

Towards A Mentally Flourishing Scotland: Consultation process as public action

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Executive Summary

This document reports on research on public mental health in Scotland as part of the European 6th Framework Programme project, KNOWandPOL: The role of knowledge in the construction and regulation of health and education policy in Europe: convergences and specificities among nations and sectors.

Here we present the findings of the Scottish Health team's primary case study for Orientation Two which examines the consultation process which led to the development of the *Towards a Mentally Flourishing Scotland Policy and Action Plan 2009-2011*.

The aim of work on Orientation Two is to study a 'public action'¹ in order to examine the relationship between knowledge and policy. As noted in the specifications guiding the work in this phase:

"Knowledge, like policy is then seen as a process; it evolves through practice, it is constituted and reconstituted through the activities of various individuals and organisations, acting differently but simultaneously."

In this report we therefore focus on the types of knowledge and knowledge based instruments used or created by those actors involved in this public action.

The second, complementary case study for Orientation Two, which will follow on from the case study presented here, will examine the development of the concept of recovery as a part of mental health improvement work in Scotland.

¹ The 'public action' concept is defined in the 'Specifications' for Orientation Two of the project in the following way:

"The term "public action" rather than "public policy" (Commaille 2004) takes this *multi-level* and *multi-actor* perspective into account:

- It includes a *relativization* of the role of the *state* and a higher importance of local, and supranational actors.
- It accounts not only for the actions of institutions but also for a variety of public and private actors, embedded in complex interdependences simultaneously at several "levels".
- It breaks away from a linear and hierarchical view of policy process and privileges a view that is more horizontal and circular."

Introduction and method

This report gives an account of our findings from research into the consultation process for the next stage of the National Programme for Improving Mental Health and Well-being. The consultation process, referred to as the *Towards a Mentally Flourishing Scotland (TAMFS)* process after the title of the consultation document which launched it², and subsequent development of the final policy and action plan took place over more than a year. It involved the creation of many documents, consultation events, the development and meeting of reference groups, the creation of consultation responses, synthesis documents and discussion papers, drafts and reports.

We have chosen this case study because the policy consultation process represents a 'critical event' in that it serves to strip an existing policy back, makes it justify itself and opens itself up to new discourses. It also represents the introduction of a new form of knowledge into the policy domain and permits us to visualise the way in which this knowledge flows through the policy community. It allows us to examine the knowledge used by a wide range of actors in their interaction with the policy ideas and each other. This action happens within a wide range of settings – within many different document forms, closed meetings, public events, private discussions and emails. This allows us to visualise how knowledge differentially functions within these different practices.

Sections 3 and 4 of this report relate the context of mental health work in Scotland and the shape that the *TAMFS* consultation process took. Sections 5, 6, 7 and 8, which follow take up specific aspects of the use of knowledge in the consultation process.

Policy consultation processes

Consultation processes are fora specifically and ideally formulated to allow new ideas to be argued, tested, upheld or dismissed in order to create a new policy to direct action. They usually consist in the initial production of a policy document by the government to which responses are collected. These responses are either written, through the submission of response documents (often pre-formatted by the government) by interested groups and individuals, or are collected and collated from the dialogue at engagement 'events' designed to promote discussion around the topic of the consultation.

Public consultation processes became common in the UK in the 1990s as part of the move toward greater public participation championed by organisations such as Demos

² The full title of the document is: *Towards a Mentally Flourishing Scotland: The future of mental health improvement in Scotland 2008-11*

and taken up by the new Blair Labour Government after its 1997 election win (Gustafsson and Driver, 2005; Martin, 2008). Public participation has also been a key focus for new post-devolution Scottish Government, with multiple public consultations taking place on a wide range of topics, from genetic information to a national dialogue around education (Haddow, Cunningham-Burley, Bruce and Barry, 2008; Munn, Stead, McLeod, Brown, Cowie, McClusky, Pirrie and Scott, 2004; Scottish Government, 2007e). In Scottish mental health policy the Millan Committee undertook an extensive consultation process which reviewed the operation of the 1984 Mental Health Act.

Policy consultation processes are designed as deliberate disruptions to the operation of policy. Ideally they function as mechanisms which allow for new approaches to policy to emerge from a consultative process which brings in new voices that disrupt the hegemonic policy order and bring forth innovative policy responses. This, of course, is the 'ideal type' and there has been a significant amount of literature critiquing the extent to which this actually happens (Cook, 2002; Rowe and Frewer, 2000; Gollust, Apse, Fuller, Miller and Biesecker, 2005). Our concern here, however, is not in the success or failure of the consultative exercise but in the way in which these processes allow for the observation of strategies used to support or resist the introduction of new policies. Consultation processes allow for the foregrounding of new policy ideas by both the government and the consultation 'public' in order to 'answer' a policy problem. Through analysing the discourse of policy documents, public responses, consultation events and so forth, we are able to examine the way new policy discourses are initially introduced and how they are received by the actors in the debate. Our interest is in examining the shape and content of the resulting discourses.

Policy consultation processes can be seen as a planned 'moment of crisis' in that they deliberately destabilise the policy order by opening up the existing hegemonic policy framework to contest. A forum is provided where new policy ideas are allowed to enter the environment and debated. These discourses may be incorporated into the new policy or resisted. Even if they are resisted outright they are still heard as part of the discourse and therefore become 'known' as a form of knowledge within this arena. Policy consultation processes therefore, whether or not they are successful in their aim to provide meaningful input into policy creation, nevertheless serve as a forum in which novel discourses are able to emerge.

Method

We used three different methods – interviews, observation and documentary analysis – in order to collect the broad range of data needed for this case study.

Interviews

We conducted ten interviews with individuals working in the Scottish Government, within local government and health boards, non-government organisations, and an independent

consultant. Amongst these respondents were those who contributed to the construction of the consultation document and final policy and action plan, individuals who developed consultation events and response documents and the individual responsible for the creation of the synthesis document based on these responses.

We used semi-structured interviewing with questions based on the position of the actor and the aspect of the consultation process we were exploring in the interview. Interviews were recorded and transcribed.

Observation

We observed all five meetings of the National Reference group convened to guide the development of the final policy and action plan and seven consultation events³. Of the seven consultation events that we observed three were hosted by local authorities and health boards and we attended one event in a rural area, one in a semi-rural area and one in a major city. We also observed two events hosted by non-government organisations. We observed both of the National Dialogue events which took place in Perth and Glasgow.

The data from our observation comprised of detailed notes of the content of presentations and discussion which took place at consultation events, including the recording of specific quotations or interactions which seemed typical of the discussion. We collected all information distributed at events, including delegate lists, PowerPoint slide handouts and so forth. We photographed all notes taken by facilitators in discussion groups.

Documentary analysis

Documents were collected that were central to the consultation process including the consultation document, review document, response documents, synthesis document and final policy and action plan. We conducted an in-depth analysis of these documents. A full list of all documents analysed is listed in Annex 1.

The use of the methods aimed to give us as full a picture as possible about the way knowledge in relation to the consultation process. The data collection can roughly be broken down into two phases:

First phase:

1. **Interviews** on the development of the National Programme and how the consultation document was developed.
2. **Observation** of a broad range of consultation events.

³ The content and organisation of these events and meetings will be discussed in the next section of the report.

3. **Documentary analysis** of the consultation document and support documents.
4. **Documentary analysis** of written responses made.

Second phase:

1. **Observation** of the National Reference Group guiding the consideration of the consultation responses.
2. **Interviews** with those responsible for organising the consultation events and/or drafting responses.
3. **Interviews** with those involved in drafting the final policy and action plan.
4. **Documentary analysis** of the final document and other documents which informed its development.

All data was entered into the qualitative data analysis programme Nvivo. It was hand-coded according to actor and theme. Once main themes had been identified from the core texts auto-coding based on key words was run on those submissions which were not coded in-depth.

1. The Scottish mental health context

Scotland is a constituent country of the United Kingdom with a population of 5.1 million. Since 1999 Scotland has had its own government which has the power to legislate within certain 'devolved' areas including health and education⁴. From devolution until the elections in May 2007 The Scottish Parliament was led by the Labour party. In May 2007 the Scottish National Party (SNP) was voted into government for the first time. The new Scottish Government organised itself around the following priorities: A greener Scotland; A healthier Scotland, A safer and stronger Scotland; A smarter Scotland; A wealthier and fairer Scotland.⁵

1.1 Mental health and ill-health in Scotland

A 2009 report by the government agency Audit Scotland stated that at any given time 850,000 people, amounting to one in six Scots, are experiencing mental ill-health (Audit Scotland, 2009). While the suicide rate has fallen by 13% since 2002, the suicide rate in Scotland is still very high in comparison to the rates in the rest of the UK (18.7 per 100,000 compared with 10.2 per 100,000 in England and Wales). In its report Audit Scotland blamed high rates of mental ill-health and suicide on high levels of social deprivation, social exclusion, alcohol and drug misuse (Audit Scotland, 2009). In 2007/08 NHS Scotland is estimated to have spent £928 million on mental health services. However it is estimated that real expenditure on mental ill-health is around £8 billion when expenses related to incapacity benefit and loss of quality of life are included (Audit Scotland, 2009).

1.2 Public mental health in Scotland

There is very little written about population approaches to mental health in Scotland prior to devolution in 1999. The reason for this is that there was most probably very little actually going on in this area at a national level prior to this time. The extent to which mental health had been marginalised and neglected in pre-devolution years in Scotland was one of the main factors which spurred on the development of mental health as a key

⁴ The demographic, political and administrative context of Scotland are described in more detail in the Scottish Health team's final report produced for Orientation One. This report can be accessed at:

http://www.knowandpol.eu/fileadmin/KaP/content/Scientific_reports/Orientation1/O1_Final_Report_Scotland_health.pdf

⁵ The SNP is a left wing party which aims for Scottish independence from the rest of the UK. For more information about the five themes see: <http://www.snp.org/government>

policy for the new Scottish Executive when it first took office⁶. One major piece of policy that was released in the years leading up to devolution was A Framework for Mental Health Services in Scotland which was released in 1997 and included some discussion and recommendations about public mental health. Recommendations for public mental health in the document are mainly related to the development of anti-stigma work in order to support the development of particular types of services, such as care in the community (Scottish Office, 1997, p.4).

The experience of devolution created an environment which fostered the development of mental health policy in general. Prior to devolution many within Scotland had felt disconnected from the processes of government, which mainly took place in Westminster in London. The process of devolution allowed Scotland to experiment with a new approach to governance and the new Scottish Government placed an emphasis on openness and consultation (Cairney, 2009). This openness allowed new ideas to enter Scottish governance through dialogue between the public, practitioners and policy makers (Smith-Merry, 2008). A document by 'see me', the Scottish Government's anti-stigma campaign for mental health, discusses the opportunity that devolution offered:

"When four of the (now) five members of the 'see me' alliance got together just before Christmas in 2000, it was to discuss the new possibilities offered by devolution of power to Scotland by the Westminster government. The partners... identified one topic in particular which the group was keen to press with members of the new Scottish Parliament (MSPs)." - ('see me' 2007, p.4)

1.3 Other developments in mental health policy post devolution

It was not only public mental health that developed significantly in the years following devolution. Initially the greatest emphasis on the development of new mental health policy was focussed on mental health services⁷. The Millan Committee was formed in the months leading up to devolution and reviewed the performance of the 1984 Mental Health Act, which guided the work of the sector. The functioning of the Committee, which conducted a large and public consultation process, reflected the openness of the new Scottish Executive. The Committee's report, released in 2001, called for the development of a new mental health act focussed on a core set of principles (Scottish Executive, 2001). It specifically spoke about the need to work more collaboratively, fairly and respectfully with mental health service users and their families. While the main focus of the report was on services it included a discussion around the development of public campaigns tackling stigma.

⁶ Until 2007 the Scottish Government was known as the Scottish Executive.

⁷ For a description of the development of mental health services in the years leading up to devolution refer to the final report for orientation one (ref.1 above)

1.4 The National Programme for Improving Mental Health and Wellbeing

Since 2001 Scottish public mental health work has centred around the work of the National Programme for Improving Mental Health and Wellbeing (the 'National Programme'). This programme aims to raise awareness and promote ideas of mental health and wellbeing, challenge stigma and discrimination, prevent suicide and promote recovery (Scottish Executive, 2007). It is viewed internationally as a leading example of a national public mental health strategy; a profile which the Scottish Government is keen to cultivate⁸ (Smith-Merry, 2008; Battams, 2009).

The National Programme is based around the following 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).

With these aims the government works towards improving the "life satisfaction, optimism, self esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support" within the whole of the population (NHS Health Scotland, 2007).

While taking a population focus the National Programme also targets specific social groups whose mental health is deemed to be more at risk. These are infants, children and young people and older people. It develops programmes nationally, many of which are administered locally so that the goals of the National Programme become part of the work of local actors. As well as linking up with the work of organisations vertically from national to local levels it also seeks to engage more horizontally across sectors not traditionally working in mental health. This engagement has been less successful - a problem partly blamed on the siloed operational styles still in operation within the Scottish Government (270309).

1.5 Key initiatives of the National Programme

The main work of the National Programme is conducted through five key initiatives. These are:

⁸ See for example its use as an example of 'good practice' in the documents surrounding the creation of the 2005 WHO Europe Declaration and Action Plan on Mental Health

- 'see me'
- the Scottish Recovery Network
- Choose Life
- Breathing Space
- Scotland's Mental Health First Aid.

The Programme has also built partnerships with public sector organisations and other Scottish Government sections in order to develop and contribute to collaborative programmes such as:

- Artfull
- Heads Up Scotland
- Scottish Centre for Healthy Working Lives.

As these initiatives and programmes represent the major work areas of the National Programme it is worthwhile describing them in a little detail here.

Breathing Space was launched as a free, national phone-line in 2004. It was originally set up to target young men, who are the demographic most prone to suicide in Scotland, and aimed to tackle lowered mood at an early stage through support and referral. Although originally targeted at young men it is open to callers of any age and gender. It also operates a website that offers support and contact details for self-referral. The phone line operates from 6pm to 2am on weekdays and until 6am on the weekends and is operated by paid staff who have backgrounds in counselling, psychology, mental health nursing or social work (Sheehy, Jones, Dobbie, Hayes and Platt, 2006; Breathing Space, 2007). Use of the service has grown steadily since its launch and by 2007 it received around 3000 calls per month (Breathing Space, 2007).

Scotland's Mental Health First Aid is a training programme that was developed in order to educate members of the public about what they should do when faced with a mental health crisis situation (NHS Health Scotland, 2003). It is based on the Mental Health First Aid training first devised by researchers at the Centre for Mental Health Research at ANU in Australia (NHS Health Scotland, 2003). The Australian training was adapted for use in the Scottish context and piloted in 2004. As of July 2007 196 instructors had been trained and 6,888 people had taken part in the full course (Hunter et al, 2008: 37).

Choose Life was launched in 2003 and is a national suicide action plan working to reduce the Scottish suicide rate by 20% by 2013 (Choose Life, 2005b). It aims to do this by raising awareness of the risk factors which may contribute to suicide, developing the

number and quality of early intervention and crisis services, supporting those who have attempted suicide and those coping with bereavement, educating the media about how suicide should be reported and by strengthening research into suicide (Scottish Public Health Observatory, 2008). A major initiative of Choose Life has been the development of the Suicide Information Research and Evidence Network (SIREN) which draws together researchers and practitioners to share research and good practice. Although a direct link with the work of Choose Life has not yet been identified there has been a reduction of 13% in the Scottish suicide rate since 2000 (Choose Life, 2005a).

'see me' is a national anti-stigma campaign aiming to raise awareness of mental ill-health and address negative stereotyping. It does this through social marketing campaigns that work to break down stigma by demonstrating that mental health is common and that those experiencing mental ill-health are ordinary people. It also tackles the negative stereotyping of people experiencing mental ill-health by the media. It is funded by the National Programme and coordinated by a coalition of five Scottish non-government organisations ('see me', 2007).

The **Scottish Recovery Network** (SRN) progresses work on recovery across Scotland. It works to develop an understanding of recovery for those who have experienced mental ill-health, practitioners and within the public more generally. It was launched as part of the National Programme in 2004 and since that time has been involved in a number of projects, the biggest of which has been the Narrative Research Project, which has collected together narratives of recovery from people who have experienced mental ill-health and recovery. This project has aimed to identify the factors that have assisted in people's recovery and provide hope to others making the journey toward recovery (Scottish Recovery Network, 2007). Their most recent major project has been the development of a Recovery Oriented Practice Indicator (ROPI) tool which practitioners can use in order to assess the extent to which they work in a way that promotes recovery⁹.

