Core Concepts of Human Rights and Inclusion of Vulnerable Groups in the National Mental Health Policies of Ireland, Kenya, South Africa, India, and Liberia

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ABSTRACT

Purpose: *Policy analysis is an important tool to ensure that policies are rights-based and socially inclusive. The aim of this study was to assess the level of commitment to core concepts of human rights and the inclusion of vulnerable groups in five national mental health policies across low-, middle- and high-income countries.*

Method: *Policy documents were evaluated using EquiFrame, a systematic policy content analysis framework. Policies were examined with regard to their coverage of 21 core concepts of human rights (Core Concept Coverage), their quality of commitment to these core concepts (Core Concept Quality), and their inclusion of 12 vulnerable groups (Vulnerable Group Coverage). An Overall Summary Ranking was also assigned to each policy with regard to it being of 'high', 'moderate', or 'low' quality.*

Results*: Each of the policies scored 'high' on Vulnerable Group Coverage and Core Concept Coverage, although there were notable omissions. All policies, with the exception of Ireland, scored below EquiFrame's criteria for Core Concept Quality. The Irish policy produced a 'high' Overall Summary Ranking; while the Liberian, Kenyan, South African, and Indian policies each received a 'moderate' Overall Summary Ranking.*

Conclusion: *All policies received their lowest scores for Core Concept Quality, signifying a need for policymakers to ensure specific policy actions and monitoring mechanisms to address human rights in mental health policies. EquiFrame offers a constructive tool for mental health policy analysis in relation to core concepts of human rights and inclusion of vulnerable groups, which are considered key in successfully realising the Sustainable Development Goals.*

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INTRODUCTION

The Constitution of the World Health Organisation (2022a) defines mental health as a state of mental wellbeing that results in the ability to cope with normal life stressors, while realising one's potential, being able to work and learn well, and being able to fruitfully contribute to the community. However, due to the lack of consensus on a mental health definition, the integration of mental health into global healthcare services is often challenging (Whiteford et al, 2013). According to the 2022 World Mental Health Report (WHO, 2022b), approximately one in eight people live with a mental disorder globally.

Despite the prevalence of mental health problems, in low- and middle-income countries (LMICs) approximately 90% of those with mental disorders, such as depression or schizophrenia, do not have access to appropriate healthcare (Carter et al, 2021), despite the availability of effective and low-cost interventions (Patel et al, 2016). Mental health disorders receive as little as 1.05% of government expenditure in low-income countries and 3.8% in high-income countries (WHO, 2021). Mental health problems therefore often remain untreated (Subramaniam et al, 2022). The treatment gap has been used to emphasise the need for governments in LMICs to take action with regard to the provision of mental health services and the social inclusion of such services (Jansen et al, 2015). In response to this treatment gap, the Lancet Commission on Global Mental Health and Sustainable Development has emphasised the need for increased resources to address the mental health of the global population (Patel et al, 2018).

Importantly, a UN report (2017) has argued that "the crisis in mental health should be managed not as a crisis of individual conditions, but as a crisis of social obstacles which hinders individual rights. Mental health policies should address the 'power imbalance' rather than 'chemical imbalance' ". The promotion and protection of human rights in mental health are therefore reliant upon a redistribution of power in the clinical, research and public policy settings (United Nations, 2017). As proposed by Kinderman (2021), a shift from the 'disease model' of mental health to a social and psychological approach will require psychological wellbeing to be addressed in the context of human rights, policy, equity, and social justice. The relationship between mental health and social exclusion is complex, with social exclusion being both a consequential and causal factor of

mental health problems (Nasser et al, 2016). Exclusion of disadvantaged groups can be costly at both an individual and societal level (Boardman et al, 2022).

In recent years, there has been an increased focus on mental health and wellbeing, as illustrated by the inclusion of mental health in the Sustainable Development Goals (SDGs) (WHO, 2015). The SDGs emphasise social inclusion and equity by declaring mental health a priority for global human development (United Nations, 2015), underpinned by the ethos of "leaving no one behind". Goal 3 directly focuses on the need for mental healthcare to be included in global health coverage, recognising that investment in mental health globally has the potential to significantly increase the prospects and productivity of persons with mental health problems (Lund et al, 2018). Crucially, the SDGs therefore rely on inclusive and rights-based policy content and policy processes to achieve these goals.

Mental Health Policies

A mental health policy may be defined as an official statement produced by government that describes a vision, with principles, ethics and objectives, and an inclusive action plan to attain this vision and improve the population's overall mental health (WHO, 2021).The WHO has developed a comprehensive Mental Health Action Plan for governments to improve population mental health. This plan identifies active governance and robust leadership as central factors for creating policies and plans to support mental healthcare and services (Thomas, 2013).

However, as outlined in the WHO's 2020 Mental Health Atlas, a total of 146 out of 171countries reported the presence of stand-alone policies/plans (86% of responding countries) for mental health (WHO, 2021). The South-East Asian Region reported the highest percentage, with 100% (n=8) of responding countries having a mental health policy, in comparison to the African region which reported the lowest percentage at 76% (n=29) of responding countries (WHO, 2021). The number of countries that reported having a stand-alone mental health policy or plan has increased in all regions since the 2014 and 2017 Mental Health Atlas (WHO, 2014, 2017).

Despite progress in the development of policies, plans and laws – including advances in the capacity to record mental health data based on a fixed set of mental health indicators across time-periods – the Mental Health Atlas 2020 reveals significant inequalities in the accessibility of mental health resources and their distribution between high-, middle- and low-income countries. The Mental

Health Atlas also continues to show substantial gaps universally between the existence of policies, plans and laws, and their implementation and monitoring (WHO, 2021).

Policy Analysis

Policy analysis is a powerful tool to address gaps in public policy outcomes and to provide an understanding for how and why governments formulate certain policies (Browne et al, 2018). Policy analysis identifies problems within existing policies and offers practical solutions for policymakers (Cairney, 2021). It typically analyses costs/benefits of public policies using a quantitative, rational approach (Hogan & Murphy, 2021).

However, there has been a recent shift in this approach, urging policymakers to integrate international human rights law for marginalised or disadvantaged groups in accessing healthcare (MacLachlan et al, 2012). Evaluating the extent to which policy content is equitable enables an assessment of vulnerable groups that are not prioritised in comparison with other groups (Amin et al, 2022). Inequitable policy content results in vulnerable groups being socially excluded, living in poverty, suffering from restricted access to resources and employment, and lack of social participation (Tangcharoensathien et al, 2018).

Mental health concerns are more prevalent in some social cohorts and often intersect with other vulnerability factors that can result in double discrimination and multiple disadvantage, such as people living with limited resources (Mannan et al, 2013), with mental health problems compounding poverty for example (Knapp et al, 2006). As proposed by Mannan et al (2013): "Formal recognition and incorporation in…mental health policies of specific mechanisms of exclusion and detailed needs of these populations is required to ensure their equitable access to healthcare". While all-inclusive terminology may be used in policies such as 'all people' or 'all citizens', this fails to recognise the specific needs, barriers to services, opportunities, and aspirations of particular vulnerable groups. Policies that are developed for the general population therefore often fail to support and include the most vulnerable groups (Ivanova et al, 2015). It is therefore critical for policymakers to formulate targeted strategies for all vulnerable groups using a rights-based approach (Eide et al, 2013).

