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Scottish Mental Health Policy: Context and Analysis

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Orientation 1

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1. Scotland: the nation and the state

We begin by providing a brief introduction to the dimensions and characteristics of the Scottish nation and government with specific regard to mental health.

1.1 Scotland's health

1.1.1 Demographics

Scotland is a country of around 5.1 million inhabitants spread across 78,772 square kilometres. While much of the population live in urban centres such as greater Glasgow, which has a population of over 2.2 million, some also reside in the very remote areas of the Scottish highlands and islands.

1.1.2 The mental health of the Scottish population

Healthcare by the Scottish National Health Service (NHS) is provided free of charge to all UK residents and is funded through general taxation. Annually there are 27.4 million general practitioner consultations in Scotland, with an estimated 25% to 30% of these consultations involving depression, stress or anxiety (Scottish Executive, 2006a; Scottish Executive, 2006b). In Scotland mental health problems are markedly more prevalent than across the border in England and the mental health of the population has declined significantly since the 1970s. Suicide rates amongst young men in Scotland have increased four-fold since 1978 and it was estimated in 2003 that 30% - 40% of work absences were related to mental health problems (Smith, 2003).

1.2 The Scottish Government

Responsibility for administering the health system in Scotland, including mental health, is held by the Scottish Government. The Scottish Government is led by a First Minister who is elected by the Scottish Parliament and a cabinet who are appointed by the First Minister. The Government was first formed in 1999 as a result of a 1997 referendum in which 74% of the Scottish population voted for the devolution of certain powers from Westminster in England. Scotland is now a constituent country of the United Kingdom and as such Westminster retains central responsibility for areas such as foreign policy, employment and social security while Scotland is able to legislate on certain 'devolved' areas such as health, education, housing and law.

1.2.1 The Scottish health system

In Scotland responsibility for health is held by the Scottish Government Health Department, which is part of the Scottish Government (the administrative arm of the Scottish Parliament). The Health Department is responsible for coordinating the health system and oversees the operation of the NHS Scotland. Within the Health Department

the Mental Health Division is responsible for leading on policy, legislation and service delivery for mental health across the NHS. The Health Department is self-conscious in its rejection of a top-down approach to health service organisation and looks toward a decentralised model which focuses on partnerships between localised service providers. Most of the day to day responsibility for mental health is held by local NHS Health Boards and local authorities, the latter of which are elected local councils. The voluntary/non-government sector also plays an important role in the organisation of mental health services via the commissioning of their services by government bodies. All of these actors play an important part in the determination of mental health policy in Scotland. The different roles of these organisations and how they relate to each other will be discussed in further detail shortly.

2. Mental health policy in Scotland – The historical context

For the purposes of this report the history of Scottish mental health policy can be roughly divided in two – that which occurred prior to the re-establishment of the Scottish Parliament in 1999, and that which occurred after. In 1997 the newly elected British Blair-led Labour government allowed a referendum to take place over whether certain legislative competencies, until then held by the UK government at Westminster in London, should be devolved to a new Scottish Government. This referendum was passed and the new Scottish Parliament first convened in May 1999. Amongst the powers devolved to the new government was a responsibility for health, including mental health. Although we break our discussion into that which occurred before and after devolution, as we will note policy on mental health in Scotland did not dramatically shift at this time but rather a process that had been gradually developing over the previous decade took on a new emphasis under the new governing regime.

2.1 Pre-history: the situation prior to 1999

Until 1999 the responsibility for mental health service provision lay with Westminster and the history of mental health services until this time was thus a British-wide one. The history of British mental health policy can be charted back to the 16th century when the City of London was made responsible for Bethlem asylum which has been in constant use for the provision of mental health services from the 14th century. The reforms of the mental health system in Britain have followed a path typical of mental health services across most developed countries. The mega-asylums of the late 1800s very gradually gave way from the 1930s onwards toward a system of out-patient treatment with the total number of residents in mental institutions slowly falling from a peak in the 1950s. The 1980s saw a dramatic increase in deinstitutionalisation and a greater sophistication of community care options. The Mental Health (Scotland) Act 1984 and the Framework for Mental Health Services in Scotland guided the operation of the mental health sector in

the years immediately prior to devolution. Each of these is discussed in further detail below.

2.1.1 The Mental Health (Scotland) Act 1984

The Mental Health (Scotland) Act 1984 replaced an earlier 1960 Act of the same name (Darjee and Chrichton, 2003). It was a consolidating Act, which means that it just re-enacted the 1960 Act along with all of the amendments made since 1960. Thus until devolution there had been no systematic reform of mental health legislation in Scotland since 1960 (Scottish Executive, 2001).

2.1.2 Framework for Mental Health Services in Scotland

The Framework for Mental Health Services in Scotland was published by the Scottish Office of the Westminster Government in 1997 in reaction to a criticism made by the Scottish Grand Committee[1] in 1995 over a "lack of formal policy objectives for mental health" in Scotland (Loudon and Coia, 2002). Interestingly, given this aim, the report stated that its purpose was not to introduce any new policy directives, but rather it sought to consolidate and re-articulate the policy already in existence and underpin the operation of this policy via a set of principles and 'priorities for action' (Scottish Office, 1997). These priorities for action were listed as being: cost-effectiveness, clinical-effectiveness, and the development of a 'yard-stick' against which progress and outcomes can be measured (Scottish Office, 1997). The document was developed after a wide consultation process which included the participation of service users and carers (Loudon and Coia, 2002). Amongst the mechanisms established to support the introduction of the Framework were the Mental Health Development Fund, which provided funding to support local Health Boards in the development of community focused mental health services, the Scottish Development Centre for Mental Health, which was devised in order "to provide development assistance, advice and support to agencies in the field", and the Mental Health Reference Group which was developed to oversee the development and implementation of the Framework.

2.1.3 A process of gradual change

During the late 1980s the gradual process of closing down large mental health facilities was gathering apace across England. Several of the experiences with deinstitutionalisation in England became 'beacons' of good practice and these examples were taken up by a group of individual psychiatrists, nurses and administrators working

[1] The Scottish Grand Committee is a committee of the Westminster Parliament which comprises of all of the Scottish based MPs who met regularly prior to devolution to debate legislation directly affecting Scotland. It has met only rarely since devolution.

in Glasgow as a way to move forward on reforming mental health services in Scotland. In the mid 1990s two conferences Slow Train Coming and Slow Train Still Waiting were held in Glasgow in order to press for action on mental health reform. Other seminars occurred in Edinburgh in the mid 1990s alongside the development of a more vocal patients movement. During this time in England many of the mental health reform processes were being led by a team based at King's College in London. The King's College approach was adopted in Scotland in the mid 1990s and was led by workers from King's. These King's workers then became involved in the development of the Scottish Development Centre for Mental Health (SDC) and have stayed involved in the process to this date. Throughout the process of reforming the mental health system in Scotland an open consultative process had developed, typified by the slogan "nothing about us without us" which points to the all embracing nature of discussions for mental health reform. This was the context in which devolution took place and was the foundation upon which the work of the Millan committee and later the National Programme for Mental Health and Well-being developed.

2.2 Contemporary history: 1999 onwards

In Scotland, mental health has become one of the signal fields of post-devolution policy making. Steps were taken immediately after devolution in order to ensure movement and change on mental health in Scotland. The major policy initiatives and legislative reforms since 1999 have been the report of the Millan Committee in 2001, the Mental Health (Care and Treatment) (Scotland) Act 2003, Scotland's National Programme for Improving Mental Health and Well-being, launched in 2001, and the document Delivering for Mental Health, published in 2006. Each of these are discussed briefly below.

