Inclusive Futures
Promoting disability inclusion

Disability Inclusion Helpdesk Report

Query	**What works in leadership and governance for mental health: a rapid evidence review**
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Query	What works to advance leadership and governance for mental health at all levels and across sectors? What are examples of effective interventions in this area?

Contents

OVERVIEW

- **Poor governance is a key barrier to integrating mental health care into health systems in LMICs.** Only 57% of WHO member states have mental health legislation in place, and 65% of low and lower-middle income countries (LMICs) lack independent oversight of how their systems comply with international human rights law. Only 62% have an updated mental health policy or plan in place, with countries in Africa and Eastern Mediterranean being least likely to have one.
- **Strengthening effective leadership and governance for mental health is a key objective in WHO's Mental Health Action Plan (2013-2020),** which sets out the global targets for 80% of member states to have a mental health policy in place that comply with human rights frameworks, and 50% of member states to have developed or updated their laws for mental health, also in line with international and regional human rights conventions, by 2020.

Evidence suggests that the following are crucial for advancing leadership and good governance for mental health (There is a growing, but still limited, **evidence base around what works** to strengthen leadership and governance):

- **Dedicated and comprehensive mental health policy** to provide detailed guidance for countries' mental health systems and the i**ntegration of mental health into wider health policy** and plans to ensure services are more accessible.
- **Integration of mental health across policy domains e.g. education and social welfare** to address social determinants of mental health and provide a comprehensive strategy to promote mental health.
- **Capacity building of mental health policymakers and planners** across governance levels to bridge the gap between mental health policy and implementation. Leadership and management skills are particularly important.
- **Capacity building and supporting leadership opportunities for service users** and service users' organisations for holding governments accountable to their obligations, and making sure that policies, laws and services are meaningful and relevant to the needs and priorities of people with lived experience of psychosocial disabilities.

Key enablers barriers include:

- Lack of political will
- Lack of resources and capacity to implement policies
- Lack of knowledge and skills to engage in policy processes and take on leadership roles
- Stigma surrounding mental health issues

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Summary[1] of issues and commitments

Governance and leadership for mental health is required from global to local levels, and global, national and local stakeholders have an important role to play in providing leadership and ensuring governance systems for mental health are effective and responsive to the needs and rights of people with mental health conditions and psychosocial disabilities. The recognition of mental health as an aspect of wellbeing in the Sustainable Development Goals (SDGs) marks an unprecedented high-level commitment to mental health, calling governments to consider mental health in national development plans and paving the way for mental health to be better integrated across multilateral and bilateral development assistance. The Sustainable Development Agenda envisions a world where "physical, mental and social well-being are assured" (General Assembly, 2015, p. 3). Goal 3 which focuses on promoting health and wellbeing includes two targets related to mental health.

- Target 3.4: "reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being",
- Target 3.5 "strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol" (ibid, p. 16).

Despite this attention, mental health remains heavily underfunded and a low priority on many low-and middle-income countries (LMIC's) national development agendas. The global average annual spending on mental health is less than 2 US dollars per person, while in low income countries (LICs), the spending is less than 0.25 US dollar per person per year (UN General Assembly, 2017b). Most of the money allocated to mental health goes into institutionalised care such as psychiatric hospitals, while comprehensive and community-based mental health services receive far fewer resources (General Assembly, 2017a; General Assembly, 2017b). There are also insufficient human resources in mental health, for example there are only two psychiatrists for the whole of Sierra Leone (Harris, D et al., 2020), and quality of training and knowledge of human rights is often compromised (General Assembly, 2017a).

Weak governance has been identified as a key challenge to integrating mental health in primary health care systems in LMICs (Petersen et al., 2017). The integration of mental health into general health care is widely recognised as an effective way to increasing access and constitutes one of WHO's key-recommendations for mental health policy development (ibid; WHO, 2019). Governance is defined as the "policy and legislative framework to promote and protect the mental health of a population, as well as health system design and quality assurance to ensure optimal policy implementation" (Petersen et al., 2017, p. 699).

