



Report

Global mental health from a policy perspective: a context analysis

Characterising mental health and recommending engagement strategies for the Mental Health Innovation Network

Jessica Mackenzie

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Overseas Development Institute

203 Blackfriars Road
London SE1 8NJ

Tel. +44 (0) 20 7922 0300
Fax. +44 (0) 20 7922 0399
E-mail: info@odi.org.uk

www.odi.org
www.odi.org/facebook
www.odi.org/twitter

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome	MHIN	Mental Health Innovation Network
CHW	Community Healthcare Workers	mhGAP	WHO Mental Health Gap Action Program
G8	Group of Eight	MNS	Disorders Mental, Neurological and Substance use Disorders
GCC	Grand Challenges Canada	NIMH	National Institute for Mental Health (USA)
HAART	Highly active antiretroviral therapy	ODI	Overseas Development Institute
HIV	Human Immunodeficiency Virus	RAPID	Research and Policy in Development Programme
IDRC	International Development Research Centre	WB	World Bank
KPP	Knowledge, Policy and Power	WHO	World Health Organisation
MDGs	Millennium Development Goals		

Terminology

This report uses a variety of terms that have several working definitions, so it is important to clarify these from the outset. The terms ‘mental health’ and ‘mental, neurological and substance use disorders’ (MNS disorders) are used regularly. Mental health is defined by the World Health Organisation as ‘a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.’¹ In consequence, the report uses the term ‘mental health policies’ to describe policies which aim to attain this state of wellbeing for all. The term ‘mental health practitioners’ refers to those actors working towards attaining broader improved experiences of mental health across a variety of conditions and MNS disorders.

Mental illness, on the other hand, refers to suffering, disability or morbidity due to mental, neurological and substance-use disorders, which can arise due to the genetic, biological and psychological make-up of individuals as well as adverse social or environmental factors.

User movements can be described as ‘individual mobilisation through a sense of morality, (in)justice and social power through social mobilisation against deprivation and for survival and identity’. Other terms can also be applied such as ‘social movement’, ‘consumer movement’ or ‘political network,’ (Frank and Fuentes, 1987).

Champions are considered to be persuasive advocates of beliefs, practices, programmes, policies or technology who can influence and facilitate change in others (Rabin et al., 2008).

Stigma is defined as ‘the phenomenon whereby an individual with an attribute which is deeply discredited

by his/her society is rejected as a result of the attribute (Goffman, 1963). ‘The term stigma refers to problems of knowledge (ignorance), problems of knowledge (ignorance), attitudes (prejudice) and behaviour attitudes (prejudice) and behaviour (discrimination)’ (Thornicroft et al., 2008).

A focusing event is an event such as a crisis or disaster, natural or man-made, which shifts attention away from the status quo. Crises, as focusing events, are powerful initiators of agenda change. Focusing events call attention to a problem which could otherwise have continued hovering under the radar of decision-makers.

This report uses the term ‘policy’ to denote ‘a purposive course of action followed by an actor or set of actors’.² Many people equate policy with legislation, but is far broader to include non-legislative decisions such as setting standards, allocating resources between organisations, changing the levels of subsidies or taxes or consulting specific groups in the policy-making process. While the private sector is also relevant, the focus of this report is specifically on the relationship between the network and policy-makers in the public sector.

The ‘policy process’ is usually considered to include the following main components: agenda setting, policy formulation, decision-making, implementation, monitoring and evaluation. ‘Policy influence’ refers to how external actors are able to interact with the policy process and affect the policy positions, approaches and behaviours in each of these areas.

1 World Health Organisation definition of Mental Health. www.who.int/features/factfiles/mental_health/en/#

2 This definition is taken from Anderson, J. M. (1975). For more detailed discussion on policy issues see Hill, M. (1997), Sabatier, P. (ed.) (1999), Sutton, R. (1999), Pollard, A. and Court J. (2005).

Executive Summary

Mental health is a critically important issue in global health today, and yet does not receive due policy attention. Mental illness will likely affect one in four people within their lifetime and neuropsychiatric conditions now account for 13% of the global burden of disease – with 70% of that burden in low- and middle-income countries (WHO, 2001; Lopez et al., 2006). Despite this, mental health has not yet achieved the policy influence that would be proportionate to its burden, nor ‘commensurate visibility, policy attention, or funding’ that is warranted (Tomlinson and Lund, 2012).

This report applies several theoretical approaches to analyse mental health as a policy issue and the particular challenges it faces. This report applies the Overseas Development Institute (ODI)’s ‘Knowledge, Policy and Power’ (KPP) framework to assess the characteristics of mental health as a policy issue. It also applies other supporting analytical approaches regarding the tractability of a policy issue and for assessing the effectiveness of global health networks. The report focusses on mental health at a global level, but highlights the need for more detailed analysis at a more local level, given that policy traction is highly dependent on local context, actors and systems of decision-making.

By characterising the different aspects of mental health as a policy issue, it becomes easier to understand why it has faced problems achieving policy influence to date and what opportunities there are to harness change. Characteristics such as stigmatisation, heterogeneity, a recently emergent user movement, the individualistic nature of treatment, the role of the informal sector, low financial investment and lack of data, all act as barriers to achieving policy traction (as well as appropriate access to care, prevention and treatment). These features mean that the salience of the issue is diminished, its actual severity and prevalence is concealed and its ‘solvability’ negatively influenced.

However some positive entry points are also identified in the characteristics of mental health as a policy issue. Public interest in mental health, particularly in high income countries, is growing. Over the past 20 years the interest in promoting mental health and providing solutions has grown dramatically (Friedli, 2009; Secker, 1998; WHO, 2001; WHO, 2013). As public interest increases there will be corresponding demand for information and advice, which leaves the global mental health community (and networks like the Mental Health Innovation Network) well placed to be heard and have influence.

While more detailed and rigorous political economy analysis is required, the **changing international policy environment** suggests that there could be a tipping point approaching in coming years for mental health. Increased international commitments and reporting against set targets will help to mitigate many of the current barriers, and the role of donors like Grand Challenges Canada (with funding from the Government of Canada) will be crucial in future. If the network can engage in the most effective way, and harness this potential upcoming opportunity, there could be a vast improvement in the way that mental health is treated as a policy issue.

The experience of different social movements across global health can provide valuable lessons for the mental health movement to learn from. While not all approaches can be grafted directly across to mental health, there are several important lessons that can be of use. Among those successful networks (HIV, tuberculosis, and the anti-tobacco movement), several had overlapping characteristics with mental health. All experienced barriers, most pertaining to stigma, lack of data or newly emergent user movements. The success factors that mental health can take from these movements include the need for movement coherence and a united ‘policy ask’; reframing the issue to suit the audience; adopting strategies to address cost; establishing (or harnessing) institutions to stabilise financial flows and binding targets; and presenting or communicating a concentrated emergence where opportunities arise (e.g. humanitarian crises). The key difference that stands out in applying these to mental health is that none of these movements faced the level of heterogeneity as a policy issue, to the extent that mental health does.

Chapter 4 lists the engagement strategies that can provide important insights for mental health and applies them to the mental health movement. Those which directly apply to the global mental health community as a whole include the need to develop a coherent policy ask across the mental health community (which may or may not be possible, given the heterogeneity of the issue); understanding the cost thresholds that policy-makers might not be willing to surpass; mapping and harnessing upcoming policy windows; as well as communicating the extent and severity of the issue. Engagement strategies specifically for the Mental Health Innovation Network (MHIN) include the creation of a knowledge exchange and continuing to strengthen network effectiveness. Some of these efforts are already underway; others would be

new to the network's activities. There is also a selection of engagement strategies identified for the Grand Challenges Canada (GCC) grantee projects operating under this network, which are informed by responses to a survey conducted by ODI in June-July 2014 for this report. The project specific engagement strategies include training for the projects (such as the Knowledge Policy and Power or KPP analyses of local operating contexts, workshops on how to write policy briefs, and a set of tools for how to engage policy-makers and the media more effectively).

These strategies and analyses provide relevant insights into the work plan of MHIN, and corresponding GCC projects, in terms of how to harness the opportunities before them, and act at this critical time as the issue approaches an important shift in the international policy environment. If successful, the global mental health community could attain the levels of policy traction, financing and public support that would correspond more closely to the actual devastating scale of the issue.

Introduction

Mental health is a critically important issue in global health today and yet does not receive due policy attention. This report characterises mental health as a policy issue, and draws upon the experience of different social movements across global health to provide lessons for this field. It presents an array of engagement strategies to specifically inform how the Mental Health Innovation Network (MHIN) can best help to improve policy influence across aspects of the global mental health community.

The origins of this report

The Mental Health Innovation Network (MHIN) was created in June 2013 in response to a growing commitment to develop, evaluate and scale up promotion, prevention and treatment innovations for mental, neurological and substance use disorders (MNS disorders) around the world. The goal of the network is to support bold ideas to improve treatments and expand access to care for mental disorders through transformational, affordable and cost-effective innovations that have potential to be sustainable at scale. The network is funded by Grand Challenges Canada (GCC).³ MHIN oversees and supports the work of 49 GCC grantees or projects, which operate across 26 different countries, developing treatment innovations for mental health.

The network's activities are supported by a team of researchers and technical officers from the London School of Hygiene and Tropical Medicine (LSHTM) and the World Health Organisation (WHO), with guidance from an advisory group of key stakeholders within global mental health. The network's role includes two main functions; synthesising existing and emerging evidence on global mental health and promoting knowledge translation and research uptake amongst potential users such as policy-makers, practitioners and the public.

In June 2013 the network hosted a stakeholder consultation to identify the needs of the group and relevant activities that could address these. The need to better understand how to engage policy-makers in the mental health arena was identified by the network as a priority. This report is a culmination of a short literature review, a series of interviews with GCC grantees and survey of the global mental health community funded by GCC.

The purpose of this report

Mental health presents an increasingly significant global health policy challenge. Mental illness will likely affect one in four people within their lifetime and neuropsychiatric conditions now account for 13% of the global burden of

disease – with 70% of that burden in low- and middle-income countries (WHO, 2001; Lopez et al., 2006). There is a dramatic shortfall of services available to those in need, with the treatment gap estimated at between 76-85% for low- and middle-income countries, and 35-50% for high-income countries. Suicide, in particular, remains one of the leading causes of death across certain age groups (especially adolescents and young adults). Nevertheless, mental illness continues to be denied adequate levels of policy traction, financing and public support that would correspond to the actual scale of the issue (Tomlinson and Lund, 2012).

The aim of this report is to share lessons learned and make recommendations on how to improve the skills and abilities of the mental health practitioners within the network to engage with policy-makers in a more systematic and informed way in their respective countries. The projects funded by GCC are predominantly based on action research and so this report will provide engagement strategies that are tailored accordingly.

The report provides a context analysis, mapping the opportunities and challenges that mental health faces as a policy issue across different country contexts and the extent to which this might differ from other policy areas, drawing upon the lessons from policy-makers and practitioners' own experiences. **Chapter 1** discusses the analytical framework that will be applied and why it is challenging to characterise global mental health as a policy issue. **Chapter 2** identifies the characteristics particular to mental health which necessarily change the way that researchers and practitioners go about achieving policy influence, by helping them to conceptualise how the policy challenges they face are unique.

Chapter 3 reviews lessons that can be drawn from other areas outside of mental health (particularly from the broader health sector) that are relevant to overcoming barriers like stigmatisation and generating support for policy change. By applying the Shiffman and Smith analytical approach, the report demonstrates how some health initiatives are more successful at achieving policy traction than others (Shiffman and Smith, 2007). It presents key lessons for the global mental health movement to consider. **Chapter 4** of the report discusses the most appropriate policy engagement strategies for the global mental health community. It draws upon the tools and frameworks developed by the Overseas Development Institute's Research and Policy in Development (RAPID) Programme in this area, to shape recommendations for the GCC grantees, and also for broader global mental health community actors to implement their work over the coming months and years.

3 See the Grand Challenges Canada website for the latest figures: www.grandchallenges.ca/grand-challenges/global-mental-health/

Chapter 1: The approach to characterising mental health as a policy issue

1.1 Depicting mental health as a policy issue

This report characterises mental health by highlighting the differences or nuances that exist in its policy engagement experience compared to more typical policy issues. One challenge is that no policy issue is ‘typical’. However the following chapters will differentiate mental health from the other policy issues (such as education or other international health policy areas), which achieve more regular policy traction. It will highlight where mental health may be experiencing particular barriers or unique engagement opportunities. Chapter one outlines the analytical framework that will be applied to achieve this.

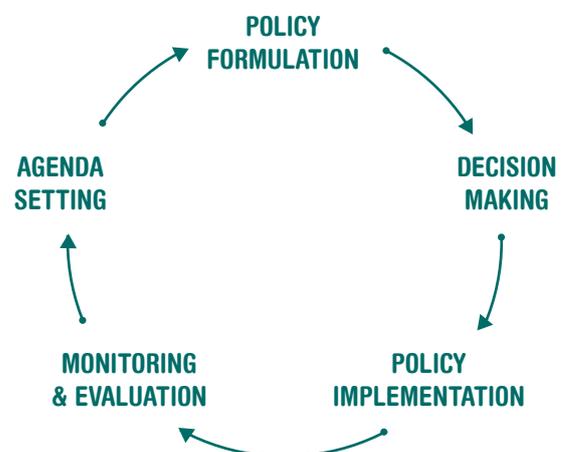
1.2 Understanding the policy-making process

To appreciate why mental health has not achieved greater policy traction requires an understanding of the policy-making process. Though there is no clear-cut delineation of the policy process which reflects the complexity of reality, Figure 1 presents a helpful conceptual overview of the critical stages of policy-making. From stage one (agenda setting), through to stage five (monitoring and evaluation of activities to measure progress and re-adjust accordingly), these form a policy-making cycle that continues to adapt and readjust, rather than progress linearly. Some stages may happen simultaneously and some may be quicker or shorter depending on the policy issue.

Understanding these different stages helps to categorise the entry points for information and action research produced by the network. For example, at the **agenda setting** stage, there is a need to raise awareness of the real burden of MNS disorders and the human, social and economic costs that flow from these. There is a need to dismantle the stigma and discrimination faced by people suffering from MNS disorders and highlight the inadequate services which ‘prevent millions of people from receiving the treatment they need and deserve’ (WHO, 2001). Evidence of mental health statistics and the magnitude or economic impact of MNS disorders in the community can help to position an issue on the policy agenda and ensure that it is recognised as warranting a policy response. Better use of evidence can also influence public opinion, cultural norms and contestation that has an indirect effect on policy-making processes.

