability and cost-effectiveness the report stated the most efficient interventions for common mental disorders (depression and panic disorder) can be considered very cost-effective (each DALY averted costs less than one year of average per capita income). It added community-based interventions for more severe mental disorders using older antipsychotic and mood stabilizer drugs meet the criterion for being cost-effective (each DALY averted costs less than three times average income per capita).

With regards to combined treatments for Common Mental Disorders and severe mental health disorders, this report suggested that such a baseline package across six low- and middle-income regions, the potential total health gain emanating from such a combination of intervention strategies is in the order of 2,000-3,000 DALYs averted per one million total population, which could be achieved at an estimated cost of I\$ 5-6 (US\$3-4) per capita in low-income settings such as Sub-Saharan Africa and South Asia, and up to I\$ 13 (US\$ 9) in more middle-income regions such as Latin America and the Caribbean.

The Disease Control Priorities Report recommendations for improving women's mental health suggests greater investment in this sector<sup>cxv</sup>. Their projection is across 34 low-income countries an additional US\$ 1.5 billion would be needed per year to implement the DCP3 women's mental health package; in lower-middle-income countries the figure is US\$ 9 billion annually. At US\$ 1.7 per capita in low-income countries this expenditure is similar to the investment required to address maternal and neonatal conditions but less than the investment required to address HIV/AIDS and other sexually transmitted infections. Each \$1 million additional investment would avert 1,063 years lost to disability among women in LMICs.

A summary of challenges around costing and cost benefit analysis of complex interventions especially those targeting adolescents revealed (Edmunds et al 2018):

- Interventions for at-risk youth that focus on a single outcome is contrary to the nature of the treatment, which will have multiple effects on clients and their communities.
- Quite a number of economic analyses suffer from small or non-generalizable samples, missing sample data, and poor quality or lack of evidence-based evaluations. This requires assumptions to be made about effect or impact.
- Problems with small heterogeneous sample by averaging data rather than using individual data; a problem better addressed by larger sample size.
- Similarly, a lack of costing data means estimations must be made about costs. Limited evidence of effect in program evaluation data or limited costing data can result in an under or over-estimation of the impacts of a program, impacting on the quality and precision of the economic analysis.

## 6.2 Presenting cost-effectiveness evidence for parental mental health

There are a number of studies demonstrating the cost effectiveness of investing in mental health at national and community level including in the workplace<sup>cxvi</sup>. For example, a study on the return on investment focusing on depression and anxiety in 36 countries found that treatment of common mental disorders (CMDs) led to improved economic productivity and health outcomes<sup>cxvii</sup>. Another study found the benefits of better health and labour force outcomes outweighed the costs by 2.3–3.0 to 1 when economic benefits only are considered, and 3.3–5.7 to 1 when the value of health returns were included.<sup>cxviii</sup> A third, focused on youth mental health, surveyed forty economic evaluations found psychosis was the mental health disorder with the most developed economic evidence cost base. Critical to the success of the programmes were a number of factors including engagement and support of families<sup>cxix</sup>.

A systematic review identified seven studies aimed at estimating cost-effectiveness of early childhood development interventions<sup>cxx</sup> each of which involved parenting interventions focused on conduct disorders, and either home visits or practice-based delivery models. Two cost- and cost-effectiveness studies from LMICs (Pakistan and Nicaragua) have also been published recently. Both involve Community Health Worker-based approaches in which health, nutritional, and child development counselling was

delivered during individual home visits<sup>cxix</sup>. These studies are promising, because they demonstrate relatively low annual costs per child (\$37-48) within the context of incremental gains in child development measures at scale.

Although Community Health Workers are likely to be a valuable resource for advancing maternal child health initiatives in resource poor-settings<sup>cxixii</sup>, their coverage of households within a community may vary<sup>cxixiii</sup>. There needs to be efforts to ensure a well-integrated service across community, primary, secondary and tertiary care and between public and private providers (including CSOs). Moreover, there needs to be strong coordination between health and other sectors. One study<sup>cxixiv</sup> reports that the cost of integrating a component on responsive stimulation with regular visits for nutrition and health (to educate mothers or caregivers) is more modest than that of establishing either a day care or a preschool program. In their assessment of an essential ECD package, Horton and Black<sup>cxixv</sup> recommend early parenting interventions, preferably before first three years of baby's life and ones targeting first time parents. UNICEF (2008) recommends 15 hours per week and a 15:1 (children to teacher) maximum ratio however not even many countries even in Europe achieve this goal.

Overall, evidence on cost and cost-effectiveness for interventions targeting parent and carer mental health with a focus on the impact on child development is limited, particularly for low-income countries in SSA. More work is needed to develop and present a comprehensive economic case for support for these particular interventions.

Budgeting for mental health services and prevention work needs a robust public finance management system. With a public finance management system in place, the way budgets are designed, allocated and used in health becomes central - leading to more credible and realistic health budgets.<sup>cxixvi</sup>

Three areas that need exploration and strengthening for a better response to the financial investment and funding avenues for global mental health.

1. Identifying 4-5 priority intervention areas in order to make the case for funding. While country and region level differences are critical and make a huge difference in policy development, it could be possible to identify 4-5 areas for priority investment e.g. adolescent pregnancy, substance use and suicides in youth, addressing developmental disabilities in children and supporting the mental health of young parents. This package could then be the focus of advocacy on increased funding.
2. Engagement with Ministries of Finance, Social Policy, Justice and Gender in addition to the Ministry of Health to promote information sharing and the integration of child and adolescent, maternal and child mental health. Linking their investment with improved national outcomes such as GDP, performance and efficiency of human resources and health or educational systems means it is possible to make the case for support for mental health and better cooperation between different sectors. Strengthening links between ECD and mental health policy and practice is a good first step.
3. Developing mental health economics and integrating the work of development and behavioural economics to better understand cost-effectiveness, return of investment or willingness to pay models. Working with the WHO and other organisations to make the case for investment is critically important. This combined with the development of indicators and goals for improvements in mental health policy and practice within broad national development agenda could help deliver progress. The discussion on the future WHO Comprehensive Mental Health Action plan targets and indicators is one such opportunity to influence the national and international agenda.

## 7. Summary and Recommendations for BvLF

In this report we have documented evidence that points to the compelling need to strengthen existing research, programming and advocacy work in parent and carer mental health. We have also cited examples of programs in different countries and contexts that seek to address these issues and where they have been proven a success. There is enormous wealth of information that has been generated in last two decades of global mental health research and advocacy targeting caregiver needs across lifespan, and early childhood development. This information needs to be better presented and harnessed to make the case for support, and where gaps remain, further research undertaken.

The summary below provides an overview of some of the main issues that BvLF may like to acknowledge as it develops further work on the subject of parental and carer mental health and in particular as it engages existing and potential partners who are already well versed in the area of ECD. The summary also highlights key areas for potential future work and support.

### 7.1 Mental health is a human right. Parents, children and families need strong mental health.

- Every parent and child have a right to health, right to live their life fully and meaningfully with respect and dignity. Societies need to offer services for families to maximize their capabilities and well-being.
- The evidence suggests that parent, child and families need stronger mental health support than there is available at the moment. This need is particularly acute in LMICs and in regions with high adversity, political uncertainty and humanitarian need. Specific attention needs to be paid to female pregnant and parenting adolescents and to fathers of all ages.
- BvLF's work in support of early childhood development and its ongoing work in partnership with others, places it in a unique position to draw on different sources of evidence and to advocate for mental health for all.

The current burden of disease due to mental health – for men, women and children – is large and growing. Yet the international and national response has been inadequate to date. There are many mental health conditions experienced by caregivers that adversely impact parenting and child health outcomes, particularly among adolescent mothers. There tends to be a focus on certain conditions in the research and implementation of programmes, for example, depression, at the expense of other conditions such as trauma, anxiety and stress disorders that deserve equal attention. Societal and environmental factors impact parent, carer and child mental health: the impact of poverty and lack of opportunity has a large effect on mental health and wellbeing.

### 7.2 Specific attention needs to be paid to pregnant and parenting adolescents and their offspring in LMICs and to fathers in all countries

- The first priority for additional mental health support must be mothers: the evidence is strongest regarding the impact of their mental health on the development of their children. However, they are not the only group that require attention.
- Services for young adults must be tailored to their needs, particularly pregnant and parenting adolescents.
- Fathers and extended caregivers need to be sensitively included in mental health programs: single fathers report particularly high levels of mental ill health.

- BvLF can help draw attention to, and advocate for, greater support for mothers, and for young parents and for fathers (two groups frequently overlooked).

The strongest evidence of impact of parent or carer mental health on child development is around the connection between mother and child. There is conclusive data demonstrating the importance of integrating mental health in maternal and child health programming.

However, given the global demographic transition that is clearly impacting many LMICs, with a significant ‘youth bulge’ in many LMICs, there is a compelling need to tailor more mental health services for young parents and carers. Pregnant and parenting adolescents are at higher risk than other parents and carers of mental health conditions that in turn adversely affect their children. Meanwhile fathers and male extended caregivers are frequently overlooked but can have a significant impact on the mental health of other family members and the development of their children. Interventions need to take account of their needs.

### **7.3 There is an important opportunity to increase mental health care under SDGs target 3.8 to achieve Universal Health Coverage.**

- All governments and relevant stakeholders must ensure mental health prevention, care and service delivery activities are integral to the policy and practice of UHC and delivery of the SDGs.
- Influential stakeholders in the mental health constituency and global health, such as donors, should use the current push for UHC-related health system reforms to ensure mental health services are embedded through health system structures.
- BvLF can use its experience of advocacy and influencing to ensure mental health is advanced as part of the SDG and UHC agenda.

Recent work by WHO and UNICEF in LMICs and global research evidence has demonstrated the importance of mental health to the achievement of the development agenda of economic growth, productivity, health equity and greater social freedom. In the momentum to achieve key SDG targets, UHC can be leveraged to make broad policy, structural and system level changes for mental health services. In ECD, progress has been achieved in physical and emotional health with early intervention and parenting programs.

### **7.4 Greater innovation and integration with ECD is essential to successful parent and carer mental health interventions if they are to lead to enhanced child outcomes.**

- There is good evidence of innovative interventions that are delivering parent and carer mental health interventions leading to enhanced child outcomes.
- Across all relevant sectors, the need is to have timely and well-designed interventions addressing interconnected aspects of parental and child mental health: this means working across sectors and disciplines.
- Parental mental health interventions that incorporate ECD elements by actively involving children are a good means to deliver successful programs rather than focusing on parental health alone.
- Given the history and role of BvLF on ECD it has a unique opportunity to help advocate for, and invest in, greater integration.

This report includes examples of wider community or networks within the community to address child mental health. However, more broadly whether the interventions are delivered at home, in community



or at primary health care clinics, or digitally, this report provides a wide range of examples of programs delivering good mental health services for parents and carers with a positive impact on their children.

While it is important to look for more innovation, equally important is for different sectors to work more closely together to deliver an integrated approach. For example, parental mental health and ECD need to come closer together. The same applies to adolescent mental, sexual and reproductive health and maternal and child health services. Greater integration produces better outcomes and can be more cost effective.

### **7.5 Generating knowledge by more research including implementation effectiveness and longitudinal designs that include critical social determinants of mental health.**

This is a significant gap in both HICs and LMICs research on parental mental health. Several vulnerable populations are missing from much of the analysis including adolescent boys and the link between parental mental health and the outcomes for children with learning disabilities, physical disabilities and intellectual impairments.

The review also revealed there needs to be communication between researchers and professionals including research institutions and research teams working on similar issues. There is an assumption that findings and models will be adaptable from one context to another, and an overwhelming focus of resources on HICs. But for models to be adaptable and innovations scaled up greater communication and sharing of information needs to happen. BvLF can help make the case not only for sharing lessons from HICs in LMICs but for greater research and innovations direction for LMICs.

### **7.6 Galvanising greater political and financial support from national governments, key international donors and policy makers for parental and carer mental health, to positively impact child development**

The mental and physical well-being of parents and children is a right that a well-functioning society must aspire to provide. Strong political will is critical to achieve the 2030 Agenda for Sustainable Development and Universal Health Coverage. We know that the cost of inaction is substantial in terms of future revenue lost to economies in the developing world, and for the long-term health and well-being of children as they transition into adulthood.<sup>cxxvii</sup> The economic cost of neglecting the burgeoning child development risk factors such as gender-based violence or intimate partner violence and parental (especially teenage maternal) ill-health is very high. BvLF can help to bring international donors and NGOs on board to address the cost of inaction by developing a convincing economic case and advocating for greater political and financial support.