2.2.1 The Report of the Millan Committee, 2001

The Millan Committee was actually convened by the Scottish Office just prior to devolution but most of its work was carried out after devolution (Darjee, 2003). The role of the Committee was to review the Mental Health (Scotland) Act 1984 and it reported its findings in the 2001 document New Directions: Report of the Review of the Mental Health (Scotland) Act 1984. The report recommended changes to the definition of 'mental disorder', procedures for detention and discharge, community care and the role of the Mental Welfare Commission in Scotland. The consultation process involved in the developing the Millan Committee's report was very extensive and continued the consultative processes that had come to typify mental health reform in Scotland over the past decade.

2.2.2 National Programme for Improving Mental Health and Wellbeing, 2001 -

Scotland's National Programme for Improving Mental Health and Well-being was launched in 2001 by the Scottish Executive Health Department and represents a population based approach to mental health policy in Scotland. It is based around four key aims: '1) raising awareness and promoting mental health and well-being; 2) eliminating stigma and discrimination around mental ill-health; 3) preventing suicide and supporting people bereaved by suicide; and, 4) promoting and supporting recovery from mental health problems' (Scottish Executive, 2007). It prioritises the following: "Improving infant mental health (the early years); improving the mental health of children and young people; improving mental health and well-being in employment and working life; improving mental health and well-being in later life; improving community mental health and well-being; and, improving the ability of public services to act in support of the promotion of mental health and the prevention of mental illness."

2.2.3 Mental Health (Care and Treatment) (Scotland) Act 2003

The development of this act was as a direct response to the findings of a major review of mental health in Scotland by the Millan Committee. The Act defines the roles and responsibilities of all those involved in the care and treatment of those with a mental health problem and is underpinned by ten principles:

- equality,
- non-discrimination,
- respect for diversity,
- reciprocity (safe and appropriate services for those in care and after discharge),
- informal care (compulsory powers as last resort),
- participation,
- respect for carers,
- least restrictive alternative,
- child welfare, and;
- benefit.

The *Act* identifies roles and organisations and explains their responsibilities in relation to service users, carers and other service providers. Other acts with peripheral responsibility for mental health in Scotland are the Adults with Incapacity (Scotland) Act 2000 which is designed to uphold the rights and welfare of those who are unable to make decisions on their own behalf.

2.2.4 Delivering for Mental Health, 2006

The document Delivering for Mental Health was published in December 2006 by the Scottish Government and was influenced by both the Framework for Mental Health Services and the more general Delivering for Health published in 2005. Delivering for Mental Health specifies actions that need to delivered in order to improve the mental health of the Scottish population. A significant aspect of Delivering for Mental Health is its emphasis on targets which can be monitored and reported on, unlike the earlier Framework for Mental Health Services document. This is a significant document which works toward a complete change of culture and behaviours for those managing and working within mental health services. A national improvement programme starting in April 2007 has been implemented in order to bring about delivery of the targets identified in the delivery plan.

3. The mental health sector in Scotland

Here we describe the organisational landscape of the mental health sector in Scotland. Further discussion of the dynamics of the knowledge relationships between organisations will be analysed in sections 4 and 5 of the report.

3.1 The National Government level

Within the Scottish Government the Health Department overseas policy and planning for health, including mental health.

3.1.1 Scottish Government: Mental Health Division

Within the mental health division of the Health Directorate there are five main areas of work:

- The National Programme for Improving Mental Health and Well-being – The work of this section of the health department is aimed at improving the mental health of the Scottish population as a whole. It works toward this goal through promoting strategies which promote positive mental health, raise awareness of mental health well-being, reduce stigma around mental illness, prevent suicide and promote recovery.

- Mental health law reform – Within this section of the mental health division researchers work on monitoring the effectiveness of the *Act* and whether all stakeholders are happy with the way it works in practice. It also acts as a policy resource for the development of other areas of government policy which touch on mental health law and in the development of future mental health law. A Mental Health Legislation Reference Group made up of representatives of all areas concerned with mental health law, including service users has met regularly

throughout the development of the law and continues to meet in order to gauge the effectiveness of the law in its day to day usage.

- Mental health delivery and services - This section works with NHS Health Boards, local authorities, the non-government sector, the Scottish Government, service users and carers in order to devise appropriate policies for mental health service delivery in Scotland. They have a specific focus on working towards the delivery of targets identified in Delivering for Mental Health and have put in place a structured performance management process and an implementation board in order to progress this.

- Policy on restricted patients – Restricted patients are those who have committed an offence which results in imprisonment but because of a mental illness are detained in hospital where they are treated and rehabilitated. There is no limit on the time they are able to be held. The Mental Health Tribunal (see below) has responsibility for discharging these patients.

- Information on section 25-31 – Section 25-31 refers to a particular section of the *Act* which details how local authorities should support those who have or have had a mental illness. This section of the Health Department provides information and advice on how local authorities can best support this sector of the population in order to promote recovery and social inclusion. An advisory group has been brought together consisting of service users, social workers, local authority managers and non-government sector representatives which meets regularly in order to advise on how this section of the act can be best put into practice.

3.1.2 Other Government bodies

Both the Mental Health Tribunal and the Mental Welfare Commission for Scotland hold competencies delegated under the 2003 Mental Health Act.

The **Mental Health Tribunal** is an 'executive agency' of the Scottish Government which makes decisions on the compulsory care and treatment of people with mental health problems. It consists of a President and 300 member tribunal panel, all of whom are publicly appointed. Tribunals are made up of three members of the tribunal panel – one legal, one medical and one general member – and are held across Scotland. There is a service user/carers' organisation reference group and professionals reference group attached to the tribunal which give feedback on the operations of the tribunal.

The **Mental Welfare Commission for Scotland** reports directly to the Scottish Ministers. Its role is to visit service users and services in order to assure that treatment is relevant, monitor the system, gather statistics, provide information and influence policy development. It also advises local authorities and Health Boards. While it may be considered in some ways to be an arm of the Scottish Government it maintains a high

degree of independence and is able to comment freely on failures in the delivery of mental health services.

3.2 The Local Level

In Scotland the provision of mental health services is carried out by **local authorities** and **NHS Health Boards** who are delegated this responsibility through the Mental Health Care and Treatment (Scotland) (2003) Act. The devolution of power to these community based, lower levels of governance reflects an emphasis on community care and the aim to move away from the delivery of services at large centrally based hospitals to smaller localised medical centres. Health Boards and local authorities are given a set amount of funding for health services by the Scottish Government (currently around £10 billion annually) which can generally be used how they see fit, although specially allocated funding can also be given for specific projects. This means that to a certain extent they can be entrepreneurial (within the bounds of the act) and engage in a degree of policy innovation. It also means that the extent of mental health services can vary from area to area. For example the per capita mental health service expenditure figures for 2004/05 across the 14 Scottish health board range from £108 in Fife to £169 in Tayside (Scottish Parliament, 2007).

3.2.1 Health Boards

14 **Health Boards** across Scotland focus on health improvement, public health, health care delivery and reducing health inequality in their local area. In order to do this they create Local Health Plans which aim to ensure a coordinated approach to health services provision amongst the partners delivering health within their jurisdiction. With regard to mental health, Health Boards appoint and maintain lists of 'approved medical practitioners' who are able to treat and diagnose mental health problems. They also provide specialised mental health services to young people and those with post-natal or perinatal related mental ill-health. The *Act* emphasises that both local authorities and Health Boards must assure independent advocacy for anyone with a mental illness. Each Health Board has its own Chief, executive and board which direct their actions, and thus have a certain degree of independence in their activities.