Strengthening effective leadership and governance for mental health is a key objective in WHO's Mental Health Action Plan 2013-2020 (WHO, 2013). National mental health policies[2] and legislation[3] that comply with international and regional human rights conventions is identified by WHO as a cornerstone of good governance and leadership for mental health (WHO, 2017) together with national mental health plans[4]. The WHO plan sets out the following global targets for 2020:

[1] This short report is based on a light-touch, rapid review of the publicly available evidence, involving 3 person days (2 researcher days, 1 expert day). It is one of four similar reviews examining the evidence on the four outcome areas articulated in DFID's draft theory of change on mental health: rights and participation, leadership and governance, services and community interventions, FCAS and humanitarian contexts. The reviews provide a snapshot of some of the key issues and focus on summarising findings from systematic reviews, evidence syntheses and key global thematic reports, including frameworks and guidance.

[2] The Mental Health Atlas 2017[2] defines a mental health policy as: "an official statement of a government that conveys an organized set of values, principles, objectives and areas for action to improve the mental health of a population" (WHO, 2017, p. 15)

[3] Mental health legislation refers to mental health-related legal provisions such as "civil and human rights protection of people with mental disorders, involuntary admission and treatment, guardianship and professional training and service structure" (WHO, 2017, p. 17).

[4] A mental health plan is a detailed document directing the implementation of the vision and objectives set out in the policy (WHO, 2019).

- 80% countries will have developed, or updated, their national policies and that those comply to international and regional human rights instruments
- 50% countries will have developed or updated their laws for mental health in line with international and regional human rights conventions (ibid.).

The Mental Health Atlas 2017 found that 72% of WHO member states have a standalone policy or plan for mental health in place, 62% of which have updated their plan in the last five years (WHO, 2017). Countries in Africa and the eastern Mediterranean are least likely to have such policies in place, although the variation between regions is not significant. A study of mental health policy in Commonwealth countries in 2017 less than half the countries had a policy in place at the time of the review and that deinstitutionalisation of mental health care was a low priority in Commonwealth countries (Bhugra et al., 2018). The Mental Health Atlas 2017 also provides countries' self-assessment of health policies/plans on compliance with five aspects regional and international human rights conventions in their mental, according to considered crucial for human rights compliance. Overall, countries reported a high level of compliance: 1) 97% of countries reported that their policy/plan promote a shift towards community-based mental health services; 2) 89% considered that their plans/policies explicitly pay attention to the human rights of people with psychosocial disabilities; 3) 81% considered that their policy/plan includes a full range of services and support to enable people to be independent and included in their communities; 4) 89% reported that their policy/plan promotes a recovery approach[5] to mental health care; and 5) 82% considered that their policy/plan enables the participation of persons with psychosocial disabilities in decision-making (ibid.).

The Mental Health Atlas 2017 found that 57% WHO member states have a standalone law for mental health, of which 40% have updated their legislation in the previous five years (WHO, 2017). The Mental Health Atlas set out five aspects for countries' self-assessment on compliance to international/regional human rights conventions in their mental health legislation. 95% of countries reported compliance to at least three of the five items, and 75% considered all five aspects of compliance being met (ibid.). To assess whether international human rights are being *de facto* adhered to by the countries, they were requested to rate the existence and functioning of an independent body or dedicated authority that monitor the compliance of the national mental health law to international human rights, for example by conducting inspections of mental health services. Over 70% of countries categorised as high-income reported that they have a body/authority providing this function in place, while over 65% LMICs reported not having this in place or having one which was not functioning (ibid.).

While governments hold the overarching obligation to ensure that mental health services are in place and comply with internationally and regionally recognised human rights standards, governance is not only about government action, but also about the relationships between government and non-governmental actors (WHO, 2013). The WHO Mental Health Action Plan emphasises that effective leadership and governance requires multi-stakeholder involvement and engagement with civil society. This entails engaging relevant stakeholders from different sectors, including employment, education and social services in order to consider the multidimensional needs and rights of people with psychosocial disabilities. Civil society engagement, especially with organisations of and for people with psychosocial disabilities and their families, is described as crucial to ensure that policies, laws and services are responsive to the needs and priorities of people with lived experience, as well as playing a key role in holding governments accountable to their obligations. The UN Special Rapporteur on the right to physical and mental health has claimed that mental health has been narrowly discussed in biomedical terms, and that states have failed to integrate the perspectives of people affected by psychosocial disabilities into policymaking (OHCHR, 2017). Supporting leadership opportunities for mental health service users and people with psychosocial disabilities is critical.