## Annex 1 – Intervention examples

### Task-sharing and integrating mental health in the community settings

#### The Friendship Bench

##### Zimbabwe

The Friendship Bench in Zimbabwe<sup>cxxviii</sup> uses a three-pronged approach of community engagement, especially training of lay health workers to deliver depression care, evidence-based problem solving and cognitive behavioural therapy and a government endorsed scale up plan.<sup>cxxix cxxx</sup> A wooden bench has become a metaphor for community engagement in low resource settings, a friendly prop to providing care. Lay health workers, known as community grandmothers, deliver cognitive behavioural therapy in a safe, comfortable environment on wooden benches outside on the clinic. Patients, referred to the benches by clinicians, receive up to six 45-minute counselling sessions, including one home visit and, in some cases, referral to other health or social services and at times to income-generating activities. Specialist support is available via mobile phones and tablets. Assessed after 6 months, the prevalence of depression was less than 10% among roughly 250 Friendship Bench participants versus roughly one-third in a control group of similar size<sup>cxxxi</sup>. The Friendship Bench project has also developed an Inuka Hero program (and study findings are underway). This is a digital chat based coaching product which aims to connect people living with common mental disorders in low resource settings to trained coaches (Heroes) who provide support via a mobile interface<sup>cxxxii</sup>

#### Thinking Healthy Program

##### Pakistan, India, Vietnam

Thinking Healthy Program (THP) carried out several feasibility trials and RCTs in India and Pakistan focusing on perinatal depression including tracking child health outcomes<sup>cxxxiii</sup>. It was the first formal intervention launched by WHO as part of a series of evidence based low-intensity open-access interventions for LMICs. The intervention is delivered by female health workers and more recently tested delivery by peers and adaptations for adolescents are ongoing<sup>cxxxiv</sup>. The intervention has demonstrated cost-effectiveness and also demonstrated acceptability, effectiveness and cross-cultural transportability with trials taking place in Vietnam, India and additional studies in Pakistan. An evaluation study on THP found that the intervention increased women's financial empowerment, increasing their control over household spending as well as increased investment on parents and girlchild in Pakistan<sup>cxxxv</sup>. THPP produced better outcomes than enhanced usual care alone, and led to moderate effects on clinical, social and functional outcomes over six months post-natal<sup>cxxxvi</sup>. THPP was delivered in 6 to-14 individual sessions in four phases (prenatal phase, baby's arrival, prenatal, early infancy, middle infancy) until the baby was 6 months old, with sessions lasting between 30-45 minutes. An earlier study from the same region<sup>cxxxvii</sup> used similar intervention approach to counsel the women about exclusive breastfeeding (EBF).

#### Group Interpersonal Psychotherapy (G-IPT)

##### Uganda, Kenya

Group interpersonal psychotherapy (G-IPT) was recently launched as a WHO endorsed low intensity intervention extending the mhGAP evidence for interventions suitable for LMICs. It was first tested in war-affected Northern Uganda with men and women including young boys and girls exposed to militarization and trauma in that region<sup>cxxxviii</sup>. The intervention at that time used the innovation of a well-developed supervision model integral to psychotherapy practice, which was combined with task-sharing involving lay health workers who acted as the primary therapists. It has made great strides in Uganda



where it was used as a community-based scale-up model for depression in women by the NGO Strong Minds, treating over 8000 women in rural and peri urban Uganda. G-IPT has also been used in Kenya to test treatment of mental illness and distress in HIV positive depression women exposed to GBV<sup>cxix</sup>. The same model combined with collaborative care implementation model has been used by to address depression and distress in caregivers of children affected by nodding syndrome<sup>cxl</sup>.

## Testing novel mental health delivery strategies

### CETA

CETA is a transdiagnostic intervention for adults and children with mental health problems and has been developed specifically for use in LMICs. Like other common elements approaches, CETA is not conceptualized as a new intervention, but rather a new approach to training lay counsellors—one focused on common elements of CBT and decision making for treatment focus, element selection, sequencing and dosing<sup>cxli</sup>.

### Farm Radio International: Addressing Youth Depression in Malawi and Tanzania

A school-based intervention for targeting depression and suicide in adolescents tested in Canada, Malawi, Nicaragua, and Tanzania has provided a robust mental health curriculum through an integrated intervention tested at schools, radio programs, and primary care clinics focusing specifically on understanding mental health better (funded by Grand Challenges Canada<sup>cxlii</sup>). Given that the burden of adolescent pregnancies and early motherhood is high in young people living in LMICs, this intervention is innovative in targeting multilevel settings, players (pupils, teachers and community members) and disorders.

### Mental Health on Air

#### Malawi, Tanzania

A first project adapted a Canadian certified adolescent depression program for use in Tanzania to train clinic healthcare providers in the identification, diagnosis, and treatment of depression in young people. It connects schools to community health centres and trains teachers and health care providers at the same time as engaging adolescents. A related project is Mental Health On Air, a unique initiative funded by Grand Challenges Canada and led by Farm Radio International in collaboration with TeenMentalHealth.org. It aims to raise awareness and reduce the stigma of teenage depression, enhance mental health literacy for educators and students through schools and develop for the first time community based mental health services for young people in Malawi and Tanzania. It combines interactive radio programs for youth, secondary school curriculum materials for teaching of mental health literacy, school-based radio listening clubs and training for primary health care providers in the diagnoses and treatment of adolescent depression<sup>cxliii</sup>. There are no RCTs yet but it remains a scalable model with the multi-country and multipronged research evidence.

## Multilevel interventions targeting children and adults for scaling up

### “Frugal Innovations” for promoting mental health among adults and children

#### Vietnam

The intervention in Vietnam, “Frugal Innovations for promoting mental health among adults and children” is carried out in collaboration with Canadian institutions to train community health workers to help patients cope with anxiety and depression, and provides telephone-based coaching and support to families of children with behavioural difficulties is somewhat innovative. The pilot project focused solely on adult depression, but the scaled-up project involves over 4000 adults and children and will include a



child and family-focused component. Materials for a distance coaching model called "Strongest Families" have been adapted and translated for Vietnamese use, and a 25-family pilot study is underway.

## **FANS**

### **Pakistan**

The family networks for developmental disability, called FANS, is another study focusing on creating family networks for families with children having developmental disabilities in Pakistan. FANS aims to task-shift from community health workers to relatives and neighbours to extend this strategy further and create support network for families. The programs organize and trains family volunteers, called "champions", to provide help to their own children and to those within their network of five to seven families. Champions provide training and care via a tablet-based, Avatar-assisted Cascade Training (ACT) system that contains interactive, intuitive modules with story-telling avatars based on the WHO mhGAP. Hamdani et al (2015, 2016, 2017) began with the use of the WHO Parents Skills training to work with community health workers first. Wireless phone-based technology supports the program in many other ways as well. Initially, family members dial into an Interactive Voice Response (IVR) system to answer questions that help identify a child likely to have a developmental disorder, reducing the need to travel to a doctor or to wait for a health worker's visit. The work builds on the cusp of scientific, technological and social innovations around developmental needs of children in Pakistan.

## **Stepped-Care Model**

### **Brazil, Chile, Peru**

The first of UNICEF's six strategies for ending violence against children relates to supporting parents, caregivers and families<sup>cxliv</sup>. A number of interventions focusing on caregivers and parents in LMICs have identified that preventing abuse, maltreatment and adverse experiences in children requires parental training and attitude change on certain deep-rooted cultural practices. Their work in Brazil, Peru, Chile and more recently in Guatemala has focused on treating depression (including perinatal) in poor women in primary care settings with a focus on empowering women as they are critical caregivers for their families<sup>cxlv</sup>. The work uses a three-pronged stepped care model and the program aimed to improve existing care with structured protocols and rationalize the use of available resources. The authors have argued that innovative programs involve changes that are impossible to assimilate in the day-to-day delivery of care<sup>cxlvi</sup>. The main innovative element in this study was role enhancement for the nonmedical group leaders, most of whom were available in the clinics and were often closely connected to local neighbourhoods. These studies have as also included adolescents<sup>cxlvii</sup>.

## **Interventions for children with parents with mental conditions in HICs**

### **Netherlands, Norway, USA**

Another set of interventions have been developed around the needs of children with parents with mental illness in the HIC context of Netherlands and Norway. Various studies<sup>cxlviii</sup> have argued that preventative interventions are urgently needed for this group given the high-risk these children face: a history of family illness is a well-known predisposing and precipitating factor in development of psychopathology in the offspring.

## **Lullaby Project**

### **USA**

In the US, the Lullaby Project targets pregnant and new mothers and fathers with musicians to write and sing personalized lullabies for their infants<sup>cxlix</sup>. The scalability of these interventions is not yet fully known however the attempt at preventing mental illness by infusing positivity, creativity and resilience in parents is noteworthy.



## **Multiple Family Group**

### **USA, Worldwide**

Multiple Family Group (MFG) is a program developed by social workers focusing on family strengthening approaches towards addressing disruptive behavioural disorders in racially diverse children in urban US.<sup>ci</sup> Developed in collaboration with families of youth with disruptive behaviour disorders and mental health providers, the intervention involved sessions which were co-facilitated by clinicians and parent advocates (parents who have previously navigated through the child mental health service system)<sup>ci</sup>. The approach informed many other programs that were co-developed by McKay and her colleagues in South Africa. The collaborative HIV/AIDS and adolescent mental health programme (CHAMP) was developed in South Africa as a developmentally-timed, multi-session, family-based intervention that had been adapted and implemented with HIV youth in South Africa and in the US<sup>clii</sup>. It was developed to improve parent-child relationships and to strengthen the adult protective shield as a protective factor against HIV infection in adolescents. The study showed that there was significant improvement in communication, supervision, monitoring and support and youth mental health and risk behaviours (less time was spent in risky behaviours). This intervention was further defined in the more recent NIH funded multi-country study called Strengthening Mental health research capacity in SSA Africa (SMART- Africa) using MFGs to address child behavioural health by involving two-to-three generations of family members in a group-based intervention. The study is based in Uganda, Kenya, Ghana, South Africa and the US. Some studies<sup>cliii</sup> have used the original MFG approach with the reasoning that having parents and their children meet together to share information, address common concerns or develop supportive networks can be an efficient and effective means of providing child and family mental health services. Even when this approach is culturally adapted and modified to address specific contexts, it still retains the original appeal.

## **Government-led interventions**

### **Chile**

In Chile, efforts are being made by the national government to strengthen response to depression in primary care settings. Research by Araya and colleagues have tested several strategies such as stepped care, task-sharing and shifting, stigma reduction and depression assessment and treatment work with adolescents in primary care clinics. In the National Depression Detection and Treatment program Ministry of Health was directly involved and was implementing the work in primary care.

### **Lebanon**

The Lebanese government has worked very actively post Syrian crises and surge of migrants from Palestine (separately and before Syrian political crisis) and Syria to strengthen its own mental health system at specialist and primary care levels as this humanitarian crises impacts the country's own populations. There are a variety of different mental health programmes the government has been trialling including the use of new technology to address the needs of refugee populations and trialling the WHO Quality Rights Approach.

### **South Africa**

In South Africa, through PRIME, EMERALD and COBALT, sMINT programs funded by UKAID, DFID, NIH, a large body of mental health implementation research and mental health systems strengthening has been generated. A large part of these initiatives includes learning contextual problems and opportunities across countries and providing policy guidance and framework to address mental health in its treatment, prevention and promotion aspects. The South African team included a large number of government and NGO stakeholders in trying to address policy and programmatic issues.



### **Uganda**

The Ugandan government has incorporated several ECD and teacher training programs and are testing behavioural strategies to address early pregnancies, HIV prevention and treatment and enabling adolescent girl participation in education and health as a way of its National level response to integrating mental health.

### **Kenya**

The Kenyan government has decided to scale up primary health care response to key mental health conditions as their ongoing strategy to provide mental health care as part of universal health coverage initiative. There is also an ongoing effort to scale up Problem management plus as a Nationally adopted intervention to address common mental disorders in women and men in low resource contexts.

## Bibliography

Abas, M., Bowers, T., Manda, E., Cooper, S., Machando, D., Verhey, R., ... Chibanda, D. (2016). 'Opening up the mind': problem-solving therapy delivered by female lay health workers to improve access to evidence-based care for depression and other common mental disorders through the Friendship Bench Project in Zimbabwe. *International journal of mental health systems*, 10, 39. doi:10.1186/s13033-016-0071-9

Abdul Momin Kazi, Jason-Louis Carmichael, Galgallo Waqo Hapanna, Patrick Gikaria Wang'oo, Sarah Karanja, Denis Wanyama, Samuel Opondo Muhula, Lennie Bazira Kyomuhangi, Mores Loolpapit, Gilbert Bwire Wangalwa, Koki Kinagwi, Richard Todd Lester 2017 Assessing Mobile Phone Access and Perceptions for Texting-Based mHealth Interventions Among Expectant Mothers and Child Caregivers in Remote Regions of Northern Kenya: A Survey-Based Descriptive Study" *JMIR Public Health Surveill* 2017 (Jan 30); 3(1):e5

Aboud FY, AK. Global Health and Development in Early Childhood. *Annu Rev Psychol* 2015;66:14.11-14.25.