Participation by marginalised groups at each stage of policy and decision-making processes is also crucial, including policy development, implementation, monitoring and appraisal (Kabakian-Khasholian et al, 2020; McVeigh et al, 2021),

captured in the slogan of "Nothing About Us Without Us". However, an inclusive policy process does not always produce an inclusive outcome, and it is therefore important for researchers to analyse the actual content of policies (Chinyama et al, 2018). The content of a policy defines the aims, anticipated beneficiaries, and potential government actions to achieve the goals of the policy (Huss & MacLachlan, 2017).

Objective

EquiFrame is a structured policy content analysis tool, designed to assess the inclusiveness of policy content by evaluating a policy's level of commitment to 12 vulnerable groups and 21 core concepts of human rights (Disability Action Council Cambodia, 2017).Using *EquiFrame*, the aim of the present study was to assess the level of commitment to core concepts of human rights and the inclusion of vulnerable groups in the national mental health policies of Ireland, Kenya, South Africa, India, and Liberia. This study is relevant to a wide range of stakeholders, including policymakers, service-users, service-providers, and civil society including organisations of persons with disabilities. The overall goal of the study was to identify best-practice mental health policies that support the efforts of the SDGs in promoting right-based and equitable mental health policies and to identify policies that may require urgent revision.

METHOD

Development of EquiFrame

EquiFrame is a validated analytical tool to evaluate the extent to which social inclusion and human rights are prioritised in public policies and policy-related documents (Mannan et al, 2011).*EquiFrame* measures the inclusiveness of a given policy to 12 specified vulnerable groups (see Appendix 1) and its commitment to 21 core concepts of human rights (see Appendix 2) (Disability Action Council Cambodia, 2017). *EquiFrame* is a flexible framework, which allows for the selection and/or addition of vulnerable groups (MacLachlan et al, 2016). However, each of the core concepts and vulnerable groups listed in *EquiFrame* are supported by a significant evidence-base, and therefore any modifications to the framework must be justified by human rights literature and documents (MacLachlan et al, 2016).

EquiFrame was established as part of a work package led by Ahfad University for Women in Sudan, as part of the multi-country EU FP7-funded project *EquitAble*

(Mannan & MacLachlan, 2012). The framework was created at consultation workshops in LMICs, with over 100 participants from various sectors and organisations (Amin et al, 2011). Since the development of *EquiFrame*, it has been used to analyse a range of different policies, including but not limited to health-related policies such as national HIV/AIDS, tuberculosis, and malaria policies (MacLachlan et al, 2016; Chinyama et al, 2018; Amin et al, 2022), national health policies and drug policies (Amin et al, 2011), disability and rehabilitation policies and plans (Mannan et al, 2012; O'Dowd et al, 2014; Disability Action Council Cambodia, 2017), management of childhood illness policy (MacLachlan et al, 2012), and orthopaedic technical services policy (VanRooy et al, 2012), in a broad range of different countries including South Africa, Namibia, Sudan, Scotland, Ireland, Spain, Malawi, India, Cambodia and Ireland.

The Framework

EquiFrame assesses a policy's commitment to 21 core concepts of human rights and inclusion of 12 vulnerable groups, with a particular focus on persons with disabilities. *EquiFrame* focuses on equitable access to healthcare for persons who may be deemed vulnerable (Mannan et al, 2011). It is based on the ethos of accessible, universal, and equitable health service provision. The framework has been developed with a focus on policy content and design, with the intention of producing a systematic, evaluative and comparative analysis of policy content.

A 'core concept' (CC) may be characterised as a "central, often foundational policy component generalised from particular instances (namely, literature reviews, analyses of statutes and judicial opinions, and data from focus groups and interviews)" (Umbarger et al, 2005). *EquiFrame's* 21 CCs encompass a range of salient concerns in human rights in the context of equity in healthcare access (Oliver et al, 2002; Braveman & Gruskin, 2003), enabling health services to be delivered as a basic human right (Gilson et al, 2008). Appendix 1 presents *EquiFrame's* core concepts, with key questions and key language on which the concepts are based.

Vulnerable groups (VGs) may be classified as "social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality" (Flaskerud & Winslow, 1998). Definitions for *EquiFrame's* VGs are presented in Appendix 2. For further details specific to the formulation of *EquiFrame* and the process of identifying core concepts and vulnerable groups, please see the *EquiFrame* manual (Mannan et al, 2011)

Selection of Policies

This study utilised a policy content analysis design. As the study was conducted on freely accessible national policies, there were no direct ethical considerations. Each of the five country's policies that are the focus of this analysis – Liberia, South Africa, India, Kenya, and Ireland – represent distinct challenges with regard to equitable service provision. These five countries show how equitable access to mental health services may be most effectively supported in contexts where more than half of the population lives below the poverty line, particularly in rural areas (Liberia); where irrespective of relative wealth, equitable access to health services has not yet been realised (South Africa); where despite a rapidly growing economy, significant health inequities persist (India); where high rates of poverty exist amidst a high burden of infectious disease (Kenya); and where universal coverage for primary healthcare has not yet been attained, as the only Western European country without a universal healthcare system (Ireland).

Mental health policies were included if they met the following criteria: (1) Mental health policy documents produced by the Ministry of Health; (2) A translated copy of the policy was available; and (3) Strategies that address mental health policies. A search was conducted to find mental health policies on the countries' national government websites. The selected policies contribute to the current body of knowledge on the extent to which national mental health policies are rights-based, equitable and socially inclusive. Each of these policies is briefly described in more detail below.

South African Mental Health Policy

The purpose of the South African 2013–2020 policy is to provide guidance to provinces for the prevention, promotion, treatment and recovery of mental health. The policy aims to address an inclusive scope of all mental disorders across all age ranges. It encompasses the human rights of people with mental health disorders and includes other stakeholders who can influence the improvement of South Africans' mental health status. The reformed Act that informed this policy aims to advance access to mental health services by ensuring the first contact of mental healthcare is through the primary healthcare system, followed by the integration of mental healthcare into general and community health services.

Kenyan Mental Health Policy

The Kenyan Mental Health Policy 2015–2030 was developed by public, private and non-State members through a consultative process, supervised by the

Ministry of Health. The policy is focused on achieving optimal health status and capacity-building of all citizens. The policy's goal is to attain the highest standard of mental health throughout the country, emphasising that all individuals in both the private and public sector are responsible for the fulfilment of this goal. Current mental health interventions in Kenya are wide-ranging and overlap with other sectors, showing the critical need for this policy to have an intersectoral and multidisciplinary approach.