Artfull is a collaboration between the Scottish Arts Council and the National Programme and has been created to "develop, promote and map the arts and the role they play in improving the mental health and wellbeing of people living in Scotland" (Scottish Arts Council, 2007). In practice this means that Artfull, through its network and web presence, acts as a hub which identifies upcoming arts and mental health related events and brings together those working and researching in this area.

Heads Up Scotland is the National Project for Children and Young People's Mental Health. It was developed in order to implement the recommendations of a 2003 report into children and young people's mental health in Scotland which recommended on the

⁹ The tool is based on a recovery index originally developed and used in the US (Ranz and Mancini, 2008).

mainstreaming of children’s mental health, the development of integrated, enhanced and joined up children’s services and a greater focus on research and teaching in this area (Public Health Institute Scotland, 2003). Heads Up prioritises partnership working with children and young people themselves. It was an integral element in bringing together those involved in the development of talking2ourselves, a website put together by 20 young people aged between 12 and 14 which gives age-appropriate advice on mental health to this age group (Talking2Ourselves, 2008)

In partnership with the NHS the National Programme helps to fund the **Scottish Centre for Healthy Working Lives**, the **National Resource Centre for Ethnic Minority Health**, the **Mental Health and Wellbeing in Later Life Programme**, the development of **National Indicators for Mental Health and Wellbeing** and the **Evidence into Action Programme**. An example of the work done by these programmes is the development of Mentally Healthy Workplace Training within the Scottish Centre for Healthy Working Lives. This training is for employers and managers in order to develop healthier work practices and support employees who are currently encountering or recovering from mental ill-health (NHS Health Scotland, 2008).

The National Programme also acts as a hub for coordinating all work done in mental health promotion across Scotland. This, along with the work of the main initiatives of the National Programme, is promoted through the WellScotland website and through their magazine *Well?* which is released twice a year (Scottish Government, 2007a; Scottish Government, 2008).

1.6 Impact of the National Programme

Of the 16 organisations that we interviewed for our earlier research for Orientation One of our project, which involved mapping the mental health sector in Scotland, six identified the work of the National Programme as being the main guiding policy for their work¹⁰.

The impact of the National Programme at both a national and international level has been highlighted within successive evaluations of the its work (Hunter, Barry and McColluch, 2008; Platt, Petticrew, MacCollam, Wilson and Thomas, 2005). Nationally, reductions in the Scottish suicide rate, and of stigma and discrimination toward people experiencing mental ill-health, has been viewed as a direct result of the work of key initiatives of the National Programme (Smith-Merry, 2008).

¹⁰ This report can be accessed at:

http://www.knowandpol.eu/fileadmin/KaP/content/Scientific_reports/Orientation1/O1_Final_Report_Scotland_health.pdf

“Initiatives such as ‘Scottish Mental Health First Aid,’ the ‘Breathing Space’ telephone line, the ‘see me’ anti-stigma campaign, work on recovery and social inclusion are all likely to be contributing to the recent reduction in the suicide rate in Scotland.” - (Tennant, Hiller, Fishwick, Platt, Joseph, Weich, Parkinson, Secker and Stewart-Brown 2007, 5-6)

Internationally the work of the National Programme has been cited as an example of good practice within work done by both WHO and the EU¹¹. Key people involved in the work of the National Programme have also been involved in the development of WHO Europe’s *Mental Health Declaration for Europe* and its accompanying *Action Plan*, and the European Commission’s *European Pact for Mental Health*.

1.7 Review of the National Programme

A major review of the first phase of work of the National Programme (2003-2006) was launched in mid 2006 in order to reflect on the work of the Programme so far and provide recommendations on how this might be improved and carried on into the next phases of its work. The Review was led by Professor David Hunter from the University of Durham, Professor Margaret Barry from the University of Ireland and Dr Andrew McCulloch, who is the Chief Executive of the Mental Health Foundation.

The Review reflected on the key successes of the National Programme, such as its status as an exemplar mental health improvement programme internationally, its work to raise the profile of mental health improvement within Scotland and its work developing the evidence base related to work in population mental health. It also reflected on some areas needing improvement, calling for the development of a ‘guiding coalition’ to direct the work of the programme, the further development of cross-sector mental health work, improved consumer work and the development of work on inequalities, cultural diversity and gender. The review made four key recommendations for the next phase of the National Programme. These were:

- 1) Model of change (needed to move from transformational to transactional change – related to leadership style)
- 2) The development of a powerful guiding coalition
- 3) The development of a shared vision of positive mental health
- 4) The development of a common language

¹¹ See our Orientation Three report on the relationship between WHO and Scotland in the field of mental health:

http://www.knowandpol.eu/fileadmin/KaP/content/Scientific_reports/Orientation3/WHO.WP12.Scotland.pdf

These recommendations were highlighted in the *TAMFS* consultation process.

1.8 Lead up to *TAMFS*

In late 2007 a consultation process for the development of the next phase of the National Programme was launched. This section of the report looks at why the consultation process took place, and why it was shaped the way that it was.

By the end of 2006 the National Programme had reached the end of one planning cycle (lasting 2003-2006) and needed to move on to the next one. Our respondents felt that there was really no question about whether or not there would be a consultation - the development of a document and consultation process just made sense (270309). Since the successful consultation processes undertaken by the Millan Committee consultation around mental health policy had become part of the way that things were done in Scotland. It was expected by the mental health community and it was supported by the government.

The Director of the National Programme decided that the main focus for the next stage of the National Programme would be on raising the profile of mental health improvement and making it central to mental health work in Scotland (270309). This was because there was a perception in the National Programme that they were being marginalised in the face of the dominance of work on mental health services. It was felt that there was a recognition that mental health improvement was important and necessary, but that the preoccupation with mental health services within an administrative structure where this was a main concern, meant that mental health promotion always took a back seat to work on services (270309). This is illustrated in the following quotation:

“Any civil servants in the major mental health post are going to spend 90% of their brain time thinking about illness and services. Because that is just what happens. If its not forensic, if its not someone playing up at the state hospital, if its not someone absconding ... your head is full of it. So to have to give brain space to someone coming along and talking about inclusion, equalities, promotion, it’s like “are you in this world?” There is always that policy juncture. When you try and put everything together under mental health policy you’ve got to have a pretty sophisticated machinery to understand all that. You’ve got to have legislation experts, illness experts, recovery experts, inclusion experts, promotion experts and these are all different tribes. These are all different people. Someone sitting talking about mental health promotion compared to someone talking about alternatives to acute hospital admission with a recovery orientation. They are on different planets. This is Mars and this is Venus....There is not an easy fit and there can be tensions.” - (270309)

Part of the problem was seen to be in the way that the mental health division was structured and how the public servants involved in the administration of the division

interpreted this structure. In both our recent set of interviews and those we conducted for our policy mapping exercise for Orientation One respondents spoke of the ongoing problems associated with the administrative silos operating inside government which blocked successful cross-departmental collaborative work (101008). This was seen as an especially significant problem for population mental health work which needed to work with a whole range of sectors to be successful. It was emphasised that population mental health is not at its core a health and illness policy but needed to be enacted within all sectors for it to be successful (270309).

This preoccupation with services for care and treatment of mental ill-health meant that in the 18 months leading up to *TAMFS* there had been a gradual loss of emphasis on mental health improvement which meant that funding and infrastructure had been gradually lost. A contributing factor to this was the emphasis on statistics related to mental ill-health as a driver of policy change. For example the release of statistics on high levels of anti-depressant prescribing in Scotland was seen to draw resources to depression initiatives that should have been allocated to population mental health work (270309). There were no statistics available that would emphasise the importance and impact of mental health improvement work so therefore it was seen as much harder to justify work in this area.

The aim of *TAMFS* was to push further the agenda of mental health improvement in this context where money for health improvement was being moved into services for the treatment of mental ill-health. Those designing the programme therefore wanted to bring mental health improvement back to give it an equal footing with work on care and treatment, which was what the National Programme was set up to do. According to one respondent the vision of the Programme had always been to:

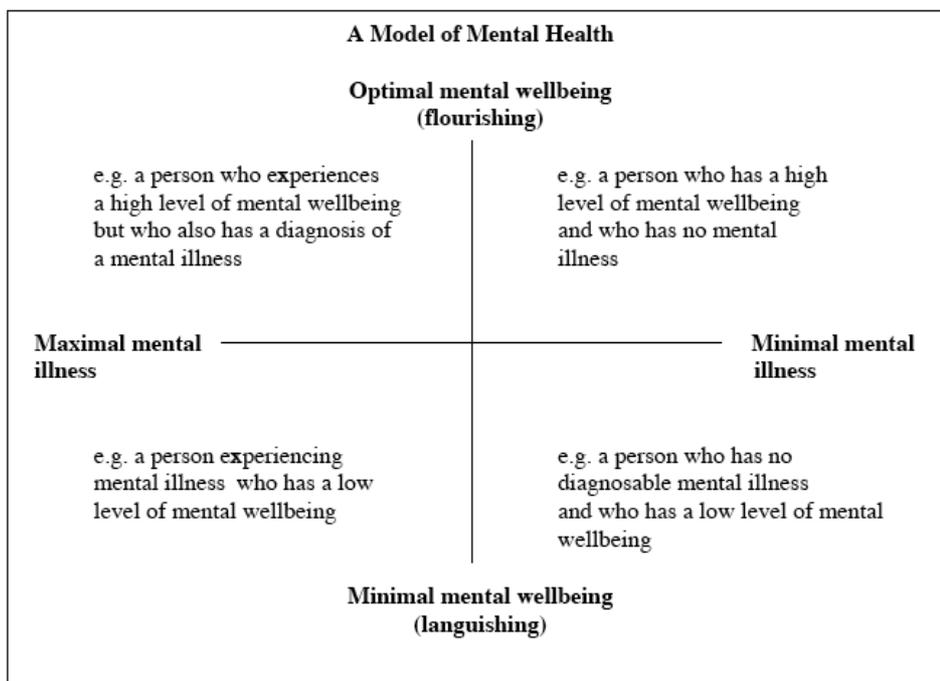
“...improve the lives of people with mental illness and improve the mental health of the population. A dual vision which we articulated much better in *Towards a Mentally Flourishing Scotland*.” - (071108)

The key way that this was articulated in the *TAMFS* document, which set it apart from other articulations of the programme in earlier policy documents, was the inclusion of a clear theoretical basis for the work to build upon. The mentally flourishing ‘dual continua model’ based on the theories of Corey Keyes and others such as Keith Tudor and Felicia Hubbard was chosen to provide this theoretical foundation¹². This model is made up of two continua (mentally flourishing to mentally languishing and maximal mental illness to minimal mental illness) which comprise an axis. See Diagram 1, presented below. Each

¹² Corey Keyes was in Scotland while the *TAMFS* document was being written and gave public lectures on his theory. A pod-cast of one of his lectures was used as a resource supporting the *TAMFS* consultation process. The pod-cast can be accessed on the wellscotland website: <http://www.wellscotland.info/towards-a-mentally-flourishing-scotland-resources>

individual is meant to recognise themselves as positioned somewhere within the full field surrounding the axis. For example you might have a diagnosis of schizophrenia but still be mentally flourishing and live a full, productive life. Likewise you could have no mental illness but still be mentally languishing and have an unfulfilling life. Importantly for policy work the axis also demonstrates that in order to produce positive outcomes work needs to be done on mental illness services (which work on the illness continuum) *and* population mental health (which works on the wellbeing continuum). This means that both need to be equally prioritised.

Diagram 1: Model of mental health based on the work of Corey Keyes (2007) presented in the Towards a Mentally Flourishing Scotland consultation document.



The theory was therefore chosen because it was one of the best “ways of representing complimentary joint production” of mental health work which brings together both services and population mental health work:

“We wanted to keep the illness services and lobby, psychiatrists, GPs, nurses on board because they are fundamental to the improvement of lives of people living with mental illness. So they get a continuum all on their own. The other continuum is the wellbeing continuum and its not good to languish in wellbeing because you are then susceptible to a whole set of other things and your life and that of those around you could be so much more and not just about economic production.” (270309)

This theory therefore provided a visual and theoretical aid which promoted the idealised administrative balance between population mental health and care and treatment of mental ill-health.

In an interview we conducted at the very start of the consultation process one of those coordinating the consultation made the following comment about the state of mental health policy in Scotland:

“...we’ve done well on suicide, we’ve done well on stigma, we’re beginning to get into inclusion, we’ve been using the mental health care and treatment act but we still haven’t got to the progressive consensus mark 3 order 3, which is that mental health is just as important as mental illness. That’s we’re we’ve got to now and that’s the proposal that we’re making to the field and the public now, is that we transform mental health into a flourishing state. But we don’t forget mental illness, because that’s the thing that we’ve done successfully. We’ve kept the mental health and illness lobby together whilst we’ve been trying to champion the mental wellbeing agenda. Other countries make the mistake of going ‘we’re about mental health promotion. Nothing to do with illness.’ We know that if you said that you’d kill off your biggest support group. So mental health services have got more focus, people with mental illness have got more focus in our society now. There is an expectation amongst the mental health community that they will recover, they can recover, that they have got capabilities, they have got assets, they have got something to give. And our recovery network – so when someone says to me ‘what do you mean by mental wellbeing? Is that not just the state of not being mentally unwell?’ and I say ‘look at the people who recover from severe and enduring mental illness. They are our wellbeing champions.’ So if you can recover from severe mental illness, what is it that you’ve got that other people can’t even have as they struggle through life’s day to day challenges? That’s the big shift, so we now shift to mental wellbeing.” - (281107)

This quotation illustrates well the context and hopes surrounding the consultation process for *TAMFS*. The next section of the report examines the structure of the consultation process.

2. Consultation process as critical episode in Scottish mental health policy

2.1 The TAMFS process

In late 2007 the consultation document *Towards A Mentally Flourishing Scotland* was launched and a consultation process was initiated in order to formulate the next stage of the National Programme. The consultation process involved a set of consultation events hosted by local authorities and health board areas (whose events were mandated by the government), NGOs and other interested groups¹³. Individuals and organisations were also invited (and in some cases mandated) to submit consultation responses. These responses were synthesised into a summary by an independent consultant. A National Reference group met over several months to consider the development of the final policy and action plan, which was put together by the Scottish Government and released in April 2009. Each of these steps of the process is discussed in depth over the following pages. For a full timeline of the consultation process within the context of work by the National Programme please refer to Table 1, below.

¹³ Local authorities are elected local councils. Health Boards focus on health improvement, public health, health care delivery and reducing health inequality in their local area. Both have a shared responsibility for mental health care and prevention work under the *Mental Health Care and Treatment (Scotland) (2003) Act*.

Table 1: Activities of the National Programme, including major events in the TAMFS consultation process (highlighted in bold).

TIME	ACTIVITY
October 2001	Launch of the National Programme for Improving Mental Health and Wellbeing.
February 2002	First meeting of the National Advisory Group advising the work of the National Programme
April 2002	Appointment of Gregor Henderson as the Director of the National Programme
April 2002	Launch of the Breathing Space helpline, a major initiative of the National Programme
October 2002	Launch of 'see me' – a major initiative of the National Programme
December 2002	Launch of the suicide prevention programme, Choose Life – a major initiative of the National Programme
September 2003	Launch of the National Programme Action Plan 2003-2006
Late 2004	Launch of the Scottish Recovery Network – a major initiative of the National Programme
May 2006	Initiation of a major Review of the National Programme
October 2007	Launch of the Consultation document Towards a Mentally Flourishing Scotland which guides the consultation process for the next stage of the National Programme
24 October 2007	Start of a three month public consultation process for the next stage of the National Programme (including a series of government funded consultation events)
December 2007	Dissemination of the findings of the Review of the National Programme
February – September 2008	Meetings of the National Reference Group devising the next stage of the National Programme
April 2008	Consultation response synthesis released
September 2008 – March 2009	Ongoing consultation by the Mental Health Division with COSLA, key practitioner groups and other Government departments concerning the content of the TAMFS policy.
April 2009	<i>Towards a Mentally Flourishing Scotland Policy and Action Plan 2009-2011 released.</i>

2.1.1 Towards a Mentally Flourishing Scotland: consultation document

The TAMFS consultation document was released in Glasgow in late October 2007. It suggested three main themes for the next stage of the National Programme. These were:

- “Promote and improve mental health and mental wellbeing.
- Prevent mental health problems, mental illness, co-morbidity and suicide.
- Support improvements in the quality of life, social inclusion, health, equality, and recovery of people who experience mental health problems or mental illness.”

– (TAMFS consultation document, Scottish Government, 2007c)

It emphasised that a “focus on addressing inequalities” underpinned each of these main themes. The consultation document also listed three questions that would guide the deliberations during the consultation process. These are listed in Box 1, below.