In **policy formulation**, evidence from MHIN can play an important role in establishing credibility of the global mental health community voice in the policy debate (influencing how decisions are made), particularly where a vacuum of information exists. MHIN can combine tacit and practitioner knowledge from the field to present information that can be incorporated into policy decisions, shaping responses that relate to mental health initiatives. MHIN practitioners’ inputs can extend to costed policy options and practical solutions that inform policy-makers’ decisions. At the **implementation** stage, the information captured by the programs helps to translate the technical skills, expert knowledge and practical experiences from the field to policy-makers so that they can improve the policy architecture to inform broader government implementation in areas like mental health financing, regulation and service delivery. Their work from the field can influence the implementation of policy through provision of realistic and generalizable solutions. This is particularly relevant to where pilot programmes are extended to new subnational areas. Finally, evidence can be used in the **monitoring and evaluation** of policy to help to identify whether policies are actually improving the lives of people suffering from MNS disorders and their communities. For example, the

Figure 1: The Policy-making cycle



GCC projects operating across 26 different countries, are pioneering participatory processes that transform the views of people into indicators and measures that can be useful to measuring policy impact. Furthermore evidence can be used to improve implementation strategies: to support better targeting and more cost-effective solutions.

Types of policy change to be considered

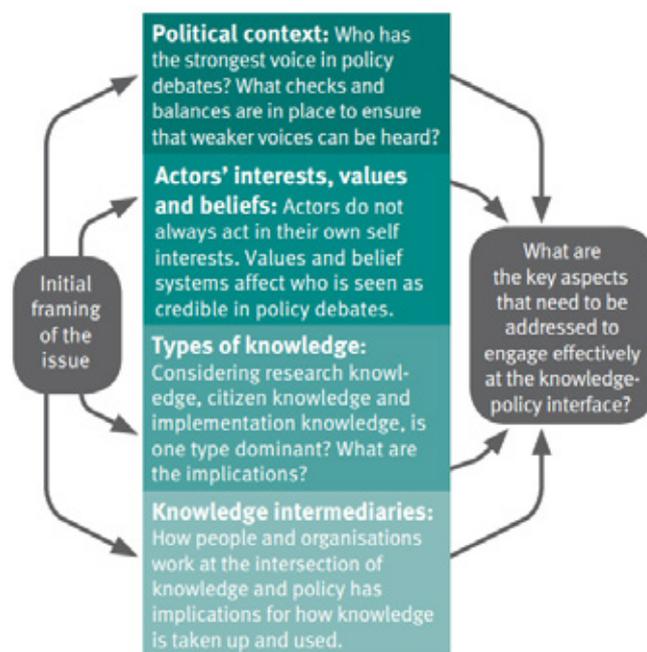
To understand the types of impact that the global mental health community may want to achieve involves understanding the *types* of policy change that exist. Policy change is often understood as changes to specific documents or pieces of legislation, but in fact there are five types of policy change that could be relevant to mental health, (Young and Mendizabal, 2009): (i) *Discursive changes*: these are changes in the labels or narratives that policy actors employ to discuss mental health. These reflect a new or improved understanding of a subject - even if it does not imply an effective change of policy or practice. (ii) *Procedural changes*: these are changes in the way certain processes are undertaken. For example, the incorporation of consultations with mental health users to otherwise closed processes, or small changes in the way that national mental health policies are implemented in the field. (iii) *Content changes*: these are changes in the content of policies including the creation of a mental health law, strategy papers, legislation and budgets. These are formal changes in the policy framework. (iv) *Attitudinal changes*: these are changes in the way policy actors think about mental health as a policy issue. (v) *Behavioural changes*: these are changes in the way that policy actors behave in relation to mental health (how they act or relate to people suffering from mental illness) as a consequence of formal and informal changes in discourse, process and content.

1.3 Analytical Framework applied in this report

There is one overarching framework and two supporting/ contributing analytical approaches applied in this report. These are helpful in diagnosing policy issues, yet have rarely been applied to global mental health to date. They are (a) ODI's Knowledge Power and Policy framework (which is applied as the central framework in this report) (b) the Sabatier and Mazmanian analytical approach (which is used to analyse tractability); and (c) the Shiffman and Smith analytical approach (applied to analyse network effectiveness).

ODI's **Knowledge, Policy and Power (KPP) framework** is explained in Chapter 2 in more detail but essentially provides a practical framework for understanding the interface between knowledge and policy and practice, and the way in which these are mediated by the operations of power (Jones and al., 2012). It is important to realise that good policy is not generated simply by increasing the amount of research on a particular topic (for example, mental health data, scalable treatment or prevention solutions or research on its economic impacts). There are

Figure 2: Knowledge, Policy and Power Framework



complex issues to navigate to ensure that the best research/ knowledge is sourced, interpreted and used in developing better mental health policies. ODI has published the KPP framework as an overarching guide. It is particularly appropriate to mental health where many of the policy interactions are identified by practitioners as being intertwined with power relationships. Its application in chapter two helps us to better understand and successfully navigate the interface between knowledge, policy and practice in mental health, and to characterise mental health as a policy issue. The framework outlines four key dimensions which require attention in order to understand how project findings or evidence translate (or don't) into policy: the political economy of the knowledge-policy interface, the actors who engage in it, the types of knowledge used and the role of knowledge intermediaries. The characteristics defining mental health as a policy issue will be presented across these four dimensions.

Sabatier and Mazmanian's analytical approach helps to determine whether an issue has tractability (that is, how manageable it is to policy-makers). This model is represented at Annex A, and entails elements such as: availability of valid technical theory and technology to solve the problem, diversity of target group behaviour, severity of the problem, prevalence of the target group in general population, and the extent of the behavioural change required.

The **Shiffman and Smith analytical approach** is one of the few conceptual frameworks developed to analyse the emergence and effectiveness of *global health movements* in terms of policy influence. It is used predominantly to

help assess some characteristics of mental health and analyse network effectiveness in this report. The approach shows that an issue's characteristics are a consequence of its severity, tractability, vulnerable groups and society's perceived responsibility towards it. It has been applied predominantly to movements such as those concerned with maternal and neonatal health, tuberculosis and pneumonia, as well as tobacco and alcohol. This is one of the first comprehensive applications of the framework to global mental health.⁴

There has been limited analysis characterising global mental health through theoretical policy analysis frameworks to date. An emerging spectrum of work exists on other health areas (such as maternal health, neonatal health, HIV and malaria) as distinct policy issues (Shiffman and Smith, 2007), but their experiences have limited application to mental health because their characteristics differ (for example, they do not face the same levels of

heterogeneity that mental health does). There is extensive material on the policy process generally and how to improve policy influence,⁵ as well as detailed analysis emerging on mental health itself, but there is limited work bridging these two fields (Desjarlais et al., 1995; WHO, 2001; WHO, 2013). This could in part be due to the fact that it is challenging to make assessment across global mental health as a whole. Any characterisation of mental health relies ultimately in diagnosing the specifics of the policy context in which it is operating, is highly dependent upon the local policy-makers, and cultural or social understandings of a diverse array of MNS disorders in that locale. Attempts to do so are at risk of being too generic to be useful, or too specific to be applicable in different cultural, social or geographic contexts. This report will conduct a broad brush assessment but caveats that any detailed analysis in future would be well served by being tailored to specific operating contexts.

4 The other is the short paper by Tomlinson, M. and Lund, C. (2012).

5 See the work of the Research and Policy in Development (RAPID) Programme, Dr Nancy Cartwright, IDRC, and others.

Chapter 2: Characterising mental health as a policy issue

The characteristics presented in this chapter emerged through the literature review conducted for this report, two workshops conducted with GCC grantees, a ten item survey across 30 international mental health projects and a series of interviews with seven practitioners in mental health (at senior project manager level) across different GCC projects.⁶ An attempt was made to weight the characteristics in terms of relative importance, however the weighting by practitioners interviewed varied so significantly (sometimes in opposition) that no clear pattern could be drawn.

Ten defining characteristics were identified that differentiate mental health from policy issues that more regularly feature in government decision-making. These are listed in box 1. It should be noted that most of these can be categorised as barriers to achieving policy traction, though one or two can be reframed as strengths. There is some overlap between them and some interrelation (one can arguably impact or influence another).

The emergent theme in the interviews, literature and survey was that power relations are very important in the mental health context (for example, the power relationships between service providers and service users). The KPP framework is a way of analysing complex relationships particularly where power relations are important.

ODI's KPP framework highlights four key dimensions which impact upon the extent to which knowledge influences policy: (i) the political economy of the knowledge-policy interface;⁷ (ii) the actors who engage in it, and their beliefs, values and interests; (iii) the types of knowledge used and the relevance, credibility and communication of that evidence; and (iv) the role of intermediaries in the political context and institutions, links, networks and trust between key stakeholders. These dimensions are not presented in any particular order in the framework, and for the purposes of this report will be applied in terms of relevance to the issue – beginning with cross-cutting characteristics, and followed by actors,

Box 1: Characteristics of mental health as a policy issue:

1. Heterogeneity
2. Stigma
3. Agency of the service user
4. Lack of data
5. Under-diagnosis
6. Individualised nature of treatment
7. Low financial investment
8. Role of the informal sector
9. International commitments and engagement
10. Effectiveness of Networks

types of knowledge, political context and concluding with knowledge intermediaries.

2.1 Cross-cutting characteristics

It is important to mention one characteristic from the outset which does not fall neatly into any one category of the KPP Framework, but applies across all four categories. That characteristic is the heterogeneity of mental health.

1. *Heterogeneity of mental health*

Mental health as a policy issue is very heterogeneous, which makes it difficult to develop a single, succinct 'policy ask' or promote one coherent solution to policy-makers. The spectrum of health states and conditions encapsulated by the term 'mental, neurological and substance use disorders' includes a wide range of conditions, from schizophrenia and depression to autism, dementia and drug dependence. These have vastly different symptoms, causes and treatments, and typically affect different demographics of the population. Furthermore, within each type of disorder the treatment solutions (often a delicate balance of pharmacological interventions coupled with psychosocial interventions) are heavily dependent on the

6 See Methodology in Annex B.

7 Note that this is political context but not necessarily politics with a capital P, vis-à-vis political parties. Rather it involves the relationships between actors, regardless of political affiliations.

individual, and ‘one size fits all’ treatments rarely exist. There are also dissenting attitudes on the underpinning epistemic assumptions regarding how to diagnose mental illness, with new approaches emerging that do not fit within diagnostic categories.⁸ This means that the global mental health community does not have a broad cohesion of classification, cause and treatment of mental health.

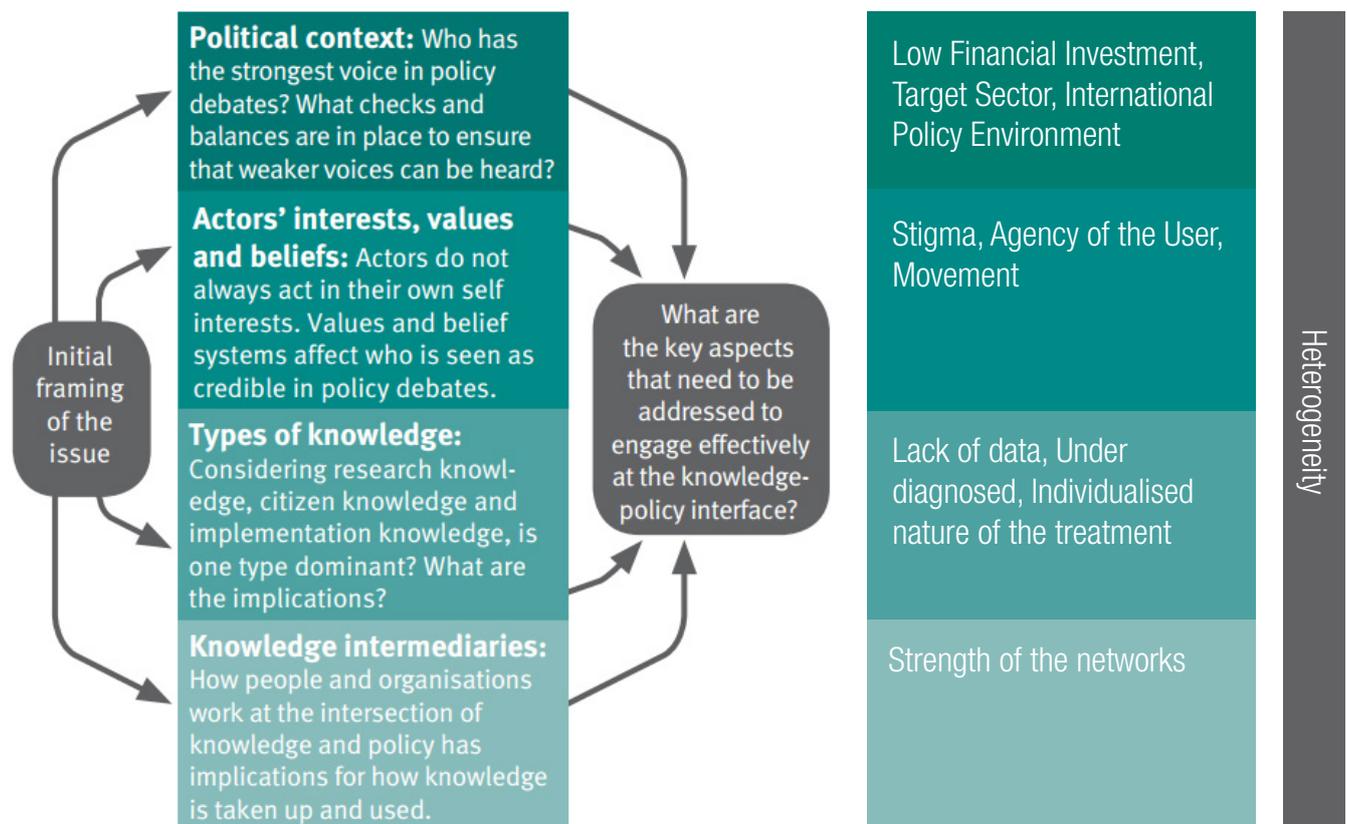
As a policy issue this means that policy-makers who become motivated to address mental health needs rarely see a simple ‘catch all’ solution because of the diversity of disorders and treatments involved. Nor that a single solution could or should be sought, but this complexity undermines the attempts to address the policy issue within the timeframe and decision-making criteria that most policy-makers face. Policy-makers are restricted by short time frames, finite resources, salient opportunity costs, powerful competing interest groups and have to work across a wide set of responsibilities with sometimes limited technical expertise in the subject matter. Furthermore mental health faces implementation challenges due to the fact that it is often cross-sectoral, requiring levels of

institutional coordination that are complex and time-consuming. Sabatier and Mazmanian highlight that the tractability of the problem (how manageable it is) is key to the uptake by policy-makers of an issue, and its success (Sabatier and Mazmanian, 1981). The heterogeneity that exists within mental health is at a disadvantage in this sense.