Abubakar I1, Aldridge RW2, Devakumar D3, Orcutt M3, Burns R3, Barreto ML4, Dhavan P5, Fouad FM6, Groce N7, Guo Y8, Hargreaves S9, Knipper M10, Miranda JJ11, Madise N12, Kumar B13, Mosca D5, McGovern T14, Rubenstein L15, Sammonds P16, Sawyer SM17, Sheikh K18, Tollman S19, Spiegel P20, Zimmerman C21; UCL–Lancet Commission on Migration and Health(2018). The UCL-Lancet Commission on Migration and Health: the health of a world on the move. *Lancet*. 2018 Dec 15;392(10164):2606-2654. doi: 10.1016/S0140-6736(18)32114-7. Epub 2018 Dec 5.

Andrew A, Attanasio O, Fitzsimons E, Grantham-McGregor S, Meghir C, Rubio-Codina M. Impacts 2 years after a scalable early childhood development intervention to increase psychosocial stimulation in the home: A follow-up of a cluster-randomised controlled trial in Colombia. *PLoS Med*. 2018;15(4): e1002556 doi: 10.1371/journal.pmed.1002556.

Aridi, J. O., Chapman, S. A., Wagah, M. A., & Negin, J. (2014). A comparative study of an NGO-sponsored CHW programme versus a ministry of health sponsored CHW programme in rural Kenya: a process evaluation. *Human resources for health*, 12, 64. doi:10.1186/1478-4491-12-64

Araya, R., Zitko, P. & Markkula, N. The Impact of Universal Health Care Programmes on Improving 'Realized Access' to Care for Depression in Chile. *Adm Policy Ment Health* (2018a) 45: 790. <https://doi.org/10.1007/s10488-018-0864-z>.

Araya, R., Zitko, P., Markkula, N., Rai, D., & Jones, K. (2018b). Determinants of access to health care for depression in 49 countries: a multilevel analysis. *Journal of Affective Disorders*, 234, 80-88. [29524750]. <https://doi.org/10.1016/j.jad.2018.02.092>.

Aridi JO, Chapman SA, Wagah MA, Negin J. A comparative study of an NGO-sponsored CHW programme versus a ministry of health sponsored CHW programme in rural Kenya: a process evaluation. *Hum Resour Health* 2014;12:64.



Arjadi, R., Nauta, M. H., Chowdhary, N., & Bockting, C. (2015). A systematic review of online interventions for mental health in low- and middle-income countries: a neglected field. *Global mental health (Cambridge, England)*, 2, e12. doi:10.1017/gmh.2015.10.

Atif, N., Krishna, R. N., Sikander, S., Lazarus, A., Nisar, A., Ahmad, I., ... Rahman, A. (2017). Mother-to-mother therapy in India and Pakistan: adaptation and feasibility evaluation of the peer-delivered Thinking Healthy Programme. *BMC psychiatry*, 17(1), 79. doi:10.1186/s12888-017-1244-z

Atif Rahman, Pamela J. Surkan, Claudina E. Cayetano, Patrick Rwagatare, Kim E. Dickson (2013). Grand Challenges: Integrating Maternal Mental Health into Maternal and Child Health Programmes. *Plos Medicine*, May 7, 2013 <https://doi.org/10.1371/journal.pmed.1001442>

Batura N, Hill Z, Haghparast-Bidgoli H, et al. (2015). Highlighting the evidence gap: how cost-effective are interventions to improve early childhood nutrition and development? *Health Policy Plan* 2015,30:813-821.

Baldwin, S., Malone, M., Sandall, J., & Bick, D. (2018). Mental health and wellbeing during the transition to fatherhood: a systematic review of first-time fathers' experiences. *JBI database of systematic reviews and implementation reports*, 16(11), 2118–2191. doi:10.11124/JBISRIR-2017-003773.

Baranov et al 2017. Maternal Depression, Women's Empowerment, and Parental Investment: Evidence from a Large Randomized Control Trial. <http://ftp.iza.org/dp11187.pdf>

Bailey D, Duncan GJ, Odgers CL, Yu W (2017). Persistence and Fadeout in the Impacts of Child and Adolescent Interventions *Res Educ Eff.*; 10(1):7-39.

Barlow J, Smailagic N, Huband N, Roloff V, Bennett C. Group-based parent training programmes for improving parental psychosocial health (Review). 2014. *Cochrane Database Syst Rev* 2014, Issue 5 Art. No.: CD002020.

Betancourt T, et al. Moderators of treatment effectiveness for war affected youth with depression in northern Uganda. *J Adolescent Health*. 2012;51(6):544–50.

Blake Helms, C., Turan, J. M., Atkins, G., Kempf, M. C., Clay, O. J., Raper, J. L., ... Turan, B. (2017). Interpersonal Mechanisms Contributing to the Association Between HIV-Related Internalized Stigma and Medication Adherence. *AIDS and behaviour*, 21(1), 238–247. doi:10.1007/s10461-016-1320-2.

Blencowe H, Cousens S, Chou D, et al. Born too soon: the global epidemiology of 15 million preterm births. *Reprod Health* 2013,10 Suppl 1:S2.

Bhana A., Mellins C. A., Petersen I., Alicea S., Myeza N., Holst H., McKay M. (2014). The VUKA family program: Piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. *AIDS Care*. 2014;(1):1–11. doi: 10.1080/09540121.2013.806770.

Boivin MJ, Bangirana P, Nakasujja N, et al. A year-long caregiver training program improves cognition in preschool Ugandan children with human immunodeficiency virus. *J Pediatr* 2013,163:1409-1416 e1401-1405.





Bolton P, et al. Group interpersonal psychotherapy for depression in rural Uganda. *Jama*. 2003; 289:3117–24.

Bonilla-Escobar, F. J., Fandiño-Losada, A., Martínez-Buitrago, D. M., Santaella-Tenorio, J., Tobón-García, D., Muñoz-Morales, E. J., ... Bolton, P. (2018). A randomized controlled trial of a transdiagnostic cognitive-behavioural intervention for Afro-descendants' survivors of systemic violence in Colombia. *PloS one*, 13(12), e0208483. doi:10.1371/journal.pone.0208483

Britto PR, Lye S, Proulx K, et al. Nurturing care: promoting early childhood development. *Lancet* 2016; published online Oct 4. [http://dx.doi.org/10.1016/S0140-6736\(16\)31390-3](http://dx.doi.org/10.1016/S0140-6736(16)31390-3).

Brown, F. L., Carswell, K., Augustinavicius, J., Adaku, A., Leku, M. R., White, R. G., ... Tol, W. A. (2018). Self Help Plus: study protocol for a cluster-randomised controlled trial of guided self-help with South Sudanese refugee women in Uganda. *Global mental health* (Cambridge, England), 5, e27. doi:10.1017/gmh.2018.17.

Chang SM, Grantham-McGregor SM, Powell CA, et al. Integrating a Parenting Intervention with Routine Primary Health Care: A Cluster Randomized Trial. *Pediatrics* 2015,136:272-280.

Charlene Coore Desai, Jody-Ann Reece & Sydonnie Shakespeare-Pellington (2017) The prevention of violence in childhood through parenting programmes: a global review, *Psychology, Health & Medicine*, 22:sup1, 166-186, DOI: 10.1080/13548506.2016.1271952.

Chomat, A. M., Andersson, N., Menchu, A. I., Ramirez-Sea, M., Pedersen, D., Bleile, A., ... Araya Baltra, R. (2019). Women's circles as a culturally safe psychosocial intervention in Guatemalan indigenous communities: a community-led pilot randomised trial. *BMC Women's Health*, 19(53). <https://doi.org/10.1186/s12905-019-0744-z>

Chibanda, D. (2017). Reducing the treatment gap for mental, neurological and substance use disorders in Africa: Lessons from the Friendship Bench in Zimbabwe. *Epidemiology and Psychiatric Sciences*, 26(4), 342-347. doi:10.1017/S2045796016001128

Chiu M, Rahman F, Kurdyak P, et al Self-rated health and mental health of lone fathers compared with lone mothers and partnered fathers: a population-based cross-sectional study *J Epidemiol Community Health* 2017;71:417-423.

Chunling L, Black M, Richter L. Risk of poor development in young children in low-income and middle-income countries: an estimation and analysis at the global, regional, and country level. *Lancet Global Health*, 2016; published online Oct 4. [http://dx.doi.org/10.1016/S2214-109X\(16\)30266-2](http://dx.doi.org/10.1016/S2214-109X(16)30266-2)  
Committee on Educating Health Professionals to Address the Social Determinants of Health., Board on Global Health, Institute of Medicine. (2016). *A Framework for Educating Health Professionals to Address the Social Determinants of Health*. National Academic Press, Washington DC.

Cooper PJ, Tomlinson M, Swartz L, et al. Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial. *BMJ* 2009,338: b974.

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., ... Born and Bred in Yorkshire (BaBY) team (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC pregnancy and childbirth*, 17(1), 45. doi:10.1186/s12884-017-1229-4.

Echeverri, C., Le Roy, J., Worku, B., & Ventevogel, P. (2018). Mental health capacity building in refugee primary health care settings in Sub-Saharan Africa: impact, challenges and gaps. *Global mental health (Cambridge, England)*, 5, e28. doi:10.1017/gmh.2018.19.

Efevbera, Y., McCoy, D. C., Wuermli, A. J., & Betancourt, T. S. (2018). Integrating early child-development and violence prevention programs: A systematic review. In J. F. Leckman & P. R. Britto (Eds.), *Towards a More Peaceful World: The Promise of Early Child Development Programmes*. *New Directions for Child and Adolescent Development*, 159, 27–54

Engle PL, Fernald LC, Alderman H, et al. Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries. *Lancet* 2011,378:1339-1353.

Engle PL, Black MM, Behrman JR, et al. Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world. *Lancet* 2007,369:229-242.

Epping-Jordan, J. E., Harris, R., Brown, F. L., Carswell, K., Foley, C., García-Moreno, C., ... van Ommeren, M. (2016). Self-Help Plus (SH+): a new WHO stress management package. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, 15(3), 295–296. doi:10.1002/wps.20355.

Fisher, J., Nguyen, H., Mannava, P., Tran, H., Dam, T., Tran, H., ... Luchters, S. (2014). Translation, cultural adaptation and field-testing of the Thinking Healthy Program for Vietnam. *Globalization and health*, 10, 37. doi:10.1186/1744-8603-10-37

Fuhr DC, Weobong B, Lazarus A, et al. (2019). Delivering the Thinking Healthy Programme for perinatal depression through peers: an individually-randomised controlled trial in India. *Lancet Psychiatry Lancet Psychiatry*. 2019 Feb;6(2):115-127. doi: 10.1016/S2215-0366(18)30466-8.

Gardner JM, Walker SP, Powell CA, Grantham-McGregor S. A randomized controlled trial of a home-visiting intervention on cognition and behaviour in term low birth weight infants. *J Paediatric* 2003,143:634-639.

Gladstone M, Oliver C, Van den Broek N. Survival, morbidity, growth and developmental delay for babies born preterm in low- and middle-income countries - a systematic review of outcomes measured. *PLoS One* 2015,10: e0120566.

Gowani S, Yousafzai AK, Armstrong R, Bhutta ZA. Cost effectiveness of responsive stimulation and nutrition interventions on early child development outcomes in Pakistan. *Ann N Y Acad Sci* 2014,1308:149-161.

Greene, M. C., Kane, J. C., Khoshnood, K., Ventevogel, P., & Tol, W. A. (2018). Challenges and opportunities for implementation of substance misuse interventions in conflict-affected populations. *Harm reduction journal*, 15(1), 58. doi:10.1186/s12954-018-0267-1

- Greene, M. C., Jordans, M., Kohrt, B. A., Ventevogel, P., Kirmayer, L. J., Hassan, G., ... Tol, W. A. (2017). Addressing culture and context in humanitarian response: preparing desk reviews to inform mental health and psychosocial support. *Conflict and health*, 11, 21. doi:10.1186/s13031-017-0123-z.
- Gupta, S., & Ford-Jones, E. (2014). Recognizing and responding to parental mental health needs: What can we do now? *Paediatrics & child health*, 19(7), 357–361.
- Gurung, B., Jackson, L.J., Monahan, M. et al. (2018). Identifying and assessing the benefits of interventions for postnatal depression: a systematic review of economic evaluations. *BMC Pregnancy Childbirth*, 18: 179. <https://doi.org/10.1186/s12884-018-1738-9>
- Hahn-Holbrook, J., Cornwell-Hinrichs, T., & Anaya, I. (2018). Economic and Health Predictors of National Postpartum Depression Prevalence: A Systematic Review, Meta-analysis, and Meta-Regression of 291 Studies from 56 Countries. *Frontiers in psychiatry*, 8, 248. doi:10.3389/fpsy.2017.00248
- Hardee, K., Gay, J., & Blanc, A. K. (2012). Maternal morbidity: neglected dimension of safe motherhood in the developing world. *Global public health*, 7(6), 603–617. doi:10.1080/17441692.2012.668919
- Harlow, Harry (1958). "The nature of love". *American Psychologist*. 13 (12): 673–685. doi:10.1037/h0047884.
- Harlow, H. F. & Zimmermann, R. R. (1958). The development of affective responsiveness in infant monkeys. *Proceedings of the American Philosophical Society*, 102, 501 -509.
- Hindin M.J., Kalamar A.M., Thompson T.-A., Upadhyay U.D. (2016). Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature *Journal of Adolescent Health*, 59 (3), pp. S8-S15.
- Honikman S, van Heyningen T, Field S, Baron E, Tomlinson M (2012) Stepped Care for Maternal Mental Health: A Case Study of the Perinatal Mental Health Project in South Africa. *PLoS Med* 9(5): e1001222. <https://doi.org/10.1371/journal.pmed.1001222>.
- Horton S, Black MM. Identifying an Essential Package for Early Child Development: Economic Analysis. In: Bundy DAP, Silva Nd, Horton S, et al., editors. *Child and Adolescent Health and Development*. 3rd edition. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2017 Nov 20. Chapter 24. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK525228/> doi: 10.1596/978-1-4648-0423-6/pt5.ch24.
- Hurt, L., Paranjothy, S., Lucas, P. J., Watson, D., Mann, M., Griffiths, L. J., ... Lingam, R. (2018). Interventions that enhance health services for parents and infants to improve child development and social and emotional well-being in high-income countries: a systematic review. *BMJ open*, 8(2), e014899. doi:10.1136/bmjopen-2016-014899.
- Hughes, P., Hijazi, Z., & Saeed, K. (2016). Improving access to mental healthcare for displaced Syrians: case studies from Syria, Iraq and Turkey. *BJPsych international*, 13(4), 84–86.
- Howard, LM, Piot, P, Stein, A. (2014). No health without perinatal mental health. *Lancet*. 384 (9566): 1723-24.