3.2.2 Local Authorities

Working alongside Health Boards are 32 **local authorities** who provide a broad range of mental health services within the community. This is summed up in the *Act* as "…a duty to provide or secure provision of care and support services for persons who have or who have had a mental disorder…" (NHS Education Scotland, 2007). They are also expected to provide preventative services, and are charged with the recruitment and training of Mental Health Officers, who are social workers with specific mental health and legal expertise, and who work separately from the health system. Mental Health Officers are

involved in the assessment of those who appear to need hospital treatment for a mental illness and work to ensure that the most appropriate form of treatment is provided.

3.2.3 Community Health Partnerships

Community Health Partnerships (CHPs) work to cement partnerships for healthcare provision by bringing together local authorities and Health Boards and ensuring the participation of patients and health professionals in all aspects of health service design. They have an important role in redesigning local services and influencing resource deployment. Through the local authorities, Health Boards and Community Health Partnerships the Scottish Government devolves power downwards. At this local level specific mental health partnerships also bring together those actors involved in the provision of all levels of mental health services.

3.3 The non-government sector

There are a large number of diverse organisations from the non-government sector active in advising on and providing mental health services**.** These organisations are an important part of mental health service delivery and act as contractors who are commissioned by local authorities in order to provide a broad range of services. They also act as vehicles for promoting the voices of service users and in influencing policy development. Examples of work that non-government actors do can be seen from the following organisations:

- The **Scottish Association for Mental Health** (SAMH) are a mental health charity which provide accommodation support, training, recovery services, employment and rehabilitation to service users and their carers and act as a lobby group.
- The **Scottish Development Centre for Mental Health** (SDC) provides services in the areas of research, development and planning for services and policy, the delivery of training and development programmes and the hosting of events.
- **Voices of Experience** (VOX) is a national service user organisation which represents the views of mental health service users. The idea for VOX came from amongst service users who wanted a national voice to represent their interests. They are funded by the Scottish Government and VOX was officially launched in December 2006. VOX is often called upon to present a service users' perspective on government committees.
- The **Highland Users Group** (HUG) advocates for users of mental health services across the highlands region of Scotland. They have a focus on encouraging service user involvement and influence over how mental health services are operated.

- The UK wide **Mental Health Foundation** is also a significant presence within the mental health system in Scotland. They bring mental health research, service delivery, advocacy and lobbying together in one organisation.
- The Scottish division of the **Royal College of Psychiatrists** is also an important player within the Scottish mental health system. The College regulates the professional practice and education of psychiatrists in Scotland. It is a strong voice in policy development and provides policy submissions and commentary on all aspects of mental health policy in Scotland.
- The **Scottish Recovery Network** (SRN) was set up by the Scottish Government's National Programme for Improving Mental Health and Well-being in late 2004 as a 'vehicle for learning and sharing ideas around recovery'. It is funded by the Scottish Government.
- The **Forensic Mental Health Services Managed Care Network (Forensic Network)** was set up by the Scottish Government in 2003. It brings together as members all those involved in any work that touches on the intersect between the criminal justice system and mental health system in Scotland - there is no opt out for membership.

4. Inter-organisational relationships in the mental health sector in Scotland

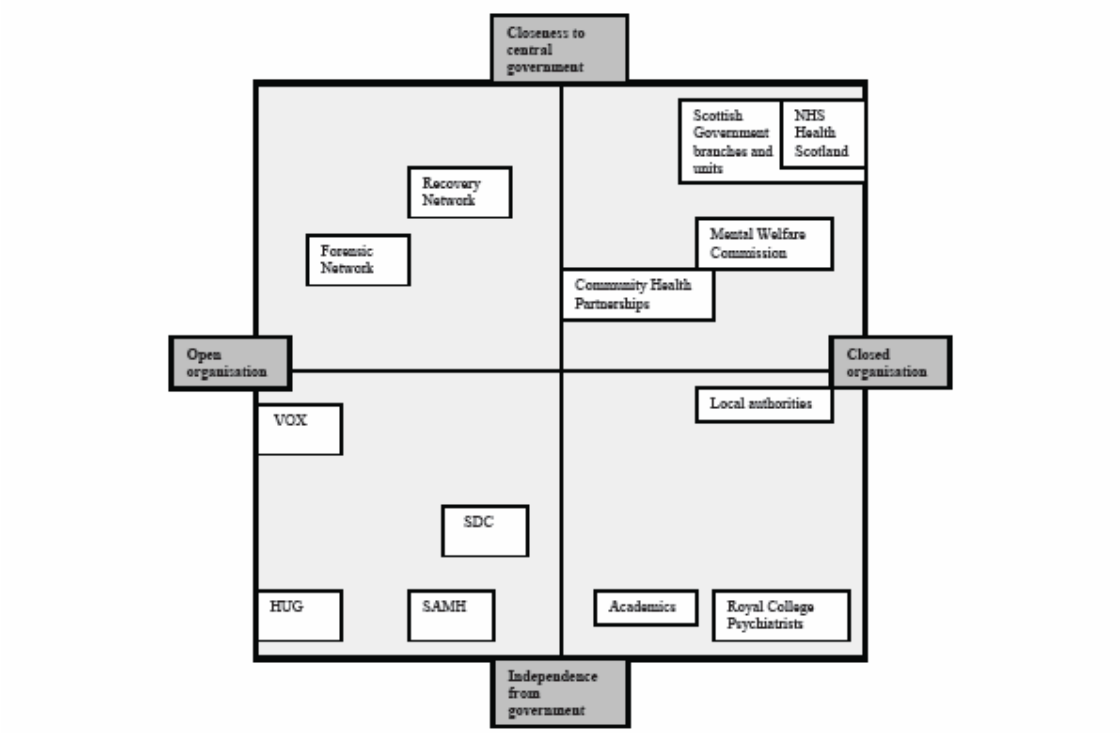
In this section of the report we comment on the multi-dimensional relationships that exist between the actors in the mental health sector in Scotland. We base this commentary on interviews that we conducted with representatives from 16 organisations across the mental health sector in Scotland (See Appendix A for a list of those organisations that we spoke to).

4.1 Organisation types and relationship to central government

The organisations that we chose to focus on for our interviews can be roughly broken down into three categories: government, not for profit organisations and networks. However, it became clear in the course of our studies that the boundaries between these three categories are not clear-cut, and that organisations tend to straddle these boundaries. In fact, it makes more sense to think about these organisations, not in terms of discrete categories, but as located in different positions on a continuum. As a first approximation, we can characterise this continuum as a two-dimensional field (see diagram 1). The (vertical) y-axis of this field represents how close an organisation is to central government; the further down the field, the more remote or independent the organisation from central government. The (horizontal) x-axis represents the extent to which the organisation functions as a network; organisations to the left of the field are

highly networked, with relatively open and/or self-selected membership, while those to the right of the field are more bounded and circumscribed in terms of their membership and admission procedures. The organisations we selected for interview can be located on this field as follows:

Diagram 1. Organisations by openness and proximity to central government.