What works

Developing dedicated, contextualised and comprehensive mental health policy is highlighted across the literature as best practice. However, this is despite the limited empirical evidence of impact. WHO's Mental

[5] A 'recovery-based approach' centers around the aspirations and goals of individuals with mental health conditions, based on their own understanding of their condition. It builds on the strengths of people with mental health conditions and considers them equal partners in their care. It further integrates an understanding of the relationship between mental health conditions and trauma, and people with lived experience of mental health conditions are involved in the service provision (UN General Assembly, 2017a).

Health Action Plan (2013-2020) recognises that a dedicated national mental health action plan serves to provide detailed direction on mental health interventions (WHO, 2013). A recent systematic review of national-level mental health policy development found they are becoming increasingly comprehensive and diverse in high-income countries (HICs) as well as in LMICs (Zhou, Yu, Yang, Chen and Xiao, 2018). The review assessed performance against nine common policy domains [6]. The domains receiving most attention were human rights and legislation, service provision and quality of services (ibid.), with South Africa and Uganda covering all nine. The review notes that many LMICs have adopted comprehensive mental health policies as their first national mental health policies, supported by international organisations and development assistance from high-income countries (HICs) (Zhou et al., 2018).There are concerns however around insufficient funding or human resources for implementation in LMICs (ibid.) and the appropriateness of direct adoption from HICs. What has worked in HICs may not be applicable or valid in LMICs as social and cultural understandings of mental health and wellbeing, and needs and priorities may be different, and the health sector commonly operates under vastly different circumstances than in HICs.

Mental health interventions are seen to be more effective if they are integrated in the wider health policy and plans (WHO, 2013). This is one of WHO's three key recommendations to countries when they develop their national mental health policy (WHO, 2019). The other two recommendations are: to provide evidence-based approaches for deinstitutionalisation of mental health services and to develop mental health services in community settings (ibid.). A systematic review found that there has been a global shift from institutionalisation to community-based mental health services in national policies since the 2000s (Zhou et al., 2018). The effectiveness of implementation has varied between HICs and LMICs. HICs were effective in shifting from mental health institutions towards increasing availability of mental health services at the community level in the 2000s, while the shift towards community-based mental health care has been slower in LMICs due to resource constraints and less developed mental health systems (ibid.). The integration of mental health services in national health systems can also be challenging when faced by the wider constraints of weak and under resourced health systems (ibid.).

Integrating mental health into policy areas beyond heath is crucial to a comprehensive and multidimensional approach and addressing the social determinants of mental health (WHO, 2013; WHO, 2014). Integrated approaches have been adopted in several HICs, where policies across different domains have paid attention to the social, economic, cultural and physical environments that can influence people's mental wellbeing (WHO, 2014). Examples include Australia, New Zealand and Scotland. The Australian government has a dedicated mental health policy in place but also integrates mental health in other policy areas such as housing, aging, and chronic disease (ibid.). Mental health professionals have emphasised the importance of mental health not being isolated in the heath domain, and the importance of collaboration and shared responsibility in responding to mental health issues across sectors such as education, agriculture, social services and judiciary (Shen et al., 2017).

Strengthening the capacity of mental health policymakers and planners. It is widely recognised that capacity building of stakeholders, including policymakers and planners, is key for strengthening mental health systems and translating mental health policies into effective plans (Keynejad et al., 2016; Petersen et al., 2017). However, most evidence from capacity building interventions targeting this groups come from HICs (ibid.). In response to the knowledge gap on what approaches work in LMICs, the Emerald programme (2012-2017), in six LMICs (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda), commissioned a systematic review of capacity building activities for policymakers and planners in LMICs (Keynejad et al., 2016). The review identified 14 studies on capacity building interventions for mental health policymakers and planners in LMICs. These present some insights into different approaches, though the review found that the evidence base was limited and of low quality (Keynejad et al., 2016; Semrau et al., 2018). Mental health leadership trainings had positive outcomes on participants' reported engagement in activities to improve mental health systems in their home countries. Though this was part of wider mental health system-strengthening programmes, and evaluations did not assess the impact of capacity building