- Jensen SK, Bouhouch RR, Walson JL, et al. Enhancing the child survival agenda to promote, protect, and support early child development. *Semin Perinatol* 2015,39:373-386.
- Kane, J. C., Elafros, M. A., Murray, S. M., Mitchell, E., Augustinavicius, J. L., Causevic, S., & Baral, S. D. (2019). A scoping review of health-related stigma outcomes for high-burden diseases in low- and middle-income countries. *BMC medicine*, 17(1), 17. doi:10.1186/s12916-019-1250-8.
- Karimzadeh, M., Rostami, M., Teymouri, R., Moazzen, Z., & Tahmasebi, S. (2017). The association between parental mental health and behavioural disorders in pre-school children. *Electronic physician*, 9(6), 4497–4502. doi:10.19082/4497
- Kieling C1, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, Rohde LA, Srinath S, Ulkuer N, Rahman A. (2011). Child and adolescent mental health worldwide: evidence for action. *Lancet*. 2011 Oct 22;378(9801):1515-25. doi: 10.1016/S0140-6736(11)60827-1. Epub 2011 Oct 16.
- Kimbui, E., Kuria, M., Yator, O., & Kumar, M. (2018). A cross-sectional study of depression with comorbid substance use dependency in pregnant adolescents from an informal settlement of Nairobi: drawing implications for treatment and prevention work. *Annals of general psychiatry*, 17, 53. doi:10.1186/s12991-018-0222-2.
- Klein P, Rye H. Interaction-oriented early intervention in Ethiopia. *Infants and Young Children* 2004,17:304-354.
- Kohrt, B. A., Asher, L., Bhardwaj, A., Fazel, M., Jordans, M., Mutamba, B. B., ... Patel, V. (2018). The Role of Communities in Mental Health Care in Low- and Middle-Income Countries: A Meta-Review of Components and Competencies. *International journal of environmental research and public health*, 15(6), 1279. doi:10.3390/ijerph15061279.
- Kumar M, Huang KY, Othieno C, et al. Adolescent Pregnancy and Challenges in Kenyan Context: Perspectives from Multiple Community Stakeholders. *Glob Soc Welf* 2018; 5(1): 11-27.
- Kumar, S. V., Oliffe, J. L., & Kelly, M. T. (2017). Promoting Postpartum Mental Health in Fathers: Recommendations for Nurse Practitioners. *American journal of men's health*, 12(2), 221–228. doi:10.1177/1557988317744712.
- Kutcher, S., Udedi, M., Gilberds, H., Brown, A., Chapota, R., & Perkins, K. (2017). Clinic outcomes of the Pathway to Care Model: A cross-sectional survey of adolescent depression in Malawi. *Malawi medical journal: the journal of Medical Association of Malawi*, 29(2), 97–102.
- Kutcher, S., Wei, Y., Gilberds, H., Brown, A., Ubuguyu, O., Njau, T., ... Perkins, K. (2017). Addressing Adolescent Depression in Tanzania: Positive Primary Care Workforce Outcomes Using a Training Cascade Model. *Depression research and treatment*, 2017, 9109086. doi:10.1155/2017/9109086.
- Kutcher, S., Wei, Y., Gilberds, H., Ubuguyu, O., Njau, T., Brown, A., ... Perkins, K. (2016). A school mental health literacy curriculum resource training approach: effects on Tanzanian teachers' mental health knowledge, stigma and help-seeking efficacy. *International journal of mental health systems*, 10, 50. doi:10.1186/s13033-016-0082-6



Kutcher, S., Wei, Y., & Behzadi, P. (2016). School- and Community-Based Youth Suicide Prevention Interventions: Hot Idea, Hot Air, or Sham? *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 62(6), 381–387. doi:10.1177/0706743716659245

Leijdesdorff S, van Doesum K, Pomac A, Klaassen R, van Amelsvoort T. Prevalence of psychopathology in children of parents with mental illness and/or addiction: an up to date narrative review. *Curr Opin Psychiatry* (2017) 30:312–7. doi: 10.1097/YCO.0000000000000341

Lempp, H., Abayneh, S., Gurung, D., Kola, L., Abdulmalik, J., Evans-Lacko, S., . . . Hanlon, C. (2018). Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: A cross-country qualitative study. *Epidemiology and Psychiatric Sciences*, 27(1), 29-39. doi:10.1017/S2045796017000634.

Lopez Boo F, Palloni G, Urzua S. Cost-benefit analysis of a micronutrient supplementation and early childhood stimulation program in Nicaragua. *Ann N Y Acad Sci* 2014,1308:139-148.

Lu C, Li Z, Patel V (2018) Global child and adolescent mental health: The orphan of development assistance for health. *PLoS Med* 15(3): e1002524. <https://doi.org/10.1371/journal.pmed.1002524>

Lund, C., Tomlinson, M., & Patel, V. (2016). Integration of mental health into primary care in low- and middle-income countries: the PRIME mental healthcare plans. *The British journal of psychiatry: the journal of mental science*, 208 Suppl 56(Suppl 56), s1–s3. doi:10.1192/bjp.bp.114.153668  
Madrasa Early childhood development program. <https://www.grandchallenges.ca/grantee-stars/1803-22173/>

Martínez, V., Rojas, G., Martínez, P., Zitko, P., Irrarázaval, M., Luttes, C., & Araya, R. (2018). Remote Collaborative Depression Care Program for Adolescents in Araucanía Region, Chile: Randomized Controlled Trial. *Journal of medical Internet research*, 20(1), e38. doi:10.2196/jmir.8021.

Maselko, J. Social Epidemiology and Global Mental Health: Expanding the Evidence from High-Income to Low- and Middle-Income Countries. *Curr Epidemiol Rep* (2017) 4: 166. <https://doi.org/10.1007/s40471-017-0107-y>

Masulani-Mwale, C., Kauye, F., Gladstone, M., & Mathanga, D. (2019). Development of a psycho-social intervention for reducing psychological distress among parents of children with intellectual disabilities in Malawi. *PloS one*, 14(2), e0210855. doi:10.1371/journal.pone.0210855.

McLeish J, Redshaw M. Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC Pregnancy Childbirth*. [journal article]. 2017;17(1):28.

McKay, M. M., Gonzales, J., Quintana, E., Kim, L., & Abdul-Adil, J. (1999). Multiple Family Groups: An Alternative for Reducing Disruptive Behavioral Difficulties of Urban Children. *Research on Social Work Practice*, 9(5), 593–607. <https://doi.org/10.1177/104973159900900505>.

Editorial. Mental health and wellbeing in children and adolescents. *The Lancet*  
Published: April 05, 2014 DOI:[https://doi.org/10.1016/S0140-6736\(14\)60587-0](https://doi.org/10.1016/S0140-6736(14)60587-0)



Meyer, S. R., Steinhaus, M., Bangirana, C., Onyango-Mangen, P., & Stark, L. (2017). The influence of caregiver depression on adolescent mental health outcomes: findings from refugee settlements in Uganda. *BMC psychiatry*, 17(1), 405. doi:10.1186/s12888-017-1566-x.

Mugisha, J., Abdulmalik, J., Hanlon, C., Petersen, I., Lund, C., Upadhaya, N., ... Kigozi, F. (2017). Health systems context(s) for integrating mental health into primary health care in six Emerald countries: a situation analysis. *International journal of mental health systems*, 11, 7. doi:10.1186/s13033-016-0114-2

Murray, L. K., Haroz, E. E., Doty, S. B., Singh, N. S., Bogdanov, S., Bass, J., ... Bolton, P. (2018). Testing the effectiveness and implementation of a brief version of the Common Elements Treatment Approach (CETA) in Ukraine: a study protocol for a randomized controlled trial. *Trials*, 19(1), 418. doi:10.1186/s13063-018-2752-y.

Murray, L., Cooper, P., Artech, A., Stein, A., & Tomlinson, M. (2016). Randomized controlled trial of the effect of a home visiting intervention on infant cognitive development in peri-urban South Africa. *Developmental Medicine and Child Neurology*, 58(3), 270–276. <http://doi.org/10.1111/dmcn.12873>

Murray, L. K., & Jordans, M. J. (2016). Rethinking the service delivery system of psychological interventions in low- and middle-income countries. *BMC psychiatry*, 16, 234. doi:10.1186/s12888-016-0938-y

Murray-Kolb, L. E., Rasmussen, Z. A., Scharf, R. J., Rasheed, M. A., Svensen, E., Seidman, J. C., ... Lang, D. (2014). The MAL-ED Cohort Study: Methods and Lessons Learned When Assessing Early Child Development and Caregiving Mediators in Infants and Young Children in 8 Low- and Middle-Income Countries. *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*, 59(Suppl 4), S261–S272. <http://doi.org/10.1093/cid/ciu437>

Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., ... Bolton, P. (2014). A Common Elements Treatment Approach for Adult Mental Health Problems in Low- and Middle-Income Countries. *Cognitive and behavioural practice*, 21(2), 111–123. doi:10.1016/j.cbpra.2013.06.005.

Mutamba BB, et al. Psychological treatments delivered by community health workers in low-resource government health systems: effectiveness of group interpersonal psychotherapy for caregivers of children affected by nodding syndrome in Uganda. *Psychol Med*. 2018; 1–11.

Mutamba, B. B., Kohrt, B. A., Okello, J., Nakigudde, J., Opar, B., Musisi, S., ... de Jong, J. (2018). Contextualization of psychological treatments for government health systems in low-resource settings: group interpersonal psychotherapy for caregivers of children with nodding syndrome in Uganda. *Implementation science: IS*, 13(1), 90. doi:10.1186/s13012-018-0785-y.

Nores M BW. Benefits of early childhood interventions across the world: (Under) Investing in the very young. *Economics of Education Review* 2010;29:271-282.

Nunes AP, Phipps MG. Postpartum depression in adolescent and adult mothers: comparing prenatal risk factors and predictive models. *Maternal Child Health J* 2013; 17(6): 1071-9.

Osok J, Kigamwa P, Stoep AV, Huang KY, Kumar M. Depression and its psychosocial risk factors in pregnant Kenyan adolescents: a cross-sectional study in a community health Centre of Nairobi. *BMC Psychiatry* 2018; 18(1): 136.



Organization WH. Community health workers: what do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. In; 2007.

Otieno, G., Githinji, S., Jones, C., Snow, R. W., Talisuna, A., & Zurovac, D. (2014). The feasibility, patterns of use and acceptability of using mobile phone text-messaging to improve treatment adherence and post-treatment review of children with uncomplicated malaria in western Kenya. *Malaria Journal*, 13, 44. <http://doi.org/10.1186/1475-2875-13-44>

Patel V, Saxena S (Eds). The Lancet Commission on Global Mental Health and Sustainable Development. Lancet 2018.

Perrier T ND, DeRenzi B, Anderson R, Kinuthia J, Unger J, John-Stewart G. Engaging Pregnant Women in Kenya with a Hybrid Computer-Human SMS Communication System. *Information and Communication Technologies and Development* 2015.

Petersen, I., Evans-Lacko, S., Semrau, M., Barry, M. M., Chisholm, D., Gronholm, P., ... Thornicroft, G. (2016). Promotion, prevention and protection: interventions at the population- and community-levels for mental, neurological and substance use disorders in low- and middle-income countries. *International journal of mental health systems*, 10, 30. doi:10.1186/s13033-016-0060-z.

Pillai, N (2008). "Right to Health and the Universal Declaration of Human Rights". *The Lancet*. 372 (9655): 2005–2006. doi:10.1016/S0140-6736(08)61783-3. PMID 19097276.