India's Mental Health Policy

This policy was created in 2014 after a Policy Group, constituted by the Government of India in 2011, recommended the need for a national mental health policy. The goal of this policy is to promote inclusivity and de-stigmatisation of mental health, while ensuring that those affected by mental disorders have access to affordable and high-quality social care and healthcare across all age ranges. The Indian government emphasises the importance of having good mental health in order to achieve overall health. Thus, this policy aims to promote mental health awareness and to prevent mental disorders and suicide.

Liberia's Mental Health Policy and Strategic Plan

The reformed Mental Health Policy and Strategic Plan for Liberia (2016–2021) was created based on evidence regarding the need for mental health investments and the profound burden of disease in the country. The policy and strategic plan were published as one document. The strategy and policy aim to expand the accessibility of all mental health clinicians by developing new wellness units in each county and rehabilitation services in all regions. The policy also emphasises the need for regulation in order to supply psychotropic drugs in an effective way. The policy aims to improve Liberia's primary care services to achieve high standards across all mental healthcare services.

Ireland's Mental Health Policy

Ireland's most recent national mental health policy, 'Sharing the Vision' (2020–2030), encompasses several aspects of the original policy 'A Vision for Change' (2006), including guidance on the effective delivery of mental healthcare services. The policy promotes a holistic view of mental health, while acknowledging the multifaceted interplay of factors that may influence mental health. The policy adopts a person-centred approach, emphasising personal decision-making within recovery, supported by best clinical practice and lived mental health experiences.

The goal of this reformed policy is to develop a mental health system that focuses on the specific requirements of individuals and the needs of the population. The national Irish mental health policy aims to ensure that this system can deliver inclusive services (to service users and their families) to promote positive mental health within communities, prevent mental disorders and ensure appropriate and effective treatment.

Within the policy, various additional vulnerable groups are discussed, including the Traveller community and LGBTQ+ community. In the present study, the Traveller community was recorded as an ethnic minority due to the structural disadvantage and social stigma experienced by this group, whereby they are named as a protected group within Irish legislation (Haynes et al, 2021).Similarly, while social attitudes towards LGBTQ+ people have significantly improved in Ireland, such individuals continue to experience discrimination and social exclusion (Irish College of General Practitioners, 2020). Thus, for the present study LGBTQ+ individuals were included as a vulnerable group within the Irish population. These additional VGs were factored into the overall scoring of the policy, and the Irish national mental health policy was therefore scored on 14 VGs, rather than the original 12 VGs included in *EquiFrame*.

Summary Indices of EquiFrame

The four summary indices of *EquiFrame* are defined below (Mannan et al, 2011):
(1)**Core Concept Coverage:** The policy was inspected with respect to the quantity of Core Concepts mentioned out of the 21 Core Concepts identified. This ratio was then expressed as a rounded-up percentage.

(2) **Vulnerable Group Coverage:** The policy was examined with respect to the number of Vulnerable Groups mentioned of the 12 Vulnerable Groups identified. This ratio was then expressed as a rounded-up percentage.

(3) **Core Concept Quality:** The policy was examined with respect to the number of Core Concepts within it that were rated as 3 or 4 (as either stating a specific policy action to address a Concept or an intention to monitor a Concept) out of the 21 Core Concepts identified; and this ratio was expressed as a rounded-up percentage. When several references to a Core Concept were found to be present, the top-quality score received was recorded as the final quality scoring for the respective Concept.

(4) Each document was given an **Overall Summary Ranking** in terms of it being of High, Moderate or Low ranking according to the following criteria:

(i) High = if the policy achieved ≥50% on all of the three scores above.

(ii) Moderate = if the policy achieved ≥50% on two of the three scores above.

(iii) Low = if the policy achieved <50% on two or three of the indices above.

Scoring

Each Core Concept obtained a score on a scale from 1 to 4. This was a ranking of the quality of commitment to the Core Concept within the policy document:

1 = Concept only mentioned.

2 = Concept mentioned and explained.

3 = Specific policy actions identified to address the Concept.

4 = Intention to monitor Concept was expressed.

For each policy, the presence of Core Concepts was assessed for each Vulnerable Group that was identified in the policy. If no Vulnerable Group was mentioned but a Core Concept was addressed, the Core Concept was still recorded

As this study comprised a policy document content analysis, there were no direct ethical considerations.

RESULTS

Table 1 presents the results of the policy content analyses of the mental health policies using *EquiFrame's* summary indices. The Irish policy produced a **High** Overall Summary Ranking; while Liberia, Kenya, South Africa, and India each received a **Moderate** Overall Summary Ranking. Each of the policies exceeded *EquiFrame's* criterion of 50% for both Vulnerable Group Coverage and Core Concept Coverage.

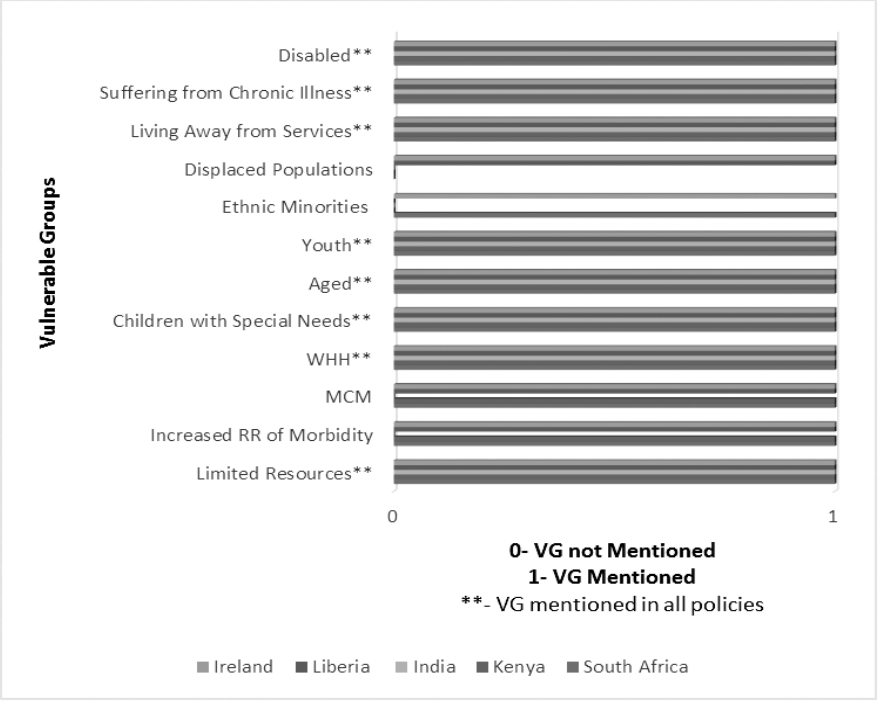
All Vulnerable Groups were mentioned at least once across all of the mental health policies. However, the Vulnerable Groups of *Ethnic Minorities* and *Displaced Populations* were only mentioned in two of the five policy documents (see Figure 1). This finding supports the construct validity of the categories used in *EquiFrame*, as they appear relevant within the policy domain, at least within the policies analysed. Notably, at least 8 out of 12 Vulnerable Groups were mentioned in each policy, i.e., *Limited Resources*, *Women- headed Household*, *Children with Special Needs*, *Aged*, *Youth*, *Living Away from Services*, *Suffering from Chronic Illness*, and *Disability*.