Box 1: Questions guiding the consultation for Towards a Mentally Flourishing Scotland.

- What shared objectives and actions for *local delivery* should be made for 2008- 11 which would be deliverable, measurable and valuable?
- What *national supports* would help local areas meet these objectives and actions?
- How can *progress* (locally and nationally) be tracked and performance assessed?”

-(Scottish Government, 2007)

Introduction of a new theoretical frame

The document specifically contextualises itself within a theoretical framework: that associated with the conceptualisation of positive mental health as the state of mentally flourishing. The phrasing of the consultation document title immediately set up its relationship with this new theory of positive mental health. The concept of positive mental health is not a new one within Scottish mental health policy but the representation of positive mental health as mentally flourishing is a new take on this theory.

The document begins by problematising the solely negative conceptualisation of mental health inherent in an illness based framework and then introduces the concept of positive mental health as flourishing as expressed by Corey Keyes. This concept is articulated in the following way:

“It is important to recognise that someone can experience signs and symptoms of mental illness and still have good or flourishing mental wellbeing just as people with a physical illness or condition can live positively and flourish and have a good sense of wellbeing. Similarly, someone may have significant mental health problems, but not have a clinically identifiable

mental illness. This is because mental wellbeing, mental health/ill health can be identified as being on two different continua.”

- (*TAMFS* consultation document, p.3 [emphasis in original])

It is then presented diagrammatically by the double continua axis already presented in Diagram 1 (in section 3.8 above).

In the *TAMFS* document the Scottish Government deliberately seeks to disrupt the conceptual basis underpinning mental health policy through introducing a new form of theoretical knowledge. Successive reviews of the National Programme had criticised the lack of a shared theoretical and linguistic understanding of the concept of ‘mental health’. Those within the National Programme had aimed for an understanding of mental health framed within a conceptualisation of positive mental health rather than an illness based framework. The concept of positive mental health starts from the premise that all individuals possess ‘mental health’ and that all exist somewhere on the spectrum between mental health and mental ill-health. Wherever individuals exist on this spectrum they are seen as needing to work on sustaining or improving their mental health. Positive mental health is thus viewed as an attainable goal that needs to be worked towards. A population based policy targeting mental health directs services and action toward attaining mental *health* for the whole of the population as opposed to services simply designed to address the mental *ill*-health of individuals. This policy is seen as complementary yet separate to policies addressing services for mental ill-health.

Those working within the National Programme have attempted to promulgate the idea of positive mental health within the work of those involved in mental health in Scotland and beyond that into the consciousness of the wider community. Reviews of the National Programme and interviews with individuals involved in its administration express disappointment that the transmission of the concept of positive mental health has not been successful (Hunter et al, 2008; Platt et al, 2005). For example, a review of the National Programme released just prior to the consultation process commented:

“The issue of a common language to describe both good mental health and mental ill health is closely related to the embedding of a shared vision discussed above. A number of those giving evidence to the panel acknowledged that the lack of a common language was problematic”

- (Hunter, et al, 2008)

The problem is seen to lie in the dominance of the prevailing conceptualisation of mental ill-health as a frame of reference. The introduction of new linguistic characterisations such as the use of the terms ‘mental health’ or ‘mental wellbeing’ have seen these terms also subsumed into the concept of mental ill-ness. In an attempt to again address this problem and promote the concept of positive mental health, the Scottish Government used the consultation process around the next stage of the National Programme to introduce a new theory of positive mental health within an accompanying linguistic frame. As the explanation and diagram explaining the flourishing theory in the document

demonstrate, this theory is associated with the use of a new technical language as signified through the use of the words mentally 'flourishing' and 'languishing'. Within the *TAMFS* document this new language becomes the frame through which the aims for the next stage of the National Programme are presented.

Introduction of an 'inequalities agenda'

"The underpinning focus for health improvement in 2008-11 is addressing inequalities. We know that good mental health and flourishing mental wellbeing are not equally distributed across the population. Similarly, mental health problems and mental illness are not randomly distributed across populations: although mental health problems will affect one in four people, it will not just be any one in four people."

– (*Towards a Mentally Flourishing Scotland*, Scottish Government, 2007)

The consultation document is also framed within, what the Scottish Government terms, an 'inequalities agenda'. Inequalities as a policy focus in Scotland has been highlighted as a result of the publication of statistics which starkly compare the health outcomes for those in the most deprived areas in comparison to the least deprived areas. For example, the most recent statistics on healthy life expectancy show that men who live in the most deprived 10th of the Scottish population can expect to live to only 66 (with 55 of these years in 'good health') whereas the least deprived 10th of the population could expect to live to 79 (with 75 of these years in 'good health')¹⁴. The Scottish Government has recognised the impact of inequalities on mental health and in 2003 it commissioned the report *Equal Minds: addressing mental health inequalities in Scotland* following on from a conference which brought people together around the issue.

The government's 'inequalities agenda' is much broader than mental health and the Ministerial Taskforce on Health Inequalities met before and during the *TAMFS* consultation and released a report *Equally Well* in June 2008¹⁵. The work/knowledge of the taskforce impacted on the creation of the *TAMFS* document. One of the National Consultation events for *TAMFS* was on the theme of inequalities and Kay Barton, the head of Health Improvement within the Scottish Government spoke about the work of the Taskforce at this event. The *Equally Well* report has a strong focus on early intervention, which is also reflected in the *TAMFS Policy and Action Plan* released in April 2009.

In addition to the consultation document there were a large number of resources available online on the wellscotland website, including the following:

¹⁴ <http://www.isdscotland.org/isd/5865.html>

¹⁵ <http://www.scotland.gov.uk/News/Releases/2008/06/19155721>

- Video presentation on the *TAMFS* document.
- Background paper: 'Developing Social Prescribing and Community Referrals for Mental Health in Scotland'.
- Resource Paper: 'Community Health Partnerships: Promoting mental health, Preventing common mental health problems'.
- Report: 'With Inclusion in Mind: The local authority's role in promoting wellbeing and social development'.
- Report: 'Mental Health Improvement: Evidence Based Message to Promote Mental Wellbeing'.
- Report: 'Mental Health Promotion: Building an Economic Case'.
- Report: 'Mental Health at Work: Developing the Business Case'.
- Report digest: 'Better Health, Better Care: Action Plan: References to Mental Health'.
- Report: 'Addressing Mental Health Inequalities in Scotland: Equal Minds: National Programme for Improving Mental Health and Well-Being'.
- Pod-cast on 'How Scotland can Flourish: Improving the Mental Wellbeing of People Living in Scotland' by Corey Keyes, who introduces his concept of mentally flourishing.

The consultation document was also released in an 'easy read' version and translated into Polish and Cantonese.

2.1.2 Consultation events

A large number of consultation events took place across all areas of Scotland as part of the *TAMFS* consultation process. Consultation events were usually conducted across a full or half day and consisted in presentations by government speakers about the consultation document, speakers from the local area or NGOs emphasising good practice in population mental health taking place in the area, followed by discussion groups designed to collect feedback on the act from event participants. Almost all of the events that we attended followed the same rough format¹⁶:

1. Introduction by the host organisation.

¹⁶ The notable exception to this was the event hosted by Universities Scotland whose half-day event consisted in several presentations by practitioners working in student mental health services followed by a government presentation and short question and answer section. No discussion groups took place at this event.

2. Introduction of the *TAMFS* document by a government speaker.
3. Examples of good practice in population mental health by practitioners and, at some events, mental health experts.
4. Discussion groups based around an example of good practice or a general discussion about the needs of a particular target group (such as young people).
5. Summary of the event by the host organisation.

We questioned those organising the events about how they had chosen the event format. None of them had ever been taught how to host an event of this type, but had rather gathered their knowledge about the appropriate form of consultation events from those that they had attended in the past. They included specific types of knowledge gathering activities¹⁷ in the events because they had seen them used to good effect at other events.

The 'standard' event format used a mix of both speakers and discussion groups and thus seems to have been designed for two purposes:

1. To provide knowledge on public mental health policy and practices via an explanation of the policy context, its theoretical dimensions and examples of good practice.
2. To gather the views of the consultation participants which could be fed back to both the government and the organisation hosting the event.

In our interviews we discussed the purpose of these events for those that had coordinated them. One respondent spoke of these events as an important opportunity to get the community of people with responsibility for mental health together so that they could learn from each other's experiences and "work out what they should be doing when the policy comes out" (080408). For this respondent the consultation process had an inter-organisational knowledge exchange function in the context of a new idea coming in from outside. It was seen as difficult to get communication within the sector happening without these sort of events taking place.

2.1.3 Consultation response documents

Over 75 response documents were received by the government¹⁸. Responses were based on discussion at consultation events, dialogue within organisations and personal

¹⁷ For example one event used table 'hosts' where participants would visit different themed tables set up at the event in a group and the table hosts would both educate them on a particular topic and gather their responses to the consultation in relation to this issue.

¹⁸ Most of the TAMFS consultation response documents are publicly available at:

reflections on the consultation document. A synthesis made of these documents (discussed in further depth at point 4.3.2 below) includes a useful breakdown of the sectors from which the responses were drawn. This is modified and reproduced in Table 2, below:

Table 2: Responses, by sector (modified from data in Griesbach, 2008, p.2)

<i>RESPONSES, BY SECTOR</i>	#
NHS, Local authorities, and coalitions between both	28
Non-government organisations	23
Service users and carers – groups and individuals	10
Medical sector	7
Other individuals	5
Statutory authorities	2
Education	1
TOTAL	76

As this table demonstrates most of the responses came from groups that currently provide services (the NHS, Local Authorities and non-government organisations) for those experiencing mental ill-health. The responses ranged in length from a short paragraph (e.g. British Medical Association Scotland response¹⁹) to over fifty pages (e.g. Lanarkshire joint response²⁰). Some organisations that hosted events, for example that by Universities Scotland, did not submit a consultation response despite this being a condition of the funding they were offered by the Scottish Government in order to host their event.

2.1.4 Consultation response synthesis

An independent consultant was hired by the Scottish Government in order to synthesise all of the consultation response documents. A set of preliminary findings were provided to the National Reference Group at its second meeting in March 2008 and the final synthesis document was published in May that year (Griesbach, 2008). It was a relatively short document of only 34 pages considering how many responses were received. The consultant emphasised that her synthesis represented a “high-level summary” of the documents and did not go into detail about the micro aspects of the responses as this

<http://www.scotland.gov.uk/Publications/2008/04/03092148/0>

¹⁹ British Medical Association Scotland response document.

<http://www.scotland.gov.uk/Resource/Doc/218343/0058535.pdf>

²⁰ Lanarkshire joint response document:

<http://www.scotland.gov.uk/Resource/Doc/218343/0058519.pdf>

was all the government had required (240608). The data included in the synthesis primarily related to the three questions guiding the consultation process (discussed in Box 1 in section 4.1.1 above). The consultant also included in the document other main themes that were prominent in the responses, such as issues around theory and the use of particular types of language, partnership working and ideas for further research.

2.1.5 National Reference Group

Planning for the National Reference Group started at the same time as the development of the *TAMFS* document. Its membership and remit was devised by the Mental Health Division of the Scottish Government. The group met five times over a period of seven months and all meetings took place in Edinburgh.

Box 2: Membership of the National Reference Group

- Representatives from the **Convention of Scottish Local Authorities (COSLA)** – Under the new Scottish government funding agreement local authorities have much more liberty to choose where funding is spent. This means that work on mental health improvement is no longer as obligatory as it has been.
- Representatives from the **Association of Directors of Social Work (ADSW)** – Social work is the main role with responsibility for mental health at a Local Authority level.
- High level representatives of **NHS Health Boards** and **Community Health Partnerships (CHPs)** – have responsibility for mental health services within the NHS at a local level.
- The Director of the **Glasgow Centre for Population Health** and the **Public Health Network** – involved in research on public mental health.
- A **Psychologist** and representatives from the **Royal College of General Practitioners** and **Royal College of Psychiatrists**.
- Representatives from **Learning Teaching Scotland, Her Majesty's Inspectorate for Education (HMIE)** and the **further education** and **higher education** sectors.
- Representatives from the **Scottish Council for the Development of Industry**, the **Scottish Urban Regeneration Forum** and **trade unions**.
- A member of the **National Programme Executive Group**.
- Several representatives of **voluntary sector organisations** involved in mental health service delivery and advocacy.
- Representatives of **older people's** advocacy groups.
- Representatives of **younger people's** organisations and advocacy groups.
- Three **service users** from Voices of Experience (VOX).
- A representative of the **Scottish Council Foundation** – a policy think tank.
- Two academics that specialise in work on mental health.
- The director of the **Scottish Development Centre for Mental Health**.
- The **mental health improvement advisor** working as a consultant to government on public mental health.

The structure of the meetings varied, but usually there would be a presentation by the government on the progress of the consultation process followed by discussion groups around particular aspects of the proposed policy and its implementation. Between official meetings of the group those putting together the policy also spoke to others working

within the government, a government 'internal reference group', other key stakeholders such as COSLA and 'expert' consultants. These expert consultants included Phil Hanlon, who is Professor of Public Health at Glasgow University, and Gregor Henderson who is an independent consultant who was contracted into the government to coordinate the National Programme over a number of years.

The operation of the National Reference Group will be discussed in further detail in sections 5 and 6 of this report.

2.1.6 Final policy document

A significant amount of time lapsed between the last meeting of the reference group in August 2008 and the release of the final policy document, *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 -2011* in April 2009. It was launched at the event 'Looking Out, Looking In: International Perspectives on Mental Health Improvement in Scotland' held in Edinburgh.

The Policy and Action Plan identifies six priority areas for action:

- "Mentally healthy infants, children and young people
- Mentally healthy later life
- Mentally healthy communities
- Mentally healthy employment and working life
- Reducing the prevalence of suicide, self-harm and common mental health problems
- Improving the quality of life of those experiencing mental health problems and mental illness" - (Scottish Government, 2009, p.10)

As its title indicates the document consists in a 'policy' and 'action plan'. The policy section outlines the values and method underpinning the delivery of the next stage of the National Programme while the action plan sets out specific 'commitments' relating to each of the priority areas identified.

The document takes what is phrased as an "outcomes approach to public sector accountability" and points to this approach sitting within an environment characterised by and in response to the Concordat and the National Performance Framework²¹ which

²¹ The Concordat is an agreement between the Scottish Government and Local Authorities. Under this agreement the Scottish Government provides an agreed amount of funding to local authorities who then may use this funding as they see fit as long as it works towards the outcomes listed in the National Performance Framework.
<http://www.scotland.gov.uk/Publications/2007/11/13092240/concordat>

emphasise both collaboration and the achievement of targets. The document describes the development of a “logic model” as integral to working in an outcomes approach and describes a logic model in the following way:

“...logic models have three main uses: policy development, tracking progress and communicating pathways to outcomes... Logic models are developed using a collaborative methodology in which stakeholders participate to ensure the models are evidence informed, logical and achievable.”

The emphasis in an outcomes approach thus seems to be on work that is collaborative, evidence-based and measurable.

The document contextualises itself within mental health work happening at a European level:

“The 2005 WHO Mental Health Declaration for Europe was signed by 52 Member States, including the UK. It outlined the main priorities for Europe for the next decade:

- fostering awareness of the importance of mental wellbeing;
- collectively tackling stigma, discrimination and inequality, and empowering and supporting people with mental health problems and their families, to be actively engaged in this process;
- designing and implementing comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
- address the need for a competent workforce, effective in all these areas;
- recognise the experience and knowledge of services users and carers as an important basis for planning and developing mental health services.

This policy and action plan demonstrates Scotland’s ongoing commitment to addressing these European priorities in a Scottish context.”

- (Scottish Government, 2009, p.50)

As this quotation demonstrates it seems important for the Scottish Government that the work that they are doing in mental health is aligned with that happening at a European

The National Performance Framework is a set of National Outcomes that the Scottish Government wishes to achieve. These outcomes are associated with a set of 45 National Indicators which are used to track progress toward the achievement of the outcomes. Further explanation of the National Performance Framework can be found at: <http://www.scotland.gov.uk/About/scotPerforms/performance>

level. This alignment validates the Scottish agenda and demonstrates its soundness as a policy approach.

The drafting and eventual content of the document is discussed in greater depth in section 6 of the report, below.

3. The knowledge of actors

In this section we discuss the main actors involved or invoked in the consultation process and describe their use of knowledge. We also investigate actors that were absent from the process but whose involvement may have been expected given the subject matter being debated. The main actors involved in the consultation process were government public servants, practitioners, service users and experts. We will discuss each of these actors in turn.

3.1 The Scottish Government

The Scottish Government was present at every stage of the consultation process. Their physical presence came in the form of public servants working within either the Mental Health Division in the Scottish Government in Edinburgh or as policy officers and programme leads from the National Health Service (NHS)²².