Potterton J, Stewart A, Cooper P, Becker P. The effect of a basic home stimulation programme on the development of young children infected with HIV. *Dev Med Child Neurol* 2010;52:547-551.

Pradhan, R., Wynter, K., & Fisher, J. (2015). Factors associated with pregnancy among adolescents in low-income and lower middle-income countries: a systematic review. *Journal of Epidemiology and Community Health*; 69(9):918-24. doi: 10.1136/jech-2014-205128.

Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, Rahman, A. (2007) No health without mental health. *The Lancet*, 370: 859-877.

Purgato et al 2018. Focused psychosocial interventions for children in low-resource humanitarian settings: a systematic review and individual participant data meta-analysis. *Lancet Glob Health*. 2018 Apr;6(4):e390-e400. doi: 10.1016/S2214-109X(18)30046-9.

Rahman A, Malik A, Sikander S, Roberts C, Creed F. (2008). Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. *The Lancet*. 372:902–909.

Rahman et al. (2015) The effectiveness and cost-effectiveness of the peer-delivered Thinking Healthy Programme for perinatal depression in Pakistan and India: the SHARE study protocol for randomized controlled trials. *Trials* 2015;16:015–1063. 10.1186/s13063-015-1063-9

Ravindran, A. V., Herrera, A., da Silva, T. L., Henderson, J., Castrillo, M. E., & Kutcher, S. (2018). Evaluating the benefits of a youth mental health curriculum for students in Nicaragua: a parallel-group,



controlled pilot investigation. *Global mental health* (Cambridge, England), 5, e4.  
doi:10.1017/gmh.2017.27

Reedtz, C., Lauritzen, C., Stover, Y. V., Freili, J. L., & Rognmo, K. (2019). Identification of Children of Parents with Mental Illness: A Necessity to Provide Relevant Support. *Frontiers in psychiatry*, 9, 728.  
doi:10.3389/fpsyt.2018.00728

Return on promotion. [https://cpa.ca/docs/File/Practice/roi\\_mental\\_health\\_report\\_en.pdf](https://cpa.ca/docs/File/Practice/roi_mental_health_report_en.pdf)  
Return on Investment.

[https://www.rand.org/content/dam/rand/pubs/research\\_reports/RR1700/RR1787/RAND\\_RR1787.pdf](https://www.rand.org/content/dam/rand/pubs/research_reports/RR1700/RR1787/RAND_RR1787.pdf)

Richter LM, Daelmans B, Lombardi J, et al. Investing in the foundation of sustainable development: pathways to scale for early childhood development. *Lancet* 2016; published online Oct 4.  
[http://dx.doi.org/10.1016/S0140-6736\(16\)31698-1](http://dx.doi.org/10.1016/S0140-6736(16)31698-1).

Ricci KA, Girosi F, Tarr PI, et al. Reducing stunting among children: the potential contribution of diagnostics. *Nature* 2006,444 Suppl 1:29-38.

Rockers PC, Zanolini A, Banda B, Chipili MM, Hughes RC, Hamer DH, et al. Two-year impact of community-based health screening and parenting groups on child development in Zambia: Follow-up to a cluster-randomized controlled trial. *PLoS Med.* 2018;15(4): e1002555.

Rose-Clarke K, Bentley A, Marston C, Prost A (2019) Peer-facilitated community-based interventions for adolescent health in low- and middle-income countries: A systematic review. *PLoS ONE* 14(1): e0210468.  
<https://doi.org/10.1371/journal.pone.0210468>.

Saxena S, Thornicroft G, Knapp M, Whiteford H (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet* 370, 878–889.

Scaling-up treatment of depression and anxiety: a global return on investment analysis. 2016.

[https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(16\)30024-4/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/fulltext)

Schneider, M., Baron, E., Davies, T., Munodawafa, M., & Lund, C. (2018). Patterns of intimate partner violence among perinatal women with depression symptoms in Khayelitsha, South Africa: a longitudinal analysis. *Global mental health* (Cambridge, England), 5, e13. doi:10.1017/gmh.2018.1

Shen, GC; Eaton, J; Snowden, LR; (2017) Mainstreaming Mental Health Care in 42 Countries. *Health Syst Reform*, 3 (4). pp. 313-324. ISSN 2328-8620 DOI: <https://doi.org/10.1080/23288604.2017.1356424>

Shonkoff J, Radner J, Foote N. Expanding the evidence base to drive more productive early childhood investment. *Lancet* 2016; published online Oct 4. [http://dx.doi.org/10.1016/S0140-6736\(16\)31702-0](http://dx.doi.org/10.1016/S0140-6736(16)31702-0).

Siegel RS, Brandon AR. Adolescents, pregnancy, and mental health. *J PediatrAdolescGynecol* 2014; 27(3): 138-50.

Sikander S, Ahmad I, Atif N, et al. (2019) Delivering the Thinking Healthy Programme for perinatal depression through volunteer peers: a cluster randomised controlled trial in Pakistan *Lancet Psychiatry* *Lancet Psychiatry*. 2019 Feb;6(2):128-139. doi: 10.1016/S2215-0366(18)30467-X.





Singla DR, Kumbakumba E, Aboud FE. Effects of a parenting intervention to address both maternal psychological wellbeing and child development and growth in rural Uganda: a community-based, cluster randomised trial. *Lancet Glob Health* 2015;3:e458-469.

Smith Fawzi MC, Andrews KG, Fink G, et al. (2019). Lifetime economic impact of the burden of childhood stunting attributable to maternal psychosocial risk factors in 137 low/middle-income countries. *BMJ Glob Health* 2019; 4: e001144. doi:10.1136/bmjgh-2018-001144

Ssewamala, F. M., Bermudez, L. G., & Santelli, J. (2017). The Power of Financial Inclusion: Reporting on the Efficacy of Economic Strengthening Interventions in Sub-Saharan Africa. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, 62(1S), S3–S5. doi:10.1016/j.jadohealth.2017.11.001.

Ssewamala, F. M., Karimli, L., Torsten, N., Wang, J. S., Han, C. K., Ilic, V., & Nabunya, P. (2016). Applying a Family-Level Economic Strengthening Intervention to Improve Education and Health-Related Outcomes of School-Going AIDS-Orphaned Children: Lessons from a Randomized Experiment in Southern Uganda. *Prevention science : the official journal of the Society for Prevention Research*, 17(1), 134–143. doi:10.1007/s11121-015-0580-9.

Tamis-LeMonda CS, Bornstein MH, Baumwell L. Maternal responsiveness and children's achievement of language milestones. *Child Dev* 2001;72:748-767.

The United Nations. (1989). *Convention on the Rights of the Child*. Treaty Series, 1577, 3.

The United Nations. (1948). *The Universal Declaration of Human Rights*.

Tol, W. A., Patel, V., Tomlinson, M., Baingana, F., Galappatti, A., Panter-Brick, C., ... van Ommeren, M. (2011). Research priorities for mental health and psychosocial support in humanitarian settings. *PLoS medicine*, 8(9), e1001096. doi:10.1371/journal.pmed.1001096.

Tomlinson M. (2018). From surviving to thriving: What evidence is needed to move early child-development interventions to scale? *PLoS medicine*, 15(4), e1002557. doi:10.1371/journal.pmed.1002557

UNESCO (2014). *Developing an education sector response to early and unintended pregnancy*. Discussion Document for global consultation. Nov 2014. Paris.

UNFPA. *Motherhood in Childhood; Facing the challenge of Adolescent Pregnancy*. 2013. <https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf> (accessed 20.7. 2018).

UNICEF (2014). *A systematic review of parenting programs for young children in LMICS*. [https://www.unicef.org/earlychildhood/files/P\\_Shanker\\_final\\_Systematic\\_Review\\_of\\_Parenting\\_ECD\\_Dec\\_15\\_copy.pdf](https://www.unicef.org/earlychildhood/files/P_Shanker_final_Systematic_Review_of_Parenting_ECD_Dec_15_copy.pdf)

UN (2015). *Transforming our World: The 2030 Agenda for Sustainable Development*. UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1



van Ginneken N, Maheedhariah MS, Ghani S, Ramakrishna J, Raja A, Patel V (2017) Human resources and models of mental healthcare integration into primary and community care in India: Case studies of 72 programmes. PLoS ONE 12(6): e0178954. <https://doi.org/10.1371/journal.pone.0178954>.

Ventevogel P, Van Ommeren M, Schilperoord M, Saxena S (2015). Improving mental health care in humanitarian emergencies. Bulletin of the World Health Organization, 93, 666–666A.

Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Lincoln, N., Bass, J., ... Weissman, M. M. (2003). Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda. World psychiatry : official journal of the World Psychiatric Association (WPA), 2(2), 114–120.

Votruba, N., Ziemann, A., Grant, J., & Thornicroft, G. (2018). A systematic review of frameworks for the interrelationships of mental health evidence and policy in low- and middle-income countries. Health research policy and systems, 16(1), 85. doi:10.1186/s12961-018-0357-2.

Walker SP, Wachs TD, Grantham-McGregor S, et al. Inequality in early childhood: risk and protective factors for early child development. Lancet 2011,378:1325-1338.

Walker SP, Chang SM, Powell CA, Grantham-McGregor SM. Psychosocial intervention improves the development of term low-birth-weight infants. J Nutr 2004,134:1417-1423.

Watkins DA, Jamison DT, Mills T., et al. Universal Health Coverage and Essential Packages of Care. In: Jamison DT, Gelband H, Horton S, et al., editors. Disease Control Priorities: Improving Health and Reducing Poverty. 3rd edition. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2017 Nov 27. Chapter 3. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK525285/> doi: 10.1596/978-1-4648-0527-1/pt1.ch3

Wei, Y., Kutcher, S., & LeBlanc, J. C. (2015). Hot Idea or Hot Air: A Systematic Review of Evidence for Two Widely Marketed Youth Suicide Prevention Programs and Recommendations for Implementation. Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Academie canadienne de psychiatrie de l'enfant et de l'adolescent, 24(1), 5–16.

Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T (2015) The Global Burden of Mental, Neurological and Substance Use Disorders: An Analysis from the Global Burden of Disease Study 2010. PLoS ONE 10(2): e0116820. <https://doi.org/10.1371/journal.pone.0116820>.  
World Health Organization. Adolescent Health and Adverse Childhood experiences. [http://apps.who.int/adolescent/second-decade/section/section\\_5/level5\\_3.php](http://apps.who.int/adolescent/second-decade/section/section_5/level5_3.php) accessed on 7th April 2019

World Health Organization (2018). Adolescent Pregnancy. Available at <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>. 6th April 2019.

World Health Organization (2015). Thinking Healthy Programme. A manual for psychological management for perinatal depression. Geneva: WHO; 2015.

Winnicott, D. W. (1971). Playing and Reality. London: Penguin Books.



World Health Organization & United Nations High Commissioner for Refugees (2015). mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies. WHO: Geneva.

World Health Organization, Unicef. Care for Child Development. Geneva, Switzerland: World Health Organization; 2012.

World Health Organization, 2003. Caring for children and adolescents with mental disorders: Setting WHO directions. Geneva,

World Health Organization (2018c). Mental health in primary care: Illusion or inclusion? WHO technical series. Geneva.

World Health Organization (2018a). Meeting report on Public Financing for UHC: Towards Implementation. WHO: Geneva.

World Health Organization. (2013). Investing in mental health: evidence for action. World Health Organization. <http://www.who.int/iris/handle/10665/87232>

World Health Organization. 2015. Atlas Interactive infographic.

[https://www.who.int/mental\\_health/evidence/atlas/interactive\\_infographic\\_2015.pdf](https://www.who.int/mental_health/evidence/atlas/interactive_infographic_2015.pdf)

World Health organization (2018b). Mental Health Atlas. Geneva: WHO.

[https://www.who.int/mental\\_health/evidence/atlas/mental\\_health\\_atlas\\_2017/en/](https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/)

Kakuma et al (2011). Human resources for mental health care: current situation and strategies for action. *Lancet* 2011; 378: 1654–63 Published Online October 17, 2011 DOI:10.1016/S0140-6736(11)61093-3

World Bank (2018). Poverty and shared prosperity. Washington DC: World Bank Group. Accessed on 15<sup>th</sup>

April 2019. UNICEF and the World Bank (2016). Ending extreme poverty. New York: UNICEF and the

World Bank Group. Published on 10<sup>th</sup> October 2016. Accessed on 15<sup>th</sup> April 2019.

World Health Organisation (2008). Integrating mental health into primary care settings: A global perspective. Geneva: WHO.

[https://www.who.int/mental\\_health/resources/mentalhealth\\_PHC\\_2008.pdf](https://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf). Accessed on 10<sup>th</sup> April 2019

World Health Organisation (2013). Arguing for universal health coverage. World Health Organization. <http://www.who.int/iris/handle/10665/204355>

Sashidharan, S., White, R., Mezzina, R., Jansen, S., & Gishoma, D. (2016). Global mental health in high-income countries. *British Journal of Psychiatry*, 209(1), 3-5. doi:10.1192/bjp.bp.115.179556

World Health Organisation (2007). Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. WHO.