2.2 The role and behaviour of actors

Several characteristics of mental health fall into what ODI has categorised as the ‘actors’ interests, values and beliefs’ dimension. Understanding the role and behaviour of actors goes beyond ascribing self-interest, and is about understanding the interplay of relevant actors’ interests, values, beliefs and credibility and the power relations that underpin these. Actors’ interests will shape who is involved in a policy issue, what they aim to get out of the process and what knowledge is prioritised for policy-making. This gives insight into likely entry points for the uptake of project findings and how to engage those actors who could affect policy changes for mental health progress.

Figure 3: Mapping characteristics of global mental health to the KPP Framework



8 Mezzich J.E et al (1999), pp 457-464.

2. Stigmatisation of mental health

The social stigma that is attributed to people living with MNS disorders translates to its treatment as a policy issue through the attitudes of the general public and the behaviour of policy-makers. As described in Thornicroft et al. (2008), it is generally understood to be a combination of problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination). The manifestations of stigma vary according to the MNS disorder, as well as the particular cultural context, but from a global historical policy perspective they frequently result in an indifference to the needs of people suffering from MNS disorders with meaningful solutions to the inequities they face.

This has meant that mental health has historically been absent from the policy-making agenda as a starting point, or else policy initiatives have been discriminatory or directed at socially excluding persons with mental illness from society (Martinez et al., 2011). In more extreme cases there has been discrimination against people living with MNS disorders to the extent that they are perceived as lacking in agency and divested of fundamental human rights (Martinez et al., 2011), resulting in policies of non-consensual treatment and involuntary confinement (Link et al., 1999).

There is evidence that stigma has impacted upon mental health policy, meaning that it is rarely acknowledged as an important public health issue, nor resourced appropriately. Despite extensive advocacy effort it was not included explicitly in the Millennium Development Goals (MDGs), even though mental health is implicit in many of the MDGs (Miranda and Patel, 2005). Nor was mental health included as a priority condition at the UN General Assembly Special Session on Non-Communicable Diseases in 2011. In fact it was barely mentioned until prompted by pertinent lobbying efforts of the WHO, the World Federation for Mental Health and others (Tomlinson and Lund, 2012). In domestic policy contexts, 55% of African countries did not have mental health legislation (and 60% of South East Asian countries) and 33% did not have a mental health plan (WHO, 2011). There have been clear and practicable policy recommendations about how to improve the prevention and treatment of mental illness from the international organisations specialising in this area.⁹ These are well documented, informed by research and packaged accessibly, yet remain largely absent from national policy agendas. In 2001 the World Health Report concluded that ‘no country has managed to achieve the full spectrum of reform required to overcome all the barriers,’ (WHO, 2001). There are two implications for policy impact arising from stigmatisation. Firstly, in terms of the type of policy change sought, the extent of *attitudinal, discursive*

and behavioural change required of policy-makers (to ensure they think about mental health and include it in the policy agenda) is more significant than other areas. These will have to shift before more substantive content and procedural shifts can follow. Secondly, in applying the Sabatier and Mazmanian approach, the behavioural change of the public (to ensure that they see mental health as an important issue and as policy is implemented) is also significant. On the sporadic occasions where mental health has attracted public attention (often following a major disaster which acts as a focussing event)¹⁰ and attains a position on the policy agenda, it is largely undertaken in a tokenistic manner without being informed by robust evidence, or including the views of people directly affected (Birkland, 1998; McMillen et al., 1997). A deeper, more holistic shift is required to attain policy influence for mental health in future.

3. Collective agency of the users

Policy-makers are not the only actors to be considered in this dimension of the KPP framework; the mental health user movement is becoming stronger and more coherent which amplifies its policy influence. There are numerous user movements emerging in mental health advocating for opportunities to shape the development, implementation and evaluation of policies which affect their lives. Historically, people living with MNS disorders have rarely been able to participate in this regard (Pilgrim and Rogers, 1999). There are clear examples of service user involvement enhancing over the last two decades, especially in countries where institutional services have shifted to a community-oriented model of care (Thornicroft and Tansella, 2005). Networks such as Australia’s National Mental Health Consumer and Carer Forum have a very real influence on government policies today.¹¹

However in areas of more acute poverty, user agency remains weak. It is acknowledged that poor mental health is both a consequence and determinant of poverty. Everyday realities of poverty like ‘insecurity and hopelessness, rapid social change and the risks of violence and physical ill-health’ help to explain this increased vulnerability to mental illness (Patel and Kleinman, 2003). These factors, coupled with stigma and heterogeneity, explain why the user movements in low- and middle-income countries continue to emerge at a slower rate.

From a policy perspective the collective agency of the users contributes directly to the policy influence an issue is able to achieve in several ways. It impacts upon the tractability of the problem (how manageable it is to policy-makers) by reducing the diversity of the target

9 These include recommendations such as to include management and treatment of MNS disorders within primary care, to help psychotropic drugs be made available, provide better in-community care and to address the professional shortfall that exists. World Health Report (2001).

10 See Miller G. (2006).

11 www.nmhccf.org.au

group's behaviour, providing coherence in the attitudes and resources of the constituency groups.¹² The emergence of user movements in mental health could become a formidable force to achieving policy traction.

2.3 Types of knowledge

Several of the characteristics defining mental health as a policy issue fall within what ODI defines as the 'types of knowledge' dimension of the KPP Framework. While the quality, accessibility and salience of the research are important for policy uptake, policy influence is affected by topical relevance and operational usefulness of an idea; it helps if a new approach has been piloted and the document can clearly demonstrate the value of a new option (Court and Young, 2003). Understanding what types of knowledge are prioritised in the local policy-making process is also important. Knowledge communicated to policy-makers should be more than academic research reports, and based on local conditions and practical experience. This correlates with the type of action-based research that the GCC projects are already collecting. By understanding the types of knowledge that policy-makers who might be supportive of mental health are most drawn to, and what the gaps are, the global mental health community can adapt their findings to have better policy influence.

4. Lack of evidence available

A fourth characteristic is the lack of evidence available on mental health statistical realities and practical solutions, which hinders ability to persuade policy-makers to act.

There are different types of data relevant to mental health: the first is data showing the extent and severity of the problem; the second is evidence of good practice, scalable treatment activities and policy models. Both categories are largely lacking in the context of mental health in low- and middle-income country settings, and both can be linked to a lack of funding. As the WHO states, its mission of reducing the burden of mental disorders and promoting the mental health of the population worldwide 'cannot be fulfilled satisfactorily if countries lack basic information about the existing infrastructure and resources available for mental health care,' (WHO, 2011). There have been important efforts in recent years to generate data and research on mental health services and promote its use. The WHO initiated the Mental Health Atlas in 2001, which was designed to collect, compile and disseminate data on mental health resources in response to this gap, making available crucial statistics across country profiles.

Relaying this to policy impact, strengthening the evidence base to inform best practice and policy in global mental health is important. ODI differentiates between

four types of evidence for policy: statistical data, analytical research, evidence from citizens and stakeholders, and evidence from monitoring and evaluation. There are different perspectives on the types of evidence needed, for different roles in the policy process. There are also power relations between the different types of evidence. For example international organisations often place high emphasis on research-based evidence, prioritising it over evidence from citizens (through CSOs and NGOs). They believe it is more robust, when actually issues of stigma and heterogeneity can suggest otherwise and it is important to triangulate – ensuring direct evidence from communities are also heard. The challenge also lies in both translating research evidence into effective policy shifts and also translating effective practice into research so that currently undocumented evidence can make its way into the published literature and thus strengthen the existing evidence base (WHO, 2013).

5. Under-diagnosis of mental illness

The silence, continuum effect and under-diagnosis that surrounds mental health restricts its tractability as a policy issue. Lack of evidence is linked to the fact that despite improved global monitoring, a significant number of people living with mental illness remain undiagnosed (WHO, 2011). This can be attributed to a range of factors, including the fact that manifestations of MNS disorders are often unobservable (hindering the definitive, simple diagnosis that exists with other medical conditions), many people suffering from mental illness do not perceive themselves as needing treatment (so they do not seek professional help); or the simple absence of language to identify the disorder if not culturally acknowledged. It is well known that stigma impacts upon reporting of suicides. In addition there is the chronic nature of mental illness and the fear of discrimination from the community which may prevent people from seeking help. Policy-makers can lean towards biomedical views of causality in mental illness like suicide prevention, rather than social determinants which complicates understanding (Suicide Prevention Australia, 2014a). An additional factor is the 'continuum' effect that is characteristic of mental health; rather than neat categories of illness and health, in reality there is a continuum between health and illness (Rose, 1992). From a policy perspective, this inhibits the issue's tractability in terms of lacking a solid evidence base, which inhibits policy-makers' appreciation of the magnitude of the problem, applicable technical theory to resolve the issue and, where the continuum effect is considered, the diversity of the user group behaviour. The magnitude of the problem and its prevalence in broader society can be one of the key

12 Reducing the diversity of a target group's behaviour is listed as a strength in Sabatier and Mazmanian's approach (Sabatier and Mazmanian, 1981), but this is a contestable point. For example, studies have shown that more diverse groups can produce better outcomes because they bring more creative approaches to problem solving (Hong and Page, 2004). But as Shiffman et al. point out heterogeneity can hamper cohesion and increase the likelihood that groups disagree on objectives. (Shiffman, (2014))

forces in driving acknowledgement and change, yet this is missing in mental health due to lack of evidence and under-diagnosis. If the global mental health community can overcome this characteristic, significant barriers to policy will become much more manageable.

6. Individualised nature of treatment

The individualised nature of treatment hinders mental health's tractability as a policy issue, particularly because there is no single, succinct solution to present to policy-makers. Mental health for each person is impacted by 'individual factors and experiences, social interaction, societal structures and resources and cultural values,' (WHO, 2004). It is influenced by experiences in everyday life, in families and schools, on streets and at work (Lahtinen et al., 1999; Lehtinen et al., 1997). Treatments often require a delicate balance of pharmacological interventions coupled with psychosocial interventions. There is no simple, 'catch-all' procedure and treatment can take place over extended periods of time, taking account of relapses, which makes treatment costly. Effective treatment is often the result of lengthy periods of trial and error, as different people react uniquely to treatment combinations.

From a policy perspective this relates to tractability of the problem for policy-makers. It impacts the perceived availability of valid technical theory and applicable solutions, and ambiguity of policy directives required (Sabatier and Mazmanian, 1981). Put simply this means that mental health achieves less policy influence as an issue because it is seen as too complicated and varied in its 'solutions' and so would translate to ambiguous policy changes. The individual nature of the treatment also arguably impacts on the ability to reframe mental health as a social rather than individual responsibility – a factor that can be key to achieving policy traction.

2.4 Characteristics pertaining to the political context

Several characteristics fall within what ODI has categorised as 'political context' within the KPP Framework. This means that they pertain to the political economy of the knowledge-policy interface; the structures and processes, institutional pressures and prevailing concepts that impact upon mental health achieving policy traction. Adopting the position that 'it's all down to political will' is not only inaccurate but also counterproductive. Understanding the political context involves determining what set of boundaries exist concerning how evidence is used in formulating mental health policy. It is important to map the opportunities for public debate, the strongest voices in those debates, the checks and balances particular to the system

which the project is engaging with, how international agreements are ratified and implemented domestically, the informal politics which affect the system, where and when policy windows may open or close and the capacity of the public service to make and deliver health policy in a way that is conducive to including mental health.

7. Low investment in mental health

Low levels of investment has several negative impacts on policy influence, including that it means funding is not available for activities to flourish, to attract organisations to work on the issue and allow champions to use resources to establish secretariats, support systems and global gatherings to link communities of practice (Shiffman et al., 2014). The low investment in mental health is both in terms of financial and human resources, by national governments, donors and the private sector. The World Health Report 2001 noted that one third of the global population was living in countries which allocate less than one % of their total health budget to mental health (Saxena et al., 2006). In 2011, WHO reported that global spending on mental health was still less than US\$3 per capita per year, and in low income countries, expenditure can be as little as US\$0.25 per person per year.¹³ This is in contrast to the fact that mental illness will affect approximately one in four people throughout their lifetimes, and the area is demonstrated as being drastically under-funded across the board (WHO, 2001). Furthermore, investment actually makes economic (as well as public health) sense; not only does investment generate health returns that are commensurate with other prioritised diseases such as diabetes and HIV, it also contributes to better physical health in adulthood and better developmental outcomes in early childhood (Sudhinaraset et al., 2013).

A number of barriers have been identified that continue to influence collective values and decision-making about investment – including 'negative cultural attitudes towards mental illness and a predominant emphasis on the creation or retention of wealth (rather than the promotion of societal well-being),' (WHO, 2014). Low investment can also be attributed to the scarcity of resources available in some countries, very visible competing priorities with significant public support, the intangible nature of mental illness, that mental health is less immediately apparent as life-threatening in most instances, and can be considered difficult and slow to treat.

From a policy perspective, low financial investment is arguably a result of other characteristics listed in this report (such as stigma and heterogeneity) but it generates its own causal effect. Financial resources are required to

13 WHO (2011) Mental Health Atlas. In addition, these resources are often spent on services that serve relatively few people. "Governments tend to spend most of their scarce mental health resources on long-term care at psychiatric hospitals," says Dr Ala Alwan, Assistant Director-General of Noncommunicable Diseases and Mental Health at WHO. "Today, nearly 70 % of mental health spending goes to mental institutions. If countries spent more at the primary care level, they would be able to reach more people, and start to address problems early enough to reduce the need for expensive hospital care."

help generate policy change; they underpin the availability of valid technical theory and technology (research and solutions require resourcing), the extent of media attention given to the issue, the advocacy campaigns of the user movement to raise public awareness, ability to develop their messaging and change attitudes. Essentially low investment prevents the research and advocacy needed to change the status quo.

8. *The role of the informal sector*

In low and middle income countries, a significant proportion of mental health treatment occurs in the informal sector. This means the care being provided is in the absence of formally recognised training programmes, without payment, without registration or regulation (Sudhinaraset et al., 2013). The result is that mental health services in many countries side-step formal policy-making systems, so are not on the policy-makers' agenda from the outset, and are largely invisible. The types of policy changes required are extensive, and in many instances discursive and attitudinal changes would be needed to raise awareness of mental health as an issue, before content or behavioural changes can occur.