We are thus looking at a diverse variety of organisations within the field of mental health policy, located more or less close to central government, and with a greater or lesser commitment to networking activities, as well as a variety of remits and functions within the mental health policy community as a whole. We interviewed two respondents from organisations whose main focus is on service user representation, five from predominantly service focussed organisations, three from organisations primarily focussed on knowledge sharing through networks, two focussed on population health, and two actors focussed on research. While many of the organisations that we focussed on in these interviews have a main focus such as service delivery or training, in most cases this is not a 'pure focus' as most would carry out a variety of roles. For example while SAMH, in terms of its staff numbers and budget turnover, might be viewed as a

service provision organisation, it also has lobbying and policy development as a key focus, and makes a significant impact in this area. All organisations that we interviewed carry out or are involved in research of one form or another.

Our sample is somewhat representative of the field as a whole in that it includes, in much the same measure as exists in the sector as a whole, organisations, units and networks that come from central government, government agencies operating at both a national and a regional level and the non-government sector. The one area which we do not represent is diagnosis specific organisations, which have a role the sector but we have not interviewed.

4.2 Organisational relationships

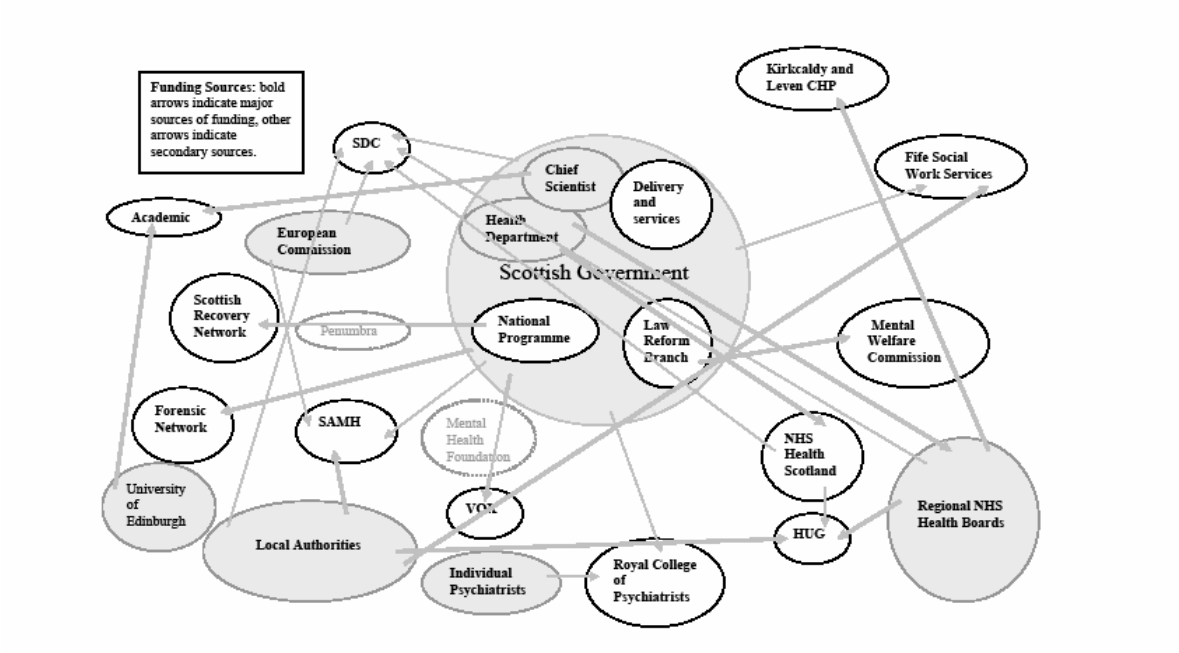
On investigating the activities of these organisations it became abundantly clear that the field as a whole was characterised, not just by organisational diversity, but by a high degree of linkage and interaction between different organisations. The field of mental health policy is itself organised as a network, sustained and articulated by a dense matrix of formal and informal linkages. All organisations that we interviewed were formally linked with many other organisations within the mental health sector in Scotland. These relationships are led by flows of money and information.

4.3 Funding

Much of the organisational activity within the mental health field in Scotland is fuelled by Scottish Government funding. Diagram 2, below, demonstrates the way funding flows through the sector.

As can be seen in this diagram, the Scottish Government funds fully the day to day work of the Scottish Recovery Network, the Mental Welfare Commission, VOX, NHS Health Scotland, the Kirkcaldy and Leven CHP and the Forensic Network. It partly funds the work of the Scottish Association for Mental Health, Fife Social Work Services and HUG. It regularly commissions most of the research work done by the academic researcher and SDC. The only organisation that we interviewed that is not funded to any great extent by the Scottish Government is the Royal College of Psychiatrists. The Scottish Recovery Network and VOX are funded through 'parent' organisations (Penumbra and the Mental Health Foundation) which administer their Scottish Government funding for them.

Diagram 2: Funding flows within the mental health sector in Scotland.



4.4 Information relationships

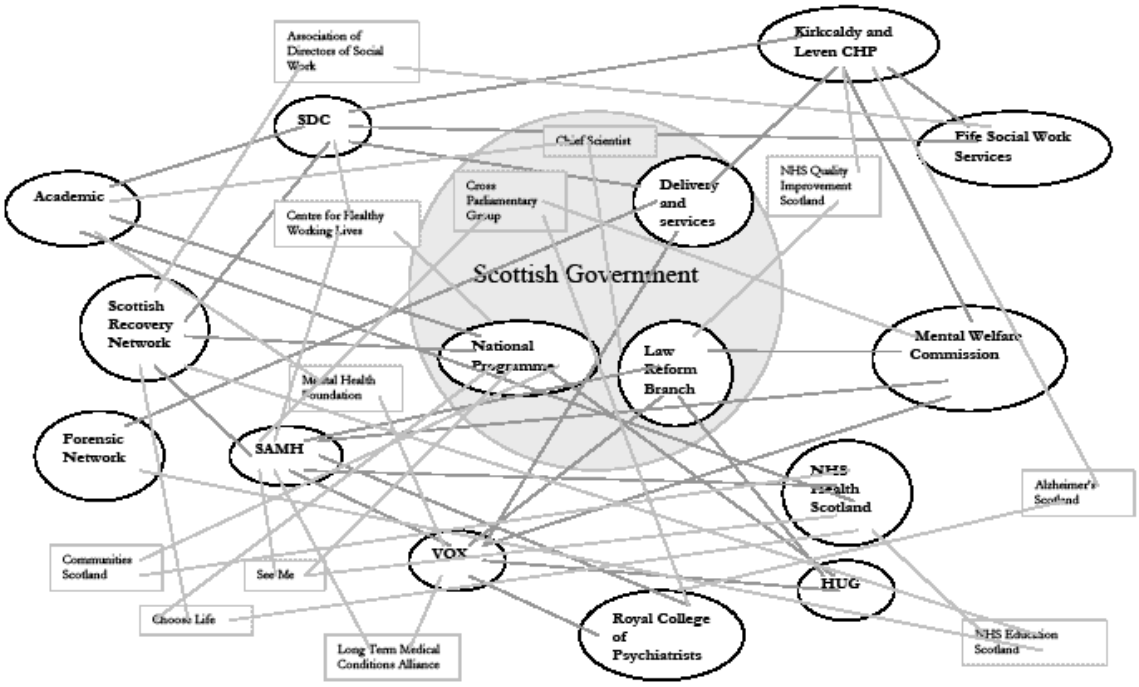
In this section we discuss the network of inter-organisational linkages which constitutes the mental health policy community in Scotland. We also highlight the international linkages that are maintained and through which international mental health knowledge becomes known.