3.1.1 Administration of the consultation process

Government actors were in charge of the consultation process and were thus able to set its terms. These terms were laid out initially through the consultation document where deliberate choices were made about the theoretical framework and the questions to be asked of those responding to the document. The government required that all local authorities and health boards convene consultation events and other organisations were also able to host events. They provided up to £1000 to cover the cost of these events. The local authorities, health boards and any organisation receiving the event funding were then required to write and submit responses to the consultation document based on the dialogue at these events.

The government pieced together the knowledge it needed in order to frame the policy in a way that would be most productive for them. The consultation document highlights particular forms of knowledge by situating itself within an inequalities framework and using the languishing/flourishing matrix espoused by Keyes for its theoretical basis. Similarly the reference group and the consultation guidance notes invited specific forms of knowledge into the consultation process.

²² We distinguish here between government employees who are public servants and those whose main work is in practice. The latter we include as 'practitioners' and will be discussed in detail later in the report.

The government created guidance and a response proforma which respondents could use if they wished. The guidance articulated the interests local areas should include in their consultation processes, identifying actors via the following request:

“...they should include a range of stakeholders with a range of interests ranging from health promotion, public health, health and social care services, to education, lifelong learning, employment, training and skills, regeneration, criminal justice, environment, business, culture and arts and others. They should also, where possible involve a range of public sector agencies, the voluntary sector and the business community (small, medium and large enterprises).”

- (Scottish Government, 2007²³)

The identities highlighted here are very broad, and this demonstrates the types of work and knowledge the government hoped to integrate their mental health agenda into. Notably absent from this list are psychiatrists and other medical practitioners, perhaps indicating a type of knowledge the government did not want present, and thus to influence, the discussion at consultation events.

3.1.2 Government involvement in consultation events

Government representatives attended and presented at all of the consultation events that we observed. Their presentations took the form of a set of PowerPoint slides which were modified according to the audience. Much of the first part of the presentations was given over to the introduction of the concept of positive mental health as a policy goal for population mental health work. Like the consultation document the slides gradually introduced the audience to the theories of positive mental health while critiquing previous theorisations of mental health. The presentations also highlighted the importance of an ‘inequalities agenda’ in mental health. One slide stated:

“Levels of mental distress and mental illness need to be understood less in terms of individual pathology, but more in terms of deprivation, social inequalities, poverty, exclusion, injustice, discrimination, inequality. These all erode essential social and psychological aspects of wellbeing.”

- (Government PowerPoint slide, TAMFS consultation)

²³ Scottish Government, 2007, Towards a mentally flourishing Scotland: the future of mental health improvement in Scotland 2008-11. A discussion paper. Some guidance notes on the discussion process.

<http://www.wellscotland.info/uploads/file.php?serve=1198246453-Discussion%20Process%20Guidance%20FINAL.doc&action=download> (accessed 10 June, 2009)

The Government presentations mention the work of Richard Wilkinson and others as experts working on health inequalities in order to contextualise the inequalities focus of the consultation. The use of 'expert' knowledge in the consultation will be discussed in further detail at section 5.4, below.

Language as a policy instrument

In both the consultation document and their presentations at consultation events the government expressed concern about promoting the right sort of language in order to convey the ideas of positive mental health. This can be seen in the following quotations:

"...we need to create an understanding of language and ideas and imbed this."

- (Government speaker, Universities Scotland event)

"...need to be careful about how these ideas are communicated."

- (Government speaker, National Dialogue event 2)

Here language is constructed as an instrument of policy, whose successful use is seen to lead to greater adoption of the theoretical basis underpinning the policy which will, in turn, lead to easier implementation of the policy. This was emphasised by one of our respondents who commented:

"...we wanted to move people away from conceiving everything to do with mental health policy to be about improving the lives of people with illness. It was that but it was also more. So we had to start helping people to disentangle in their brains the language of mental health equals illness. So mental health is much more than just the alleviation of illness. So that's exactly what we were doing. We were saying look at both sides all the time." - (270309)

The consultation events were thus viewed as a chance to educate the policy 'public' about the theory of positive mental ill-health that underpins the work of the programme. The first step in doing this was the laying down of the right type of language through which the theory could be understood. In this way language functions here as a basic instrument of policy learning.

International knowledge

"The world is watching what we do."

- (Government presentation, Lanarkshire consultation event)

One of the PowerPoint slides used in the government presentations at consultation events highlighted the National Programme as internationally significant. It did this firstly by drawing attention to the citation of the work of the programme within the work to develop the WHO Mental Health Declaration and Action Plan for Europe and the work

of the European Union. It also stated that the work of the National Programme is aligned with “International Recognition of the Importance of Promoting Mental Health, Preventing Illness and Improving the Quality of Life, Social Inclusion and Rights of People Experiencing Mental Health Problems and Mental Illness” [capitalisation in context], thereby situating the Scottish mental health agenda in relation to international work in the area. With this slide the government uses international knowledge in order to validate the work of the National Programme by demonstrating its relationship with an international agenda, and specifically that of prominent international bodies such as WHO and the EU.

Indicators

“Mental health can be measured.”

- (Government presentation, Greenspace Scotland consultation event)

In the government presentations the use of indicators was promoted as a way to endorse the positive mental health approach. They emphasised the development of indicators that are able to measure positive mental health. The Warwick Edinburgh Mental Well-being Scale (WEMWBS) is an indicator which aims to measure positive mental health (mental well-being). It consists in set of 14 statements such as “I’ve been feeling interested in other people” or “I’ve been feeling loved” to which respondents, considering the previous two weeks, respond either: none of the time, rarely, some of the time, often, all of the time. WEMWBS was devised in order to fill the gap in evidence for interventions around positive mental health and population based-mental health strategies.

The presentations emphasised the fact that the Scottish Government has chosen to include findings from WEMWBS as an indicator of its performance within the National Performance Framework. The Scottish Government has listed WEMWBS as one of its 45 national indicators of government performance: “Increase the average score of adults on the Warwick-Edinburgh Mental Wellbeing Scale by 2011”. It is included alongside indicators such as “60% of school children in primary one will have no signs of dental disease by 2010” or “Improve knowledge transfer from research activity in universities”.

The government presentations urged local areas to use the WEMWBS tool in order to justify work on public mental health or demonstrate the success of programmes and ensure ongoing funding. Some preliminary data from the use of the indicator was presented in government presentations. However, it was not the data produced by WEMWBS that was highlighted as important but rather the very existence of the indicator and its use by the Scottish Government. The indicator was seen as a way of marking the importance of work on positive mental health and thus provided a validating function for the *TAMFS* policy and actions that result from it.

3.1.3 Government involvement in the National Reference Group

The government set out the terms and membership of the National Reference Group (listed in Box 2 in section 4.1.5 above). The chosen membership of the reference group demonstrates both the knowledge that the government prioritises in mental health improvement and the actors that they feel need to be included in order for the implementation of the policy to be successful. It represents, in its proportions, a different group of interests than that included in the consultation events. There is more representation, for example, from the medical sector and the education sector. Some of these appointments were viewed as 'political' rather than in the best interests of the development of the policy. This was seen to be the case with respect to the inclusion of the Royal College of Psychiatrists within the group (270309).

The government played a very active role in the National Reference Group meetings by setting the agenda, inviting speakers and chairing discussion. Some felt that this role was a little too prominent and that they should not have acted in such a directive way (270309). However, there is evidence from our observation that there was a genuine engagement by the government with the opinions of the reference group. When government speakers introduced new ideas and policy options these were not simply endorsed by the group. In one meeting it became clear that the reference group disagreed with a proposition that the government put forward – a proposal that the government subsequently did not proceed with.

3.1.4 Government knowledge in the final policy and action plan

The use of knowledge in the government's construction of the final policy document is discussed in detail in section six of this report.

3.1.5 Summary thoughts: Scottish Government knowledge

The Scottish Government does not create knowledge, but rather it gathers and organises it. Its involvement in the consultation was as a hand guiding the process. It directed how knowledge should be understood (in this case through the selection of appropriate theory) and what types of knowledge should be gathered (consultation events and inviting specific types of actors to contribute and through devising instruments such as indicators to support the policy implementation). In this way it set up the conditions in which knowledge could be created but did not generate its own knowledge. The government selected between others' knowledge according to what it needed to achieve. The Keyes 'flourishing' theoretical model, for example, was chosen because it articulated theoretically the balance felt to be needed between services and population mental health in order to achieve a 'mentally healthy' Scotland. The government engineered the consultation events so that it brought this theoretical knowledge together with the experience based knowledge of practitioners (discussed in the next section of the report) in order to create knowledge which would move mental health improvement work

forward through the next stage of the National Programme. This work at the consultation stage was thus a necessary complement to the creation of the *TAMFS Policy and Action Plan* where the Scottish Government brought together different forms of knowledge in the form of a document that would direct the spheres in which this action should take place.

3.2 Practitioners

Practitioners were very involved in the consultation process for *TAMFS*, but only within certain stages. The knowledge they used came from their embodiment of a knowledge dependent and authorised by the experience they have derived through their work. It was not the training they received for their roles that was viewed as important in validating their knowledge (as it may have been, for example, for a psychiatrist) but the practical experiences they have gained while carrying out their work.

In using the term 'practitioner' we refer to individuals involved in directly administering and carrying out programmes and services to members of the public. Examples of the roles of those practitioners who attended the events are: social workers, outdoor education officers, teachers, librarians, nurses, service coordinators and service managers.

3.2.1 Practitioners at consultation events: good practice

"As well as evidence we need to listen to what practitioners have said through the process, which may not be evidence based." - (230109)

Practitioners were the actors most frequently present at the consultation events, comprising approximately 80% of delegates at those events that we observed. Practitioners took both an official role in consultation events as guest presenters, and as members of the consultation 'public'.

Practitioner knowledge in presentations

Those practitioners presenting at events seemed to be chosen because of their ability to provide an insight into the way that the goals of the National Programme could be manifest within work which took place 'on the ground' in their programmes. For example, at the National Dialogue event that took place in Perth, several practitioner presentations elaborated on the work taking place within their organisations. One of the presenters spoke about the range of different programmes in place in Dundee which aimed to address the problems associated with poverty and inequality. The presentation highlighted the level of need in the target community (through the presentation of statistics), the services that were offered to address this need and the outcome of the programme, which was said to "transform people's lives". The structure of this presentation was typical of those that we observed.

Presentations such as these served an important purpose for those conducting the consultation event by demonstrating that the agenda being suggested for the National Programme in the *TAMFS* document was relevant and realistic. They did this in four ways. Examples of good practice demonstrated that the *TAMFS* agenda:

- was possible – through showing examples of work in the area already being conducted.
- was necessary – through the presentation of disturbing statistics on the levels of mental ill-health in the community.
- could be realised – by demonstrating that the goals of *TAMFS* are well aligned with the way services for mental health are currently ordered.
- demonstrated tangible outcomes for the population targeted by the programme.

For those practitioners presenting, the presentation could be seen to validate their own work through the positive esteem gained as a result of being chosen as an example of good work in population mental health.

Practitioner knowledge in workshops at consultation events

At several of the consultation events that we observed practitioners also led workshops where they introduced a small group of participants to their experience of administering a particular programme. A short practice-based presentation would be followed by a facilitated discussion which would discuss the practice example in relation to both the questions guiding the consultation (listed in Box 1, above) and the experiences of those in the workshop group. One of our interview respondents (080408), who had been charged with organising one of the consultation events, spoke about the benefit of this workshop format for those within his organisation. In detail he described the way that he had deliberately included these examples of good practice within the event in order to demonstrate to those working in his health board about the ways in which they might introduce the work of the National Programme into their own work. Examples of good practice were seen to make the *TAMFS* agenda “real” and thus help in, what he felt to be, the inevitable process of implementation of this agenda (080408). The benefits of these presentations of good practice in a workshop setting were also reflected on in one of the response documents:

“Around 25 colleagues from a broad range of agencies agreed to present updates of current innovative work areas from across Greater Glasgow and Clyde ... this was in order to “bring to life” the themes of the national document with real examples of practice. There has been significant feedback since the event that these case studies helped delegates contribute better to the debate on *Towards a Mentally Flourishing Scotland*, and also had benefits for networking and practice sharing across the Board area.”

- (Greater Glasgow and Clyde area consultation response)

Practitioners as participants

Practitioner knowledge gained through experience gave authority to the voices of those attending the consultation events as participants. All discussions frequently included discourses in which practitioners drew on examples from their own work in order to make an argument or prove a point. These discussions of good practice usually took the form of small vignettes. The following quotations provide an example of this:

"...we need programs that support all vocations in schools. For example healthy living initiatives in schools – where kids run their own tuckshop – they developed their own business and made a profit. This gave more opportunity for further development of skills and other benefits."

- (Discussion group, Lanarkshire consultation event)

"In Derry there is high suicide mostly centred around a particular bridge in town, so hairdressers and taxi drivers have been trained in what to do with a person expressing desire to suicide."

- (Discussion group 2, National Dialogue event, Glasgow)

"People working in local services need better training. Some areas have people going into services. For example a library and declaring that they have a mental illness and seeing what the reaction is – like a 'mystery shopper'"

- (Discussion group 2, National Dialogue event, Perth)

"Locally what has worked well with Choose Life has been trying to plant a seed and let it grow – men's groups. Men's mental health stuff is going on but it's not joined up. We need to allow a network to develop around this."

- (Discussion group 3, National Dialogue event, Perth)

It was not just examples of good practice that were provided in order to demonstrate how the work of the National Programme should proceed. Examples of bad practice, or problems with the provision of some services and policy, were also provided:

"They need to create a mentally healthy work/life balance and workplace culture. [In this organisation] there is awareness raising but it is not followed through. Everyone is working over their hours. Here people live to work, not work to live... If your own manager is working 24/7 then that is not making a good example for rest of the staff."

- (Discussion group 1, Highlands consultation event)

“The problem is that people associate LGBT issues with sex education and so it is hard for [services] to get into schools. The impact of discrimination for LGBT people is that the normal avenues for mental health support and services are closed. Services need to state that they are open to talking about LGBT issues. The elephant in the room is that there are Roman Catholic schools that would not talk about it.”

- (Discussion group 2, National Dialogue event, Glasgow)

In the discussion and workshop groups instances of good and bad practice were ‘traded’ in a dialogue between the participants. For example, in the dialogue of one discussion group an example of good practice in joint working was offered by a presenter (Discussion group 1, National Dialogue event, Glasgow). Other people’s own examples of good working were then added through the discussion, which were countered by further examples of bad practice, in this case in relation to funding and problems with community empowerment which was blamed on a loss of skills in community work. This dialogue based on the trading of practice examples gradually built up a sense of what might be appropriate practice in relation to the *TAMFS* policy.

The trading of good and bad practice allowed the boundaries of work in the area to be ‘rehearsed’. Through the processes of the consultation appropriate practices were therefore developed in relation to the new policy being discussed. This process is educational in that it teaches those who will have to implement the new policy about how this may best take place. In this way the consultation process acts as a way of cementing the new policy in the minds of those who will have to do the work and arms them with strategies for how the work of the policy can be taken forward.

3.2.2 Practitioner knowledge in consultation response documents

As discussed above, the overwhelming majority of response documents were from organisations that directly provided services and programmes directed at population mental health or services for those experiencing mental ill-health. For one of our respondents the consultation response was secondary to the event – a necessary step in terms of its responsibilities to government, but not greatly important in and of itself (080408). However for others the process of writing the consultation response worked in a similar way to the participation of practitioners in events in that it allowed the organisation to rehearse the actions they might put in place to implement the policy once it was released. For example, the Lanarkshire response included a list of actions that would be implemented when the *TAMFS* policy was released:

“**Example 3 Health Promoting Health Service** provides the opportunity to enhance well-being by designing services which meet physical health needs and promotes well-being. This could be supported via staff training and a WELL-BEING framework. Well-being indicators could be used to measure impact. For example,

at a Lanarkshire event for older people the experiences of 5 older ladies from the Falls Service in Wishaw were recorded. They had heard about the event through the staff at the Falls Service. In speaking to the ladies it was impressive what they were saying about the falls service. They spoke very highly of the staff and were talking about the benefits to their well-being through making friends, reducing isolation, increasing confidence and feeling physically better as a result of the service they were given. It was impressive to see the nature of intervention i.e. using leisure services for rehabilitation, which promotes social inclusion, de-medicalises the issue and promotes sustainability after treatment.”