9. *A changing international policy environment*

The ninth characteristic is the changing international policy environment – the extent of international commitments and engagement which exist within the global governance structure, and how they open up policy opportunities for mental health. International policy environments have a direct influence on domestic policy change, by providing windows of opportunity, generating debate and awareness, and most importantly through the creation of binding targets and commitments that are then ratified in local laws and policies. After decades of limited recognition, there are several indicators that major changes are afoot for mental health in the international policy environment, culminating in the WHO's Mental Health Action Plan 2013-2020. The Plan represents the first ever real political commitment to mental health by the 194 Member States of WHO. Targets stipulate that 80% of countries will have developed or updated their mental health policy in line with international and regional human rights instruments, rates of suicide will have decreased by 10%, countries will regularly report against core set of indicators and service provision to severe mental disorders will have increased by 20%. Furthermore, 50% of countries will have developed or updated their mental health law in accordance with international and regional human rights instruments by 2020. Beyond the Mental Health Action Plan other

important political commitments include the Resolution on Autism and the G8 initiative on dementia.

Other signals lie on the horizon. Having failed to achieve incorporation into the MDGs, campaigners are working to include mental health in the post-2015 development agenda with some hope that existing drafts reflect this.¹⁴ This would provide meaningful targets that are highly visible on an influential platform in the international policy environment. Finally, there has been the announcement of a potential joint meeting between the World Bank and WHO on mental health in 2015. The meeting will likely be attended by finance ministers and major economic players, and will be important to help reframe the mental health burden in economic terms and strengthen funding flows to the field. Engaging the major economic actors in mental health advocacy is an essential element that needs to be prioritised (WHO,2013).

And finally, there have been few but consistent donors behind the mental health movement, including GCC and the Canadian Government. These donors have supported transformative ideas to improve treatments and expand access to care for mental disorders through affordable and cost-effective innovations. This consistency of funding and support is crucial to the sector but could be increased with help from other funders. As a relative indication of scale, GCC (one of the major donors in global mental health) has funded 61 projects with \$31.5 million globally, which would not constitute major funding in other health areas.¹⁵

2.5 Knowledge intermediaries

The fourth dimension in the KPP framework emphasises the importance of knowledge intermediaries in affecting policy change. This includes communities, networks and groups like the media and civil society organisations. The types of **knowledge intermediaries** operating can greatly impact upon the traction of a policy issue, particularly the extent and quality of their operations.¹⁶ Knowledge intermediaries who are communicating between research (or findings generated by the projects) and uptake by policy-makers, need to think through a range of possible approaches to ensure their role is effective. They typically perform six functions (informing, linking, match-making, engaging, collaborating and building adaptive capacity), though some organisations or individuals may not realise that the role they play could be labelled as 'knowledge intermediary'. There is also extensive academic publication on the different types of networks and their strengths, such as policy communities (Pross, 1986), epistemic communities (Hass, 1991) and advocacy coalitions

14 Such as the FundaMentalSDG Movements www.fundamentalsdg.org/show-your-support.html and draft wording of the Post-2015 development agenda purportedly included wording on mental health, Open Working Group, post-2015 Development Agenda, Proposed Goal 3. Attain healthy life for all at all ages (as on 10th June 2014). www.sustainabledevelopment.un.org/focussdgs.html

15 Malaria vaccines attract over \$300 million per year for example.

16 Knowledge intermediaries can be organisations or individuals doing a dedicated job or including it in part of their ongoing work.

(Sabatier and Jenkins-Smith, 1999), which all, to differing extents, perform these intermediary functions.

10. Strength of the few existing mental health networks¹⁷

The final characteristic is the strength of the few networks operating in mental health and their improved ability to generate policy change – but more research is needed.

In many ways, the effects of the other characteristics all impact upon this one. Effectiveness pertains to the extent the network is able to deliver improvements across global mental health, or more generally, to change the world to meet its members perceptions of what reality should look like (Sikkink, 2009). Very few empirical studies exist analysing the factors affecting success of social movements who mobilise attention and resources for different global health issues. Some health networks have achieved political success and been able to attract great resources (child immunisation, family planning and HIV/AIDS for instance), whereas others received little attention or resources (such as malnutrition and pneumonia), (Shiffman and Smith, 2007). Mental health has been described as an area of analytical neglect and ‘conspicuously underdeveloped’ (Cress and Snow, 2007). There are only a handful of researchers working on determining the underlying factors of success (Shiffman and Smith, 2007). Five factors have been identified which help to determine the strength of networks. The first is the policy community cohesion; the degree of coalescence between the network actors. The second is the quality of the leadership; the presence of individuals capable of uniting the policy community and acknowledged as strong champions for the cause. The third is the effectiveness of the guiding institutions or coordinating mechanisms with a mandate to lead activities for the network (such as MHIN). The fourth is their capacity to mobilise civil society and grass roots organisations to press political authorities to address the issue. The fifth is their ability to frame and publicly portray the issue in a way that resonates with external audiences, particularly political leaders who control resources (Shiffman and al., 2014).

Though there may not be a wide variety of networks in mental health compared to other social movements (like those that exist around HIV/AIDS, child immunisation, or different types of cancer), the ‘attitudes, resolve and technical resources of the mental health networks that exist’ are well developed (Rogers and al., 1997). The strength is due in part to the policy cohesion which exists within them. This can in part be attributed to the acute stigma that mental illness is faced with, which unites actors against outside attitudes. It also is self-selecting in that people operating in this field are typically motivated by

stronger forces than monetary incentives or prestige, which adds a drive and longevity to their involvement (Rogers and al., 1997). There is strong individual leadership in the sector, for example, the core group of individuals behind the publication of the World Health Report 2001, those behind the creation of MHIN and others working within key institutions such as the WHO, LSHTM, NIMH and GCC. There is also strong professional expertise through the involvement of a high number of technical specialists (predominantly psychologists) in these networks. Guiding mechanisms are starting to emerge that are well resourced and attuned to best practice, such as MHIN and collaborative hubs under NIMH. Capacity to mobilise civil society is unclear but initiatives such as MHIN could be key in raising awareness to achieve this. The ability to frame mental health issues is somewhat undermined by the heterogeneity of MNS disorders but strong public awareness campaigns have begun to emerge particularly in the UK, USA and Australia. From a policy perspective the strength of these networks will determine whether they can mobilise public opinion or change attitudinal behaviours of policy-makers in order to position mental health on the policy agenda.

2.6 Conclusions for this chapter

By characterising the different aspects of mental health, it becomes easier to understand why it has faced problems achieving policy influence to date and what opportunities there are to harness change. Characteristics such as stigmatisation, heterogeneity, an only recently emerging user movement, the individual nature of treatment, the informal sector, low financial investment and the lack of data coupled with under-diagnosis all act as barriers to achieving policy traction. These features mean that the salience of the issue is diminished, its actual severity and prevalence is concealed/supressed, while impacting negatively upon its ‘solvability’, all inhibiting its uptake and influence in the policy-making process.

However some positive entry points can be identified. Firstly, there is something of a vacuum. Few mental health actors are operating in many national contexts and so when practitioners and advocates from this network do meet with policy-makers, they are typically the authoritative voice on the issue. In some instances, particularly outside of high income countries, they may be one of the first to engage the policy-maker on mental health, which can be a powerful tool, a clear advantage that mental health has over other policy areas. In other policy areas, such as climate change, or family planning, different groups compete to be heard. Policy-makers receive conflicting information and views about the severity of an issue or how to solve it, which reduces

¹⁷ There is some overlap of this characteristic with agency of the users. User movements include the people burdened with MNS disorders, whereas networks is a broader category which includes people working in the field of mental health, families and communities who cooperate in an organised effort to improve the conditions of those suffering from mental illness.

its credibility and hampers uptake. Furthermore, public interest in mental health is growing. Over the past 20 years the interest in promoting mental health and providing solutions has grown dramatically (Friedli, 2009; Secker, 1998; WHO, 2001; WHO, 2013). As public interest increases there will be corresponding demand for information and advice, which leaves this network well placed to be heard and have influence.

Secondly, while more detailed and rigorous political economy analysis is required, the changing international policy environment suggests that there could be a tipping point approaching in coming years for mental health.

Increased international commitments and reporting against set targets will help to mitigate many of the current barriers. If the network can engage in the most effective way, and harness this potential upcoming opportunity, there could be a vast improvement in the way that mental health is treated as a policy issue. For this reason it is important to understand what has and has not worked across different social movements and policy issues in the past, particularly those with similar features to mental health. That way mental health can position itself to operate in the most effective way possible.

Chapter 3: Lessons learned from other areas

3.1 Introduction

While there are many policy issues that warrant societal and government response, there are only a few that capture the attention of policy-makers, the imagination of the public and achieve actual policy influence. It is therefore important to understand what elements make a movement successful so as to draw lessons that can be applied to mental health. Accordingly, this chapter will outline some engagement strategies that have worked in different cases, and brought issues to the policy fore. It will examine the approaches of the HIV/AIDS, tuberculosis, pneumonia, tobacco and alcohol social movements, and the differences between their approaches. All suffered from stigmatisation, some level of heterogeneity, low funding levels, unclear solutions and incomplete data and yet managed to achieve policy influence. This chapter will briefly outline the theoretical concepts which help to explain how social movements gain traction, then proceed to analyse the engagement strategies that shifted perceptions, helping them rise to the forefront of the policy agenda.

The factors which make some social movements more successful than others when advocating for health issues is a relatively new area of systematic academic inquiry. HIV/AIDS is one of the few well documented areas. Interesting investigation is underway, to be published later this year, which directly informs this area. A three year study is being led by Dr Shiffman and funded by the Bill and Melinda Gates Foundation titled 'The effectiveness of global health policy networks' under the 'Global Health Advocacy and Policy Project' (Shiffman and al., 2014). They have so far made available their conceptual framework, initial observations and early reports at several conferences, many of which are highly relevant to this enquiry (Shiffman and Smith, 2007).

The study examines the effectiveness of six global health policy networks, in three pairs, with relatively similar characteristics: tuberculosis and pneumonia; tobacco and alcohol; and newborn and maternal survival. While some health policy networks have had significantly greater progress, for instance polio, malaria, tuberculosis, many have achieved less policy progress, including pneumonia, diarrheal diseases and maternal mortality. By contrasting pairs of health issues with corresponding characteristics (almost like a control group) the study aims to elicit what the key factors are in determining success of social

movements. The factors which have been found to play a key role are: whether there are competing health priorities upon which the issue can align itself; how palpable the commercial opposition; global agreements which underpin policy commitments; severity of the issue; tractability; vulnerability of the group; perceived social responsibility; network structure and strategy.

3.2 Discrepancy of policy influence among health networks

The HIV/AIDS movement has made enormous progress in capturing policy-makers' attention, attracting funding to the issue and helping to overcome associated stigma. In 2001, HIV/AIDS represented 5.3% of deaths in low- and middle-income countries. Since then, new HIV levels have fallen by a staggering 38% and UNAIDS is reporting the lowest levels of new HIV infections this century. It transitioned from 1992, when donor funding was as low as seven %, to receiving more than a third of global donor health financing only a decade later.¹⁸ In July 2014, UNAIDS reported that new HIV infections and deaths were decreasing, marking an end to the epidemic a realistic prospect by 2030. Furthermore, in overcoming stigmatisation, 90% of people in sub-Saharan Africa who now learn they are HIV positive seek treatment (UNAIDS, 2014).

Tobacco and alcohol are the two leading causes of death and illness among addictive substances, with roughly equal burden. They have similar global disability adjusted life-years: 4.5% for alcohol (third among all risk factors in 2004) and 3.7% for tobacco (sixth among all risk factors in 2004). Despite this parity, tobacco has made much greater progress in terms of social recognition, policy influence and funding. The primary policy differences can be seen in the global agreements which regulate these addictive substances. The Framework Convention on Tobacco Control which was enacted in 2004 provides strict regulation, recognition of the health impact of the disease and the social responsibility to mitigate its impact. By contrast there is no equivalent global agreement for alcohol.

Tuberculosis and pneumonia are the two leading causes of death and illness among communicable diseases of the respiratory system. Pneumonia has a higher global burden (there are 1.5 million deaths from pneumonia among children alone, whereas there are 1.1 million deaths in

¹⁸ In 2003 HIV/AIDS funding was at 35.1% of donor health financing. (Shiffman, 2008).

total due to tuberculosis). However despite these statistics, tuberculosis made much greater progress in terms of policy traction and attracting funds. For example, 180 countries are now implementing the Directly Observed Treatment, Short-course (DOTS) strategy, an estimated 6.8 million lives saved compared with pre-DOTS care, with 46 million people successfully treated between 1995 and 2010. Pneumonia by contrast has only half of affected children see a doctor, only 20% receive antibiotics and half of cases could be prevented by two vaccines, but are reaching only 42% and 6% of children (WHO, 2014; UNICEF, 2012).

There were seven key ways in which the HIV, tuberculosis and anti-tobacco movements were able to generate problem recognition within society and present a feasible solution and achieve policy traction.¹⁹ These elements were; they maintained policy coherence with one united ‘policy ask’; they changed the industry structure to be publicly deserved good; they reframed the issue, in terms of severity and a short causal connection; their advocacy and communication strategy was targeted and feasible with strong leadership; institutions were created to stabilise the market and they were conscious of selectivity and timing in their approach.

3.3 Strategies and factors of success among these networks

1. Movement Coherence and the united ‘policy ask’

The HIV movement was not only powerful due to its strong, united networks, but it was able to unite around a single coherent ‘policy ask’. In recognition of the damage that tensions and dissenting voices would cause, the movement developed an early consensus around exactly what it was that they would ask of policy-makers and the public. The movement cohered around access to treatment as the singular coherent policy request, and in particular making expensive anti-retrovirals available, regardless of people’s ability to pay. The movement cohered around access to treatment rather than, for example, the roll out of prevention strategies. This increased its tractability with policy-makers, and helped it to achieve influence. Later, once the movement was on the policy agenda and funding was secured, the HIV movement was able to introduce more complexity to the policy debate, and now has a complex agenda of issues being considered and implemented.²⁰

The HIV movement’s success in being able to develop a coherent policy ask has been contrasted by some social movement analysts to the Climate Change movement’s lack of success. Analysts have commented that the Climate

Change movement’s epistemic community is still debating where to focus their efforts and there is not yet a coherent single policy ask, but rather an array of competing options.²¹ The movement’s divergence of policy requests is delaying or hindering its progress in the opinion of many experts, ranging from green growth, to emissions trading schemes and carbon taxes. HIV overcame these obstacles by internalising its debates and externally presenting a singular coherent request of national and international policy-makers.

2. Changing the industry structure

Once the policy ask was determined, the HIV movement went about changing the industry structure. They changed the market for anti-retrovirals from one based on an ability to pay,²² to one based on global access. Essentially, by problematising the good, they achieved market transformation. They transformed anti-retrovirals from a private, excludable good to a merit good, perceived as deserving of public finance. Though there is not necessarily a direct market equivalent, a similar shift in mental health might be the appreciation of mental health as an important contributor to individual and societal well-being rather than equating with it with mental illness, misery and threatening behaviour (Kapstein and Busby, 2013).