In total, 11 of the 21 Core Concepts were mentioned in all five policy documents (see Figure 2). The Core Concept of *Entitlement* was only mentioned in the Liberian Mental Health Policy. It was the only Core Concept not mentioned in the Irish policy. Particularly noteworthy was the Mental Health Policy of Ireland, which mentioned all Vulnerable Groups and only excluded 1 Core Concept. Having reflected on the more general findings from the application of the framework to each of the five policies, findings are presented below in more detail with respect to individual policy documents.

Table 1: *EquiFrame* Summary Indices Scorings across Policies

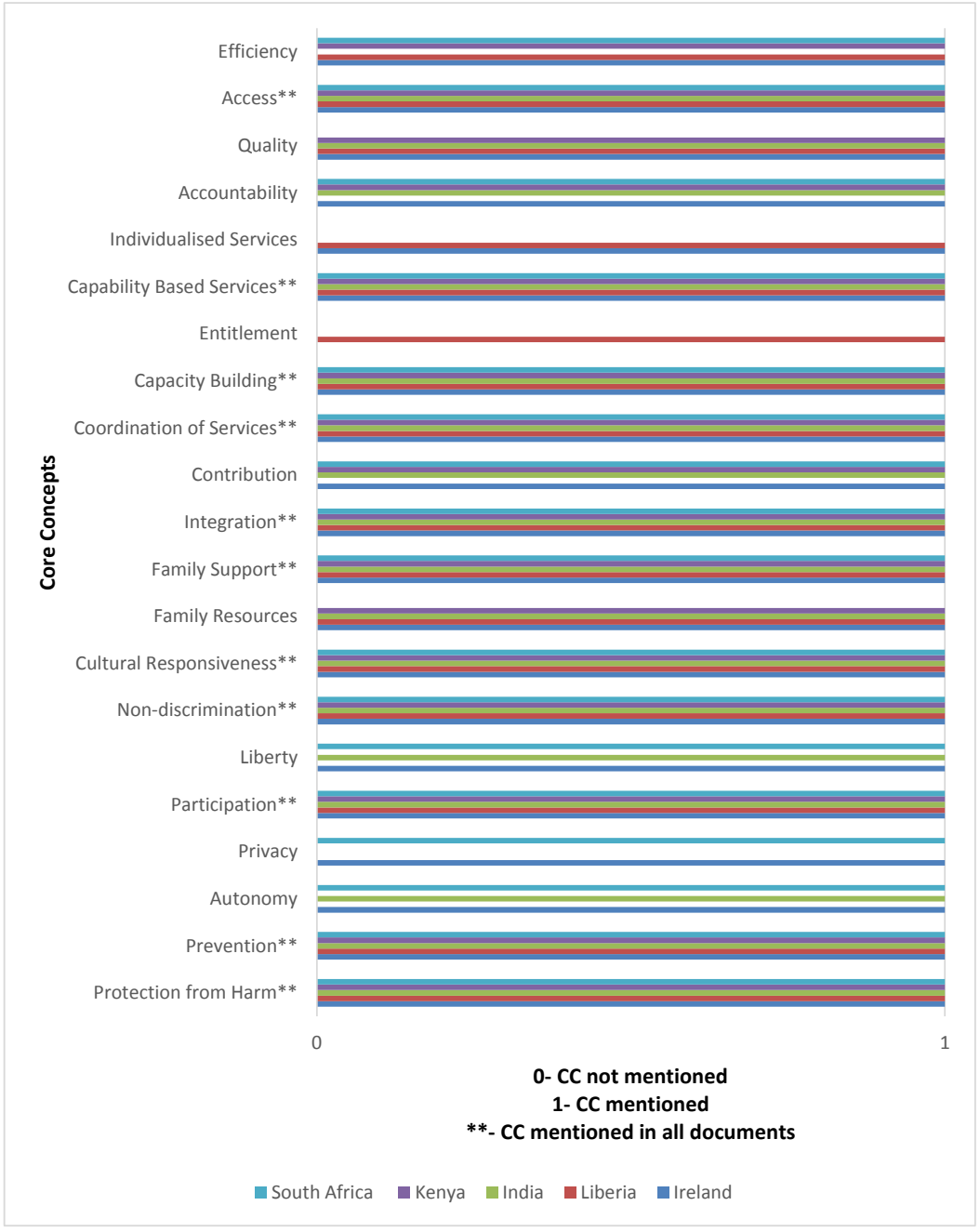
Mental Health Policy	Vulnerable Group Coverage	Core Concept Coverage	Core Concept Quality	Overall Summary Ranking
India	67%	81%	43%	Moderate
Ireland	100%	96%	53%	High
Kenya	84%	77%	48%	Moderate
Liberia	92%	77%	43%	Moderate
South Africa	92%	81%	38%	Moderate

Figure 1: Vulnerable Groups mentioned in each Policy



WHH = Women Headed Household; MCM = Mother Child Mortality; Increased RR of Morbidity = Increased Relative Risk of Morbidity

Figure 2: Core Concepts mentioned in each Policy



South Africa's Mental Health Policy

Vulnerable Group Coverage for this policy was 92%. The VG of *Suffering from Chronic Illness* was most frequently mentioned (37 times), followed by *Disabled* (23 times),*Youth* (22 times), *Increased Relative Risk for Morbidity* (16 times),and *Women-Headed Household* and *Limited Resources* (both mentioned 14 times). The remaining VGs were all mentioned under 10 times, while the VG of *Displaced Populations* was not mentioned in the policy (see Figure 3).

Core Concept Coverage for this policy was 81%. A total of four Core Concepts were not mentioned explicitly in the policy, namely *Family Resources*, *Entitlement*, *Individualised Services* and *Quality*. The most frequently mentioned Core Concept was *Co-ordination of Services* (32 times), followed by *Capacity Building* and *Prevention* (both mentioned 22 times), *Integration* (21 times), and *Capability Based Services* (20 times). The remaining Core Concepts were each mentioned less than 10 times.

With regard to Core Concept Quality, the document received a score of 38%. Eight of the Core Concepts mentioned were scored as '3' or '4', signifying that the policy either indicated actions to address the concept or expressed an intention to monitor the concept. The Core Concepts of *Integration*, *Capacity Building* and *Non-discrimination* were each mentioned with an expressed intention to monitor the Core Concept. The Core Concepts of *Cultural Responsiveness*, *Autonomy*, *Protection from Harm*, *Co-ordination of Services* and *Capability Based Services* were mentioned in relation to particular policy actions to address the Core Concept.