- (Lanarkshire response document)

This example presents how the *TAMFS* policy might be taken forward in practice. It reflects on the discussion of good practice which took place in the Lanarkshire consultation event in order to give a practical example about how the policy might proceed. This demonstrates the way that the process of the consultation can be visualised as the ‘first stage of implementation’. Those in charge of mental health in Lanarkshire have already, as a result of the consultation, investigated how they will need to implement the eventual policy.

3.3 Service user and carer knowledge

The involvement of the ‘end users’ of policy has been viewed as an important part of policy making for mental health in Scotland and organisations of service users have been specifically funded in order to fulfil this role for mental health policy²⁴.

Both service user and carer knowledge was present within the consultation process for *TAMFS*. While carers attended most consultation events it was service user rather than carer knowledge that was more present in the process. In this report we therefore also mainly focus on service user knowledge. Service users were present at every stage of the consultation process. They were included in every consultation event that we observed, and held several positions on the National Reference Group.

Service user knowledge derives from their direct and personal experience of mental ill-health. There is a long history of the implementation of mental health policies and service practices that have impacted negatively on the lives of those experiencing mental ill-health. This history impacts on the way that dialogue between service users and others involved in mental health services and policy takes place. Politically, the government needs to be seen to include service users in consultation processes so that they can be seen as open to their views after ignoring them for so long, but the extent to which their

²⁴ An example of this is the group Voices of Experience (VOX).

knowledge is actually used was questioned by some of the service users involved in the consultation.

3.3.1 Service users in consultation events

Unlike practitioners and government representatives, service users and carers did not give presentations on their experience at the consultation events but were most active as participants in discussion groups. As with practitioners, the service users and carers we observed based their knowledge on personal experience and often transmitted this knowledge through the use of small vignettes used to illustrate a point. For example in one discussion group a service user told how she was involved in recovery training with psychiatrists in her local health board area (Discussion group 2, National Dialogue Event, Perth).

While most of the service users and carers at the consultation events called for more involvement in population mental health work, several service users questioned their own participation in the process. This was because the *TAMFS* policy is a population based mental health policy, rather than one concerned with the direct operation of services targeting mental ill-health. A 'traditional' policy regime which focuses on mental illness rather than mental health has viewed the subjects of the policy as those who are experiencing mental ill-health and in need of treatment. Such a policy is focussed on services and its public are therefore service users. A policy which takes a population approach and focuses on the mental *health* of the entire population thus necessitates the visualisation of a different, 'public'.

Problems raised by a failure to engage and define the right type of public were discussed at length in several of the consultation discussion groups that we observed. Take for example the following quotation:

"We need to move away from 'service users' to 'members' – so people with mental ill health who haven't used services can be included too.... 'patient and public involvement' is a good term because all are potential service users."

- (Discussion Group 2, National Dialogue event, Perth)

Service users drew attention to the fact that the voice of the population, viewed as central to the success of the *TAMFS* policy, had not been factored into the consultation process. Although *TAMFS* had been a public consultation process it was felt that there had been no obvious attempt to engage with those outside the direct community already involved in mental health promotion and services. It was felt that a failure to engage the population at large with the ideas of positive mental health meant that the policy could not be successful.

Service users also questioned the extent to which service users as a whole could meaningfully participate in consultation processes and policy engagement in general. Use

of an overly 'technical' language was seen to disable policy engagement and disrupt policy learning. This can be seen in the following dialogues between service user participants in two different discussion groups:

"- Not an 'easy read' document so limits who can understand and discuss it...

- But the general public is not engaged in it. The agenda needs to be translated into the language of the public."

- (Discussion group 1, National Dialogue event Perth)

"- We lose sense that there is a skill in coming along to meetings and taking part and speaking. This is a learned skill and we need to recognise it.

- Glasgow has a 'jargon buster', which is about 40 pages long."

- (Discussion group, Greenspace Scotland event)

These dialogues position particular types of technical or specialist language as working to alienate the subjects of the debate by limiting their ability to either hear the policy message or engage with it in a productive way. Language is positioned as an instrument of policy with the power to include or exclude individuals and through this enable or disable policy development and implementation.

Service user knowledge did not 'travel well' through the process. Service user voices were present at the consultation events and reference group meetings but did not readily move from this context into the consultation response documents. This may be as a result of the form that service user knowledge was presented in. Personal experience is difficult to quantify and the vignettes in which service user knowledge were presented do not easily fit within some document forms.

3.4 'Expert' knowledge

Under this category we discuss the knowledge of individuals brought into the process as 'experts' either to present at consultation events or to produce the papers that accompanied the consultation or deliberations of the National Reference Group. We also include the knowledge of those experts who were not physically involved in the consultation, but which was evoked by participants and those constructing the key documents used. We will briefly list and describe the experts in order to provide an understanding of the type of expertise valued in the consultation.

Phil Hanlon

Phil Hanlon is Professor of Public Health at the University of Glasgow²⁵. His expertise was drawn on at several stages in the consultation. He spoke as an expert in public mental health at one of the consultation events that we observed. He produced a paper for the National Reference Group and was consulted on drafts of the Policy and Action Plan. The following quotation describes his involvement in the process:

“Phil produced a side of A4 and a bit which went to the reference group and I certainly read that and it influenced things. At one stage when we developed some drafts we identified a few people who we wanted to get comments from and Phil was one of those and made very helpful and extensive comments and a lot of those were incorporated.”
- (230109)

Two of our respondents commented on his influence on government thinking about positive mental health in Scotland (230109; 281107).

Keith Tudor

Keith Tudor is an author and psychologist who has written widely on mental health promotion. His theories were combined with those of Corey Keyes (discussed below) in order to produce the dual continua model represented in Diagram 1, above. He was commissioned by the Scottish Government to write a ‘concepts and definitions paper’ on mental health promotion. This paper was provided as a resource to the National Reference Group. Tudor attended the National Dialogue event in Perth and briefly spoke about the theories underpinning the dual continua model.

Corey Keyes

Corey Keyes is an academic working in Sociology at Emory University in Atlanta, USA²⁶. Keyes devised the mentally languishing/ flourishing concept which was incorporated into the dual continua model. In October 2007, just prior to the launch of the *TAMFS* document he presented a seminar in Scotland titled, ‘Towards a Mentally Flourishing Society: why we need mental health promotion’. This seminar was recorded by the government and used as a resource to support the consultation process. It appears on the wellscotland website as a downloadable pod-cast alongside the consultation document and other resources.

²⁵ For more information on Phil Hanlon refer to his page at Glasgow University: <http://www.gla.ac.uk/departments/publichealthhealthpolicy/ourstaff/philhanlon/>

²⁶ Keyes’ academic web page: <http://www.sociology.emory.edu/ckeyes/>

David Hunter

David Hunter is Professor of Health Policy and Management at the University of Durham in England²⁷. He was one of three international experts directing the 2007 Review of the National Programme. He gave a presentation on the Review at the National Dialogue event held in Perth.

Allyson McCollum

Until early 2009 Allyson McCollum directed the Scottish Development Centre for Mental Health (SDC). She spoke at several events and drew on her experience as the director of an organisation offering mental health research and practice and development. She was the 'expert' most cited within the consultation event – perhaps reflecting the experiential knowledge of Scottish mental health work built up by her organisation through their work.

Richard Wilkinson

Richard Wilkinson is a Professor of Medical Epidemiology at the University of Nottingham in England. His work on inequality was invoked on several occasions in the consultation event presentations and discussion groups and at the National Reference Group. He is an academic and popular author whose work focuses on the impact of income inequality on health inequality. Wilkinson spoke at the SDC's Annual Conference in Glasgow in October 2007 which is the event at which the *TAMFS* document was launched.

Carol Tannahill

Professor Carol Tannahill is Director of the Glasgow Centre for Population Health. She presented as an expert at one of the meetings of the National Reference Group. Her presentation focused on mapping solutions that reflect the complex matrix of factors that contribute to poor mental wellbeing. This matrix includes a mix of both social and individual factors and she argued that solutions should therefore not just be centred around mental health services.

Other experts named in the consultation process were people such as Oliver James (English author and psychologist), Lynne Friedli (English public mental health specialist) and Richard Eckersley (Australian academic and author).

As this list demonstrates, the experts whose knowledge was included in the consultation are mostly public health specialists and academics. Academic knowledge was not prominent in the consultation events and only visualised through the presentation or citation of the work of these experts. It was more prominently used in the reference group, which included academics and was provided with papers and presentations by

²⁷ More information is available on Hunter's academic web page:
<http://www.dur.ac.uk/school.health/staff/?username=dhs0djh>

Keith Tudor, Phil Hanlon and Carol Tannahill. The experts present a mixture of local actors who know the Scottish 'scene' and international experts who provide the theoretical and epidemiological perspectives which frame the work of the National Programme.

3.5 'Silent' actors

3.5.1 Politics

Political actors were mostly absent from the consultation process. The only political actors individually named at events were Alex Salmond (the current Scottish First Minister), Kjell Bondevik (a former Norwegian Prime Minister who has spoken openly about his experience of depression) and Margaret Thatcher (a former UK Prime Minister, who was blamed by participants for structural problems effecting mental health services).

The Scottish Nationalist Party (the SNP) who form the current Scottish Government were the most prominent political actor spoken about. They were discussed in relation to their organisation of the Scottish Government around key outcomes and indicators, which was seen to effect the way that mental health was prioritised. They were also discussed in relation to their rearrangement of the bureaucracy of the public service which was seen to aid in cross-sector collaboration. It was claimed that the benefits of this reorganisation were not utilised effectively by the Mental Health Division, which meant that cross-sector working on mental health improvement could not take place (270309).

The *TAMFS* document was discussed with relevant ministers before its finalisation and release. The Minister for Public Health and Sport, Shona Robison provided a Foreword to the Policy and Action plan. The foreword commented on the government's aims for Scotland and for mental health. It highlighted cross-sector working and emphasised both the social and individual responsibility for promoting mental health. Robison ended with the following statement, which emphasised both the international standing of Scottish mental health work and the centrality of measurement through indicators as a policy tool:

"We are internationally renowned for our work on mental health improvement in Scotland. Over the next two years, this policy and action plan will build on these strong foundations and advance our work through tangible and measurable actions."
- (Scottish Government, 2009, p.3)

This ministerial involvement and endorsement was seen as important for the validation of the document and was noted at several meetings of the National Reference group.

3.5.2 Psychiatry

Psychiatrists did not participate at most of the consultation events and were not invited to do so by the government. They were not amongst the practitioner groups that were suggested by the government in its guidance notes as appropriate participants for consultation events. The government may have feared that the presence of psychiatric knowledge at consultation events may have unsettled the message of positive mental health being promoted at these events. Psychiatric knowledge challenged the mentally flourishing framework, as evidenced in the response document submitted by the Royal College of Psychiatrists, which made the following comments:

“Section 4.1 splits “mental well-being” into three dimensions, without any discussion or referencing of why “emotional, social and psychological” components should together amount to well-being. Section 4.2 proposes that “someone could experience signs and symptoms of mental illness and still have good or flourishing mental well-being”. Given that most conventionally accepted definitions of mental illness include the experience of distress of some kind, (eg “A *clinically recognisable set of symptoms or behaviour associated in most cases with distress and interference with personal function.*” (World Health Organisation, 1992)) this statement is of questionable validity.... In our view, “mental illness” and “mental well-being” are profoundly intertwined, and simplistic two-dimensional models may not do justice to their complexity, nor to the lived experience of people with mental health problems.”

- (Royal College of Psychiatrists consultation response, p.2)

Given what we have argued about the educative function of consultation events for practitioners an alternative voice challenging the theoretical basis underpinning the consultation document would have been unwelcome in this environment.

However, as discussed earlier, psychiatrists were invited to attend the meetings of the National Reference Group. Here the involvement of psychiatry was important for validating the consultation process and its outcome. One of our respondents spoke about the position of the Royal College of Psychiatrists on the National Reference Group. They felt that politically they needed to include the College on the group but that it was not necessary for policy development in population mental health:

“Why does the Royal College of Psychiatrists have to be on the *TAMFS* reference group? Why? They need to know that this is an important thing that is happening that will help their world, but they don’t need to be on it. But you can’t have that yet.” (270309)

The inclusion of psychiatry was thus still seen as symbolically central to any major work being done on anything to do with mental health.

There may be other, more practical, reasons for why psychiatry was not more prominent in the consultation process. Psychiatry is not well organised in Scotland as compared to England. In our interviews for Orientation one we heard that the Royal College of Psychiatrists in London had over 50 staff working for them where there were only two staff working for the College in Scotland. Also, psychiatry has traditionally had little to do with the day to day work of public mental health, given that their focus is on the treatment of mental ill-health. It seems that in Scotland this may be in the process of changing as psychiatry has been recently involved in the work of the National Programme around recovery, where psychiatrists have been asked to consider using the Recovery Oriented Practice Tool. Their use of this tool has been specified in the key mental health services policy document *Delivering for Mental Health* (Scottish Government, 2008b).

3.5.3 Community as therapeutic agent

The most frequently cited actor by those participating in the consultation process was the community. The community was viewed as an actor which had the capacity to effect change in an individual's mental health. It was characterised as both a risky, problematic entity and as a panacea for mental health. When functioning well it was characterised as being able to act as a therapeutic agent, alleviate mental ill-health and promote "flourishing".

Through the dialogue in the consultation process an idealised, mentally healthy community is imagined and then worked toward. The discussion builds up a range of identifying features that characterise the mentally flourishing community. Taken together the dialogue at consultation events and through documents gradually develops the mentally flourishing community as a distinct and multi-faceted entity. The idealised mentally flourishing community is positioned as a site where individuals are able to actively participate in how the community functions. It is also characterised as supportive and as providing opportunities for individual self-development.

"In mentally healthy communities people feel: safe, respected, supported. They are places where people have opportunities for social interaction skills, participation, influence and have access to resources."

– ('Expert' presentation, consultation event)

"...a mentally flourishing Scotland is underpinned by communities where people live and work in quality, sustainable places, which promote positive mental health and wellbeing, and where individuals and groups can play an active role in the decision making and management of their neighbourhoods."

– (Greenspace Scotland consultation response)

In contrast to this another dialogue runs through the consultation which portrays a counter vision of the problematic community which is bad for people's health and needs to be worked against.

A long list of actions or environments are listed as needing to be carried out or created in order to create the idealised mentally flourishing community, but the key mechanisms or processes through which these actions should take place are not articulated. The imagined community is thus idealised and evoked as a space either good or bad for mental health but with no fixed identity that can be practically worked toward.

3.6 Actor knowledge: summary of key points

1. The government did not create knowledge. It selected and brought together forms of knowledge in circumstances where others could create new knowledge.
2. The government focused on theory and language as important policy instruments and used and created statistics, targets and indicators as key tools for policy change and validation.
3. International validation of their work on mental health improvement seems to be important to the government.
4. Practitioner knowledge was based on the experience they gained in their day to day administration of programmes or interaction with clients.
5. Practitioner knowledge was often presented in the form of demonstrations of 'good practice', that were presented orally.
6. Trading of good practice has an educative function in the context of a policy consultation process. Practitioners can learn from each other and think about innovative practice in relation to the new policy. This process is important for the implementation of the policy. Consultation can thus be seen as the first stage of implementation.
7. Presentations of good practice are useful for the government in that they offer a validation of how the policy may be taken forth in practice. This demonstrates that the government's agenda is achievable.
8. The participation of service users in the consultation debate was questioned given that this consultation process concerned a population mental health strategy, not one focused on services for mental ill-health.
9. Service user knowledge did not travel well through the process. It was present in the 'spoken word' events (consultation events and reference group) but present to a much lesser extent in written documents.

10. Political actors were silent in the process apart from the validation that the Minister's introductory statement brought to the Policy and Action Plan. They were seen to have influence on the policy through their bureaucratic organisation of the government.
11. Psychiatry was not specifically invited into the consultation events but was seen as a necessary part of the National Reference Group in order to validate the Policy and Action Plan.

4. Knowledge dynamics

This section looks at how different forms of knowledge 'flowed' through the consultation process. We take each part of the consultation process sequentially according to the time that each document or event was produced and look at how knowledge flowed from one stage to the next. We examine how the knowledge in the consultation document flowed into consultation events, from events into response documents, response documents to the synthesis document and so forth.

4.1 Consultation document to consultation events

Knowledge flowed well between the consultation document and the consultation events which we observed. For all but one of the events the presentations and discussion themes chosen all engaged with the topics and theory presented in the consultation document. Most presentations provided concrete examples of mental health improvement work in practice and spoke about creating a practice environment that balanced services for care and treatment of mental ill-health with population measures. This may indicate either that the communication strategies of the policy consultation events were successful or that this audience was already well aware of the importance of this agenda to their work.