4.4.1 National links

The mental health policy community in Scotland comes into being through relationships between actors. These relationships are forged through a variety of formal and informal means. In our interviews we asked respondents what formal and informal links they have with others within the mental health community in Scotland. Respondents identified a multiplicity of linkages through avenues such as committee memberships, project collaboration and commissioner/provider relationships. Linkages were also made through events such as meetings, training, seminars and conferences. All interview respondents also emphasised the significant informal relationships they have with other organisations within the mental health sector in Scotland. In diagram 3, below, we have visually represented the linkages between the organisations that we interviewed and other Scottish based organisations identified by the respondents. The organisations that we interviewed are highlighted in bold. We have only included organisations that were

mentioned in the interviews more than once as to include all of the organisations mentioned would have been visually confusing.

Diagram 3: Inter-organisational linkages



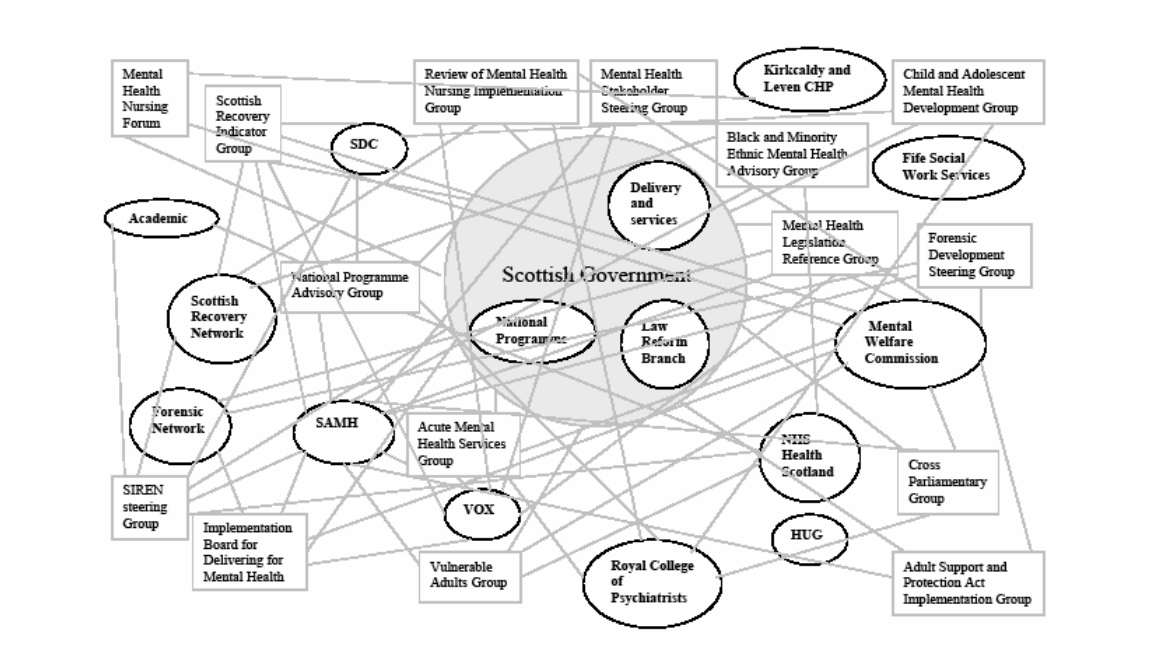
The significance of these linkages cannot be understated, because through these links the system is created and a shared understanding of the collective policy making community is developed. This serves to both strengthen the policy community and strengthen the policy direction adopted.

Committees and groups

It became very clear in our interviews that groups and committees act as important sites for shared participation in policy making through which the policy community is built. The interviews revealed a complex web of committees and groups which facilitate knowledge flow and relationships within the mental health sector in Scotland.

Diagram 4, below, illustrates the groups that respondents are involved in, and the connections that are formed with other actors through their membership of these groups. This is a complex diagram and is not meant to be read as such, but to illustrate the highly complex nature of interactions and relationships that come into being through these groups.

Diagram 4: Complex of committees through which mental health policy making occurs



We can make several basic comments about the shape of the mental health sector in Scotland as it relates to group membership based on this diagram. The actors most frequently active within these groups are the Scottish Government, VOX, the Mental Welfare Commission, the Royal College of Psychiatrists and SAMH. These groups represent the administrators, the service users, the quality controllers, the medical experts and the service providers within the sector. The Scottish Government sits on all groups. Those organisations on the periphery and not part of any group are regional rather than national organisations. The diagram demonstrates that the main committees, in terms of frequency of membership, are the Implementation Board for Delivering for Mental Health, the National Programme Advisory Group and the Mental Health Legislation Reference Group, and the SIREN steering group. The first three of these groups advise on the work of the three main Mental Health Branches of the Scottish Government.

The significance of these groups for the development of policy around mental health in Scotland will be discussed in detail in section 6.1.1 of the interpretative synthesis below.

4.4.2 International links

Meanwhile, all organisations that we investigated apart from the Kirkcaldy and Leven CHP utilised links to international organisations, networks, or knowledge in their work. The most frequently cited international link was with the International Initiative for

Mental Health Leadership (IIMHL) whose involvement was specifically cited by nine of those interviewed. Other significant inter-country links were with researchers working in recovery and peer support in the USA, and with service user, research and service delivery organisations in New Zealand, Australia and Canada. Several respondents also cited the use of knowledge produced by the EU and WHO.

5. Knowledge

In this section we look at which forms of knowledge come into the mental health policy community in Scotland, what forms of knowledge are created by the policy community, and what knowledge is viewed as determining the operation of the sector.

5.1 Policy documents

The interview respondents named several prominent policy documents as being the official overarching priorities guiding the mental health sector as a whole in Scotland. Most of these documents were put together by the Scottish Government. Eleven identified Delivering for Mental Health, which outlines specific actions and targets that need to delivered in order to improve the mental health of the Scottish population. Four identified Delivering for Health (the Kerr Report), which has the same focus as Delivering for Mental Health, but is applied to the operation of the health system as a whole. Five identified the *Mental Health (Care and Treatment) (Scotland) Act 2003*, which guides through law the priorities, rights and responsibilities of all those who either have a mental illness or are involved in the care of the mentally ill. Six identified the population health based approach articulated within the National Programme for Improving Mental Health and Well-being. Another document identified by two respondents was Rights Relationships and Recovery: the National Review of Mental Health Nursing in Scotland, which is viewed as having changed the culture of mental health nursing, and through this the operation of the whole system. Other documents mentioned as guiding the work of individual organisations and actors were the *Adults with Incapacity (Scotland) Act 2000* (which is designed to uphold the rights and welfare of those who are unable to make decisions on their own behalf), NHS Health Department Letter (HDL) (2006) 48 (which guides the development and operation of forensic mental health services), the Framework for Mental Health (put together by the Scottish office prior to devolution and which outlines the principles which should underpin the delivery of mental health services in Scotland, with an emphasis on joint planning for mental health), the HEAT targets (which guide the operation of the NHS), and the mental health priorities published by the Chief Scientist's Office within the Scottish Government.

Very few respondents criticised the Scottish Government priorities reflected in these documents and those criticisms that were mentioned were focused more on operational issues in relation to these documents rather than the overarching policy priorities

expressed. Based on these interviews it seems that what we might call a progressive consensus is a distinctive characteristic of the Scottish mental health policy community. We will continue to test if this is a correct assumption to have made about the system and if so, why this is the case when similar systems, such as that in place in England, are currently marked by difficulties with consensus forming, which impedes policy and legislative development.