[6] These are: 1) mental health service organising, 2) mental health services provision, including prevention, treatment, rehabilitation, provision of medicines, service availability and accessibility, 3) mental health service quality, 4) human resources in mental health, 5) mental health legislation and human rights, 6) mental health advocacy, including stigma-alleviation, awareness raising and empowering service users, 7) administration and coordination within mental health systems, and collaboration across sectors, 8) monitoring and research, including information systems and monitoring and evaluation of policy implementation and services, and 9) financing and budgeting of mental health, including insurance coverage (Zhou et al., 2018).

activities alone. The Emerald programme found that policymakers and planners, prioritised leadership skills among their training needs but struggled to identify capacity building needs to begin with as they commonly lacked understanding of mental health systems (Semrau et al., 2018). The Emerald programme also found that it was important to target staff at the at the regional and district levels, as well as the national level, as this is usually where implementation challenges occurs (Petersen et al., 2017). The review emphasises the importance of tailoring management and leadership programmes to the country context and local leadership culture, as Western-centred approaches to leadership training were identified as a concern in several counties in Africa (Keynejad et al., 2016).

Leadership and political will to implement mental health policy and system reforms is needed at the political and practitioner level - in mental health and the wider health system. Practitioners' attitudes towards mental health systems reform have proved influential for how policy reforms play out on the ground (Shen et al., 2017). Countries with strong support from their mental health workforce to implement changes have seen good results in bringing services to the community-level. In Spain, mental health practitioners went on strike and formed professional associations to push for a shift from biomedical models. In Chile, a psychiatric hospital started supporting community-based mental health services and formed a network of mental health professionals supporting the approach. In Ethiopia, international non-governmental organisations (NGOs) and mental health workers worked together to bring psychosocial support to rural communities (ibid.).

Local research to support implementation of policy goals. Shen et al. (2017) found that once policy goals in favour of deinstitutionalisation and community-based approaches have been formulated, locally led research is crucial to advancing effective implementation e.g. to identify gaps. In Rwanda, researchers found that for deinstitutionalisation to be effective, district hospitals first need to strengthen the focus on the quality of the services (Shen et al., 2017).

Support and collaboration with mental health advocacy and service user groups to integrate service users' perspectives into policy and strengthen accountability. A systematic review from 2016 found that consultations with mental health service users in policy formulation processes increased the likelihood of improved mental health services and outcomes (Semrau et al., 2016). However, the evidence base is limited as many of the studies were low quality and focused on delivery of services rather than policy (ibid.). Most evidence of effective mental health advocacy and policy influencing comes from HICs (Hann et al., 2015) though there are some examples from LMICs. A systematic review highlights an example from Romania, where local organisations and people with psychosocial disabilities formed coalitions to policy promoting mental health services at the community level (Semrau et al., 2016). The coalitions were successful in influencing government officials to visit mental health institutions and submitted a declaration signed by more than 80 organisations to the Minister of Health (Hayward and Cutler, 2007). The activities are seen to have increased the government's stated commitment to mental health reform (ibid.) - government officials expressed commitment to developing community-based mental health services following visits to mental health institutions, and the Minister of Health publicly promised reforms (ibid). A survey with 78 mental health professionals from 42 different countries found civil society instrumental in driving change in mental health policy and implementation and emphasised the importance of considering the perspectives of service users and advocates with lived experience in policy making (Shen et al., 2017).

Support mental health service user/ survivor leadership. The importance of service user participation in mental health system strengthening has gained attention globally (*see evidence review on 'what works on rights and participation for people with mental health conditions'*). However, some service users and survivors have argued that the concept of participation is not strong enough on its own as it assumes that decision-makers and influential people *invite* selected people to participate (O'Hagan, 2009). Leadership is seen as a stronger concept as it does not rely on goodwill and relies on service users' power on their own terms (ibid.). The literature on what works to promote mental health service user and survivor leadership in LMICs is very limited (Price, 2018). Most literature has focused on promoting leadership for people with disabilities generally and is descriptive in nature rather than based on rigorous research of interventions (ibid.). O'Hagan (2009) suggests a framework for understanding service user and survivor leadership on three levels: the individual, service and systematic level (O'Hagan, 2009). The individual level emphasises the importance of service users and survivors being leaders in their own recovery. Approaches that have been used to promote this are: recovery-centred education; use of peer-support; and shared decision making between service-providers and service users in treatment plans and medication management (ibid.). Effective survivor-led initiatives at the service level have involved governance