Only one of the consultation events that we observed failed to pick up on the theme of the consultation. The Universities Scotland event consisted of a series of presentations that were not about mental health improvement, but were about the administration of services for mental ill-health to students. There was no discussion of the *TAMFS* agenda until the final presentation which was given by a government speaker.

4.2 Consultation events to response documents

"This wasn't really done very scientifically. I just read through the discussion notes and got a feeling of what the main points had been" (080408)

We interviewed individuals responsible for synthesising the information collected at four of the consultation events that we attended. Those putting together the information relied on the notes that they took on the day along with notes taken by discussion group facilitators and notes made on 'flip charts' by the groups. One respondent spoke of the difficulties encountered in putting this together as a result of notes being indecipherable or lost (080408).

All those putting together the responses emphasised that they were after an overall flavour of the ideas raised at the events, rather than specific suggestions. As one

respondent noted, there was a need “to focus on the key things being said and the main areas of agreement.” (280508) This would mean that innovative responses to the policy consultation which were not widely known would not make it through to response documents.

Unlike the consultation events hosted by these organisations, there were not many examples of good practice offered in the response documents of organisations that provided services. Stories of good practice were still offered in the documents, but these did not take the form of personal vignettes and were backed up with ‘hard evidence’, rather than personal experience. For example:

“Review level evidence demonstrates that programmes promoting positive mental health are effective in improving multiple areas of functioning and in reducing the risk of mental health problems.” - (Lanarkshire response document)

The form of the document here has an important bearing on the types of knowledge that they are able to contain. The practices of these more formalised documents, or the organisations that produce them, seem to need to rely on ‘formal’ data to be valid in an environment where codified targets and evidence are the most respected form of knowledge.

4.3 Response documents to synthesis

A private consultant was contracted in by the government in order to synthesise the knowledge from the consultation responses. In one of our interviews the consultant who wrote the synthesis document commented on the way that they systematically went through the responses in order to identify and draw out the main themes emerging. As discussed earlier, the data in the synthesis report was organised around the three questions guiding the consultation process with other prominent themes also noted. As the consultant noted, no matter how systematic and structured the process was made it was felt that there would always be knowledge left out and a loss of innovative policy options when a short synthesis document of only 34 pages was made to bring together over 75 policy responses (270508).

This inevitable constriction of knowledge meant that some knowledge had to be left out. Certain forms of knowledge were more likely not to make it into the consultation synthesis from the responses. For example, while good practice was seen as a good thing, as reflected in the discussion of a suggestion of the development of a ‘good practice’ database, there were very few examples of good or bad practice included in the synthesis document. There was thus a gradual lessening of the use of good and bad practice the further through the chain of consultation events and texts this knowledge travelled. This may be because good practice has a specific use within the discursive context of consultation events but has a much more limited role to play in documents. In

consultation events the function of good practice is (as discussed at section 5.2, above) toward the mutual education of a practice community through the sharing or 'trading' of practice examples. Good practice when used in documents is not traded in this way and is used as a singular exemplar of successful policy implementation. Examples of bad practice, perhaps for good reason, is almost non-existent in the synthesis document. The loss of this type of knowledge may thus be less about the priorities guiding those devising the response and synthesis documents and more about the 'form' that these documents conventionally take.

4.4 Synthesis to reference group and final policy and action plan

The synthesis was a very important document in the consultation process because it was the main link between the data from the data gathering stage of the consultation process (the consultation events and response documents) and the development of the policy and action plan. This is because the National Reference Group and the individual public servant charged with writing the policy and action plan did not read individual response documents and did not attend multiple consultation events, so this was the only link they had with this earlier stage of the process (230109).

The reference group was provided with an early draft version of the synthesis document at its second meeting which was used as an aid for discussion. It was also sent the final version of the document, but this was not directly discussed in the meetings. We could find no direct intertextual references to the text of the synthesis document in the final policy and action plan.

4.5 Reference group to final policy and action plan

They National Reference Group did appear to have some direct impact on the drafting of the Policy and Action plan. The reference group saw three drafts of the Policy and Action Plan in April 2008, May 2008 and August 2008 and were able to comment on these. For example, at one meeting the government introduced a possible social marketing scheme with the help of some graphic designers, but the idea for the scheme was rejected by the group. At another meeting – the last – the public servant engaged in writing up the final policy document spent an hour with members of the group going through the proposed policy document line by line. Members of the group asked for the removal of confusing diagrams and for particular pieces of text to be altered. The offending text and diagrams did not appear in the final policy document. Reference group members were also invited to provide email responses on this version of the document.

4.6 The TAMFS policy and action plan

The public servant charged with constructing the final policy and action plan had not been involved in the consultation process until quite late in its proceedings. They entered the process after the consultation events had finished and only attended one meeting of the National Reference Group (230109). This meant that they relied on documents and advice from others to find out the content of the consultation process up to that point. Other evidence drawn upon came from the meetings of an internal government reference group, who provided advice on how the agenda might work in with that of other areas of the Scottish Government. A further series of closed, invited, consultation events was also developed in order to get specific advice about action on each of the priority areas identified in the final policy and action plan. For example there was a session on children and young people and to this were invited key actors from the health sector, voluntary projects, local government and so forth. These events advised on how the proposed TAMFS agenda would work in with other work being done in this area and what specific actions might be considered useful in relation to this (230109).

The Policy and Action Plan went through several drafts, the first of which was provided to the reference group in April 2008. We have analysed the May 2008 and August 2008 drafts that we had access to and the final policy document in order to give some indication of how the document developed over time.

4.6.1 Draft a: May 2008

This document is 6,700 words and is very much a draft document. It is written in note form and made up of three sections. The first section includes sections introducing the ideas underpinning the programme and the wider policy context in which it sits. It lists the focus of activity for the next stage of the National Programme, which will be:

- improving the lives of people who experience mental health problems and mental ill health.
- the prevention of mental health problems, mental illness and suicide.
- the promotion of wellbeing.

Section two lists the specific actions that will be taken under each of these headings:

- **Improving lives:** Improving the lives of those who experience mental ill-health through improving social inclusion, reducing stigma, and working on physical health and employment.
- **Prevention and early intervention:** of “mental health problems, mental illness, com-morbidity and suicide, with a focus on key risk and protective factors and the wider determinants of illness and health.” Here prevention

and early intervention work is clearly situated within theories of positive mental health and the idea of the dual continua: "...includes differentiating more clearly between what is a 'clinical' problem and treating the underlying causes and symptoms and what is about supporting, responding to and coping with 'life's challenges and changes'."

- **Promoting wellbeing:** "The promotion of mental health or mental wellbeing is the concentration on the positive dimensions of mental health." This section includes a definition of mental wellbeing: "Mental wellbeing refers to three main dimensions – emotional, social and psychological wellbeing. This includes our ability to cope with life's problems and make the most of life's opportunities, to cope in the face of adversity and to flourish in all our environments; to feel good and function well, both individually and collectively. Mental wellbeing ranges from good or high mental health or flourishing at one end of a continuum to poor mental health or languishing or at the other." This definition includes in this last sentence a reference to the theory of mentally flourishing which framed the *TAMFS* consultation document. This section also discusses the development of a wider range of indicators for measuring positive mental health.
- This section of the document also includes an **Overview** which lists the main areas in which these three overarching actions should be enacted. These are; early years, employment and working life, community regeneration, public service delivery and enhancing 'mentally healthy places'.

The rest of the document specifies ideas for local delivery, support for delivery and governance and accountability.

4.6.2 Draft b: August 2008

At 23,000 words this is a very different document to that circulated to the National Reference Group in May. It is much more in depth and has a different overarching structure than the previous draft. It is structured around the following main sections: Our Approach; Implementation Framework for Action and Strategic Priorities; The Action Plan; Implementation Support; and Summary of Actions. Most of these sections contain a great deal of detail about rationale and proposed actions.

Our Approach: contextualises mental health improvement work in Scotland within Scottish Government priorities, international work and ideas on mental health, including those of WHO. It also discusses the practical implications of the Single Outcome

Agreements²⁸ and the relationship of the work of the National Programme to that in other government departments and local governments.

Implementation Framework for Action:

This section highlights the 'underpinning principles' of the policy. These are 'inequalities', the creation of a 'balance' between work on individual and social determinants of mental ill-health, the development of 'partnerships' and 'integration' of work between and within areas, 'participation' of those with a lived experience of mental ill-health, a 'population' approach and action based on a 'social model of health'²⁹. It also lists a set of "strategic priorities":

<p>Mental health improvement for the early years of life</p> <p>Mental health improvement for school aged children</p> <p>Mentally healthy continuing education</p> <p>Mentally healthy workplaces</p> <p>Mentally healthy communities</p> <p>Mental health improvement in later life</p> <p>Increasing mental health improvement literacy</p> <p>Increasing self help</p> <p>Preventing depression and anxiety</p> <p>Preventing suicide</p> <p>Preventing self harm</p> <p>Improving the quality of life of those experiencing mental illness</p>

The three 'actions' listed in chapter four of the May 2008 draft are listed as aims in this section but these actions are not expressed in depth as they are in that draft. For example, wellbeing is no longer defined using the Keyes mentally flourishing/languishing

²⁸ The recent Audit Scotland report on mental health explains SOAs: "With the introduction of the concordat between the Scottish Government and COSLA in 2008, certain council funds are no longer ring-fenced. This means that funds previously used fully or partly for supporting people with mental health needs (eg, Mental Health Specific Grant, Choose Life, Changing Children's Services Fund (CCSF) and Supporting People) are now part of a council's general allocation and councils decide what these funds should be spent on.... It is too early to assess the impact of funding changes for councils on mental health services. The councils in our fieldwork have made no major changes to the levels of funding previously ring-fenced."

http://www.audit-scotland.gov.uk/docs/health/2009/nr_090514_mental_health.pdf

²⁹ The document suggests the inclusion of Dahlgren and Whitehead's (1991) widely used diagram of the social determinants of health.

continua concept. Mental wellbeing is not defined in the document in any way although mental wellbeing literacy is listed as a key outcome within the section 'National Actions'.

Action Plan

This section is split into National Actions and Local Actions.

National Actions are: Mental health improvement in the early years of life; Mental health improvement for school aged children; Mentally health continuing and further education; Mentally healthy workplaces; Mentally healthy communities; Mental health improvement in later life; Preventing depression and anxiety; Preventing suicide; Preventing self harm; Improving the lives of those experiencing mental illness; Increasing mental health improvement literacy; Increasing self help; Ensuring equality considerations are integrated into all major Scottish Government driven activities for mental health improvement; and, Mainstreaming mental health improvement across government policies. The actions listed in this section are discussed in depth with 'specific actions' listed, for example, "NHS Health Scotland will investigate further the evidence to support the effectiveness of lifestyle messages for mental health improvement".

The 'local actions' listed are not prescriptive but give some suggestions for work that might be taken forward. The optional nature of this section is in line with the move to Single Outcome Agreements for local governments which means that local areas will have to negotiate proposed actions at a community level.

Implementation Support:

This section lists the administrative steps that need to be taken to support the development of the work of the National Programme. It includes sections on 'Developing intelligence/knowledge', which emphasises the further development of theories of mental health and illness, the creation of more 'data' on mental health and illness (including the further development of WEMWBS type scales for new populations such as young people, which was discussed in the May 2008 draft), information on the causes and consequences of mental ill-health, and the gathering of evidence on effective interventions.

4.6.3 Final policy and action plan: April 2009.

The final *TAMFS Policy and Action Plan* released to the public in April 2009 is a much shorter document which at only 8000 words is almost a third of the length of the draft that the National Reference Group saw in August 2008.

Six strategic priorities are listed in the document:

Mentally healthy infants, children and young people

Mentally healthy later life

Mentally healthy communities

Mentally healthy employment and working life

Reducing the prevalence of suicide, self-harm and common mental health problems

Improving the quality of life of those experiencing mental health problems and
mental illness

This condensed list includes nine of the twelve priority areas listed in the previous draft of the document but does not specifically refer to continuing education, self-help or mental health literacy as the draft document did.

The action plan lists each of the strategic priorities, discusses them and assigns relevant commitments which the government will strive to meet. It also identifies partners that it will collaborate with in order to meet these commitments. For example, under Priority 1: Mentally Healthy Infants, Children and Young People is listed commitment four:

“NHS Health Scotland will work with key stakeholders to develop a set of national indicators for children and young people’s mental wellbeing, mental health problems and related contextual factors by 2011.”

Some of the commitments are specific and contain definite targets, for example:

“Commitment 15: Working with partners, NHS Health Scotland will develop a secure, confidential suicide register for Scotland by December 2009.”

While others are not so specific:

“Commitment 13: The Scottish Government will take forward work to develop consensus on what it would mean to be an exemplar employer and agree standards and consider an implementation plan for public health bodies to achieve the standards.”

The creation of specific commitments links directly to the introduction of an ‘outcomes approach’ with its emphasis on actions that are measurable. As discussed earlier at section 4.1.6, the emphasis on commitments and collaboration aligns this document within an administrative culture dominated by the Concordat and National Performance Framework.

The big changes that seem to have been made between the first draft shown to the reference group, and the final policy document are the:

1. addition of an 'outcome action' approach as a framework.
2. addition of commitments.
3. loss of the dual continua/mentally flourishing theory.
4. loss of a focus on mental health literacy.

In a way these changes make sense because they meet the needs of the policy and action plan format which is created according to a fairly strict document form. These type of documents perform the function of telling an audience what the new policy is and how it should be implemented. Early drafts of the policy did not include definite commitments and focused more heavily on defining concepts and groups of actors. This was not seen as appropriate for a policy document of this type. Policy actors learn from reading and writing other policy documents, what is expected of a certain type of document. A conceptualisation of the stylistic attributes of a particular document form, placed within the particular context of the process in which it is written works to produce the document in a specific way:

"...my perspective of where we were at that moment was that, the consultation document was well received but there were no clear actions in it and if this was really to be a policy and action plan, getting things into implementation, we needed to be very clear and specify what actual commitments we were going to make or what commitments we thought other organisations should undertake. And some of my insight for that, into that, came from Delivering for Mental Health, which was very clear.... It had very clear commitments and it had gone down well. It was very easy to see when commitments had been achieved and when they hadn't and how well people, including government, were working towards them."

- (230109)

As this quotation demonstrates the public servant putting together the Policy and Action Plan had 'learnt' from other documents that were seen to be successful examples of mental health policy and the *TAMFS* document had thus come to resemble other similar policy documents.

A developing focus on commitments might be seen as connected to a decreasing emphasis on the importance of a strong theoretical underpinning for the policy as emphasised but the absence of the dual continua/ flourishing theory or emphasis on mental health literacy in the final document. When the *TAMFS* process was being developed it had a significant amount of input from a specialist consultant in public mental health who had a strong interest in the theoretical dimensions of the work he was doing. When this consultant left the National Programme during the consultation process

the direction of the process in the government went to a team whose background was mostly as public servants. This change could be seen as contributing to the framing of further *TAMFS* work within the 'outcome action' approach which fits neatly with other approaches taking place within the Scottish Government, such as the Single Outcome Agreements or the National Performance Framework.

The new public service team conducting the consultation process also expressed views in the reference group about the unnecessary use of theory which was seen to complicate the work rather than add to it. In one of the reference group meetings a heated debate took place about the shape of a new social marketing campaign for positive mental health. The government speaker made the point that while theory was good and necessary at one level it was not necessary for individuals to know the theory behind why they were doing things.

"Although we need to know the theory behind the document, we do not need to explicitly state this in the document."

- (Government speaker, National Reference Group, 22 May 2008)

"[reference group member 1]: The missing building block is literacy about this. The connection between people and wellbeing needs to be understood.

[government speaker]: is this necessary? Do people need to know this link to do it?

[reference group member 1]: yes it is. They need to know, for example, why we do the 'five a day' for fruit and vegetables.

[reference group member 2]: No, you just need to say 'exercise is good for mood'.

[government speaker]: We need to know the theory but to what extent do others need to know?"

- (Discussion, National Reference Group, 22 May 2008)

"We may need to simplify the language we use to make it more tangible to those receiving the message and not so much reflect the underlying theories structuring the work."

- (Government speaker, National Reference Group, 22 May 2008)

Where the consultant initially directing the consultation process used theory to explain and clarify the work of the programme, this government speaker, who played a key part in the development of the final document, repeatedly expressed the need to simplify the message of the programme through decreasing its emphasis on theory.

One of the interviewees suggested that the policy and action plan would work best if it contained no theory or framework for action, but rather worked as a short and punchy list of action points which clearly spelt out who should do them and how they should be done (270309). Questioned on this further, the respondent stated that the main point of placing the theory within the consultation document was in order to get people thinking about it and talking about it as part of the dialogue at events and through the document writing associated with the consultation process. These processes were seen as very important for getting the conceptualisation of positive mental health taken up by those working in mental health promotion in Scotland.