5.2 Research Priorities

Research priorities were outlined as being dependent on several factors, the main ones being the wishes of the organisation's funders or commissioners, government policy, network members' priorities, legislation, or the actions of the CEO or governing board. Within the Scottish Government, the Law Reform branch conducts research which assists in the implementation of the Mental Health Act and its regulation, while the National Programme focuses on policy development, project creation and support and evaluation in the area of population mental health. The research priorities of the Mental Health Delivery and Services unit are directed by the policy document Delivering for Mental Health and are aimed at supporting the mental health sector in the implementation of the targets in this document.

The two service user organisations HUG and VOX prioritise research which enhances service user involvement, lobbying and anti-stigma campaigning. Service user involvement and work on recovery is also a research priority for the Scottish Recovery Network and SAMH. In addition to this SAMH prioritises work on equality, diversity and mindfulness based interventions. The work of the SDC and the individual academic researcher is largely directed by the commissions that they receive. The research priorities of Fife Social Work Services are around training for service delivery, the Royal College of Psychiatrists focuses on lobbying and member education, and the Mental Welfare Commission states that its research priority is work that informs best practice in mental health care in Scotland. For NHS Health Scotland, the Forensic Network and the Kirkcaldy and Leven CHP their main research priority is to do work which helps services to meet the expectations of what the Scottish Government ministers require of them as defined through policy documents and other directives.

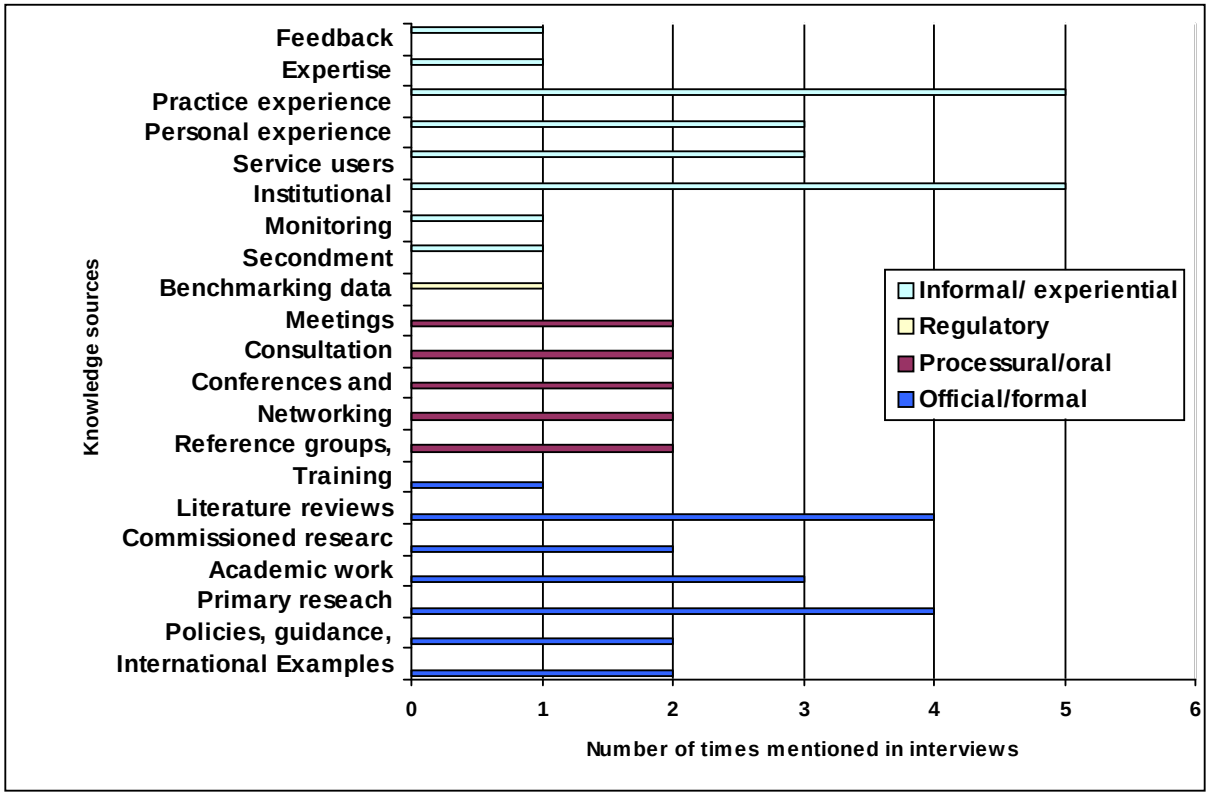
5.3 Knowledge inputs

Knowledge enters the mental health policy community via a multitude of entry points. In our interviews we asked questions which directly considered how respondents gathered the knowledge that they use. We did not define the term 'knowledge' for our respondents. We asked them about their own personal background in order to consider how the personal experiences of those individuals that comprise the mental health policy community contribute to how knowledge is shaped and used by the community.

5.3.1 Knowledge sources

Table 1, below, illustrates the different knowledge sources that respondents explicitly identified that they drew from in their work. We have roughly broken this down into four different knowledge types. These are:

Table 1: Knowledge sources by frequency and knowledge type[2]



- **official/formal**: Within this category we place knowledge sources that are from official sources or are formalised in some way. The format of these sources is often bound by codes which dictate how they are devised and what sorts of data they contain.

- **processural/oral**: In this category we include all sources where knowledge is transmitted orally through meetings, consultation, reference groups and so forth.

[2] See Appendix B for a presentation of this data that includes an indicator of which organisations referred to which knowledge sources.

Knowledge here is created and transformed through the process of meeting and talking.

- **regulatory**: In this category we include knowledge that comes from regulatory tools such as benchmarking, targets and so forth.
- **informal/experiential**: Here we include knowledge that could be described as tacit, informal or experiential. It is knowledge that does not come from a codified or formalised source and cannot be tested for objective validity.

This table portrays a policy community where the dominant source of knowledge input into the community is evenly split between formal or official knowledge, and informal and experiential knowledge. The other main form of knowledge input is that created and transformed through face to face meetings, conferences and consultation events. The collection of data via tools such as benchmarking does not seem to be an important source of knowledge.

5.3.2 Experience

Those working across the mental health sector in Scotland bring with them knowledge from personal experience, through training and education, and practical experience gained through their careers. This experience determines which types of knowledge they value and how they manage information.

The interviews revealed that those working in the Scottish Government have come into their roles from a wide variety of backgrounds. Many have been career civil servants while others have worked within academia, service delivery, communications and marketing. There is also a programme of secondment in operation in the Government where practitioners such as psychiatrists, social workers and teachers are seconded into the Government when their expertise is needed for the creation of a specific policy. Those currently working around mental health within NHS Health Scotland tend to have experience and qualifications in public health, health improvement and sociology. It was emphasised in the interview that staff could come into roles in NHS Health Scotland from a very wide variety of backgrounds and that there was no particular qualification that was the norm. Within local government those interviewed are all social workers with specific qualifications in mental health and those working with the Kirkcaldy and Leven CHP have previously worked in the local NHS health board. Commissioners working for the MWC are appointed through a public appointments process administered by the Scottish Government. Commissioners come from a range of backgrounds including psychiatry, psychology, social work, law and advocacy. Mental health and learning disability service users and carers are also represented.