The concentration of the market was also in their favour. Because the anti-retroviral market was relatively new, power was concentrated in only a few firms. This meant that there were fewer veto points to overcome (Putnam, 1988). Furthermore, given it was a new market, the rules and relationships were arguably still emerging, so were more malleable to change. There was a fluidity to the industry structure that the movement was able to exploit in their favour.

3. Reframing the issue

The HIV movement was very successful in tailoring its messages to its audience by reframing the issue to make it more palatable to the public and policy-makers alike. They used several frames, at different points in the movement to resonate with different political climates and groups. The first was to make absolutely clear the severity of the issue.

This was made possible through the research available at the time, which highlighted the prevalence of the disease in the population and magnitude of the effects. In South Africa, for instance, research findings demonstrated that infection levels were as high as 29% of the population. Furthermore, research showed the staggeringly high mortality rates and average life expectancy declining dramatically. Using this information the experienced civil society movements in countries at the fore of the

19 These categories are largely sourced from the Conference Panel hosted by the Centre for Global Development, *How Social Movements Succeed, lessons from HIV/AIDS*, January 2014.

20 International AIDS Conference Agenda (2014).

21 Conference Panel hosted by the Centre for Global Development, (2014).

22 AIDs drugs were the most expensive drug ever put out on the market at the time. (Kapstein, 2013).

disease (South Africa had a strong legacy of activism post-Apartheid) were able to frame the HIV issue. They succeeded in achieving issue attention because they were able to reframe HIV/AIDs as a threat to human well-being and national security, and at other times they framed it in economic development terms (Shffman, 2009). The advocacy effort also harnessed several important focussing events, such as the Millennium and the MDGS, which led to international commitments, and in turn, to financial investment and programmes.

The movement reframed the issue with a short causal connection between an action (the provision of anti-retroviral drugs) and needless death. This means that policy-makers believed they could actually influence these deaths and that therefore impact would be easy to achieve. This changed the attitudes of policy-makers involved, becoming a powerful advocacy frame and made the issue more tractable.

In a similar vein, the anti-tobacco movement engaged in successful issue reframing. This meant that the anti-tobacco movement managed to shift the perception from individual to social responsibility (Shiffman, 2009), something that has not occurred with the alcohol control movement, an addictive substance which retains its public perception as an individual responsibility. Furthermore the anti-tobacco movement developed a tight network which integrated scientists and policy experts, whereas alcohol remains a loose network, consisting largely of scientists.

4. Strategies to address cost

The HIV movement kept their influencing strategies palatable, particularly in regard to what the likely cost would be to policy-makers and the government as a whole. In contrast to movements like climate change where solutions have been calculated as high as 1-2% of GDP, HIV recognised that significant costs would be off-putting or too much of a leap for most policy-makers (Stern, 2005). The change of behaviour required would be too great. The HIV movement ensured that the costs of extending access to treatment of an existing product, were within reach, and increased incrementally as support gathered. They were careful to minimise the costs that would be involved in the policy ask, to assist with its tractability.

5. Institutions to stabilise the market or financial flows

Successful social movements require a set of institutional arrangements that create the rules and help to solidify the regime. These prevent any withdrawal of commitment and progress as the initiatives are implemented. For the HIV movement this included institutions like the Global Fund, which provided security and predictability of funding irrespective of political shifts, electoral cycles and global financial shocks. For mental health the political commitment has been secured through the Mental Health Action plan 2013-2020 which locks in measurable targets for governments that will be monitored and reported on.

However the attached funding flows and accountability structures have yet to be developed which underpin this. Secured long term financial institutional arrangements (outside of laudable initiatives from singular donors like the GCC), are a necessary next step for mental health. The involvement of financial elements will be essential in coming years to the success of the field.

6. Selectivity and timing (inside and outside track)

Knowing when to engage in a debate and seize an opportunity is key to catalysing success in social movements. Sequencing and selectivity are very complex and most authorship on the subject recommends tailored political economy analysis to the context and issue at hand. The HIV Movement has been commended for their effective use of simultaneous 'inside' and 'outside' track advocacy. This meant that while more radical and visible activism may have taken place in the public eye on the 'outside' the movement were simultaneously providing trusted professionals and experts helping inside government health departments on the 'inside' to actually resolve the problems through policy change. Furthermore, the HIV community were fortunate in their creation of a demonised 'other' through their advocacy campaigns targeting large pharmaceutical companies and western governments. This also emerged at a time when the movement could harness the focusing event of the millennium, where a focus on alleviating poverty was heightened, as well as a growing irreverence for international trade and intellectual property protection for wealthy companies and countries at the expense of developing country realities.

Even so, it is worth noting that the commitments and funding flows took several years to demonstrate impact on the actual disease statistics. There was a sequencing 'lag'. At least ten years after consolidated advocacy began, the commitment and focusing events transpired. Even when financial investment flows initially began it is important to realise that actual changes in morbidity and mortality rates took several years to emerge. The below diagram illustrates the intersection between the political commitments and funding flows – which began around the year 2000, but took on real significance around the year 2004-2005. It is worth noting that shifts in life expectancy and the morbidity and mortality rates did not begin to turn around until 2005 onwards – suggesting at least a five year lag between political commitments, financing and the time it took to establish and implement programmes, before any impact on lives changes in consequence began to show.

Furthermore, the existence of a salient singular policy solution (the HAART research) emerged as early as 1996. Advocacy campaigns had been in operation as early as the 1980s, but began to operate more effectively in the late 1990s, with strong leadership and endorsement from the highest political levels, such as Nelson Mandela's endorsement of TAC's advocacy campaign and the HIV

movement. The financial backing of one sector authority, in this case the Bill and Melinda Gates Foundation, was a factor in the creation of a tipping point, just before the millennium where policy commitments began to flow.

7. Concentration of emergence

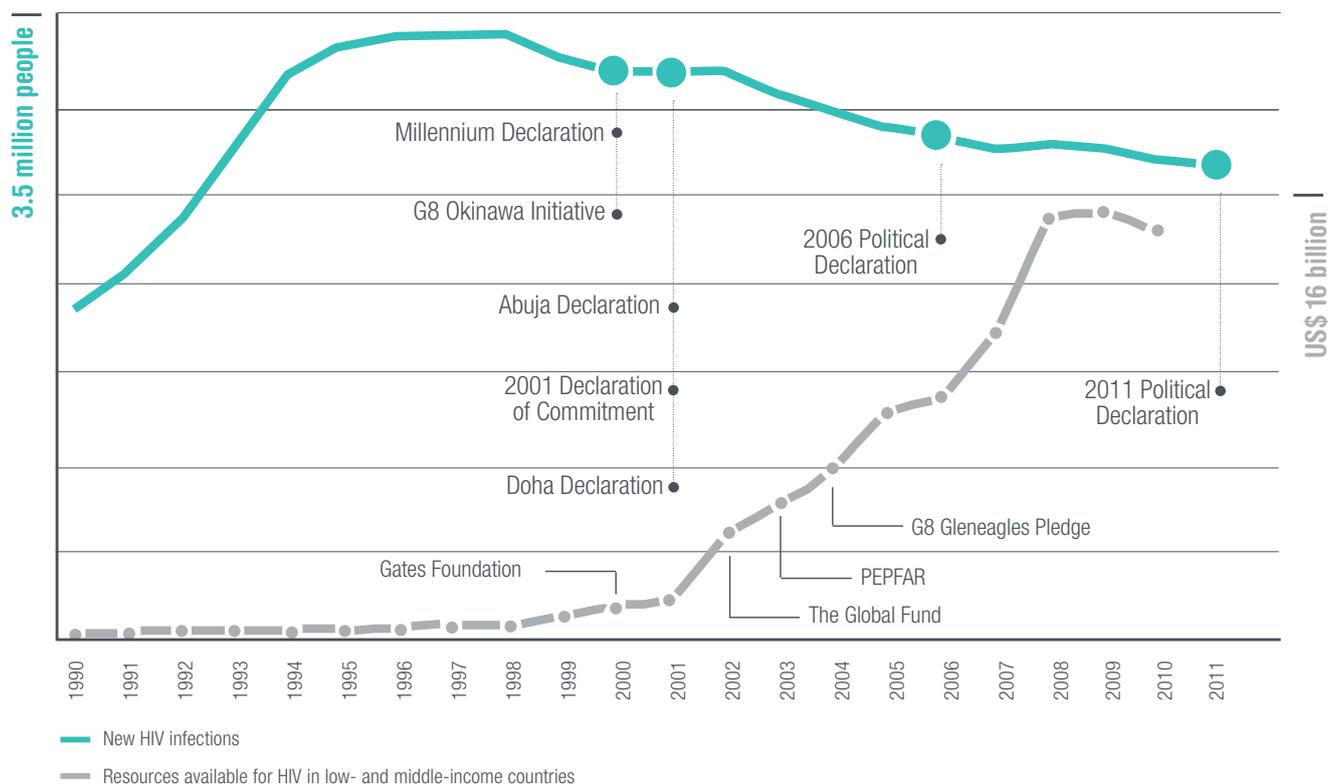
Related to selectivity and timing is the concentration of the emergence of the health issue into the public eye. There are several possible explanations for the difference between the success of tuberculosis in comparison to pneumonia, but in this direct contrast between the two groups one of the key findings is the timeframe and concentration of emergence. Tuberculosis had a sudden appearance in both the United States and Europe in late 1980s which drew attention to it as an issue, whereas pneumonia had a continuous but manageable existence over time.²⁴ Flowing from this, tuberculosis was granted its own programmes and separate funding stream, supported by HIV/AIDS co-infection and the Global Fund, whereas pneumonia became submerged and forgotten as it was integrated or ‘mainstreamed’ into broader child survival initiatives. The network for tuberculosis was united and had an effective advocacy strategy particularly the ‘Stop Tuberculosis Partnership.’²⁵

The pneumonia networks have not operated with the same structure or strategy – their groups are relatively newly formed with tensions between clusters.

3.4 Conclusions

The experience of different social movements across global health can provide important insights for the mental health movement to learn from. While not all approaches can be grafted directly across to mental health, there are several important lessons that can be of use. Among those successful networks (HIV, tuberculosis, and the anti-tobacco movement), several had overlapping characteristics with mental health. All experienced barriers within the ‘actors’ interests, values and beliefs’ dimension of KPP (mostly pertaining to stigma or recently emergent user movements). Both HIV and tuberculosis faced similar difficulties under the ‘types of knowledge’ dimension to mental health – there was a lack of data available and the diseases were likely under-diagnosed. The tobacco movement was less disadvantaged in this way though. All started from positions similar in the political context with low financial

Figure 4: New HIV infections, global policy responses and investments²³¹



24 Shiffman, J. (2012) Presentation at Cornell University Nutrition Works Conference. Publication forthcoming.

25 With 110 partners, operating in 100 countries, and a Secretariat hosted by the WHO in Geneva, the Stop Tuberculosis Partnership is highly successful. At the 2014 AIDS Conference in Australia, the Stop Tuberculosis Partnership attended with the motto ‘two diseases, one fight’ demonstrating close alliance with the HIV movement. www.stoptb.org

Table A: Movement characteristics compared to mental health

Health Movement	Cross-cutting (Heterogeneity)	Actors Beliefs (e.g. stigma)	Types of Knowledge	Political context	Intermediaries (networks)
HIV		X	X	X	X
Tuberculosis		X	X	X	X
Pneumonia			X	X	
Anti-tobacco		X			X
Alcohol		X			X

investment, and changing international policy environments. The key difference that stands out is that none suffered the cross-cutting characteristic of heterogeneity to the extent that mental health does. This absence of heterogeneity is a key differentiating factor (see Table A above).

Chapter four lists the engagement strategies that can provide important insights for mental health and applies them to the mental health movement. Those which directly apply include the need to develop a coherent policy ask across the mental health community (which may or

may not be possible, given the heterogeneity of the issue); understanding the cost thresholds that policy-makers might not be willing to surpass; mapping and harnessing upcoming policy windows; communicating the severity of the issue and build network effectiveness. Some of these efforts are already underway and some would be new to the community's activities. It is important to note that the mental health movement is coalescing roughly ten to twenty years behind most of the health movements assessed in this chapter.

Chapter 4: Strategies to increase policy influence

4.1 Introduction

This chapter recommends a range of engagement strategies for the global mental health community to apply. Two broad categories are provided: (i) lessons from other areas and engagement strategies for MHIN to improve the way that it supports the global mental health community (at the international level); and (ii) engagement strategies for the network to support projects operating in local contexts (at the national or subnational level).

4.2 Application of lessons from other areas to mental health

Based on the findings of chapter three there are several lessons to be gleaned from the HIV, tuberculosis, pneumonia, alcohol and anti-tobacco movements, which are directly relevant to mental health. These techniques were of use to successful health movements, and the network may want to consider applying them in their own work in addition to establishing a knowledge exchange, which would provide helpful materials, coordinate findings from country contexts and elicit best practice solutions, to underpin these goals. It could also consider establishing a monitoring and evaluation system to measure the network's policy influence. An overview of these activities is presented in a table at Annex B.

Lessons and strategies from other health networks

Based on the lessons outlined in chapter three, successful health movements were able to build consensus around a **coherent, policy ask**. While MHIN has crafted a coherent policy ask, this is less apparent for the global mental health community as a whole. This involves understanding the range of policy options available, being able to prioritise based on clear information, understanding what is achieving impact in the field from scalable activities and hosting debates that will build consensus around a coherent 'policy ask' or approach. This may not be possible due to the heterogeneity of mental health (discussed in chapter two) but remains one of the key lessons learned from other health movements that have achieved policy traction. Some national contexts have been able to achieve this effectively, for example in Australia the National Coalition for Suicide has seen a number of diverse NGOs join forces to establish a clear single voice for change – even aligning their implementation plans and higher level strategy documents (Suicide Prevention Australia, 2014a). One of the more attractive types of

policy ask for a heterogeneous policy issue for example might be the creation of binding commitments, national targets and reporting against these, as the Mental Health Action Plan is now poised to do, or something akin to the GCC goal of 'increasing access to treatment and services' for people living with MNS disorders.

The mental health community is well positioned to achieve policy influence in coming years if they can unite around this type of coherent policy ask. There are relatively few players at the global level, making it manageable to align their mandates and interests. GCC, WHO, LHSTM, the UK Department for International Development (DFID) and the US National Institute of Mental Health are the key players, and with their leadership, the MHIN or other endeavours may provide a unifying force that will bring cohesion to the policy community. This group of international leaders in mental health could then coordinate in-country efforts and drive the policy process at the global level.

As outlined above, high costs asked of policy-makers will require sacrifice of issues that are important to them (the opportunity cost), which in turn makes it harder to advance the mental health agenda. Depending upon the policy ask, mental health may like to develop an advocacy strategy around the severity of the issue, the manageability of the costs, how funding would be spent, demonstrating value for money and a commitment to measuring impact.