structures that are led by service users and survivors, management decisions being jointly made between the governing body and staff/members of the service, promotion of different leadership approaches such as leading one's own recovery and taking leadership in certain activities, and that the organisation is guided by clearly defined values (ibid.). The systematic level has involved service users and survivors assuming leadership roles as public servants, politicians, planners and funders of services, researchers and in advocacy (ibid.). Support for leadership development and opportunities for service users and survivors is therefore crucial. This can include skills trainings (leadership and communications), opportunities to expand professional networks, and trainings on mental health systems and governance structures (ibid).

Examples of effective interventions

Example 1: Integration of mental health into Uganda's national health policy. As recommended by the WHO, Uganda has integrated mental health into its wider health policy. The integration was enabled by the creation of a mental health unit in the Ministry of Health and the appointment of a Mental Health Coordinator (Mackenzie and Kesner, 2016). The integration saw some immediate positive results, with mental health services being generally strengthened and becoming more accessible (ibid.). However, in the two decades since Uganda adopted this integrated approach, little progress has been made towards national coverage of mental health services. The bulk of Uganda's mental health funding goes to the national psychiatric hospital rather than services provided in primary healthcare facilities and communities (Molodynski et al., 2017). Nevertheless, Uganda is held as an example of a low-income country that has developed an integrated and comprehensive mental health policy. A systematic review recently assessed Uganda's mental health policy as comprehensive, as it covers all nine different domains that are seen in mental health policy (Zhou et al., 2018).

Example 2: Service user led mental health advocacy in Sierra Leone. The Mental Health Coalition Sierra Leone (MHC) was established in 2011 to make mental health a priority. The coalition is made up of mental health service users, family, service providers, civil society actors and government officials (Hann et al, 2015). The group empowers stakeholders to advocate for their needs and voice priorities. They successfully engaged in policy processes to develop Sierra Leone's first mental health policy and promote the integration of mental health into the national poverty reduction strategy paper. MHC advocated for the rights and needs of mental health service users in policies (ibid.). A study[7] of MHC's mental health advocacy found that networking and communicating were key components behind MHC's achievements (ibid.). MHC networked with key stakeholders in mental health, including within the government, to form formal and informal ties in order to gain influence. The relationship they built with the Ministry of Health and Sanitation (MoHS) was recognised as being of special importance as it allowed them to slowly build interest and political will for mental health within the government. The study points out that building political will takes time and that mental health remains a relatively low priority compared to many other issues. However, respondents observed some positive changes in the governments approach to mental health. Sierra Leone's first mental health policy was launched on World Mental Health Day in 2012, after MHC had pushed for its formal launch (ibid.).

Risks and enablers

Lack of political will. A survey with mental health experts from over the world (78 in 42 countries) with experience of working with the shift towards deinstitutionalisation of mental health care (either as rolling out community-based services or downscaling institutionalised care) found that limited political will was a major barrier to implementing mental health policies. The lack of political commitment was seen from the highest to the sub-national governance level (Shen et al., 2017). The empowerment of other stakeholders, including mental health service users, and mental health advocacy are recognised as holding the potential to push political leaders to act and live up to their

[7] The study consisted of 15 key-informant interviews with government officials, development partners, traditional healers and people from religious groups, NGOs, educational institutions and private sector service providers, and 9 focus group discussions with MHC members, former service users, family members of service users, service providers and police. The research took a participatory approach and researchers trained selected MHC members to be involved in the design and implementation of the research.

commitments (Hann et al, 2015). Feedback mechanisms for mental health services and building the capacity of service users to provide feedback from their experience of mental health systems and services have been outlined as key approaches to ensuring the services live up to required standards (Petersen et al., 2017).