The background of staff within the network organisations is very varied within and between organisations. For those working within VOX and HUG their experience as

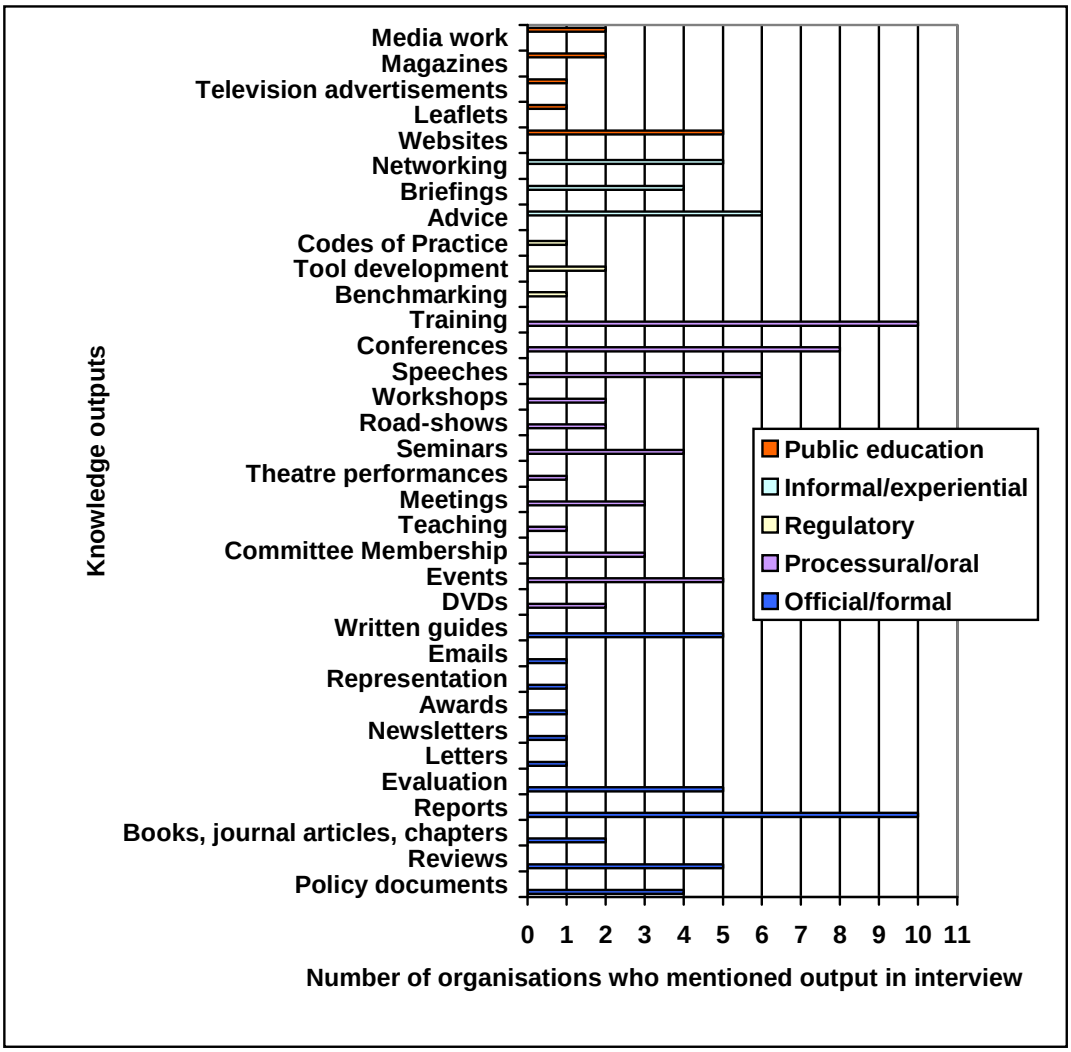
mental health services users was highlighted by respondents as the most significant experience that they bring to their positions. In the Forensic Network most of those employed are practitioners such as psychiatrists or nurses with a background in forensic mental health. Those employed by the Scottish branch of the Royal College of Psychiatrists come from an administrative background not related to mental health and the college members are all psychiatrists. Most of the staff working for SRN come from a social science background and within SAMH most staff within the head office have degrees in the social sciences. Within SDC all staff except those working in administration have degrees and many have a Masters or PhD. Most staff come from a social sciences background. The academic researcher has qualifications in social policy and sociology and has worked in mental health research for 30 years.

As this data shows, amongst the organisations that were the focus of our interviews, the dominant academic background of employees is social science and most staff have undergraduate qualifications.

5.4 Knowledge outputs

During the interviews respondents identified a very wide array of knowledge outputs produced by their organisation. These included reports, training, codes of practice, speeches and presentations, conferences and events, newsletters, networking, emails and websites, magazines, policy documents, benchmarking, DVDs, theatre performances, workshops, letters, leaflets, seminars, television ads, media work, reviews, committee membership, advice, evaluation, road-shows, tool development, peer reviewed journal articles, books, book chapters, teaching, briefings, written guides and meetings. Table 2, below, breaks down these knowledge outputs into types of knowledge produced and lists how many organisations stated that they a certain type of knowledge. As with table 1 we also break down the list according to knowledge types. In addition to those categories used in table 1 we have added an extra category of knowledge type – **public education**. In this category we include knowledge that is produced with the general public as its target audience.

Table 2: Categories of knowledge production by output and organisation[3]



As this table shows, while formalised knowledge presented through traditional formats, such as in the form of the policy report or written guides, are significant outputs, we also find that knowledge sharing events such as training and conferences are just as frequently mentioned. We will discuss the significance of this in section 6.2.1 of the 'interpretive synthesis' section of this report, below.

[3] See Appendix C for a presentation of this data that includes an indicator of which organisations referred to which knowledge sources.

6. Interpretive Synthesis

The first phase of the Know&Pol project has focused on understanding knowledge and policy through mapping both the social and cognitive dimensions of the policy communities that we have chosen to investigate. The interpretive synthesis section of our report acknowledges this focus and is broken down into two sections, the first of which focuses on relationships and the second on knowledge.

6.1 Relationships

The way in which knowledge is adopted, transformed and passed on in policy making is contingent on the nature of the policy community in which this process takes place. The policy community is formed through relationships made in specific locations and through specific types of interaction. In the diagrams above we have specified relationships that link those within the sector. The mental health system in Scotland is far more complex and sophisticated than can be represented in such a two-dimensional diagrammatic form. Policy making takes place in (at least) four dimensions; across space and territory, at different levels of organisation and government, and over time. However, despite this limitation the diagrams presented here do go some way toward demonstrating the features of the mental health policy making community in Scotland.

The first thing that can be noted is the centrality of the Scottish Government within the system. When examining the list of organisations, networks and groups that contribute to the mental health system in Scotland it looks to be on the surface a decentralised system with many actors. Diagram 2, however, which specifies the funding relationships between those that we interviewed, demonstrates a far more centralised system, heavily reliant on Scottish Government funding. The centralisation of the sector is not merely indicated by funding structures and is also evident in the high degree of consensus demonstrated in the interviews over policy priorities reflected in government documents such as *Delivering for Mental Health*. As discussed earlier, there was little conflict over legislation, the goals of the sector, or its administration and funding expressed in the interviews. This is surprising given that conflict of this nature plagues many other mental health systems, such as England which has seen disruptive and highly emotive debates about the mental health sector which have impeded progress in policy and legislative change. This sparks the question as to how such a consensus has been achieved within the Scottish system, and this question will be further explored in the next phase of our research.