It is important that movements are secured by **institutions** which make binding the commitments, monitor progress against targets and hold parties accountable to prevent any regression of support. Mental health is well placed in this regard given the recent adoption of the WHO's Mental Health Action Plan (2013-2020) by 194 member states at the 66th World Health Assembly. This ensures that all 194 governments have committed themselves to work towards the achievement of the stated objectives and associated targets. Furthermore, if wording on mental health is retained in the Post-2015 Development this will also provide helpful institutional backing to mental health progress. The other aspect of institutional support which the HIV movement relied upon in its success was the predictability and security of funding flows, provided through the Global Fund. Mental health has some political support through the WHO and research funding from partners like GCC, but lacks the stability and flexibility that an international financial institution would deliver. The upcoming engagement of the World Bank, and

associated financial delegates, in 2015 will be a key step forward for the mental health movement in this regard.

In order to be able to anticipate and prepare for **policy windows** (or to harness focussing events) it is important that MHIN continues to be resourced. To be able to map and anticipate when policy windows will arise, coordinate the information and messaging on policy solutions in advance – so as to be able to seize these when they arise and communicate effectively – is crucial, and requires substantial resourcing.

Chapter three highlights the need to manage **network operations** strategically – engaging divergent groups within the mental health community, developing consensus, establishing an effective communications strategy throughout the process, mapping audiences, framing and refining messaging,²⁶ hosting debates and potentially managing disputes in-house where appropriate (though this may not be something the mental health community decides is necessary), (Shiffman and Smith, 2007).

The global mental health community has already been communicating the **severity of the issue** with increasing success. Efforts such as the Mental Health Atlas, the World Health Report and various other publications and conferences are all helping to raise awareness about the prevalence and severity of mental illness globally. Given the lack of policy traction, and continued stigmatisation, these communications efforts remain important and should be continued.²⁷ A major lesson from chapter three is that the issue has to be perceived as severe and also that it is a societal responsibility rather than an individual one. Continued efforts to present information on mental health could actively reframe this in future. Along these lines, efforts to frame mental health in terms of economic cost as well as through social and human rights approaches will have varying levels of success with different audiences.²⁸

Building the Knowledge Exchange for the Network

Most of these efforts will be more successful when underpinned by the **knowledge exchange**. Many of the projects operating in the global mental health community are already developing their own

engagement techniques. One of the key roles for the network is to capture and synthesise the learning happening within the network. Furthermore, it can package and tailor this learning in a way that is appropriate to specific hubs, for example country specific material for the same MNS disorder, or same policy obstacles.

The network is establishing a knowledge exchange in early 2015. This will develop useful materials for the network, capture and share learning from the various GCC projects across the world. It will provide website and social media activities, address the needs of regional hubs and provide tools tailored to specific group needs, enable face to face interactions, and build skills across the network. It will operate across three areas: building capacity of GCC projects to **supply** knowledge, act as an **intermediary** (and engage other intermediaries, such as the media) in its advocacy, and engage policy-makers to increase the **demand** for evidence on practicable mental health solutions/initiatives to help effect policy change.

While it may be easier to identify and understand only in hindsight why particular interlocutor features emerged and triggered or supported change, there are ways of anticipating how best to influence policy (Tembo, 2013). This knowledge exchange will be positioned to play an important role **creating a repository** of success stories, how to guides for mental health policy shifts, and realities from the field from which practitioners can learn. This will involve capturing ‘stories of change’ and collecting a series of ‘episode study’ write ups for the network.²⁹ These materials will be able to be used by the network to advocate for change through the media, advocacy groups and other avenues. The knowledge exchange can also assist with capturing **effective negotiations techniques** for change. Examples from other policy areas have been useful to practitioners trying to achieve policy traction.³⁰ The knowledge exchange can create a library of tactical examples which have succeeded in different country contexts, such as the New Tactics in Human Rights’ Program has achieved (see box 2).

26 For more information on how to frame mental health as a policy issue to different audiences, there is a body of work available, for example. Benford, R. and Snow, D. (2000).

27 With some caution; sometimes efforts to impress severity of an issue can trigger a sense of fatalism or belief that the problem cannot be overcome (Benford, 2005).

28 For example, Milliband, E. Speech in UK reframing mental health as one of the key economic issues facing Britain today. Central pillar of opposition policy. www.newstatesman.com/politics/2012/10/ed-milibands-speech-mental-health-full-text. Further research into this area could present the network with a set of practical framing recommendations vis-à-vis audiences.

29 A recent example of a story of change is here: www.ksi-indonesia.org/id/index.php/publication/other/item/168-story-of-change-new-village-law-indonesia.html. And another is here: www.ksi-indonesia.org/id/index.php/publication/other/item/169-story-of-change-improving-health-services-west-lombok.html

30 This examines past and present techniques for negotiation in climate change, what works, what doesn’t and recommends how to strengthen future negotiation techniques: www.odi.org/node/22730

Box 2: Tactical Examples from Country Contexts (Human Rights)

The ‘New Tactics in Human Rights’ Program captures examples of what is working in different country contexts and packages them in accessible ways for others to adopt.

- **Case Study A:** a story collection and human rights advocacy project about women’s access to reproductive healthcare. This partnership illustrates how those experiencing human rights violations can be the ones directing the strategy.
- **Case study B:** collaboration to prepare a shadow report for Egypt’s review by the UN, demonstrating partnerships between international and national human rights organisations.
- **Case study C:** helped to build a coalition of community groups and leaders to overcome difficulties and working together with a diverse group of organisations.
- **Case study D:** demonstrates how to build leadership, create an agenda and keep to that agenda in times of crisis
- **Case study E:** demonstrates where a group were able to work with a coalition of experts and not “be the expert.”
- **Case study F:** demonstrating partnerships between human rights organisations and non-traditional organisations
- **Case Study G:** used a collaborative tactic to engage governmental officials who are traditionally viewed as adversaries.

Source: www.newtactics.org/conversation/building-strong-human-rights-partnerships-and-coalitions

Establishing a monitoring and evaluation system to measure policy impact

The network could also consider becoming a leader in the field by establishing a **monitoring and evaluation system** aimed specifically at capturing policy influence achieved across the network’s activities. While strong GCC grantee monitoring and evaluation systems are already in place, there are few systems geared towards measuring policy impact specifically. This is an innovative step because there is so little evidence demonstrating that mental health policy interventions have worked to date, resulting in real impact.³¹ It could help to identify, or could report against the policy ask if one is developed.

Evidence that mental health oriented interventions work is patchy is demonstrated by the fact that almost no one has managed to do this to date. There are very few evaluations of policy interventions having a positive impact upon mental health. There seems to be a lot of confusion and no strong narrative has emerged – a tool that would be very useful to advocate for change. An overview of the approaches to monitoring and evaluation exists which the network could easily draw upon (Tsui, Hearn and Young, 2014). Furthermore, tailored material exists on how to establish evaluations for large, complex global initiatives.³²

To help visualise this set of lessons and engagement strategies for the network at the international level, they are detailed in the table below, across the different stages of the policy-making cycle (outlined in chapter one).

4.3 Recommended engagement strategies and capacity development for MHIN projects operating in country contexts

What the network projects have identified for themselves in terms of needs

The GCC projects have largely **identified what areas of future assistance they require** to achieve policy influence. In a survey conducted for this report in June-July 2014, the GCC grantees identified the areas that they found most challenging in terms of policy engagement and where they would most like assistance. The grantees surveyed are working across 26 countries on how to improve treatments and expand access to care for mental disorders through transformational, affordable and cost-effective innovations which have potential to be sustainable at scale. The projects engage policy-makers quite regularly in their work; out of 30 projects surveyed, one quarter stated that policy engagement was a core part of their job or something they were involved in more than once per month. Their main reasons for engaging policy-makers are also substantive undertakings, with meaningful discussions and significant policy changes being attempted. Half the projects are attempting to shift the mental health agenda to be broader or more inclusive; more than half are promoting wider changes in national government mental health programmes; almost half (45%) are involved in changing or drafting national or sub-national mental health policies; a third are trying to arrange the procurement and supply of psychotropic drugs; most of the projects seek local government assistance with resourcing,

31 There is a distinct absence of policy impact evaluation in mental health and funding for this type of policy evaluation is more limited than for clinical research. (Goldman et al., 1998).

32 Better Evaluation: www.betterevaluation.org/blog/complex_global_initiatives

Table B: What this approach would look like - Network activities targeting the policy process and evidence needs

Policy stage and key objectives for actors (taken from Fig 1)	Activities	Evidence considerations
Agenda setting	(a) Coordinate evidence to enhance credibility	Crystallise as a policy narrative around the issue Tailor this to political environments based on KPP analysis and international level
Convince policy-makers that the issue requires attention	(b) Extend advocacy campaign (c) Foster links between researchers, practitioners, CSOs and policy-makers	Ensure findings are communicated effectively between these groups, establish forums.
Policy Formulation	(a) Network to operate as a 'resource bank' for what works well in mental health	Consolidate high quality and credible evidence-based solutions that are proven to work and can be taken to scale.
Inform policy-makers of the options to build a consensus of action	(b) Channel resources and expertise into the policy process	Adapt information and package it to appeal to policy-makers, maintain credibility as a resource.
Decision-making	(a) Provide a resource that can be called on at short notice by those working on the inside track. When policy-makers engage on their particular problem, answers at the ready are useful. (b) Let it be known that there is a bank of expertise around mental health to draw upon.	Identify people who are willing to be called up and talk about mental health issues and solutions, make their contact details available, communicate them to policy-makers. Develop a public affairs strategy to publicise the network's expertise and its relevance to policy-makers
Implementation	(a) Enhance the sustainability and reach of the policy (b) Act as dynamic 'platforms for action'	Relevant and generalisable across different contexts. Operational guidance – how to do it.
Complement government capacity	(c) Innovate in service delivery (d) Reach marginal groups	Directly communicated with policy-makers
Evaluation	(a) Link policy-makers to beneficiaries and their families (end users).	Consistency over time, monitoring mechanisms that provide continuity. Ensure input remains relevant to policy windows
Review experience and channel into policy process	(b) Provide good quality, representative feedback.	Communicated in clear and accessible way.

Adapted from Court, J., et al., (2006).

particularly staff time to attend training (75%); as well as other resourcing in the form of 'in kind' requests (35%).

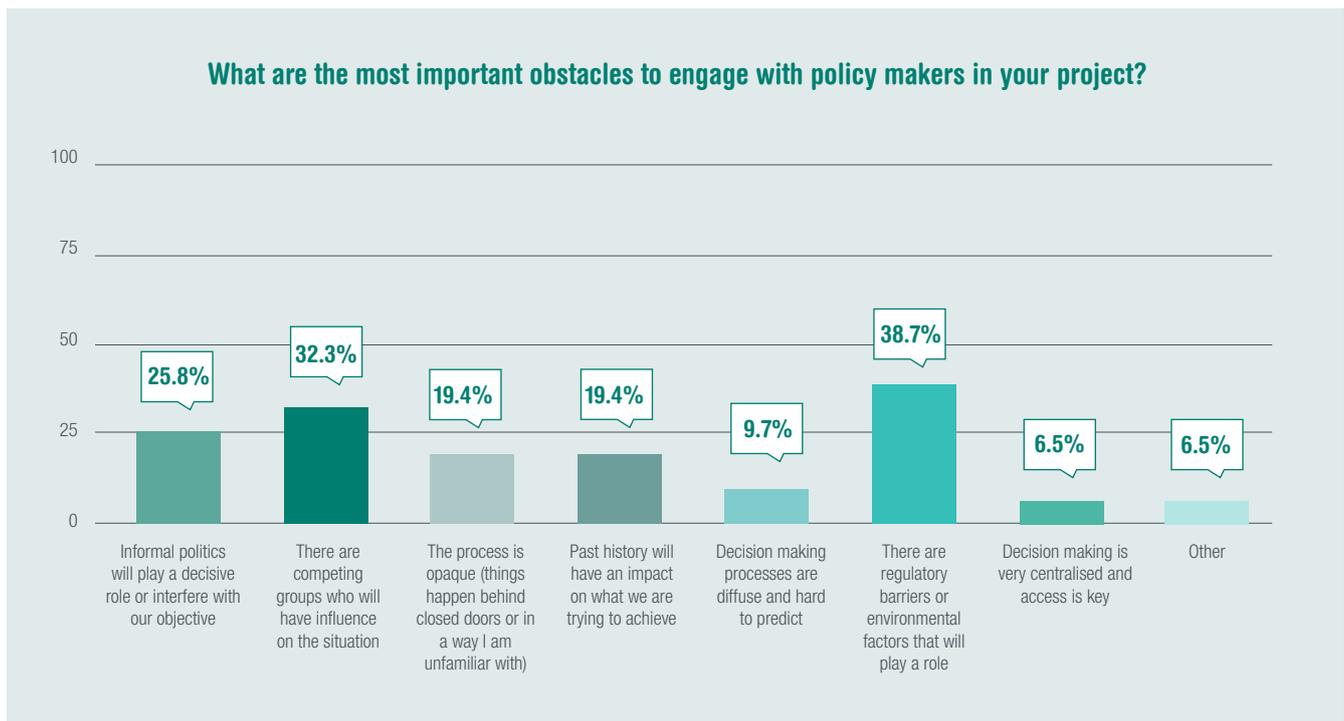
The main audiences for their results are government or local communities, with 70% targeting national government and 67% sub-national government.³³ The key obstacles (from their perspective) to achieving policy change are fairly evenly spread, and there is variety depending on the country and MNS disorder being addressed. The most commonly cited obstacles were regulatory barriers or environmental factors (such as stigma); competing groups who have influence; informal politics which interfere, historical tensions playing an unseen role and opaque policy processes that are hard to anticipate or access. Some of those mentioned in the

'other' section included high turnover of government staff (so relationships and continuity are hard to build), over-reliance on intermediaries (especially multilateral organisations) for access or to communicate project needs, and that while policy-makers might commit formally, there is no follow through to implementation in reality.

The way that findings from the projects are communicated to policy-makers (and beneficiaries or the public) primarily takes the form of toolkits, seminars and workshops, media articles, academic articles and dialogue with partners. Some of the outputs seem unwieldy for the target audience; there were a number of academic reports cited as being for either policy-makers or beneficiary groups, where more tailored

³³ Compared to 40% civil society groups or non-government organisations and 10% private sector.