Lack of resources and capacity to implement policies. Funding for mental health remains a major barrier to good governance in LMICs (Hann et al, 2015; Petersen et al., 2017). Experiences from various countries have shown that successful policy development does not necessarily translate into implementation (Hann et al, 2015). A mental health policy is arguably a manifestation of some level of political will, however, sufficient resources to implement mental health policies are often not allocated. This is due to various reasons such as lack of political will and capacity to deliver implementation, resource constraints and competing demands (ibid.). Capacity building for mental health policymakers and planners has been identified as crucial for mental health system strengthening, however, the evidence base of what works to build capacity of this group in LMICs is limited (Keynejad et al., 2016). This calls for an upscale of contextually meaningful and appropriate capacity building interventions for policymakers and planners, and rigorous research and evaluations to generate evidence of what works in LMICs (ibid.).

Resistance from medical professionals. The 2017 survey with mental health professionals found the shift from institutionalisation to community-based services sometimes resisted by professionals working in mental health institutions (Shen et al., 2017). General health practitioners may also not see mental health services as a primary health care responsibility, but something provided by specialists (ibid.). Shen et al. (2017) argue that consultations with health workers are critical to bringing change(ibid.).

Lack of knowledge and skills to engage in policy processes and take on leadership roles. Limited knowledge of rights and lack of skills can act as a barrier to leadership; a consequence of the marginalisation of people with psychosocial disabilities in society (Semrau et al, 2016; O'Hagan, 2009). Empowering people to know their rights and capacity in advocacy and policy engagement are necessary first steps to equip groups and individuals with knowledge and skills to participate in policy processes and hold governments accountable to their obligations (Semrau et al, 2016). Skills building focused on leadership is similarly important to empower service users and survivors to take on and be effective in leadership roles for mental health (O'Hagan, 2009). BasicNeeds[8] and CBM[9] have co-developed an advocacy toolkit for mental health service users and caregivers which has been tested in six self-help groups in Uganda (ibid.). The advocacy strategies targeted district-level policy makers and mental health programme implementers and build on the assumption that duty-bearers will be more responsive to issues that are raised by people with lived experience of psychosocial disabilities themselves (ibid.).

Stigma surrounding mental health issues. Mental health issues remain stigmatised across the world and people with psychosocial disabilities experience widespread discrimination; this can affect how leaders and decision-makers approach mental health. A study of a local organisation's work to advocate for mental health in Sierra Leone found that the organisation encountered stigma as a barrier when they worked with the government (Hann et al, 2015). Awareness raising was required at various levels from nurses working with mental health to officials in the highest levels of decision-making, in order to overcome commonly held beliefs about mental health conditions and stigmatising of people with psychosocial disabilities (ibid.). Similarly, in Uganda, stigmatising attitudes have been found to be widely held by people working in health care and social services (Molodynski et al., 2017). As such, stigma is a crucial barrier to address at all levels in order to enable health practitioners, leaders, decision-makers and service users and survivors to contribute to good governance and leadership for mental health.

[8] BasicNeeds is an international non-governmental organisation that works to improve the lives of people living with psychosocial disabilities and epilepsy.
[9] Acronym for the non-governmental organization The Overseas Christian Disability Charity.

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Disability Inclusion Helpdesk Report

About Helpdesk reports: The Disability Inclusion Helpdesk is funded by the UK Department for International Development, contracted through the Disability Inclusion Team (DIT) under the Disability Inclusive Development Programme. Helpdesk reports are based on between 3 and 4.5 days of desk-based research per query and are designed to provide a brief overview of the key issues and expert thinking on issues around disability inclusion. Where referring to documented evidence, Helpdesk teams will seek to understand the methodologies used to generate evidence and will summarise this in Helpdesk outputs, noting any concerns with the robustness of the evidence being presented. For some Helpdesk services, in particular the practical know-how queries, the emphasis will be focused far less on academic validity of evidence and more on the validity of first-hand experience among disabled people and practitioners delivering and monitoring programmes on the ground. All sources will be clearly referenced.

Helpdesk services are provided by a consortium of leading organisations and individual experts on disability, including Social Development Direct, Sightsavers, Leonard Cheshire Disability, ADD International, Light for the World, BRAC, BBC Media Action, Sense and the Institute of Development Studies (IDS). Expert advice may be sought from this Group, as well as from the wider academic and practitioner community, and those able to provide input within the short timeframe are acknowledged. Any views or opinions expressed do not necessarily reflect those of DFID, the Disability Inclusion Helpdesk or any of the contributing organisations/experts.

For any further request or enquiry, contact enquiries@disabilityinclusion.org.uk

Suggested citation:

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