6.1.1 Committees and groups

As demonstrated in the discussion of diagram 4 the network of committees and groups plays a significant part in the policy creation and the development of the policy

community in Scotland. Specifically the significance of these groups lies in the way that they:

1. form links between actors through which actors come to know and understand each other as part of the policy network. They thus come to 'own' the policy framework adopted because they feel part of the community.

2. act as forums for the collaborative development of policy. This collaboration validates the policy outcome through adding transparency to the process via the involvement of large numbers of disparate actors.

3. the collective engagement involved in group policy development implicates group members in the development of policy. Actors are more likely to support the policy position adopted if they feel that they have been involved in the creation of the policy.

Diagram 4 indicates that the world of agencies and institutions is in fact a world of networks and groups. Actors are relevant only to the extent that they maintain multiple relationships with others: it is this that gives the 'system' its systemic quality. By the same token, the capacity to act is predicated on 'knowing the system'. 'Knowing', 'system', and 'policy' become coterminous. The interviews demonstrated that one of the key ways that the system becomes known is through the complex web of groups which bring organisations and individuals together.

As discussed earlier the groups most frequently participated in by the interview respondents were related to the policy and legislative work of the Scottish Government. The presence of so many organisations on these Scottish Government advisory groups may in part explain why organisations are happy to support and go along with the work of the Government – because they are part of the process they feel more connected to the policies that they are being told to implement. As Freeman (2006) notes when discussing the collective development of policy documents: "the collective engagement entailed in creating such works [in this case a policy programme]– a process of suggestion, negotiation, and experiment – in effect creates the community, which is in turn required to produce them."

6.2 Knowledge

6.2.1 Communicative knowledge sharing events

The focus on communicative knowledge sharing events ('talking events') shown in both Table 1 and Table 2 demonstrates that within the policy making community in Scotland there is an emphasis on sharing and building knowledge through talking events. The respondents highlighted their involvement in networking, conferences, events, committee membership and meetings as significant forms of both knowledge input and output. This

points to a policy community where knowledge is created through meeting and talking via formal and informal networks.

The highlighting of these events also demonstrates an understanding of knowledge as processural and dynamic rather than as merely an object that is adopted in a final static form and once used and transformed is passed on in an equally static way.

We argue that talking events, either singular or as part of a series of such events, act as critical moments in the development of mental health policy in Scotland. They represent a critical juncture in the development of a policy for a number of reasons:

1. They serve as ways for building and visualising the policy community. This happens through the process of inviting participation from different sectors or through the self selection involved in open invitations. At these events participants are able to visualise the other actors and roles that are also implicated in the policy creation process. This creates a network between the actors involved and thus works toward the production of the policy community.

2. They bring together disparate actors that may otherwise be left out of a document focused process. This validates the policy development process because it provides an avenue for a larger number of voices to take part and thus 'own' the process through being implicated in the development of the policy.

3. They offer a chance for the policy development process to become 'transparent' and thus break down the sense of alienation that members of the policy community may feel from the policy creation process.

4. They strengthen the network of relationships upon which the policy community is built. These events offer a chance for those involved to talk to one another and thus entrench the bonds between the different actors and strengthen the network.

5. They allow for both tacit and formal knowledge to come together in one setting and inform the policy creation process.

We hypothesise that as a result of these effects the critical role of talking events facilitates a process where the development and implementation of the resulting policy is less contentious and more straightforward. The sense of collective purpose and legitimation of the policy process brought about by the critical 'talking event' is sustained into the consolidation and implementation periods of policy development through continued communication brought about by participation in reference groups, seminars and training.

7. Conclusions and further directions

This paper has brought together our preliminary analysis based on our interviews and documentary analysis for Orientation one. We will continue to build on these results as further analysis takes place and through the next stages of our research which will further our understanding of the role of knowledge in the development of mental health policy making in Scotland.

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Annexes

Appendix A

Interviews were conducted with individuals working within the following organisations:

Scottish Government - National Programme for Improving Mental Health and Well-being

Scottish Government - Mental Health Delivery and Services unit

Scottish Government - Mental Health Law Reform branch

Scottish Government – Population Health Branch

Forensic Mental Health Services Managed Care Network (Forensic Network)

Mental Health Team within Fife Local Authority Social Work Services

Academic researcher, University of Edinburgh.

NHS Health Scotland

Mental Welfare Commission (MWC)

Highland Users Group (HUG)

Scottish Development Centre for Mental Health (SDC)

Royal College of Psychiatrists (RPsych)

Scottish Recovery Network (SRN)

Voices of Experience (VOX)

Scottish Association for Mental Health (SAMH)

Kirkcaldy and Leven Community Health Partnership (Kirkaldy and Leven CHP)

Appendix B

Knowledge sources by organisation and knowledge type

Knowledge Source	*Organisations*	*Knowledge type*
International examples	I A	1
Policies, guidance, legislation	O M	1
Primary research	I H J O	1
Academic work	I C B	1
Commissioned research	P N	1
Literature reviews	H I J K	1
Training	M	1,2
Reference Groups, committees	A E	2
Networking	K B	2
Conferences and events	B G	2
Consultation	K B	2
Meetings	D G	2
Benchmarking data	C	3
Secondment	A	4
Monitoring	A	4
Institutional knowledge	H O N L F	4
Service users	N D G	4
Personal experience	I D G	4
Practice experience	C M B N L	4
Expertise	K	4
Feedback	A	4

Key to organisations:
A- Scottish Government - Mental Health Law Reform branch
B- Scottish Government - National Programme for Improving Mental Health and Well-being
C- Scottish Government - Mental Health Delivery and Services unit
D- Highland Users Group (HUG)
E- Royal College of Psychiatrists (RPsych)
F- NHS Health Scotland
G- Voices of Experience (VOX)
H- Scottish Development Centre for Mental Health (SDC)
I- Scottish Recovery Network (SRN)
J- Academic researcher, University of Edinburgh.
K- Forensic Mental Health Services Managed Care Network (Forensic Network)
L- Mental Welfare Commission (MWC)
M- Mental Health Team within Fife Local Authority Social Work Services
N- Scottish Association for Mental Health (SAMH)
O- Kirkcaldy and Leven Community Health Partnership (Kirkaldy and Leven CHP)
P- Scottish Government – Population Health Branch

Key to types of knowledge:
1 = official/formal
2 = processural/oral
3 = regulatory
4 = informal/experiential

Appendix C

Categories of knowledge production by output and organisation

Knowledge Output	*Organisations**	*Knowledge type*
Policy documents	C K O P	1
Reviews	D F G I K	1
Books, peer reviewed journal articles, chapters	J K	1
Reports	C E F H J K L N O P	1
Evaluation	B F H J P	1
Letters	L	1
Newsletters	A	1
Awards	F	1
Representation	G	1,4
Emails	I	1,4
Written guides	F K I M O	1,5
DVDs	D I	2
Events	B D F H K	2
Committee membership	E G N	2
Teaching	K	2
Meetings	D E N	2
Theatre performances	D	2
Seminars	C F M P	2
Road-shows	H L	2
Workshops	D H	2
Speeches	C E G I N P	2
Conferences	C D E G H I K N	2
Training	A B D E F H K L M N	2
Benchmarking	C	3
Tool development	F I	3
Codes of practice	A	3
Advice	E G K L M N	4
Briefings	H L N P	4
Networking	B H I K L	4
Websites	B I K N P	5
Leaflets	F	5
Television advertisements	F	5
Magazines	B N	5
Media work	L N	5

* For key to organisations see Appendix B above.

Key to types of knowledge:

1 = official/formal

2 = processural/oral

3 = regulatory

4 = informal/experiential

5 = public education