Figure 5: Obstacles to engaging policy-makers



package of outputs, such as a policy brief and workshop or other event, might be more effective.³⁴

The key areas that the projects requested assistance with in future were: training in how to communicate their findings better to policy-makers (including in how to write policy briefs); how to predict entry points in the policy cycle; how to capture and share success stories with other mental health practitioners; to better understand who they key players are and how to influence them; as well as understanding their own capacity as a project team and what they can build upon.³⁵

Capacity development for project teams – some tools to meet these requests

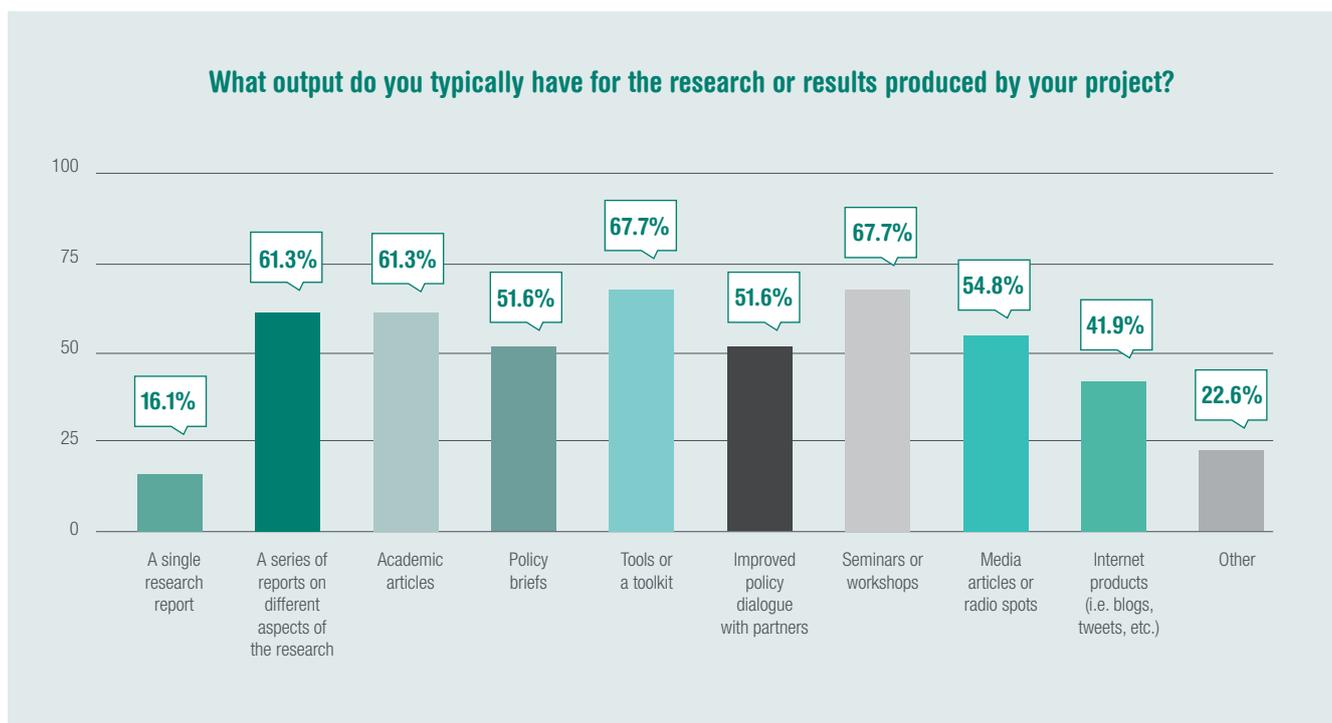
Based on the areas of need that the projects have identified, there are a range of tools and training that could be useful which the network could provide in coming years. Some of the requests are fairly complex and unfortunately there is no ‘silver bullet’ to achieving policy influence. Many of these tools however could draw upon the knowledge exchange and materials it collects from across the global health community. In addition, any training and learning required could take the form of workshops, accompanied by in-country or remote mentoring.

For over a decade the Research and Policy in Development team at ODI has worked around the world to understand how to develop engagement strategies which are tailored to the local context. The result is

ROMA – the RAPID Outcome Mapping Approach – a guide to understanding, engaging with and influencing policy. Applied as a whole, ROMA would help the project teams in their local contexts to diagnose the specific policy influence problem (what its root causes are and why it persists, including mapping systemic or institutional factors); develop a strategy (identifying their specific policy influence objective, developing a set of realistic stake-holder focused objectives, theory of change and communications strategy specifically for policy influence, how to identify your policy influence capacity gaps and map existing resources); and developing a monitoring and learning plan for your policy influence aims. The challenge is twofold. Firstly, the GCC projects are busy implementing their activities and ROMA is a comprehensive and in-depth approach that they may not have time for. Secondly, several of the steps that ROMA recommends, are already underway in some form - though in pockets of activity: for example all projects have participated in developing a theory of change, though not for policy influence specifically; some stakeholder analyses have been conducted and communications strategies are completed but are not specifically targeting policy-makers. However, ROMA does not necessarily have to be applied in its entirety and is an iterative adaptable approach. This section will now provide a set of recommendations from across the tools that RAPID has developed (predominantly

³⁴ See comparative breakdown across target audience – cross tabulation comparison, Survey Report, July 2014.

Figure 6: Communicating findings (output type)



ROMA), that could address some of the gaps identified by the projects in their work.

Almost one third of the projects surveyed nominated that they would most like to improve their **ability to access policy-makers**. This includes building team capacity to help them map their local context, stakeholder analysis, developing strategies for how to secure funding, build government ownership of programmes (and longevity of engagement), developing context specific strategies for how to make changes to domestic policies, or to increase human resource allocations to mental health activities. This is something the network could provide help with. There are a range of activities available that MHIN may like to explore further, however two tools may be particularly useful: (i) applying the Alignment, Influence and Interest Matrix (AIIM) - a short activity that can be conducted in a half-day or one day workshop for a single project team; and (ii) a KPP analysis - a more in-depth process that could be conducted with the team in-country.

AIIM is a stakeholder analysis tool, helping teams to identify the audiences of research-based, policy influencing interventions, but also suggests a possible course of action towards main stakeholders (Mendizabal, 2010). This would help project teams to map who the policy-makers are, what their interest is in an issue and whether they are aligned or opposed to the project's agenda and devise possible strategies. As a second tool, the projects have requested assistance in better understanding their local

policy context, identifying policy windows on the horizon and how to overcoming informal politics. These could be catered to through conducting a local KPP analysis specific to the project (see Annex C).

The second most popular request from projects was for assistance with **how to improve the communication of their findings** to a range of audiences. The requests included better understanding on how to write a policy brief, communicate findings more effectively and engage with the media. This is a more straightforward request which the network could more simply cater to, through the provision of training or assistance from the network in how to draft effective advocacy strategies and practical policy communications training. It would be relatively straight forward to deliver training on how to write a policy brief (something that one in five projects asked for), training in how to develop a communication strategy targeting policy-makers, as well as developing relevant manuals and templates for projects to access.³⁶ It is important to stress to projects that policy briefs are just a tool and that a holistic communications strategy needs to underpin these. Often this approach is enhanced by face-to-face meetings with policy-makers where research findings are presented in a workshop style, and policy-makers participate in interpreting the findings and develop specific recommendations or action plans for their use (ExpandNet, 2011). There are also tools available which the knowledge exchange may like to draw upon which

35 These answers were all provided in an open ended question which asked 'Thinking about the way in which your project will need to engage policy-makers, what are the top three areas/factors you would like more information on or assistance with?'

Box 3: Requests for policy engagement assistance identified by the projects

1. **How to gain access to and influence local policy-makers - 30%**
(Includes general team capacity building in mapping the local context, how to secure funding, build government ownership of programmes, make changes to domestic policies, or increase human resource allocations to mental health activities)
2. **Improving research communications - 15%**
(Includes how to write a policy brief, communicate findings and engage the media)
3. **How to create incentives for greater engagement (demand) by policy-makers - 13%**
(Includes understanding local policy-makers' needs and priorities to be able to better leverage these)
4. **Learning from the success (and failure) of others in mental health - 12%**
(Includes attending seminars with other mental health partners to share and learn from their experiences and learn from their and international success stories of engaging policy-makers on mental health activities)
5. **Better general understanding of the policy-making process - 8%**
6. **How to build relationships with intermediaries - 8%**
(Includes engaging advocate groups and local think tanks)
7. **How to garner the support of community leaders and champions - 6%**
8. **Understanding international policy changes and local implications - 4%**
9. **Access to toolkits and templates – 4%**

Source: ODI Survey Conducted June-July 2014

are useful for disseminating information with a goal of scaling up pilot projects in particular (ExpandNet, 2011), and media engagement recommendations of arranging site tours or using film to share findings in a more engaging manner (Fullilove, 2006).

The third area that the GCC projects nominated was to be able to **create incentives for greater engagement (demand) by policy-makers**. This involves understanding local policy-makers' needs and priorities. This is not a simple request and would be something that the knowledge exchange could tailor its materials and general training. However one tool which could be help to achieve this

if resources and timing allow, is the local application of the KPP framework (see Annex C). Another strategy to address this is to include key stakeholders in research from the outset to increase the likelihood of producing useful research findings and communicating them effectively. This is a critical step in helping translate research into practice, if access can be acquired (see point above). By identifying key stakeholders (who will use or are directly affected by the finding results, or those that could be potential barriers if not engaged), and identifying opportunities for their input at each stage of research (including helping shape the research question, protocol, interpreting findings and in advocacy of the findings) a project will develop much greater ownership and be likely to experience policy influence (FHI 360, 2014). Communicating with policy-makers early on in the project process can be an opportunity to determine their interest in the research, to decide on their level of involvement and role, and to help develop strategies for obtaining their support. This allows space to plan project budgets and timelines to accommodate their input, which though time intensive and costly can be valuable to the project goals in the long term. For example, rolling out pilots in new sub national areas or changing local laws and regulations later based on findings (MacQueen et al., 2012). In 2014, FHI 360 has developed an overarching toolkit which could be very useful to GCC projects and can be accessed at no cost.³⁷

The projects also asked for **opportunities to learn from the success (and failure) of others in mental health**. This could easily fit within the existing practice of the regular GCC-hosted conferences, and can be built upon by the provision of online-forums, hosted by the knowledge exchange or shared documentation, lessons and toolkits that the knowledge exchange collates. More focused regional hubs might also provide the opportunity to learn from those in a similar geographic area, or hubs based on the MNS disorder being addressed.

The fifth area that projects identified was the need to better **understand general policy-making processes**. This could be addressed through the knowledge exchange which could collate existing materials from the literature and adapt them to be relevant to mental health. Several overview policy process briefs are available online, and training workshops could be conducted by experts in the field in a way that is relevant to the project teams in their local contexts. Some general training has been delivered at conferences on policy-making processes with one to two team members in attendance who are then expected to report back to their broader project teams in-country.

36 Extensive materials and training courses have been developed on this topic by both the International Development Research Centre (IDRC) and ODI. Some useful examples include: (i) Toolkits for researchers: www.idrc.ca/EN/Resources/Tools_and_Training/Pages/default.aspx and www.idrc.ca/EN/Programs/Evaluation/Pages/CR4I.aspx. (ii) A paper on how to write a policy brief www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/594.pdf and (iii) training in how to broker knowledge and communicate it more effectively www.odi.org/programmes/rapid/evidence-creation-research-communications

37 FHI 360 Toolkit can be accessed here: www.fhi360.org/sites/default/files/webpages/se-toolkit/quick-guide.pdf

There may be a need to provide some support or mentoring to help ensure that the information is relayed to teams in country effectively. Another approach would be to train the whole project team in-country and conduct local KPP analyses, mapping potential champions and potential policy windows. This would also include number eight in the request list – **understanding international policy changes and local implications**.

Another request was to better understand **how to build relationships with intermediaries**. The request included being able to engage advocate groups, civil society representatives who could use the findings from the project to rally for change and network with and engage local think tanks who could use the project's findings in their publications. This could be done through an application of ROMA specific to intermediaries in the local context. One such application might be a stakeholder analysis mapping exercise (or AIIM application) to determine which intermediaries were best placed to act as a policy entrepreneur on behalf of the project, then an application of progress markers to determine desired behavioural change in the intermediaries behaviour over time, force field analysis to mitigate competing priorities or challenges and perhaps the creation of an impact log to monitor progress. Projects would be able to use the tools available on the ROMA website (at no cost), or could be accompanied by mentoring or additional training if needed.³⁸

The survey also highlighted that projects wanted assistance with **how to garner the support of community leaders and champions**. There is a range of material available that the knowledge exchange could draw upon to inform efforts on this topic (FHI, 2010). By cultivating the support of community leaders, or other persuasive advocates who can influence policy-makers and help to facilitate change, the projects could increase the likelihood that their findings are taken up by policy-makers and commitments are followed through on. Engaging champions from different spheres of influence (for example a mix of political leaders, technical health leaders and community leaders) can help facilitate and institutionalise change at multiple levels (FHI, 2014). Including these champions in any advocacy planning can help them to realistically assess the longevity and investment of time required, and some may require financial support (travel expenses for example) to implement any advocacy activities associated with garnering government endorsement (FHI, 2010).

Several projects highlighted that they wanted to **better understand changes occurring at the international policy**

level (such as mhGAP) and the local implications that would result, so that they could communicate these better to policy-makers in their national or subnational contexts. This would be a straightforward matter for the network to provide explanatory materials for projects to access, and key talking points for when they meet with local policy-makers, or templates for relevant documentation. The presentations which have already been delivered at GCC conferences could address this.

A final request by the projects was the need to have **access to toolkits and templates relevant to policy influence**. This would be a core function of the knowledge exchange and material is widely available. Several initial toolkits which could be made readily available on the network website include the following: (i) The policy impact toolkit which RAPID developed for 3ie can be accessed here; (ii) materials also exist on the Research to Action website which would be useful here; (iii) there are a range of publications (including accessible two page policy briefs) on these different optics by RAPID available here; and (iv) the Economic and Social Research Council has an impact guide available here.

A key step across these requests: Conducting Knowledge, Policy and Power Analyses

The KPP framework can also be applied to local contexts and be very helpful to the projects understanding the contexts that they are operating in and how to achieve better policy influence. It applies to local context issues, digging beneath them to understand the drivers and constraints of policy and practice. On the one hand, KPP can provide a toolkit for understanding how political economy features shape the space for mental health. For example, using KPP can help to assess how the level of decentralisation affects the types of knowledge needed to improve mental health policy implementation, or analyse how actor values and interests affect decision-making processes. On the other hand, it also highlights the ways in which project findings and research can influence political economy features, such as: how solutions to collective action problems depend, in part, on groups' beliefs about resources and the actions of others that are influenced by flows of knowledge; how values, disciplinary paradigms and new information shape actors' views of their own interests; and how intensive development and application of knowledge can improve the effectiveness of actors wanting to carry out certain activities.