Another reason why the document may have come to look the way it did (with its management rather than theoretical focus) is that after the National Reference Group last met in August the internal government reference group and meetings with COSLA continued. This increased the influence of internal government conceptions of policy and practice and lessened the influence of external ideas.

The development of the final Policy and Action Plan seemed very much to be an autonomous and 'closed' process, very different from the 'public' process of the consultation events and National Reference Group. At this stage the person, or group of people, who drafted the policy became very important as they were able to call upon new knowledge or de-prioritise some forms of knowledge without external scrutiny. The interview we conducted with the public official involved in writing up the policy document took place before the release of the Policy and Action Plan. This means that although we have some insight into the process we are not in a position to be able to say exactly what went on between the final draft seen by the National Reference Group and the published Policy and Action Plan. We hope to interrogate this process further in future interviews.

4.7 Knowledge dynamics: summary points

1. The knowledge written into the consultation document flowed largely unchanged into the presentations at consultation events
2. The discussions of 'good practice' from the consultation events were not present in the same quantity or form in the consultation response documents. Representations of good practice became more formalised and used 'harder evidence' in the response documents.
3. The synthesis document represented an inevitable narrowing of knowledge as the response documents were reduced into a short 'high-level' summary.
4. Major themes relating to the main questions asked in the consultation document made up the majority of the synthesis document. This meant that innovative practice ideas were not included in the synthesis.

5. The synthesis document was a key 'moment' in the consultation process as the National Reference Group and the individual developing the final policy and action plan did not read the individual consultation response documents or attend more than a couple of the events.
6. Extensive changes were made to the draft policy and action plan after the National Reference Group last saw it. At this point the consultation became a 'closed' process where the interests and priorities of those drafting the final policy and action plan became very important in shaping the document.

5. Knowledge instruments

5.1 Consultation as education

In section 2.1 we began by defining consultation processes as “fora specifically and ideally formulated to allow new ideas to be argued, tested, upheld or dismissed in order to create a new policy to direct action”. This may be what consultations are designed to do, but it is clear from our analysis that this is not their only purpose. Within the *TAMFS* consultation the purpose of creating a new policy seemed at some stages to be secondary to the purpose of ‘education’ of the policy ‘public’.

Different actors used the consultation process for different educative purposes. In our discussion of practitioner knowledge (section 5.2, above) we showed that for organisations hosting consultation events these served the purpose of educating those working within their organisation or area about the role that they had to play in doing the work of the National Programme. This ‘education’ took place via presentations made by government, practitioners and experts. It also occurred through the back and forth dialogue of practitioners sharing good practice.

For organisations working more peripherally in relation to traditional mental health work they used the consultation process to educate both those within their own organisations and the sector as a whole that they had a valid role to play in the work of the National Programme. This can be seen in the following quotation from one of our interviews:

“Obviously we wanted the National Programme to be represented [at our event]... We wanted to make sure [the event] had a very strong mental health slant and that very much the national mental health agenda recognised the impact and importance of [our organisation]... So actually we were making a very strong statement not only to [our organisation’s] practitioners but to health practitioners that there is a strong recognition of [our organisation’s work].” - (290508)

For the government the consultation document and events also provided an opportunity for educating a captive audience about the issues and practices involved in the implementation of policy and practice for population mental health. The use of language and theory were important instruments in this work.

This educative function seemed to be a very important one in this consultation process and should be seen as complementary and necessary in relation to the process of consulting to influence the development of the next stage of the policy. Through its educative function the consultation process worked to carve out a new space for policy action which would mean an easier transition to the new policy and a greater depth of policy awareness which would, in turn, lead to better policy implementation. In this way

we can visualise the consultation process as functioning as the first stage of policy implementation. Consultation processes in themselves thus act as a macro instrument of policy.

5.2 Theory

“In the absence of evidence we need to work with theory and plausibility”

- (230109)

The consultation document and government presentations at consultation events focussed on the introduction of a new theoretical framework within which mental health work should be conceptualised. As discussed in depth in section 3.8, the mentally flourishing framework was chosen because it realised in theory the government’s aim that mental health improvement work be seen as equally important in relation to work on mental health services (270309). However as the policy consultation process progressed the mentally flourishing dual continua theory became much less prominent in the process and ended up being dropped from the final *TAMFS Policy and Action Plan*.

One of our respondents commented that the decision to use the theory related to its status in relation to other types of knowledge. They spoke in depth about the choice to include the dual continua theory in the policy document (230109). Use of the theory was seen as a logical step for the consultation document as it provided a justification for the policy approach taken where no other evidence existed that would justify the policy. In the *TAMFS* consultation document theory was thus used instrumentally in place of other evidence when there were no other forms of evidence available. However, by the time that the policy and action plan came to be written other forms of knowledge had become available which were seen to challenge the ‘authority’ of the theory as evidence underpinning the work of the National Programme.

The use of theory as evidence was challenged when statistical data became available. Data from WEMWBS was cross-matched with data on inequalities which seemed to contradict to a certain extent the dual continua theory. The data did not reflect what may have been expected in each of the four quarters of the dual continua spectrum (illustrated in Diagram 1, above):

“...we can map out on the dual continuum data on mental health problems and mental wellbeing and what we think we are probably going to find is that three of those match the data, but one of them doesn’t. So what does that tell us?”

- (230109)

It was not clear why this was the case, but the creation of this data served to destabilise the dual continua theory for those developing the policy and action plan. Theory, then,

was seen as important, but was 'outclassed' as a form of reliable policy evidence in the face of 'data' sourced from measures and indicators.

5.2.1 Social/individual factors

"There is a tension in this group. Some say that individuals are expected to change themselves, but this oversimplifies things. There are societal factors that stop people from making changes in their lives. It would be a step backwards if we forget this."
– (Practitioner, National Reference Group)

A small current of discordance running through the consultation process derived from the purported conflict between those who view a lack of positive mental health as stemming from societal factors versus those who see it as stemming from more individual factors. One side of the argument was that social factors determine an individual's mental health, and therefore that action should take place on a societal level in order to improve the population's mental health. Those who support this perspective cite the work of Richard Wilkinson on health and inequality. The perceived other side of this argument comprised those who believe that individual factors are responsible for the quality of an individual's mental health and that all action on mental health should thus take place at an individual level. Although there were some in the consultation process who self identified with the 'social factors' perspective we could not identify anyone who clearly identified with the 'individual factors' perspective.

Neither of these 'forms' of approach to mental health was clearly expressed in the consultation events, but rather what was expressed was a hybrid mixture of both. The National Reference Group, on the other hand, was far more tuned in to this purported split and it was raised in several meetings. Members of the group questioned the way the *TAMFS* document emphasised the individual and their ability to act to change their lives given the life circumstances that they have to cope with daily. It was also mentioned in the interviews we conducted with key actors, perhaps reflecting that this was a theoretical issue in play amongst those in more senior positions rather than those working on the ground.

5.3 Language

The instrumental use of language in this consultation process was discussed in detail in section five of the report in relation to the knowledge of government actors and service users. The Scottish Government was shown to situate language failure as partly to blame for a failure of policy to be fully implemented or understood by the 'right' groups of people. Likewise service users and carers spoke about use of the wrong types of language as responsible for the exclusion of certain groups that should be included in the consultation process and the work of the National Programme, but were not.

Another indicator of the importance of language as an instrument of policy is in the emphasis placed on the need for a common language:

“...when talking about mental health, mental wellbeing and mental illness there needs to be consistency in language used.”

- (NHS Borders multi-agency response³⁰)

“...we need a common language”

- (Practitioner presentation, National Dialogue event, Perth)

“Need a common language – a mental wellbeing glossary?”

- (NHS Tayside response)

“Mental health literacy and developing a common language at all levels should be prioritised ...”

- (NHS Lothian Health Promotion response)

This theme was repetitively articulated throughout the consultation process. There was a frustration amongst a range of actors about the inability for a shared language to be developed that could simply express the theoretical basis underpinning the work of the National Programme. A lack of a shared language was seen to result in limited shared working around the goals of the National Programme and a failure for the message of positive mental health to spread into other fields.

These examples show that for many of those taking part in the consultation process, language was viewed as an important instrument whose correct use would lead to successful policy outcomes.

5.4 Indicators

“[It] needs a robust performance framework (as in the Renfrewshire case presented) for local areas. We need to be able to show what impact improving mental health and wellbeing has.”

- (Discussion group one, National Dialogue event, Glasgow)

“We haven’t been talking about targets. Outcome measurements are important.”

³⁰ All response documents referred to in this article can be found at <http://www.scotland.gov.uk/Publications/2008/04/03092148/0> (accessed 10 December 2008)

- (Discussion group, Greenspace Scotland consultation event)

Our analysis pointed to a growing interest in the creation and use of statistics and, following on from this, the development of indicators for mental health policy in Scotland. This raises questions about why indicators and statistics are seen to have such utility for mental health policy.

The use of indicators in mental health policy has gradually developed since devolution. Statistics on suicide were one of the initial public drivers for mental health policy change in Scotland (281107). Statistics showed how big the problem of suicide was and validated radical action. They forced the government's hand and created an environment where significant legislative and policy innovation could take place. Since then statistics on depression and anti-depressant prescribing have been used in order to drive further policy action in certain areas. The impact of suicide statistics on mental health policy in Scotland demonstrated the power of statistics to drive policy change. The creation of new statistics via the creation of indicators for new aspects of mental health policy may be seen as a direct result of this.

"If you are focusing on an area of health improvement and want people to put a focus on it then you can do this through an indicator." - (101008)

In our interviews for our Orientation One report³¹, which mapped the mental health policy landscape in Scotland, we found there was a common understanding that policy needed indicators in order to be effective and for bureaucrats and practitioners to implement it. For example, *Delivering for Mental Health*, which directs the operation of mental health services in Scotland, was praised because it contained indicators which could be measured. Those involved in the TAMFS consultation process also expressed the idea that indicators are one of the best ways to validate policy, practice and funding. As one government speaker commented; "our aim is to make policy valuable, measurable and deliverable". This was seen to be very important because they "don't want to just make a value statement" (Government presentation, Lanarkshire consultation event).

Government speakers and others highlighted the creation of a new set of indicators for positive mental health in Scotland: the Warwick Edinburgh Mental Well-being Scale (see Box 3, below).

³¹ This research can be found in the Orientation One report which can be accessed at:

http://www.knowandpol.eu/fileadmin/KaP/content/Scientific_reports/Orientation1/O1_Final_Report_Scotland_health.pdf

Box 3: The Warwick Edinburgh Mental Well-being Scale (WEMWBS)

The Warwick Edinburgh Mental Well-being Scale (WEMWBS) is an indicator which aims to measure positive mental health (mental well-being). It consists in a set of 14 statements such as "I've been feeling interested in other people" or "I've been feeling loved" to which respondents, considering the previous two weeks, respond either: 'none of the time', 'rarely', 'some of the time', 'often', or 'all of the time'. It is a relatively new policy instrument which was developed in 2005 and launched in 2006. It was devised in order to fill the gap in evidence for interventions around positive mental health and population based-mental health strategies. It is meant to be a cross-cutting policy instrument that can be used across all areas of policy, but so far its use has been confined to population mental health work. The Scottish Government has listed WEMWBS as one of its 45 national indicators of government performance: "Increase the average score of adults on the Warwick-Edinburgh Mental Wellbeing Scale by 2011". It sits alongside indicators such as "60% of school children in primary 1 will have no signs of dental disease by 2010" or "Improve knowledge transfer from research activity in universities".

The development and use of these indicators in government policy was seen as a marker of policy success for the work of the National Programme. One respondent commented:

"We now have...indicator 15, which we knew we were going to have: indicator 15 of 45 government indicators is improve mental wellbeing by 2011, as measured by the Warwick Edinburgh Mental Wellbeing scale. So we're in the game.... If you don't have an indicator and you don't have a target you're not in the game. So we've got one and we're in the game, and that's just good policy management. Without that we'd be scrabbling to get on the top table. These 45 indicators are going to be discussed by every single cabinet secretary by the permanent secretary and by the first minister. They don't get signed off unless the first minister, the deputy minister and the finance minister agree to them. It's phenomenal."
- (281107)

This view was emphasised in all government presentations at consultation events.

It was felt that a lack of indicators meant that particular policies and programmes could not be justified to funders and agencies because their effectiveness could not be adequately gauged. This is emphasised in the following quotations:

"Data talks. This is why you need data and you can use this scale [WEMWBS] to gain data and prove your services are working."

- (Practitioner presentation, Lanarkshire consultation event)

"Money goes to areas that are measurable (and there are not many of these areas) so now we are working on making more things measurable."

- (Government presentation, Universities Scotland consultation event)

Making policy measurable was seen as especially significant with regard to the introduction of new Single Outcome Agreements³² between the Scottish Government and local authorities, which means that funding for mental health is not 'ring fenced' by the Scottish Government centrally and local authorities are free to spend it where they want. Clever use of the mental health indicators was viewed as a way of justifying expenditure on mental health within this new funding regime.

The dominance of the use of indicators in policy and practice was not, however, taken for granted. In one of our interviews a policy maker who had been involved in the creation of new indicators and targets also expressed doubts about their utility. Despite this he felt that their creation and use was part of the current political and public service environment in Scotland at the moment and that if you wanted to get things done you had to include them in your work:

"I'm not a personal advocate of targets. I'm not a personal advocate of performance management. For me I'm more interested in how you're doing as an agency or a public sector organisation at what we're doing. I find the pseudo-science of performance management irksome and predicated on a rational model of A to B. I could bring all of your collective intellectual capacity into saying why that's not necessarily a good thing. But that's what governments do, its what politicians do - they promise a manifest of commitments which can then be turned into words and phrases and targets that show the public and the communities and people whether or not we're going in that direction. Now you be the judge whether or not this is good: 'well, we made this target as a government. We asked the NHS to deliver and they can't deliver so that's why we keep bashing NHS managers when they can't deliver waiting time targets. We're the government, we've set these targets. They're the assholes who can't deliver it.' So is that a good way of achieving consensual policy change? Is that a good way of involving the public sector in meeting your agenda? I don't think so, it sounds pretty punitive to me. However it's the name of the game - at the moment."

- (281107)

In a discussion group at one consultation event there was a heated discussion over whether or not mental health workers are, or should be, working within an "outcomes driven world" where indicators are a primary part of policy (Discussion group 1, National Dialogue Event, Glasgow). It was argued that policy makers and practitioners could not operate without them because that is the lens through which everyone understood and

³² There was some concern expressed by mental health practitioners at the consultation events about the effect of the introduction of Single Outcome Agreements on the work of the National Programme.

legitimated policy success or failure. At other points in the consultation other, more practical, concerns were raised about the use of indicators. Some spoke about the difficulties encountered in trying to make actions occur through indicators, which was expressed as a need to get the measures 'right'. There was also a concern about the falseness of indicators: that indicators could never adequately represent actions/phenomena. These concerns are expressed in the following quotations:

"To be honest if you are not reporting a red light on a target for Delivering for Mental Health then you don't have to do anything. So if you have for example a 50% reduction in the suicide rate (maybe accidentally) then you don't have to do anything....There should be a per annum reduction in suicide - cleverer targets. Should be more about process not targets."

- (Discussion group two, National Dialogue event, Perth)

"How to measure outcomes needs to be flexible and measure different types of 'success'."

- (Discussion group one, National Dialogue event, Glasgow)

"How do you evidence [money not spent] when people are looking for statistics and economic approach – how to represent savings?"

- (Discussion group two, National Dialogue event, Glasgow)

One of our respondents spoke of a time several years before *TAMFS* when the statistics on anti-depressant prescribing were used to drive work on depression to the detriment of work on mental health improvement (270309). Here the anti-depressant statistics were working 'too well' meaning that other work in areas not so easy to quantify was being forgotten. There was no stark statistic that could be used to promote mental health promotion work. In an effort, perhaps, to counter these concerns the government speakers at consultation events spent time in their presentations emphasising that the new indicators developed for measuring positive mental health – WEMBWS - should be trusted and used.

Early drafts of the Policy and Action Plan included measuring mental wellbeing as an important part of communicating the concept of positive mental health. It recommended the following work on mental wellbeing indicators:

- “• Further development and refinement of adult indicators
- Further development and refinement of mental wellbeing scale(s) including WEMWBS
- Development of wellbeing indicators for children and young people.”

- (May 2008 Draft, TAMFS Policy and Action plan)

The introduction of these new indicators extended the boundaries of the governable space yet further. Although included in both drafts of the *TAMFS Policy and Action Plan* they were not, however, included in the final policy document (see discussion in section 6.6 above) but were removed along with the whole section on mental wellbeing.