Accordingly, the South African National Mental Health Policy scored above 50% for Core Concept Coverage and Vulnerable Group Coverage, and below 50% for Core Concept Quality. The policy therefore scored above 50% on two of three of *EquiFrame's* summary indices and was given an Overall Summary Ranking of 'Moderate'.

Figure 3: Core Concepts and Vulnerable Groups identified in the South African Mental Health Policy

concept	No. of times concept occurred in document	Limited Resources	Increased RR of Morbidity	MCM	WHH	Children with Special Needs	Aged	Youth	Ethnic Minorities	Displaced populations	Living Away from Services	Suffering from Chronic Illness	Disabled
Protection from Harm	6												
Prevention	22							1					
Autonomy	2											1	
Privacy	1						1	1					
Participation	7												
Liberty	2												
Non-discrimination	8								1				3
Cultural Responsiveness	4												
Family Resources													
Family Support	5											1	
Integration	21	1	1									1	1
Contribution	3												
Coordination of Services	32	1										1	1
Capacity Building	22												1
Entitlement													
Capability Based Services	20											1	
Individualised Services													
Accountability	2												1
Quality													
Access	3												
Efficiency	2	1											
No. of times VG mentioned		14	16	14	2	7	6	22	4		4	37	23

Kenyan Mental Health Policy

Vulnerable Group Coverage for this policy was 84%. The document failed to mention two VGs, namely *Displaced Populations* and *Ethnic Minorities*. While *Suffering from Chronic Illness* was the most frequently mentioned Vulnerable Group (18 times), all other Vulnerable Groups were mentioned less than 10 times throughout the document. The VGs of *Living Away from Services* and *Women-Headed Household* were only mentioned once in the policy (see Figure 4).

Core Concept Coverage for this policy was 77%. *Co-ordination of Services* was explicitly mentioned 35 times, followed by *Capacity Building* (18 times), *Integration*, *Prevention*, and *Capability-Based Services* (13 times each). All other Core Concepts were mentioned less than 10 times. The policy failed to mention five Core Concepts - *Autonomy*, *Privacy*, *Liberty*, *Entitlement*, and *Individualised Services.*

Ten of these Core Concepts were scored as '3' or '4', meaning that the policy either indicated actions to address the concept or expressed intention to monitor the concept. These Core Concepts were *Participation*, *Co-ordination of Services*, *Efficiency*, *Accountability*, *Capacity Building*, *Quality*, *Integration*, *Prevention*, *Family Support*, and *Contribution*. Due to the policy scoring above 50% for two of three of *EquiFrame's* summary indices, the policy received a 'Moderate' Overall Summary Ranking.

Figure 4: Core Concepts and Vulnerable Groups identified in the Kenyan National Mental Health Policy

concept	No. of times concept occurred in document	Limited Resources	Increased RR of Morbidity	MCM	WHH	Children with Special Needs	Aged	Youth	Ethnic Minorities	Displaced populations	Living Away from Services	Suffering from Chronic Illness	Disabled
Protection from Harm	2												
Prevention	13											1	
Autonomy													
Privacy													
Participation	8												
Liberty													
Non-discrimination	5	1										1	
Cultural Responsiveness	6				1			1				1	
Family Resources	4												
Family Support	7												
Integration	13												
Contribution	3												
Coordination of Services	35											1	
Capacity Building	18							1					
Entitlement													
Capability Based Services	13												
Individualised Services													
Accountability	2												
Quality	5		1										
Access	9	1											
Efficiency	4												
No. of times VG mentioned		9	3	4	1	2	4	8			1	18	7

India's Mental Health Policy

Vulnerable Group Coverage for this policy was 67%. *Increased Relative Risk for Morbidity*, *Mother Child Mortality*, *Ethnic Minorities*, and *Displaced Populations* were not mentioned throughout the policy. *Youth* was the most frequently mentioned Vulnerable Group (12 times), while all other Vulnerable Groups mentioned were cited less than 10 times.

Core Concept Coverage was 81%.The Core Concepts of *Privacy*, *Entitlement*, and *Individualised Services* were not mentioned in the policy. *Co-ordination of Services* was the most commonly mentioned Core Concept (13 times), followed by *Access* (11 times), and *Capacity Building* (10 times). The remaining Core Concepts were mentioned less than 10 times throughout the document (see Figure 5).

Core Concept Quality was 43%, with eight Core Concepts being expressed with regard to specific policy actions to address the CC (no CCs were expressed with the intention to monitor). These CCs were *Participation*, *Co-ordination of Services*, *Family Resources*, *Access*, *Capability-Based Services*, *Capacity Building*, *Non-discrimination*, *Family Support*, and *Integration*. The policy scored above 50% for two of *EquiFrame's* summary indices and below 50% for Core Concept Quality. The document therefore received a 'Moderate' Overall Summary Ranking.

Figure 5: CCs and VGs identified in the Indian National Mental Health Policy

concept	No. of times concept occurred in document	Limited Resources	Increased RR of Morbidity	MCM	WHH	Children with Special Needs	Aged	Youth	Ethnic Minorities	Displaced populations	Living Away from Services	Suffering from Chronic Illness	Disabled
Protection from Harm	3							1					
Prevention	6												
Autonomy	1												
Privacy													
Participation	6												
Liberty	1												
Non-discrimination	8												1
Cultural Responsiveness	2												
Family Resources	1												
Family Support	3												
Integration	6												
Contribution	2												
Coordination of Services	13												
Capacity Building	10												
Entitlement													
Capability Based Services	7												
Individualised Services													
Accountability	2												
Quality	4												
Access	11	2											
Efficiency											1	1	1
No. of times VG mentioned		9			1	4	2	12			2	4	7

Liberian National Mental Health Policy and Strategic Plan

Vulnerable Group Coverage for the Liberian National Mental Health Policy and Strategic Plan was 92%.The policy mentioned all VGs, with the exception of *Ethnic Minorities*. The most commonly mentioned VG throughout the policy was *Suffering from Chronic Illness* (25 times), followed by *Youth* (16 times). All remaining VGs were cited less than 10 times in the document (see Figure 6).

The policy's Core Concept Coverage was 77%. The Core Concept of *Capacity Building* was referred to in the document most frequently (30 times), followed by *Prevention* (27 times), *Co-ordination of Services* (17 times), *Integration* (15 times) and *Capability-Based Services* (13 times). The remaining Core Concepts mentioned were cited less than 10 times. The document did not explicitly mention *Autonomy*, *Privacy*, *Liberty*, *Contribution*, or *Accountability*.

With regard to Core Concept Quality, the following Core Concepts received a score of '3': *Participation*, *Prevention*, *Capacity Building*, *Quality*, *Co-ordination of Services*, *Integration*, *Family Support*, *Individualised Services*, and *Capability- Based Services*. The document's overall Core Concept Quality was 43%. The Liberian National Mental Health Policy scored above 50% for two of *EquiFrame's* summary indices and below 50% for Core Concept Quality. The policy therefore received a 'Moderate' Overall Summary Ranking.