The KPP framework provides the tools to analyse a lot of what the projects suggest is missing in their work. An understanding of how the policy process works in reality in their locale, what is motivating the policy-makers, how

38 An example of an in-country application (including progress markers) can be found here: www.roma.odi.org/Case_study_putting_ROMA_into_practice_in_Zambia.html

to overcome the role of informal politics, what types of knowledge are being drawn upon most, when windows of opportunity may or may not present themselves and what intermediaries can be drawn upon to assist with improving their policy influence. The project teams are busy implementing their programmes and have limited resources or time available for yet another activity, and this would need to be conducted with their input. However an

KPP analyses would be one of the best ways to ensure that the findings from their work have actual policy impact, as well as helping to ensure that they are able to roll out their work if they go to scale, convincing policy-makers to approve the project be applied in other sub-national areas. A KPP analysis would assist the projects to understand how to better navigate their policy environments.

Conclusion

The ultimate goal of the Global Mental Health Program is to support bold ideas to improve treatments and expand access to care for mental disorders through transformational, affordable and cost-effective innovations that have potential to be sustainable at scale. In order to achieve this, they need to overcome a range of barriers including stigma and heterogeneity to achieve real policy traction, garner broad-based public support and attract significant, long term and secure funding.

There are three key messages to take from this report that would serve the network well to incorporate in their activities going forward. Firstly, the most successful social movements have crystallised a **united, singular policy ask**. Though MHIN already has this, the broader global mental health movement as a whole may like to consider this in their plans for future policy influence. One suitable example is the Mental Health Action Plan targets which the vast majority of governments are now committed to report against. How the global mental health community achieves this will be a complex effort of coordination and prioritisation, that would require more in-depth political economy analysis, but it is clear that the role of major donors like GCC would be crucial. Secondly, the network will greatly benefit from the **knowledge exchange** that can successfully underpin its current activities. Many of the projects are already developing their own engagement techniques; the network will be able to capture and synthesise this learning and then package and tailor the information (such as successful negotiation techniques, advocacy campaigns that have harnessed champions in the policy space) in a way that useful to specific hubs across the global mental health community (for example country specific material, the same MNS disorder, or targeted to

address the same policy obstacles). Finally, a range of **capacity development activities for the projects** across their areas of need will be important to delivering successful cost-effective transformational activities that can be taken to scale across different national contexts. Understanding how to engage policy-makers will be critical to the success of the projects and simple tools such as analyses of local operating contexts, training in how to communicate their project findings effectively to policy-makers and harnessing appropriate windows of opportunity would make an important difference to their success.

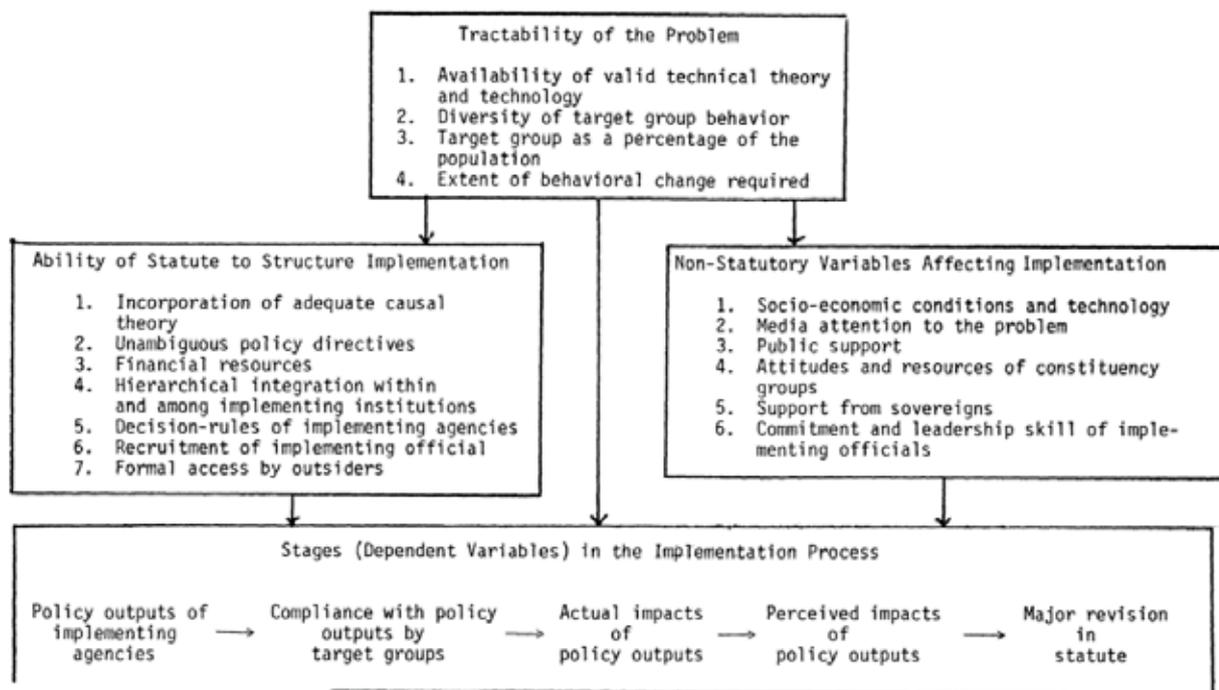
Important progress has been made in recent years to position mental health more as a priority in international health policy and on the global stage. This has been done through the work of initiatives such as the World Health Report in 2001, the creation of the Mental Health Atlases, the World Federation of Mental Health bulletins, the Lancet's Global Mental Health Series (Patel et al., 2011), GCC's work establishing the MHIN and others.³⁹ Opportunities such as the creation of MHIN will serve as important platforms to develop policy cohesion, share and rank scalable activities (providing the 'solutions' that policy traction in health depends upon) and air internal debates. However there is still a lot of work to be done to change public and policy-maker attitudes towards the tractability of mental health as an issue, and the stigma with which it is associated. The community now approach a point where the post millennium development goals are being shaped and there are important opportunities presenting themselves. Now is the opportune time for the global mental health community to harness the existing momentum and decide how they will engage going forward.

39 PLOS Medicine Journals, the New York University Learning Network for Global Mental Health, Centre for Global Mental Health and many other important initiatives have also contributed.

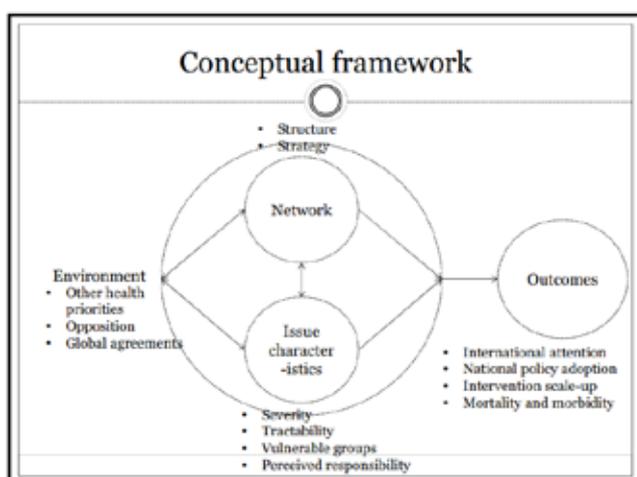
Annex A: Theory

The theory, frameworks and analytical approaches that were applied in this report are outlined here.

A. Sabatier and Mazmanian analytical approach



B Shiffman et al – Global Networks



Conceptual Approach

Other relevant theories applied in this report

1. Kingdon's Multiple Streams Framework, in Kingdon, J. W. (1995). *Agendas, alternatives, and public policies* (2nd ed.). New York: Longman.
2. Birkland's Focusing events, in Birkland, T. A., (1998) *Focussing Events Mobilization and Agenda Setting*, *Journal of Public Policy*. Cambridge.
3. Punctuated Equilibrium Theory, in Baumgartner F. and Jones B. (1993) *Agendas and Instability in American Politics*. American Politics and Political Economy Series. Chicago: University of Chicago Press.
4. Social Construction Framework in Ingram H., Schneider A. L. & DeLeon, P. (2007), 'Social Construction and policy design', in P.A. Sabatier (ed.). *Theories of the policy process*. Boulder, Westview Press.

Annex B: Methodology

The methodology for this report is outlined here. This report was written over a short period - the author was commissioned for under one month of input days – and so more extensive and in-depth analysis is recommended for the topic and the pathways forward for the global mental health community. This report was to characterise mental health as a policy issue, highlight several lessons learned and potential areas for inquiry that the global mental health community can consider in their future work. More analysis of the elements of success that similar social movements achieved in the field of health is very important, as is the work that Dr Jeremy Shiffman is taking forward on the effectiveness of global health networks. Political economy analysis specific to GCC's role in distilling what potential options there are for a coherent policy approach across global mental health, is another area of enquiry that would be very valuable. The work specific to the GCC projects and their particular geographic and political contexts requires methodical diagnosis, using the tools outlined in Chapter 4.

This report was based upon four key inputs. These inputs include: (i) a brief literature review (see the analytical approaches and references applied above in Annex A and the References section in Annex D) covered

over a limited two week period of research, (ii) the design and implementation of a ten item survey across 31 mental health projects based in Africa, South East Asia, South Asia and Latin America on the policy barriers that they face and their capacities, (iii) in-depth interviews with seven key practitioners in the mental health field (conducted via skype and in person, lasting between 60 minutes to 120 minutes each, and (iv) a full one-day consultative workshop to test and confirm the findings of the report with approximately 100 mental health practitioners from over 30 countries. This full day workshop was conducted in Seattle in October 2014 during the Grand Challenges Seattle Conference, and was generously funded by GCC.

The report itself has been peer reviewed by sixteen colleagues working in policy influence, mental health or international development initiatives more broadly. These peer reviewers include: John Young, Louise Shaxson, Ajoy Data, Caroline Cassidy, Dr Anne Buffardi (ODI), Kim Borrowdale (Suicide Prevention Australia), Marguerite Reagan, Dan Chisholm (WHO and LSHTM), Ellen Morgan, Dr Soumitra Pathare, Dr Byamah Mutamba (GCC and GCC projects), Shirin Merola, Angus Kathage, Miriam Smith and Katie Barker (international development practitioners).

Annex C: Knowledge, Policy and Power Overview

Option for the projects: conducting Knowledge, Policy and Power Analyses

The Research and Policy in Development team at ODI has spent the last twelve years helping researchers and policy-makers to make better use of knowledge, influencing policy-making and in particular, through research-based evidence. All the case studies that RAPID has worked on illustrate that good policy is not generated simply by increasing the amount of research on a particular topic (for example, mental health). There are complex issues to navigate to ensure that the best findings are sourced, interpreted and used in developing better mental health policies. One key message from this work is that there is no explicit 'how to' guide, partly because there is no blueprint to achieve policy influence: each situation demands an approach closely tailored to the specific context. As an overarching guide for how to go about this however, ODI has published the Knowledge, Policy and Power (KPP) Framework. This is an important tool for the networks (and projects) to apply in order to better understand and successfully navigate the interface between knowledge, policy and practice in their local contexts. It can help them to understand how they can improve the uptake of their work to shape local mental health policy

The framework outlines four key dimensions (as discussed in Chapter two) which require attention in order to understand how project findings or evidence translate (or don't) into policy: the political economy of the knowledge-policy interface, the actors who engage at it, the types of knowledge used and the role of knowledge intermediaries.

Systematic mapping of the **political context** is necessary to improve the success of knowledge-policy interactions. Adopting the position that 'it's all down to political will' is not only inaccurate but also counterproductive. This process involves determining what set of boundaries exist for if and how evidence is used in formulating health policy in that local context. It is important to map the opportunities for public debate, the strongest voices in those debates, the checks and balances particular to the system which the project is engaging with, how international agreements are ratified and implemented domestically, the informal politics which affect the system, where and when policy windows may open or close and

the capacity of the public service to make and deliver health policy in way that is conducive to including mental health. This would meet the request of several projects regarding how to understand the policy processes and how to overcome the role of informal politics which they mentioned in the survey (Box 3).

Understanding the **role and behaviour of actors** goes beyond ascribing self-interest, and is about understanding the interplay of relevant actors' interests, values, beliefs and credibility and the power relations that underpin these. Actors' interests will shape who is involved in a policy issue, what they aim to get out of the process and what knowledge is prioritised for policy-making. If the projects can understand what constitutes credibility in the local context, it will help assess how they can frame an issue and shape the evidence. This gives insight into likely entry points for the uptake of project findings and how to engage those actors who could affect policy changes for mental health progress, as requested in the projects surveyed (Box 3).

The projects would benefit from understanding what **types of knowledge** are prioritised in the local policy-making process. Knowledge communicated to policy-makers should be more than academic research reports, and need to be complemented by other forms of knowledge, based on local conditions and practical experience. This correlates with the type of action-based research, (such as base-line data, project results) that the projects are already collecting. However by understanding the types of knowledge that policy-makers in their local context are most drawn to, the projects can adapt the communication of their findings to have better influence policy. It may be that data, citizen-voice based evidence or practical knowledge have more impact.

Projects need to be aware of the types of **knowledge intermediaries** operating locally that they can draw upon, as well as the extent and quality of these intermediaries.⁴⁰ Anyone working in this field as a knowledge intermediary and communicating between research or findings generated by the projects and uptake by policy-makers needs to think through a range of possible approaches to ensure their role is effective. They typically perform six

40 Knowledge intermediaries can be organisations or individuals doing a dedicated job or including it in part of their ongoing work.

functions (informing, linking, match-making, engaging, collaborating and building adaptive capacity), though some organisations or individuals may not realise that the role they play could be labelled as ‘knowledge intermediary’. There are intermediaries both inside and outside of government, who can be influential players in how findings influence policy, and useful to the projects to draw upon. It is important for the projects to be able to assess factors like the freedom of the media, as well as which civil society organisations, non-governmental organisations and networks exist to help them to bridge this interface, and how effective they are, to engage them for assistance.

The KPP framework provides the tools to analyse a lot of what the projects suggest is missing in their work. An understanding of how the policy process works in reality

in their locale, what is motivating the policy-makers, what types of knowledge are being drawn upon most, when windows of opportunity may or may not present themselves and what intermediaries can be drawn upon to assist with improving their policy influence. The project teams are busy implementing their programmes and this would need to be conducted with their input, but would be one of the best ways to ensure that the findings from their work have actual policy impact, as well as helping to ensure that they are able to roll out their work if they go to scale, convincing policy-makers to approve the project be applied in other sub-national areas. A KPP analysis would assist the projects to understand how to better navigate their policy environments.

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Overseas Development Institute
203 Blackfriars Road
London SE1 8NJ
Tel +44 (0)20 7922 0300
Fax +44 (0)20 7922 0399

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