World Health Organization. (2003). Investing in mental health. World Health Organization. <http://www.who.int/iris/handle/10665/42823>



Woods-Jaeger, B. A., Kava, C. M., Akiba, C. F., Lucid, L., & Dorsey, S. (2016). The art and skill of delivering culturally responsive trauma-focused cognitive behavioural therapy in Tanzania and Kenya. *Psychological trauma : theory, research, practice and policy*, 9(2), 230–238. doi:10.1037/tra0000170

Yousafzai, Aisha K et al. 2016. Effects of responsive stimulation and nutrition interventions on children's development and growth at age 4 years in a disadvantaged population in Pakistan: a longitudinal follow-up of a cluster-randomised factorial effectiveness trial. *The Lancet Global Health* , Volume 4 , Issue 8 , e548 - e558

Yousafzai AK, Rasheed MA, Rizvi A, Armstrong R, Bhutta ZA. Effect of integrated responsive stimulation and nutrition interventions in the Lady Health Worker programme in Pakistan on child development, growth, and health outcomes: a cluster-randomised factorial effectiveness trial. *Lancet* 2014,384:1282-1293.

Zafar, S., Sikander, S., Hamdani, S. U., Atif, N., Akhtar, P., Nazir, H., ... Rahman, A. (2016). The effectiveness of Technology-assisted Cascade Training and Supervision of community health workers in delivering the Thinking Healthy Program for perinatal depression in a post-conflict area of Pakistan – study protocol for a randomized controlled trial. *Trials*, 17, 188. <http://doi.org/10.1186/s13063-016-1308-2>

Zhou, W., Yu, Y., Yang, M., Chen, L., & Xiao, S. (2018). Policy development and challenges of global mental health: a systematic review of published studies of national-level mental health policies. *BMC psychiatry*, 18(1), 138. doi:10.1186/s12888-018-1711.

## ENDNOTES

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- <sup>i</sup> Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T (2015) The Global Burden of Mental, Neurological and Substance Use Disorders: An Analysis from the Global Burden of Disease Study 2010. *PLoS ONE* 10(2): e0116820. <https://doi.org/10.1371/journal.pone.0116820>.
- <sup>ii</sup> Winnicott, D. W. (1971). *Playing and Reality*. London: Penguin Books
- <sup>iii</sup> Nature Education, accessed on 7<sup>th</sup> April 2019
- <sup>iv</sup> McLeish J, Redshaw M. Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC Pregnancy Childbirth*. [journal article]. 2017;17(1):28.
- <sup>v</sup> World Health organization (2018). *Mental Health Atlas*. Geneva: WHO. [https://www.who.int/mental\\_health/evidence/atlas/mental\\_health\\_atlas\\_2017/en/](https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/)
- <sup>vi</sup> Osok J, Kigamwa P, Stoep AV, Huang KY, Kumar M. Depression and its psychosocial risk factors in pregnant Kenyan adolescents: a cross-sectional study in a community health Centre of Nairobi. *BMC Psychiatry* 2018; 18(1): 136.
- <sup>vii</sup> Kimbui, E., Kuria, M., Yator, O., & Kumar, M. (2018). A cross-sectional study of depression with comorbid substance use dependency in pregnant adolescents from an informal settlement of Nairobi: drawing implications for treatment and prevention work. *Annals of general psychiatry*, 17, 53. doi:10.1186/s12991-018-0222-2.
- <sup>viii</sup> Schneider, M., Baron, E., Davies, T., Munodawafa, M., & Lund, C. (2018). Patterns of intimate partner violence among perinatal women with depression symptoms in Khayelitsha, South Africa: a longitudinal analysis. *Global mental health (Cambridge, England)*, 5, e13. doi:10.1017/gmh.2018.1
- <sup>ix</sup> Hahn-Holbrook, J., Cornwell-Hinrichs, T., & Anaya, I. (2018). Economic and Health Predictors of National Postpartum Depression Prevalence: A Systematic Review, Meta-analysis, and Meta-Regression of 291 Studies from 56 Countries. *Frontiers in psychiatry*, 8, 248. doi:10.3389/fpsy.2017.00248
- <sup>x</sup> Hardee, K., Gay, J., & Blanc, A. K. (2012). Maternal morbidity: neglected dimension of safe motherhood in the developing world. *Global public health*, 7(6), 603–617. doi:10.1080/17441692.2012.668919
- <sup>xi</sup> Hahn-Holbrook, 2018
- <sup>xii</sup> UNFPA. *Motherhood in Childhood; Facing the challenge of Adolescent Pregnancy*. 2013. <https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf> (accessed 20.7. 2018).
- <sup>xiii</sup> Schneider, 2018
- <sup>xiv</sup> Ibid
- <sup>xv</sup> UNICEF. *Adolescence Health*. <https://data.unicef.org/topic/maternal-health/adolescent-health/> (accessed 17.04.19)
- <sup>xvi</sup> Howard, LM, Piot, P, Stein, A. (2014). No health without perinatal mental health. *Lancet*. 384 (9566): 1723-24.
- <sup>xvii</sup> UNFPA, 2013
- <sup>xviii</sup> Siegel RS, Brandon AR. Adolescents, pregnancy, and mental health. *J PediatrAdolescGynecol* 2014; 27(3): 138-50.
- <sup>xix</sup> Kumar, S. V., Oliffe, J. L., & Kelly, M. T. (2017). Promoting Postpartum Mental Health in Fathers: Recommendations for Nurse Practitioners. *American journal of men's health*, 12(2), 221–228. doi:10.1177/1557988317744712.
- <sup>xx</sup> Pradhan, R., Wynter, K., & Fisher, J. (2015). Factors associated with pregnancy among adolescents in low-income and lower middle-income countries: a systematic review. *Journal of Epidemiology and Community Health*; 69(9):918-24. doi: 10.1136/jech-2014-205128.
- <sup>xxi</sup> Nunes AP, Phipps MG. Postpartum depression in adolescent and adult mothers: comparing prenatal risk factors and predictive models. *Matern Child Health J* 2013; 17(6): 1071-9.
- <sup>xxii</sup> Kumar, S. V., Oliffe, J. L., & Kelly, M. T. (2017). Promoting Postpartum Mental Health in Fathers: Recommendations for Nurse Practitioners. *American journal of men's health*, 12(2), 221–228. doi:10.1177/1557988317744712
- <sup>xxiii</sup> Osok J, Kigamwa P, Stoep AV, Huang KY, Kumar M. (2018). Depression and its psychosocial risk factors in pregnant Kenyan adolescents: a cross-sectional study in a community health Centre of Nairobi. *BMC Psychiatry* 2018; 18(1): 136
- <sup>xxiv</sup> UNESCO (2014). *Developing an education sector response to early and unintended pregnancy*. Discussion Document for global consultation. Nov 2014. Paris. <http://news.trust.org/item/20190606234356-stcbo/>
- <sup>xxv</sup> <https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders>
- <sup>xxvi</sup> Chiu M, Rahman F, Kurdyak P, et al (2017). Self-rated health and mental health of lone fathers compared with lone mothers and partnered fathers: a population-based cross-sectional study *J Epidemiol Community Health* ;71:417-423.
- <sup>xxviii</sup> Ibid
- <sup>xxix</sup> Kumar, S. V., Oliffe, J. L., & Kelly, M. T. (2017). Promoting Postpartum Mental Health in Fathers: Recommendations for Nurse Practitioners. *American journal of men's health*, 12(2), 221–228. doi:10.1177/1557988317744712

- <sup>xxx</sup> Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., ... Born and Bred in Yorkshire (BaBY) team (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC pregnancy and childbirth*, 17(1), 45. doi:10.1186/s12884-017-1229-4.
- <sup>xxx</sup><sup>i</sup> Baldwin, S., Malone, M., Sandall, J., & Bick, D. (2018). Mental health and wellbeing during the transition to fatherhood: a systematic review of first-time fathers' experiences. *JBI database of systematic reviews and implementation reports*, 16(11), 2118–2191. doi:10.11124/JBISRIR-2017-003773.
- <sup>xxx</sup><sup>ii</sup> Barlow J, Smailagic N, Huband N, Roloff V, Bennett C. Group-based parent training programmes for improving parental psychosocial health (Review). 2014. *Cochrane Database Syst Rev* 2014, Issue 5 Art. No.: CD002020.
- <sup>xxx</sup><sup>iii</sup> Huu Bich & Rempel, 2013-2015
- <sup>xxx</sup><sup>iv</sup> Bhana A., Mellins C. A., Petersen I., Alicea S., Myeza N., Holst H., McKay M. (2014). The VUKA family program: Piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. *AIDS Care*. 2014;(1):1–11. doi: 10.1080/09540121.2013.806770.
- <sup>xxx</sup><sup>v</sup> Ssewamala, F. M., Karimli, L., Torsten, N., Wang, J. S., Han, C. K., Ilic, V., & Nabunya, P. (2016). Applying a Family-Level Economic Strengthening Intervention to Improve Education and Health-Related Outcomes of School-Going AIDS-Orphaned Children: Lessons from a Randomized Experiment in Southern Uganda. *Prevention science : the official journal of the Society for Prevention Research*, 17(1), 134–143. doi:10.1007/s11121-015-0580-9.
- <sup>xxx</sup><sup>vi</sup> Petersen, I., Evans-Lacko, S., Semrau, M., Barry, M. M., Chisholm, D., Gronholm, P., ... Thornicroft, G. (2016). Promotion, prevention and protection: interventions at the population- and community-levels for mental, neurological and substance use disorders in low- and middle-income countries. *International journal of mental health systems*, 10, 30. doi:10.1186/s13033-016-0060-z.
- <sup>xxx</sup><sup>vii</sup> Lund, C., Tomlinson, M., & Patel, V. (2016). Integration of mental health into primary care in low- and middle-income countries: the PRIME mental healthcare plans. *The British journal of psychiatry : the journal of mental science*, 208 Suppl 56(Suppl 56), s1–s3. doi:10.1192/bjp.bp.114.153668
- <sup>xxx</sup><sup>viii</sup> Mugisha, J., Abdulmalik, J., Hanlon, C., Petersen, I., Lund, C., Upadhaya, N., ... Kigozi, F. (2017). Health systems context(s) for integrating mental health into primary health care in six Emerald countries: a situation analysis. *International journal of mental health systems*, 11, 7. doi:10.1186/s13033-016-0114-2
- Murray, L. K., Haroz, E. E., Doty, S. B., Singh, N. S., Bogdanov, S., Bass, J., ... Bolton, P. (2018). Testing the effectiveness and implementation of a brief version of the Common Elements Treatment Approach (CETA) in Ukraine: a study protocol for a randomized controlled trial. *Trials*, 19(1), 418. doi:10.1186/s13063-018-2752-y.
- <sup>xxx</sup><sup>ix</sup> Ssewamala, F. M., Bermudez, L. G., & Santelli, J. (2017). The Power of Financial Inclusion: Reporting on the Efficacy of Economic Strengthening Interventions in Sub-Saharan Africa. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, 62(1S), S3–S5. doi:10.1016/j.jadohealth.2017.11.001.
- <sup>x</sup><sup>i</sup> Lund, C., Tomlinson, M., & Patel, V. (2016). Integration of mental health into primary care in low- and middle-income countries: the PRIME mental healthcare plans. *The British journal of psychiatry : the journal of mental science*, 208 Suppl 56(Suppl 56), s1–s3. doi:10.1192/bjp.bp.114.153668
- <sup>x</sup><sup>ii</sup> Siegel RS, Brandon AR. Adolescents, pregnancy, and mental health. *J Pediatr Adolesc Gynecol* 2014; 27(3): 138-50.
- <sup>x</sup><sup>iii</sup> Kumar, S. V., Oliffe, J. L., & Kelly, M. T. (2017). Promoting Postpartum Mental Health in Fathers: Recommendations for Nurse Practitioners. *American journal of men's health*, 12(2), 221–228. doi:10.1177/1557988317744712.
- <sup>x</sup><sup>iiii</sup> Pradhan, R., Wynter, K., & Fisher, J. (2015). Factors associated with pregnancy among adolescents in low-income and lower middle-income countries: a systematic review. *Journal of Epidemiology and Community Health*; 69(9):918-24. doi: 10.1136/jech-2014-205128.
- <sup>x</sup><sup>lv</sup> World Health Organization. (2008). *Maternal mental health and child health and development in low and middle income countries : report of the meeting, Geneva, Switzerland, 30 January - 1 February, 2008*. World Health Organization
- <sup>x</sup><sup>lv</sup> World Health Organization, United Nations Children's Fund, World Bank Group (2018). *Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.
- <sup>x</sup><sup>lvi</sup> World Health Organization. (2008). *Maternal mental health and child health and development in low and middle income countries : report of the meeting, Geneva, Switzerland, 30 January - 1 February, 2008*. World Health Organization
- <sup>x</sup><sup>lvii</sup> Sikander S, et al. (2019) Delivering the Thinking Healthy Programme for perinatal depression through volunteer peers: a cluster randomised controlled trial in Pakistan *Lancet Psychiatry* Lancet Psychiatry. 2019 Feb;6(2):128-139. doi: 10.1016/S2215-0366(18)30467-X.
- <sup>x</sup><sup>lviii</sup> The Lancet (2018). *The Lancet Commission on Global Mental Health and Sustainable Development*.