Figure 6: CCs and VGs identified in the Liberian National Mental Health Policy and Strategic Plan

concept	No. of times concept occurred in document	Limited Resources	Increased RR of Morbidity	MCM	WHH	Children with Special Needs	Aged	Youth	Ethnic Minorities	Displaced populations	Living Away from Services	Suffering from Chronic Illness	Disabled
Protection from Harm	2												
Prevention	27											1	1
Autonomy													
Privacy													
Participation	2												
Liberty													
Non-discrimination	6												
Cultural Responsiveness	1												
Family Resources	4												
Family Support	6							1				1	
Integration	15												
Contribution													
Coordination of Services	17												
Capacity Building	30							1				1	
Entitlement	1												
Capability Based Services	13												
Individualised Services	3							1					1
Accountability													
Quality	8												
Access	8	1											
Efficiency	2												
No. of times VG mentioned		9	2	8	2	3	2	16		1	2	25	7

Ireland's National Mental Health Policy

Vulnerable Group Coverage for the Irish National Mental Health Policy was 100%. The VGs of *Increased Relative Risk for Morbidity* and *Women-Headed Household* were only mentioned once in the document. *Youth* was the most frequently mentioned VG (21 times), followed by *Disability* (20 times), and *Suffering from Chronic Illness* (13 times). The remaining VGs were all cited 10 times or less throughout the policy (see Figure 7). Notably, the policy also included additional VGs in the Irish population, including LBGTQ+ people (4 times) and the Traveller Community (2 times). Thus, this policy mentioned 14 VGs in total.

Core Concept Coverage for this policy was 96%. The policy mentioned all Core Concepts, with the exception of *Entitlement*. The most commonly mentioned CC was *Access* (84 times), followed by *Co-ordination of Services* (51 times), *Integration* (35 times),*Capability-Based Services* (30 times), *Prevention* (27 times), *Capacity Building* (18 times), and *Participation* (12 times). The remaining Core Concepts were mentioned less than 10 times throughout the policy (see Figure 7). This policy produced the highest frequency counts for the number of times that a Core Concept was mentioned.

The policy's Core Concept Quality was 53%. The CCs of *Integration*, *Participation*, *Access*, and *Non-Discrimination* were all expressed with an intention to monitor;

while *Contribution*, *Capability-Based Services*, *Family Resources*, *Co-ordination of Services*, *Prevention*, *Capacity Building*, and *Family Support* were mentioned with specific policy actions to address the CC. The Irish National Mental Health policy scored above 50% on all three of *EquiFrame's* summary indices and was therefore given an Overall Summary Ranking of 'High'.

Figure 7: Core Concepts and Vulnerable Groups identified in the Irish National Mental Health Policy

concept	No. of times concept occurred in document	Limited Resources	Increased RR of Morbidity	MCM	WHH	Children with Special Needs	Aged	Youth	Ethnic Minorities	Displaced populations	Living Away from Services	Suffering from Chronic Illness	Disabled
Protection from Harm	7												
Prevention	27												
Autonomy	1												
Privacy	1												
Participation	12												1
Liberty	3												
Non-discrimination	9												
Cultural Responsiveness	2												
Family Resources	4												
Family Support	5												
Integration	35												2
Contribution	5												1
Coordination of Services	51					1		1				1	
Capacity Building	18												
Entitlement													
Capability Based Services	30												
Individualised Services	2												
Accountability	8												
Quality	4												
Access	84	2		1				1		1	1	1	1
Efficiency	5							1					1
No. of times VG mentioned		9	1	6	1	7	7	21	5	5	4	13	20

DISCUSSION

The aim of the present study was to assess the level of commitment to Core Concepts of human rights and the inclusion of Vulnerable Groups in the national mental health policies of Ireland, Kenya, South Africa, India, and Liberia. The overall goal of the study was to identify best-practice mental health policies that support the efforts of the SDGs in promoting right-based and equitable mental health policies and to identify policies that may require urgent revision.

Significant variability was found for *EquiFrame's* summary indices across the national mental health policies analysed. Particularly noteworthy was the Irish Mental Health policy as the only policy to receive a 'High' Overall Summary Ranking. This policy explicitly mentioned all Vulnerable Groups and mentioned 20 out of 21 Core Concepts. Although all other policies received a 'Moderate'

Overall Summary Ranking, significant differences were nonetheless found between policies regarding Vulnerable Group Coverage and Core Concept Coverage, as reflected in Table 1. All policies received their lowest scores for Core Concept Quality, signifying a need for policymakers to ensure specific policy actions and monitoring mechanisms to address human rights in mental health policies. This finding aligns with the 2020 Mental Health Atlas, which reported substantial gaps between the existence of policies, plans and laws, and their implementation and monitoring (WHO, 2021). Similarly, in a previous *EquiFrame* analysis of the mental health policies of Malawi, Namibia, and Sudan, Mannan et al (2013) reported that Core Concept Quality was below *EquiFrame's* criterion of 50% for the Sudanese and Malawian mental health policies.

Vulnerable Group Coverage

Each of the policy documents exceeded *EquiFrame's* criterion of 50% for Vulnerable Group Coverage. Despite all policies scoring above 50%, there was a stark contrast for Vulnerable Group Coverage across policies. For example, the Indian mental health policy scored the lowest for Vulnerable Group Coverage at 67%, and the Irish mental health policy scored the highest at 100%. The Indian, Kenyan, and Liberian mental health policies failed to explicitly mention the VG of *Ethnic Minorities*. Ethnic minorities are common across all countries and cultures, despite the variation of particular ethnic minorities within countries. The Irish mental health policy mentioned the Traveller community, which was recorded as an ethnic minority group in this study. Irish Travellers constitute an indigenous minority, with distinctive cultural values, history, language, traditions, and customs (https://itmtrav.ie/what-is-itm/irish-travellers/), of which nomadism is a key component (McElwee et al, 2003). Importantly, ethnic minorities are more vulnerable to mental health issues, discrimination, and greater disadvantage (Elliott & Masters, 2009).Ethnic minority groups, who may already face prejudice and discrimination with regard to their group affiliation, may confront double stigma when faced with mental health problems (Gary, 2005).

Notably, the Irish mental health policy also included other Vulnerable Groups, such as the LGBTQ+ community. Being a part of the LGBTQ+ community is correlated with an increased risk for mental health issues and stigma (Wishart et al, 2019) and the LGBTQ+ community is a group that should be acknowledged globally (Connell et al, 2017). Recognising particular mechanisms of exclusion and the detailed barriers and needs of specific Vulnerable Groups in policies is

critical to ensuring equitable healthcare access.

Although all Vulnerable Groups were mentioned in at least one of the analysed policies, it is important to examine if all vulnerable groups are equally salient across different types of policies (MacLachlan et al, 2012). When analysing policies, certain assumptions may lead to conceptual foreclosure. For example, it may be argued that mental health policies already address the *Increased Relative Risk for Morbidity* group, therefore negating the need to evaluate the policy's inclusion of this group. However, the high comorbidity of mental health disorders (Roca et al, 2009) demonstrates the critical need to include this Vulnerable Group in mental health policies. It is important to be able to compare policies regarding the inclusion of vulnerable groups and to then study the contextual relevance of such groups (MacLachlan et al, 2012).