- <sup>xlix</sup> Zhang, S. et al. (2018). Effect of Caregiver's Mental Health on Early Childhood Development across Different Rural Communities in China, *Int. J. Environ. Res. Public Health*, 15(11): 2341. Available at <https://doi.org/10.3390/ijerph15112341>
- <sup>l</sup> World Health Organization, United Nations Children's Fund, World Bank Group (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.
- <sup>li</sup> Harvard Center on the Developing Child: Serve and Return. Available at: <https://developingchild.harvard.edu/science/key-concepts/serve-and-return/>
- <sup>lii</sup> Charlene Coore Desai, Jody-Ann Reece & Sydonnie Shakespeare-Pellington (2017) The prevention of violence in childhood through parenting programmes: a global review, *Psychology, Health & Medicine*, 22:sup1, 166-186, DOI: 10.1080/13548506.2016.1271952.]
- <sup>liii</sup> World Health Organization, United Nations Children's Fund, World Bank Group (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.
- <sup>liv</sup> Gupta, S., & Ford-Jones, E. (2014). Recognizing and responding to parental mental health needs: What can we do now?. *Paediatrics & child health*, 19(7), 357–361.
- <sup>lv</sup> Gupta, S., & Ford-Jones, E. (2014). Recognizing and responding to parental mental health needs: What can we do now?. *Paediatrics & child health*, 19(7), 357–361.
- <sup>lvi</sup> Patel V, Saxena S (Eds). The Lancet Commission on Global Mental Health and Sustainable Development. *Lancet* 2018.
- <sup>lvii</sup> Karimzadeh, M., Rostami, M., Teymouri, R., Moazzen, Z., & Tahmasebi, S. (2017). The association between parental mental health and behavioral disorders in pre-school children. *Electronic physician*, 9(6), 4497–4502. doi:10.19082/4497
- <sup>lviii</sup> Braveman P., Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*. 129(1\_suppl2):19–31. doi: 10.1177/003335491412915206
- <sup>lix</sup> WHO (2010), A Conceptual Framework for Action on the Social Determinates of Health, WHO
- <sup>lx</sup> Britto PR, Lye S, Proulx K, et al. (2016). Nurturing care: promoting early childhood development. *Lancet* 2016; published online Oct 4. [http://dx.doi.org/10.1016/S0140-6736\(16\)31390-3](http://dx.doi.org/10.1016/S0140-6736(16)31390-3).
- <sup>lxi</sup> Schneider, M., Baron, E., Davies, T., Munodawafa, M., & Lund, C. (2018). Patterns of intimate partner violence among perinatal women with depression symptoms in Khayelitsha, South Africa: a longitudinal analysis. *Global mental health (Cambridge, England)*, 5, e13. doi:10.1017/gmh.2018.1
- <sup>lxii</sup> Lempp, H., Abayneh, S., Gurung, D., Kola, L., Abdulmalik, J., Evans-Lacko, S., . . . Hanlon, C. (2018). Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: A cross-country qualitative study. *Epidemiology and Psychiatric Sciences*, 27(1), 29-39. doi:10.1017/S2045796017000634.
- <sup>lxiii</sup> Schneider, M., Baron, E., Davies, T., Munodawafa, M., & Lund, C. (2018). Patterns of intimate partner violence among perinatal women with depression symptoms in Khayelitsha, South Africa: a longitudinal analysis. *Global mental health (Cambridge, England)*, 5, e13. doi:10.1017/gmh.2018.1
- <sup>lxiv</sup> Franke H. A. (2014). Toxic Stress: Effects, Prevention and Treatment. *Children (Basel, Switzerland)*, 1(3), 390–402. doi:10.3390/children1030390
- <sup>lxv</sup> Zhou, W., et al (2018). Policy development and challenges of global mental health: a systematic review of published studies of national-level mental health policies. *BMC psychiatry*, 18(1), 138. doi:10.1186/s12888-018-1711-1
- <sup>lxvi</sup> WHO (2001), Mental disorders affect one in four people. WHO. [https://www.who.int/whr/2001/media\\_centre/press\\_release/en/](https://www.who.int/whr/2001/media_centre/press_release/en/)
- <sup>lxvii</sup> WHO (2013). Mental health action plan 2013-2020. World Health Organization. <http://www.who.int/iris/handle/10665/89966>
- <sup>lxviii</sup> WHO (2018b). Mental Health Atlas. Geneva: WHO. [https://www.who.int/mental\\_health/evidence/atlas/mental\\_health\\_atlas\\_2017/en/](https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/)
- <sup>lxix</sup> WHO (2012) Quality Rights tool kit to assess and improve quality and human rights in mental health and social care facilities. Geneva, World Health Organization.
- <sup>lxx</sup> Kohrt et al (2018). The Role of Communities in Mental Health Care in Low- and Middle-Income Countries: A Meta-Review of Components and Competencies. *International journal of environmental research and public health*, 15(6), 1279. doi:10.3390/ijerph15061279.
- <sup>lxxi</sup> Ji and Chen (2016) cited in Watkins DA, Jamison DT, Mills T., et al. (2017) Universal Health Coverage and Essential Packages of Care. In: Jamison DT, Gelband H, Horton S, et al., editors. *Disease Control Priorities: Improving Health and Reducing Poverty*. 3rd edition. Washington (DC): The International Bank for Reconstruction and Development / The

World Bank; 2017 Nov 27. Chapter 3. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK525285/> doi: 10.1596/978-1-4648-0527-1/pt1.ch3)

<sup>lxxii</sup> UN (2015). Transforming our World: The 2030 Agenda for Sustainable Development. UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1; and WHO (2013). Arguing for universal health coverage. World Health Organization. <http://www.who.int/iris/handle/10665/204355>

<sup>lxxiii</sup> Sashidharan et al (2016). Global mental health in high-income countries. *British Journal of Psychiatry*, 209(1), 3-5. doi:10.1192/bjp.bp.115.179556

<sup>lxxiv</sup> Shen, GC et al (2017) Mainstreaming Mental Health Care in 42 Countries. *Health Syst Reform*, 3 (4). pp. 313-324. ISSN 2328-8620 DOI: <https://doi.org/10.1080/23288604.2017.1356424>

<sup>lxxv</sup> The Lancet (2018) The Lancet Commission on Global Mental Health and Sustainable Development.

<sup>lxxvi</sup> Sashidharan, Set al. (2016). Global mental health in high-income countries. *British Journal of Psychiatry*, 209(1), 3-5. doi:10.1192/bjp.bp.115.179556

<sup>lxxvii</sup> The Lancet, (2018) The Lancet Commission on Global Mental Health and Sustainable Development.

<sup>lxxviii</sup> Shen, GC et al (2017) Mainstreaming Mental Health Care in 42 Countries. *Health Syst Reform*, 3 (4). pp. 313-324. ISSN 2328-8620 DOI: <https://doi.org/10.1080/23288604.2017.1356424>

<sup>lxxix</sup> WHO (2018) Mental Health Atlas 2017.

<sup>lxxx</sup> Ibid

<sup>lxxxi</sup> Ibid.

<sup>lxxxii</sup> World Health Organization (2017). Policy Options on Mental Health. A WHO-Gulbenkian Mental Health Platform Collaboration. Geneva: WHO; 2017.

<sup>lxxxiii</sup> Petersen, I., Evans-Lacko, S., Semrau, M., Barry, M. M., Chisholm, D., Gronholm, P., ... Thornicroft, G. (2016). Promotion, prevention and protection: interventions at the population- and community-levels for mental, neurological and substance use disorders in low- and middle-income countries. *International journal of mental health systems*, 10, 30. doi:10.1186/s13033-016-0060-z.

<sup>lxxxiv</sup> World Health Organization (2015). Thinking Healthy Programme. A manual for psychological management for perinatal depression. Geneva: WHO; 2015.

<sup>lxxxv</sup> Fuhr DC, et al. (2019). Delivering the Thinking Healthy Programme for perinatal depression through peers: an individually-randomised controlled trial in India. *Lancet Psychiatry* 2019 Feb;6(2):115-127. doi: 10.1016/S2215-0366(18)30466-8; Sikander S, et al. (2019) Delivering the Thinking Healthy Programme for perinatal depression through volunteer peers: a cluster randomised controlled trial in Pakistan *Lancet Psychiatry* 2019 Feb;6(2):128-139. doi: 10.1016/S2215-0366(18)30467-X.

<sup>lxxxvi</sup> Ibid.

<sup>lxxxvii</sup> Murray, L. K., & Jordans, M. J. D. (2016). Rethinking the service delivery system of psychological interventions in low and middle income countries. *BMC Psychiatry*, 16(1). <https://doi.org/10.1186/s12888-016-0938-y>

<sup>lxxxviii</sup> Murray et al (2018). An evaluation of a common elements treatment approach for youth in Somali refugee camps. *Global Mental Health* 5, e16.

<sup>lxxxix</sup> Kohrt, et al. (2018). The Role of Communities in Mental Health Care in Low- and Middle-Income Countries: A Meta-Review of Components and Competencies. *International journal of environmental research and public health*, 15(6), 1279. doi:10.3390/ijerph15061279.

<sup>xc</sup> Ibid.

<sup>xc</sup> Hurt, L., et al (2018). Interventions that enhance health services for parents and infants to improve child development and social and emotional well-being in high-income countries: a systematic review. *BMJ open*, 8(2), e014899. doi:10.1136/bmjopen-2016-014899.

<sup>xcii</sup> Grand Challenges Canada Website: <https://www.grandchallenges.ca/grantee-stars/tts-0821-05/>

<sup>xciii</sup> Grand Challenges Canada Website: <https://www.grandchallenges.ca/grantee-stars/tts-0802-05/>

<sup>xciv</sup> Masulani-Mwale, C. et al (2019). Development of a psycho-social intervention for reducing psychological distress among parents of children with intellectual disabilities in Malawi. *PLoS one*, d0210855.

<sup>xcv</sup> Hetrick, S et al (2017). Integrated (one-stop shop) youth health care: best available evidence and future directions. *Medical Journal of Australia*, Supplement (207) no.10. 20 November 2017.

<sup>xcvi</sup> DCP (2018) Improving women's mental health. [http://dcp-3.org/sites/default/files/resources/DCP%20Gender\\_Improving%20Womens%20Mental%20Health\\_0.pdf](http://dcp-3.org/sites/default/files/resources/DCP%20Gender_Improving%20Womens%20Mental%20Health_0.pdf)

<sup>xcvii</sup> Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, Saxena S (2016) Scaling-up treatment of depression and anxiety: a global return on investment analysis. *The Lancet Psychiatry*; 3: 415-424

<sup>xcviii</sup> [Lancet Commission on Global Mental Health, 2018](#)



- <sup>xcix</sup> As recommended by [Lancet Commission on Global Mental Health, 2018](#), and endorsed by [Recommendations of UK Summit, 2018](#)
- <sup>c</sup> Financing for Global Mental Health, Lions Head Global Partners, 2018 <https://unitedgmh.org/index.php/global-finance/>
- <sup>ci</sup> Gilbert B.J., Patel V., Farmer P.E., Lu C. (2015) Assessing Development Assistance for Mental Health in Developing Countries: 2007–2013.
- <sup>cii</sup> Lu, C., et al (2018). Global child and adolescent mental health: The orphan of development assistance for health. *PLoS medicine*, 15(3), e1002524. doi:10.1371/journal.pmed.1002524
- <sup>ciii</sup> Lu C, Li Z, Patel V (2018) Global child and adolescent mental health: The orphan of development assistance for health. *PLoS Med* 15(3): e1002524. <https://doi.org/10.1371/journal.pmed.1002524>
- <sup>civ</sup> As agreed under the and endorsed by both [Lancet Commission on Global Mental Health, 2018](#) and endorse by the [Recommendations of UK Summit, 2018](#)
- <sup>cv</sup> Chisholm D, et al (2016). Scaling up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry*; published online 12 Apr. [http://dx.doi.org/10.1016/S2215-0366\(16\)30024-4](http://dx.doi.org/10.1016/S2215-0366(16)30024-4)
- <sup>cvi</sup> WHO (2018). Mental Health Atlas 2017.
- <sup>cvi</sup> Ibid.
- <sup>cvi</sup> Kakuma R, et al (2011). Human resources for mental health care: current situation and strategies for action. *Lancet*. 378(9803):1654–1663. doi: 10.1016/S0140-6736(11)61093-3.
- <sup>cix</sup> WHO (2016). Mental Health Atlas 2015.
- <sup>cx</sup> WHO (2016). Mental Health Atlas 2015.
- <sup>cx</sup> WHO (2018). Mental Health Atlas 2017.
- <sup>cxii</sup> Romeo, Byford & Knapp, (2005). Economic evaluations of child and adolescent mental health interventions: a systematic review, *J Child Psychol Psychiatry*. 2005 Sep;46(9):919-30.
- <sup>cxiii</sup> Horton S, Toledo EDIC, Mahon J, et al. Identifying an Essential Package for Adolescent Health: Economic Analysis. In: Bundy DAP, Silva Nd, Horton S, et al., editors. *Child and Adolescent Health and Development*. 3rd edition. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2017 Nov 20. Chapter 26. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK525251/#> doi: 10.1596/978-1-4648-0423-6/pt5.ch26
- <sup>cxiv</sup> Levin C, Chisholm D. Cost-Effectiveness and Affordability of Interventions, Policies, and Platforms for the Prevention and Treatment of Mental, Neurological, and Substance Use Disorders. In: Patel V, Chisholm D, Dua T, et al., editors. *Mental, Neurological, and Substance Use Disorders: Disease Control Priorities, Third Edition (Volume 4)*. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2016 Mar 14. Chapter 12. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK361929/> doi: 10.1596/978-1-4648-0426-7\_ch12
- <sup>cxv</sup> University of Washington (2018). Disease Control Priorities 3: [Improving Women’s Mental Health](#). University of Washington (2018).
- <sup>cxvi</sup> <https://www.odi.org/sites/odi.org.uk/files/resource-documents/10573.pdf>
- <sup>cxvii</sup> Chisholm D, et al (2016). Scaling up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry*; published online 12 Apr. [http://dx.doi.org/10.1016/S2215-0366\(16\)30024-4](http://dx.doi.org/10.1016/S2215-0366(16)30024-4)
- <sup>cxviii</sup> Chisholm D, Sweeny K, Sheehan P. (2016). Scaling up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry* 2016; published online 12 Apr. [http://dx.doi.org/10.1016/S2215-0366\(16\)30024-4](http://dx.doi.org/10.1016/S2215-0366(16)30024-4)
- <sup>cxix</sup> Hamilton M et al (2017). Identifying attributes of care that may improve cost-effectiveness in the youth mental health service system. *Medical Journal of Australia*, Supplement (207) no.10. 20 November 2017.
- <sup>cxx</sup> Batura N, Hill Z, Haghparast-Bidgoli H, et al. (2015). Highlighting the evidence gap: how cost-effective are interventions to improve early childhood nutrition and development? *Health Policy Plan* 2015;30:813-821.
- <sup>cxix</sup> Gowani S, Yousafzai AK, Armstrong R, Bhutta ZA. (2014). Cost effectiveness of responsive stimulation and nutrition interventions on early child development outcomes in Pakistan. *Ann N Y Acad Sci*. 2014;1308(1):149–161; and Lopez Boo F., Palloni G., & Urzua S. (2014). Cost-benefit analysis of a micronutrient supplementation and early childhood stimulation program in Nicaragua. *Annals of the New York Academy of Sciences*, 1308, 139–148.
- <sup>cxix</sup> WHO (2007). Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. WHO.
- <sup>cxix</sup> Aridi, J. O., Chapman, S. A., Wagah, M. A., & Negin, J. (2014). A comparative study of an NGO-sponsored CHW programme versus a ministry of health sponsored CHW programme in rural Kenya: a process evaluation. *Human resources for health*, 12, 64. doi:10.1186/1478-4491-12-64
- <sup>cxix</sup> Bundy D A P, Horton S. 2017. “Impact of Interventions on Health and Development during Childhood and Adolescence: A Conceptual Framework.” In *Disease Control Priorities (third edition): Volume 8, Child and Adolescent*

Health and Development, edited by Bundy D A P, Silva N de, Horton S, Jamison D T, Patton G C, editors. . Washington, DC: World Bank

<sup>cxv</sup> Ibid

<sup>cxvi</sup> WHO (2018c). Mental health in primary care: Illusion or inclusion? WHO technical series. Geneva; WHO (2018b). Mental Health Atlas. Geneva: WHO.

[https://www.who.int/mental\\_health/evidence/atlas/mental\\_health\\_atlas\\_2017/en/](https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/)

<sup>cxvii</sup> Smith Fawzi MC, Andrews KG, Fink G, et al. (2019). Lifetime economic impact of the burden of childhood stunting attributable to maternal psychosocial risk factors in 137 low/middle-income countries. *BMJ Glob Health* 2019; 4: e001144. doi:10.1136/bmjgh-2018-001144

<sup>cxviii</sup> Abas, M., et al (2016). 'Opening up the mind': problem-solving therapy delivered by female lay health workers to improve access to evidence-based care for depression and other common mental disorders through the Friendship Bench Project in Zimbabwe. *International journal of mental health systems*, 10, 39. doi:10.1186/s13033-016-0071-9; Chibanda (2017) Chibanda, D. (2017). Reducing the treatment gap for mental, neurological and substance use disorders in Africa: Lessons from the Friendship Bench in Zimbabwe. *Epidemiology and Psychiatric Sciences*, 26(4), 342-347. doi:10.1017/S2045796016001128

<sup>cxix</sup> Abas, M., Bowers, T., Manda, E., Cooper, S., Machando, D., Verhey, R., ... Chibanda, D. (2016). 'Opening up the mind': problem-solving therapy delivered by female lay health workers to improve access to evidence-based care for depression and other common mental disorders through the Friendship Bench Project in Zimbabwe. *International journal of mental health systems*, 10, 39. doi:10.1186/s13033-016-0071-9

<sup>cxx</sup> Chibanda, D. (2017). Reducing the treatment gap for mental, neurological and substance use disorders in Africa: Lessons from the Friendship Bench in Zimbabwe. *Epidemiology and Psychiatric Sciences*, 26(4), 342-347. doi:10.1017/S2045796016001128

<sup>cxxi</sup> Chibanda, D. (2017). Reducing the treatment gap for mental, neurological and substance use disorders in Africa: Lessons from the Friendship Bench in Zimbabwe. *Epidemiology and Psychiatric Sciences*, 26(4), 342-347. doi:10.1017/S2045796016001128

<sup>cxixii</sup> Grand Challenges Canada. See: <https://www.grandchallenges.ca/grantee-stars/tts-0822-05/>

<sup>cxixiii</sup> Atif, N., et al (2017). Mother-to-mother therapy in India and Pakistan: adaptation and feasibility evaluation of the peer-delivered Thinking Healthy Programme. *BMC psychiatry*, 17(1), 79. doi:10.1186/s12888-017-1244-z; Sikander S, et al. (2019) Delivering the Thinking Healthy Programme for perinatal depression through volunteer peers: a cluster randomised controlled trial in Pakistan *Lancet Psychiatry Lancet Psychiatry*. 2019 Feb;6(2):128-139. doi: 10.1016/S2215-0366(18)30467-X; Fuhr DC, Weobong B, Lazarus A, et al. (2019). Delivering the Thinking Healthy Programme for perinatal depression through peers: an individually-randomised controlled trial in India. *Lancet Psychiatry Lancet Psychiatry*. 2019 Feb;6(2):115-127. doi: 10.1016/S2215-0366(18)30466-8.

<sup>cxixiv</sup> Fuhr DC, Weobong B, Lazarus A, et al. (2019). Delivering the Thinking Healthy Programme for perinatal depression through peers: an individually-randomised controlled trial in India. *Lancet Psychiatry Lancet Psychiatry*. 2019 Feb;6(2):115-127. doi: 10.1016/S2215-0366(18)30466-8.

<sup>cxixv</sup> Baranov et al 2017. Maternal Depression, Women's Empowerment, and Parental Investment: Evidence from a Large Randomized Control Trial. <http://ftp.iza.org/dp11187.pdf>

<sup>cxixvi</sup> Ibid.

<sup>cxixvii</sup> Rahman et al. (2015) The effectiveness and cost-effectiveness of the peer-delivered Thinking Healthy Programme for perinatal depression in Pakistan and India: the SHARE study protocol for randomised controlled trials. *Trials* 2015;16:015–1063. 10.1186/s13063-015-1063-9

<sup>cxixviii</sup> Bolton P, et al. (2003) Group interpersonal psychotherapy for depression in rural Uganda. *Jama*; 289:3117–24; Betancourt T, et al. (2012) Moderators of treatment effectiveness for war affected youth with depression in northern Uganda. *J Adolescent Health*. 2012;51(6):544–50; Verdelli, et al (2003). Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 2(2), 114–120.

<sup>cxixix</sup> Onu, C., et al. (2017). Brief Report: Sexual Violence Against HIV-Positive Women in the Nyanza Region of Kenya: Is Condom Negotiation an Instigator?. *Journal of acquired immune deficiency syndromes (1999)*, 74(1), 52–55. doi:10.1097/QAI.0000000000001135

<sup>cxli</sup> Mutamba BB et al. Psychological treatments delivered by community health workers in low-resource government health systems: effectiveness of group interpersonal psychotherapy for caregivers of children affected by nodding syndrome in Uganda. *Psychol Med*. 2018; 1-11.

<sup>cxlii</sup> Murray, L. K., et al (2014). A Common Elements Treatment Approach for Adult Mental Health Problems in Low- and Middle-Income Countries. *Cognitive and behavioral practice*, 21(2), 111–123. doi:10.1016/j.cbpra.2013.06.005

- cxlii <https://www.grandchallenges.ca/grantee-stars/0090-04/>
- cxliiii Kutcher, S., et al (2017). Suicide Prevention. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 62(4), 296–297. doi:10.1177/0706743717695087; Wei, Y., Kutcher, S., & LeBlanc, J. C. (2015). Hot Idea or Hot Air: A Systematic Review of Evidence for Two Widely Marketed Youth Suicide Prevention Programs and Recommendations for Implementation. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Academie canadienne de psychiatrie de l'enfant et de l'adolescent*, 24(1), 5–16.
- cxliv UNICEF (2014). A systematic review of parenting programs for young children in LMICS. [https://www.unicef.org/earlychildhood/files/P\\_Shanker\\_final\\_Systematic\\_Review\\_of\\_Parenting\\_ECD\\_Dec\\_15\\_copy.pdf](https://www.unicef.org/earlychildhood/files/P_Shanker_final_Systematic_Review_of_Parenting_ECD_Dec_15_copy.pdf)
- cxlv Araya R, et al (2003). Treating depression in primary care in low income women in Santiago, Chile: a randomised controlled trial. *Lancet*. 361:995–1000. Araya, R., Zitko, P. & Markkula, N. The Impact of Universal Health Care Programmes on Improving 'Realized Access' to Care for Depression in Chile. *Adm Policy Ment Health* (2018a) 45: 790. <https://doi.org/10.1007/s10488-018-0864-z>.
- cxlvi Chomat et al (2019) Women's circles as a culturally safe psychosocial intervention in Guatemalan indigenous communities: a community-led pilot randomised trial. *BMC Women's Health* 2019:53 <https://doi.org/10.1186/s12905-019-0744-z>
- cxlvii Martinez (2018) Social contact as a strategy for self-stigma reduction in young adults and adolescents with mental health problems. *Psychiatry Res*. 2018 Feb;260:443-450. doi: 10.1016/j.psychres.2017
- cxlviii Leijdesdorff S, et al (2017). Prevalence of psychopathology in children of parents with mental illness and/or addiction: an up to date narrative review. *Curr Opin Psychiatry*. (2017) 30:312–7. 10.1097/YCO.0000000000000341; Reedt, C., et al (2019). Identification of Children of Parents With Mental Illness: A Necessity to Provide Relevant Support. *Frontiers in psychiatry*, 9, 728. doi:10.3389/fpsy.2018.00728
- cxlix For further information, see: <https://www.carnegiehall.org/Education/Social-Impact/Lullaby-Project>
- cl McKay, M. M., Gonzales, J., Quintana, E., Kim, L., & Abdul-Adil, J. (1999). Multiple Family Groups: An Alternative for Reducing Disruptive Behavioral Difficulties of Urban Children. *Research on Social Work Practice*, 9(5), 593–607. <https://doi.org/10.1177/104973159900900505>.
- Editorial. Mental health and wellbeing in children and adolescents. *The Lancet*  
Published: April 05, 2014 DOI: [https://doi.org/10.1016/S0140-6736\(14\)60587-0](https://doi.org/10.1016/S0140-6736(14)60587-0)
- cli Gopalan, G., et al (2014). Child Welfare Involved Caregiver Perceptions of Family Support in Child Mental Health Treatment. *Journal of family strengths*, 14(1), 1–25.
- clii Bhana, A., et al (2014). The VUKA family program: piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. *AIDS care*, 26(1), 1–11. doi:10.1080/09540121.2013.806770
- cliii Gopalan, G. et al. (2014). Child Welfare Involved Caregiver Perceptions of Family Support in Child Mental Health Treatment. *Journal of family strengths*, 14(1), 1–25.
- and Ssewamala, F. M., et al (2018). Strengthening mental health and research training in Sub-Saharan Africa (SMART Africa): Uganda study protocol. *Trials*, 19(1), 423. doi:10.1186/s13063-018-2751-z