Core Concept Coverage and Core Concept Quality

While each of the policies exceeded *EquiFrame's* criterion of 50% on Core Concept Coverage, the Liberian, Indian and Kenyan mental health policies failed to include the Core Concept of *Privacy*; and the Liberian and Kenyan policies did not mention the Core Concepts of *Autonomy* and *Liberty*. Each of these Core Concepts plays a vital role in the protection of people with mental health problems. It is crucial that the right to privacy is protected for those with mental health concerns (United Nations, 2015). With regard to autonomy, informed consent is a key component in receiving appropriate care and treatment for mental health disorders (WHO, 2008). Correspondingly, the right to liberty ensures the protection of Vulnerable Groups from unwarranted confinement when in the custody of a mental health system or service provider (Mannan et al, 2011). The right to liberty is also crucial to ensuring that individuals have the right to make informed decisions regarding their personal mental health (Cairney, 2019).

The Irish, Indian and South African mental health policies failed to include the Core Concept of *Entitlement*, indicating the need for policies to demonstrate how Vulnerable Groups may qualify for specific benefits that are relevant to them. Individuals with mental health disorders are entitled to similar rates of disability benefits as those who suffer from a physical disability (WHO, 2008). Specifying entitlements and disseminating information on such entitlements amongst service-users can aid in treatment-seeking processes and alleviate financial concerns.

With regard to Core Concept Quality, with the exception of the Irish mental health policy, all policies scored below *EquiFrame's* criterion of 50%. Importantly, the Liberian and Indian policies failed to express any intention to monitor the implementation of Core Concepts that were mentioned. Although the Irish policy scored above *EquiFrame's* criterion of 50%, it only received a score of 53% for Core Concept Quality. This finding adds to and supports previous findings from the WHO, which highlighted a limited number of countries that have successfully developed monitoring mechanisms for mental health resources (WHO, 2021). The Core Concept Quality scores in this study illustrate the need for policymakers to more effectively ensure specific policy actions and monitoring mechanisms for Core Concepts of human rights in mental health policies.

Study Limitations

This study analysed the South African National Mental Health Policy which was in operation from 2013–2020 and is therefore effectively out of date. However, at the time of the study, a revised version of this policy had not yet been made available. This was also the case for the Liberian Mental Health policy, which was dated from 2016–2021. A revised version of this policy had not yet been published at the time that this study was conducted, so the analysis dealt with the most up-to-date version of the policy that was available in 2021. The Indian National Mental Health policy was developed in 2014 and did not have a fixed date of termination/revision. Importantly, as the development of the Indian and South African mental health policies precedes the adoption of the SDGs by UN Member States in 2015, these policies cannot fully support the SDGs. The lack of adherence to the SDGs in terms of social inclusion in these policies indicates an urgent need for policy revision.

During the development of *EquiFrame*, a number of stakeholders argued that policies often use the term "all" with regard to "all people" in order to be fully inclusive, negating the need to mention particular vulnerable groups (MacLachlan et al, 2012). Notably, all the analysed policies used broad terminology at times, such as "all people" or "all citizens". However, such policies still mentioned specific Vulnerable Groups while failing to mention others, which may exacerbate the social exclusion of these groups. For example, the Indian policy referred to persons with disabilities, but failed to consider ethnic minorities. The use of broad and all-encompassing terminology fails to address the needs, concerns, and barriers to accessing health services of particular vulnerable cohorts (Mannan

et al, 2012). Thus, this study did not account for broad terminology such as "all" and "all people" in its analyses.

Although it was not feasible to analyse a broader range of policies in this study, future analysis of cognate policies – such as transportation, health, social protection, and education policies – may support co-ordination of services and integration of mental health across different sectors. If mental health is not prioritised across all sectors and national policies, it will not be possible to realise the interdependent goals set out in the SDGs (Smith, 2018).

While *EquiFrame* focuses on *policy content*, it is important to also examine *policy processes* in terms of social inclusion and adherence to human rights, such as policy development, implementation, monitoring and evaluation. For this purpose, *EquIPP* (Equity and Inclusion in Policy Processes) is a framework for the development of equitable and inclusive policy processes and is applicable across high-, middle-, and low-income countries (Huss & MacLachlan, 2016; MacLachlan et al, 2016; Ebuenyi et al, 2021). Participation in the development of policies ensures that the needs of Vulnerable Groups are represented and provides an opportunity for such groups to hold their government accountable (Jones, 2009).For example, Chinyama et al (2018) analysed the content of the Malawian HIV and AIDS Policy using *EquiFrame*, alongside the participation of Vulnerable Groups in policy processes using *EquiPP*. Using *EquiFrame* and *EquIPP* in future studies will enable an evaluation of the extent to which both mental health policy content and policy processes are rights-based, equitable, and socially inclusive. As proposed by MacLachlan et al (2019), "policy assessments, through the use of methodologies such as EquiFrame and EquIPP, can tell us much about the priority accorded to issues of inclusion of vulnerable groups and about prevailing negative attitudes and behaviours in society".

It is also noteworthy that while *EquiFrame* produces a list of Vulnerable Groups developed through extensive participatory consultations, it is not possible for the framework to list all existing vulnerable groups across all contexts. For example, many of the social groups recognised by the Global Fund (The Global Fund, 2020) as most at-risk are not accounted for by *EquiFrame*, including transgender individuals, drug users, sex workers and prisoners. This point emphasises the need for researchers to be aware of the flexibility of the *EquiFrame* framework in accordance with context and purpose. If policymakers and stakeholders are not aware of the specific Vulnerable Groups within their population, this will hinder the analysis of policy content. The objective of *EquiFrame* is to provide

guidance for policy content analysis by providing various summary indices in accordance with the Core Concepts of human rights and equity. However, as all Core Concepts and Vulnerable Groups included in EquiFrame are supported by a substantial evidence base, it is advised that any modifications to the framework are well-rooted in human rights documents and literature relative to the particular context (MacLachlan et al, 2016).

CONCLUSION

Policymakers recognise the value of policy analysis, as it enables them to show a commitment to endorsing social inclusion and human rights in their policies (MacLachlan et al, 2016). While *EquiFrame* was developed for content analysis of policy documents, the framework may also be advantageous to other guidance and planning documents where human rights coverage and social inclusion are relevant. The use by researchers and policymakers of these freely accessible policy analysis tools, namely EquiFrame and EquIPP, can support social inclusion and human rights in mental health service provision. Greater understanding of the content of such documents can be gained by assessing the context in which the document was developed.

The critical need for mental health policy reform is extensively acknowledged by policymakers, mental health professionals and scholars (WHO, 2018). Policymakers have emphasised the need for a collaborative approach with regard to mental health policies that avails of knowledge from decision-makers, service-providers, and service-users (Mechanic et al, 2014). In order to achieve this collaborative approach, there must be active and meaningful participation of marginalised groups in the development of policies to support successful policy implementation (MacLachlan et al, 2014). Importantly, communicating policy analysis findings with communities and policy beneficiaries is also critical to attaining the desired outcomes of policies.

Inclusive and equitable public policies are a key component in attaining the SDGs. As proposed by Huss and MacLachlan (2017), "policies must confer entitlements, protect the human rights of vulnerable groups, whilst aligning actions and objectives with the global vision of sustainable development". In comparison to 2014 and 2017 data, the WHO 2020 Mental Health Atlas indicated that a greater number of countries reported that their policies encouraged a shift towards respecting the human rights of individuals with a mental health condition and psychosocial disabilities, an increase in mental health resources

within the community, and the promotion of independence and inclusion of these individuals (WHO, 2021). Despite this, the number of countries that reported adopting a recovery approach to mental healthcare and the inclusion of vulnerable groups in the decision-making processes of policies decreased slightly from 2017 (WHO, 2021).

Although each of the policies in this study demonstrated moderate to high levels of commitment to Core Concepts of human rights and inclusion of Vulnerable Groups, there is a need for revision of all policies to address the low scores received for Core Concept Quality. There is an urgent need for updated Indian and South African National Mental Health policies due to the date of their development. As these policies were created in 2014 and 2013, respectively, they cannot fully support the SDGs, which were adopted by India and South Africa in 2015. It is evident that each of the policies analysed in this study requires urgent revision with regard to the development of monitoring mechanisms and specific policy actions addressing Core Concepts of human rights. *EquiFrame* offers a valuable tool for evaluating Core Concepts of human rights and inclusion of Vulnerable Groups in national policies, which are considered key in successfully realising the SDGs.

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Appendix 1: Table of Core Concepts and Definitions

No	Core concept	Key question	Key language
1.	**Non-discrimination**	Does the policy support the rights of vulnerable groups with equal opportunity in receiving health care?	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics (i.e., Living away from services; Persons with disabilities; Ethnic minority or Aged).
2.	**Individualised Services**	Does the policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Vulnerable groups receive appropriate, effective, and understandable services.
3	**Entitlement**	Does the policy indicate how vulnerable groups may qualify for specific benefits relevant to them?	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grant.
4	**Capability- based Services**	Does the policy recognise the capabilities existing within vulnerable groups?	For instance, peer to peer support among women- headed households or shared cultural values among ethnic minorities.
5.	**Participation**	Does the policy support the right of vulnerable groups to participate in the decisions that affect their lives and enhance their empowerment?	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.
6.	**Coordination of Services**	Does the policy support assistance of vulnerable groups in accessing services from within a single provider system (inter-agency) or more than one provider system (intra-agency) or more than one sector (inter-sectoral)?	Vulnerable groups know how services should interact where inter-agency, intra-agency, and inter-sectoral collaboration is required.
7.	**Protection from Harm**	Are vulnerable groups protected from harm during their interaction with health and related systems?	Vulnerable groups are protected from harm during their interaction with health and related systems.
8	**Liberty**	Does the policy support the right of vulnerable groups to be free from unwarranted physical or other confinement?	Vulnerable groups are protected from unwarranted physical or other confinement while in the custody of the service system/provider.
9.	**Autonomy**	Does the policy support the right of vulnerable groups to consent, refuse to consent, withdraw consent, or otherwise control or exercise choice or control over what happens to him or her?	Vulnerable groups can express "independence" or "self-determination". For instance, a person with an intellectual disability will have recourse to an independent third party regarding issues of consent and choice.
10.	**Privacy**	Does the policy address the need for information regarding vulnerable groups to be kept private and confidential?	Information regarding vulnerable groups need not be shared among others.

No	Core concept	Key question	Key language
11.	**Integration**	Does the policy promote the use of mainstream services by vulnerable groups?	Vulnerable groups are not barred from participation in services that are provided for general population.
12.	**Contribution**	Does the policy recognise that vulnerable groups can be productive contributors to society?	Vulnerable groups make a meaningful contribution to society.
13.	**Family Resource**	Does the policy recognise the value of the family members of vulnerable groups in addressing health needs?	The policy recognises the value of family members of vulnerable groups as a resource for addressing health needs.
14.	**Family Support**	Does the policy recognise individual members of vulnerable groups may have an impact on the family members requiring additional support from health services?	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support.
15.	**Cultural Responsiveness**	Does the policy ensure that services respond to the beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic, or linguistic, aspects of the person?	i) Vulnerable groups are consulted on the acceptability of the service provided. ii) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, i.e., respectful of the culture of vulnerable groups.
16.	**Accountability**	Does the policy specify to whom, and for what, services providers are accountable?	Vulnerable groups have access to internal and independent professional evaluation or procedural safeguard.
17.	**Prevention**	Does the policy support vulnerable groups in seeking primary, secondary, and tertiary prevention of health conditions?	
18.	**Capacity Building**	Does the policy support the capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups?	
19.	**Access**	Does the policy support vulnerable groups- physical, economic, and information access to health services?	Vulnerable groups have accessible health facilities (i.e., transportation; physical structure of the facilities; affordability and understandable information in appropriate format).
20.	**Quality**	Does the policy support quality services to vulnerable groups through highlighting the need for evidence-based and professionally skilled practice?	Vulnerable groups are assured of the quality of the clinically appropriate services.
21.	**Efficiency**	Does the policy support efficiency by providing a structured way of matching health system resources with service demands in addressing health needs of vulnerable groups?	

Appendix 2: Table of Vulnerable Groups and Definitions

No.	Vulnerable Group	Attributes or Definitions	Supporting Literature
1.	**Limited Resources**	Referring to poor people or people living in poverty	See Annex XXII
2.	**Increased Relative Risk For Morbidity**	Referring to people with one of the top 10 illnesses, identified by WHO, as occurring within the relevant country.	See Annex XXIII
3.	**Mother Child Mortality**	Referring to factors affecting maternal and child health (0-5 years).	See Annex XXIV
4.	**Women Headed Household**	Referring to households headed by a woman	See Annex XXV
5.	**Children (with special needs)**	Referring to children marginalized by special contexts, such as orphans or street children	See Annex XXVI
6.	**Aged**	Referring to older age	See Annex XXVII
7.	**Youth**	Referring to, younger age without identifying gender	See Annex XXVIII
8.	**Ethnic Minorities**	Referring to non-majority groups in terms of culture, race or ethnic identity	See Annex XXIX
9.	**Displaced Populations**	Referring to people who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence	See Annex XXX
10.	**Living Away from Services**	Referring to people living far from health services, either in time or distance	See Annex XXXI
11.	**Suffering from Chronic Illness**	Referring to people who have an illness which requires continuing need for care	See Annex XXXII
12.	**Disabled**	Referring to people with disabilities, including physical, sensory, intellectual or mental health conditions, and including synonyms of disability	See Annex XXXIII