Part of the utility of WEMWBS is that it marks out a new space as governable – that of positive mental health and this is important when the words used to express the theory have been deemed to be so unsuccessful. It is as if numbers do what words cannot. A set of indicators becomes the shared language that everyone can use.

5.5 Knowledge instruments: summary points

1. For organisations hosting consultation events these served the purpose of educating those working within their organisation or area about the role that they had to play in doing the work of the National Programme. This 'education' took place via presentations presented by government, practitioners and experts. It also occurred through the back and forth dialogue of practitioners sharing good practice.
2. For organisations whose work was peripheral to the traditional sphere of mental health work involvement in the consultation process externally and internally validated the organisation's participation in population mental health work.
3. We can visualise the consultation process as functioning as the first stage of policy implementation.
4. In the *TAMFS* consultation document theory was used instrumentally in place of other evidence when there were no other forms of evidence available. However, by the time that the policy and action plan came to be written other forms of knowledge had become available which were seen to challenge the 'authority' of the theory as evidence underpinning the work of the National Programme.
5. Theory was 'outclassed' as a form of reliable policy evidence in the face of 'data' sourced from measures and indicators.
6. Language was viewed as an important instrument whose correct use would lead to successful policy outcomes.
7. Knowledge is linguistically constituted and if it is not understood then the policy cannot be shared. Language thus contributes to the creation of a policy community.

8. Those involved in the *TAMFS* consultation process expressed the idea that indicators are one of the best ways to validate policy, practice and funding.
9. WEMWBS marks out a new space as governable – that of positive mental health. The WEMWBS indicators are important when the words used to express the theory have been deemed to be unsuccessful in marking out this new space.
10. Numbers do what words cannot. A set of indicators becomes the shared language that everyone can use.

6. Summary and conclusions: Knowledge

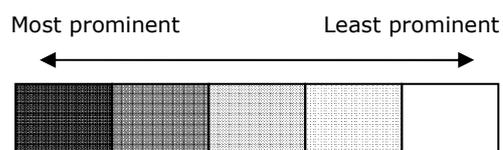
This concluding section of the report reflects on the way that the knowledge discussed in sections five, six and seven relates to each other within the *TAMFS* consultation process.

Diagram 2, below, highlights the way that a range of different forms of knowledge were evoked at different stages of the consultation process. It shows the way that some forms of knowledge dominated the initial stages of the consultation but were virtually dismissed by the final stage. It also demonstrates that knowledge did not appear and disappear from the consultation process in a linear way.

Diagram 2: Dominance of knowledge types in different stages of the consultation process.

	Practitioner knowledge	Government knowledge: mentally flourishing theory	Government knowledge: inequalities	Expert knowledge	Service user/ carer knowledge
Pre-consultation development of <i>TAMFS</i>					
<i>TAMFS</i> document					
Consultation events					
Consultation reports					
Synthesis document					
Reference group					
Development of the final policy and action plan					

Key to boxes: Reflects the relevant dominance of different types of knowledge in different stages of the consultation. From most prominent to least prominent.



6.1 Knowledge processing: creation, loss and change

The main points of knowledge production in the consultation process were the consultation events and, to a lesser extent, the National Reference Group and other 'closed' reference groups. Within these contexts the site of knowledge creation is in the discussion – the back and forth trading of theory, good practice, lived experience, opinion and so forth. Here knowledge is taken from one setting (academic theory, good practice, personal experience and so forth), reflected on in relation to a new setting and shared. This knowledge is a direct outcome of the consultation process, although not a very concrete one as it is not, as we have seen, readily encoded in documents. It does, however, serve to help in the conceptualisation of the new policy for the people who are going to implement it and in this way the knowledge has a productive yet intangible outcome.

“The challenge is that you could write a whole 40 page document on children and young people and that’s the kind of level of information we actually got... It could have been 10 bits of flip chart with bullet points all over them. So the challenge was condensing that to something that at least gave a bit of an indication.” - (230109)

Consultation processes give rise to huge amounts of data. How much data and what type of data should make it through to the eventual policy document? A vast amount of data entered the process in the texts of the consultation document, reports, response documents and other papers and via the dialogue at consultation events, reference groups and other forums. Very little of this 'formal data' flowed through and was present in the *TAMFS Policy and Action Plan*.

Through observing the consultation events and talking to our respondents in interviews we could identify many points of data slippage, where data was inadvertently lost. This can be seen, for example, in the Greenspace Scotland event, which brought together a large number of people working in fields not directly linked with mental health services. Greenspace Scotland put together a substantial consultation document based on the discussion at the event but this consultation document was received too late to be included in the consultation synthesis document. This meant that the data from the event was not accessible either to those in the National Reference Group or to the person who devised the final policy and action plan as they did not attend the event and only read the synthesis document, not individual responses. Universities Scotland likewise did not write a response document and did not take up their spot on the National Reference Group, meaning that the knowledge from their consultation event was also lost. Knowledge from this event could therefore go no further in the consultation process except in the impressions gained by the government speaker who attended the event and took part in the brief question and answer session. One respondent also noted that the note taking at the consultation event that they had organised had been patchy and that they had not been able to read some of the notes made on discussions (080408).

This meant that they were unable to reflect on all of the discussion notes in their construction of the response document for their organisation.

Data was also inevitably lost through the choices made by those writing documents. Choices were made when key documents – consultation responses, the response synthesis and the *TAMFS Policy and Action Plan* – were written. The authors of these documents used matrixes of their own devising in order to decide what should be included and excluded. They made choices about what the main points should be based on their own reading of other data. Conventions around document style also dictated what should be included in a document. A policy and action plan, for example, cannot just comprise of a list of examples of good practice if it is to be understood and worked with in the way that it is meant to be.

Importantly we need to question the presumption that we have made that this should in fact be a linear process. In our report we initially made the assumption that knowledge flows throughout the consultation process should happen in a linear way – that knowledge should enter the process and be used or dismissed. The idea was that through following knowledge forms through this process we should be able to see which types of knowledge turn up in the final policy document. This would in turn tell us what knowledge forms are important in mental health policy making in Scotland. Our analysis of this case study has demonstrated that this initial view was a little simplistic, because knowledge flows in and out at different stages of the process as needs dictate. Diagram 2, above, shows this by demonstrating that the way that different forms of knowledge are used in the consultation does not follow a linear pattern.

If we assume that knowledge is not linear, we need to look at each stage of the process as a separate entity which creates the conditions which allow particular forms of knowledge to appear. There seem to be multiple, complex reasons why different types of knowledge are highlighted at certain times and not others. Consultation events create the circumstances where the good practice of practitioners, or personal experience of service users, as expressed in vignettes, can emerge as a form of knowledge, but this knowledge cannot easily flow into the next stage of the process as to codify this knowledge means that to some extent it is lost. The consultation response document, as a form, is focused on the creation of responses to questions asked by the government in the consultation document. In order to be understood by the government these responses need to be communicated in a strict form that has little room for vignettes such as those produced at events by practitioners or service users. The theme of the vignettes may be taken up in the response documents, but the personal, experiential nature of the data, which gives it much of its power, is lost. There seems to be an understanding in Scotland that personal knowledge has little weight as a 'valid' form of evidence in the eyes of policy makers, and for this reason will not be included as evidence in policy documents (230109). This can be seen in the following quotation:

“Part of the challenge is drawing together all of this consultation stuff when you haven’t got such a concrete evidence base etc. You’ve got to weigh up what is opinion and what is truly underpinned by a theoretical, plausible argument.”

- (230109)

For these reasons the vast majority of the practitioner or service user knowledge put into the consultation process could not flow into other stages of the consultation process. This however, does not mean that this knowledge was not valuable – an idea reflected on in our earlier discussion at section 7.1 of consultation processes as education.

6.2 Instability of knowledge: a conclusion without a conclusion

Our analysis of this consultation process demonstrates how difficult it is to make absolute statements about the use of knowledge in policy making. The use of knowledge in this consultation seemed to be entirely dependent on the context in which it was enacted. This context changed rapidly and quickly gave rise to unintended consequences in unexpected areas. New policy instruments arise to fit ever evolving policy contexts in which knowledge does not emerge in a linear pattern. The use of particular forms of knowledge in policy is thus highly complex and disordered and dependent on variables that are not easily controlled or predicted.

Diagram 2 presented at the start of this section visually articulated the way that different forms of knowledge were unevenly highlighted at different stages in the consultation process. Some knowledge was apparently lost. But ‘lost’ is perhaps not the right word here. The knowledge is perhaps not lost, but just not relevant or not ‘see-able’ at some stages. For example the knowledge created by practitioners when they talked through good practice in response to the consultation document may not be lost because it does not flow directly into the consultation responses and final policy and action plan. Instead it may be lying dormant, waiting for the implementation of the policy where it will again emerge and be prioritised.

In concluding we can list some of the variables effecting the emergence of different types of knowledge within the consultation process:

- Discourse practices³³ – the type of practice in which a discourse is enacted depends on what type of knowledge is prioritised. For example, consultation events give way to embodied knowledge such as good practice or personal experience. This knowledge is not able to be contained so easily within a highly

³³ In using the term ‘discourse practice’ we borrow from the schema developed by Norman Fairclough’s (1992; 1995) to illustrate the multi-level analysis involved in critical discourse analysis.

structured document such as a policy and action plan, where strict conventions govern what content is acceptable.

- Individuals – what gets written down on paper in the end is determined to a certain extent by who does the writing. At each enactment of knowledge within every stage of the process different configurations of power and knowledge determine what knowledge is included. The leadership style and personal knowledge of those in leadership positions within the Mental Health Division determined what sorts of knowledge were prioritised within, for example, the discussions in the National Reference group.
- Political environment – the political environment will have a ‘high order’, macro bearing on what knowledge is prioritised in the process. For example, the SNP’s prioritisation of the use of indicators through its National Performance Framework meant that indicators were more highly prized than other forms of policy instrument.
- Availability of instruments – in our discussion of theory we noted that there was what could be called a ‘hierarchy of instruments’ functioning. Theory was valid evidence for policy development only when the evidence produced by a more reliable instrument such as, in this case, data from an indicator, was not available.

This case study of public action has been about the production of an interim settlement about what mental health policy making should mean in Scotland. The consultation process threw up and created knowledge which led to a preliminary stabilisation of the policy through the publication of the policy and action plan. The next stage of the public action is centred on implementation, which will again destabilise the policy and will, through the processes and instruments of implementation, produce a new knowledge order.

7. Comparison zones

These comparison zones are used to compare data from this case study with case studies being completed by the other research teams involved in this project.

7.1 Timeline of events related to the public action

TIME	ACTIVITY
October 2001	Launch of the National Programme for Improving Mental Health and Wellbeing.
February 2002	First meeting of the National Advisory Group advising the work of the National Programme
April 2002	Appointment of Gregor Henderson as the Director of the National Programme
April 2002	Launch of the Breathing Space helpline, a major initiative of the National Programme
October 2002	Launch of 'see me' – a major initiative of the National Programme
December 2002	Launch of the suicide prevention programme, Choose Life – a major initiative of the National Programme
September 2003	Launch of the National Programme Action Plan 2003-2006
Late 2004	Launch of the Scottish Recovery Network – a major initiative of the National Programme
May 2006	Initiation of a major Review of the National Programme
October 2007	Launch of the Consultation document Towards a Mentally Flourishing Scotland which will guide the consultation process for the next stage of the National Programme
24 October 2007	Start of a three month public consultation process for the next stage of the National Programme (including a series of government funded consultation events)
December 2007	Dissemination of the findings of the Review of the National Programme
February – September 2008	Meetings of the National Reference Group devising the next stage of the National Programme

April 2008	Consultation response synthesis released
September 2008 – March 2009	Ongoing consultation by Mental Health Division with COSLA and other Government departments concerning the content of the TAMFS policy.
April 2009	<i>Towards a Mentally Flourishing Scotland Policy and Action Plan 2009-2011</i> released.

7.2 Public Action as paradigm shift

This public action attempts to move policy for mental health in Scotland into a new sphere – policy which focuses on mental health as an equal and necessary complement to services addressing mental *ill*-health. Traditional approaches to mental health policy in Scotland have almost wholly focussed on services developed in order to help those currently experiencing mental ill-health. The National Programme for Improving Mental Health and Wellbeing is a population based approach to mental health which aims to address stigma around mental ill-health, prevent suicide, promote recovery and raise awareness of mental ill-health. It had been felt by those working in the National Programme prior to the TAMFS consultation that there needed to be a much greater emphasis on promotion of positive mental health. The TAMFS consultation document released to guide the consultation process around the next stage of the National Programme developed this further as a policy priority.

7.3 Knowledge conflicts

There were a range of different forms of knowledge presented in this debate and there were some areas of conflict. The main points of conflict identified were:

- conflict around the language that was being introduced and used in the consultation process.
- conflict about the level to which service users were included in programme design and implementation.
- conflict between psychiatrists, services and policy makers about the theorisation of mental health used in the consultation document.
- conflict between a social versus an individual model of mental health work.
- conflict around the use of indicators for mental health work.

It is probably also helpful to look at this question in terms of absences – what knowledge is absent from this public action. For example the general public was absent from the

consultation process that we were observing. Despite the fact that this is a policy directed at the population very generally and not at those who are experiencing mental ill-health it was service users and carers who were invited to the reference group and consultation events – not the public more generally. Also some actors – and their knowledge – were more present at certain times in the process than at others. For example, apart from the one submission made to the consultation on behalf of the Royal College of Psychiatrists, psychiatry was largely absent from the consultation events and response documents. However, psychiatry was present in the devising of the policy response through its inclusion in the National Reference Group which the government convened to guide the consultation process.

7.4 Policy makers, influence and knowledge production

Those involved in the policy consultation tried to influence the conditions of knowledge production both directly and indirectly. The government influenced knowledge production directly. For example, in relation to the consultation process the government set up the terms of reference around which the consultation revolved via the policy document that it produced to guide the process. It then told all health boards and local authorities that they must hold consultation events and government representatives were sent to all consultation events to present the proposed policy. The government decided on the terms of reference, structure and events of the National Reference Group and then a government employee from the NHS created the draft policy document.

Many of the organisations involved in the consultations used their participation in the process as a way of influencing the conditions of knowledge within their own organisation. Consultation events thus became less a means for influencing government policy and more geared toward the education of a practitioner population about what was expected of them in the development of mental health improvement within their own work.

The leadership style and style of knowledge use by the different people involved in the organisation of the National Programme and consultation process seem to have had a considerable impact on their shape and content. As demonstrated in our discussion of the creation of the *TAMFS Policy and Action Plan* the different approaches of those directing the consultation has impacted heavily on the content and theoretical framework included in the final policy document.

7.5 What are the constellations where knowledge and policy unite?

Knowledge and policy united at every stage of the consultation process. This is what the consultation process was designed to do.

We prefer to focus in on different 'enactments' of the relationship between the two. Examples of particular forms of enactment in the consultation process are:

Knowledge of actors:

1. Good practice - through the presentation of good practice within practitioner presentations and discussion at consultation events. The trading of forms of good practice gradually develops an understanding amongst practitioners about how the implementation process for the new policy should be taken forward.
2. Worst practice – examples of bad practice around policy and implementation were also provided as an important form of knowledge for the creation of new policy. They worked a similar way to the trading of good practice.
3. Personal experience – the extensive reference to personal experience by practitioners and service users as evidence for how the National Programme should or shouldn't function.
4. Expert knowledge – expert knowledge was used to validate the theoretical approach which underpins the work of the National Programme.

Knowledge instruments:

5. In the *TAMFS* consultation document theory was used instrumentally in place of other evidence when there were no others forms of evidence available. However, by the time that the policy and action plan came to be written other forms of knowledge had become available which were seen to challenge the 'authority' of the theory as evidence underpinning the work of the National Programme. Theory was thus 'outclassed' as a form of reliable policy evidence in the face of 'data' sourced from measures and indicators.
6. Language was viewed as an important instrument whose correct use would lead to successful policy outcomes. Knowledge is linguistically constituted and if it is not understood then the policy cannot be shared. Language thus creates the common community.
7. Those involved in the *TAMFS* consultation process expressed the idea that indicators were one of the best ways to validate policy, practice and funding. WEMWBS marks out a new space as governable – that of positive mental health. This is important when the words used to express the theory have been deemed

to be unsuccessful in marking out this new space. Numbers do what words cannot. A set of indicators becomes the shared language that everyone can use.

7.6 Knowledge in the public sphere?

There is little public debate about this public action. It is not particularly contentious for the public. Mental ill-health has been traditionally something that is *not* spoken about by the public and the National Programme has sought to address this through its initiatives. The aim is to normalise mental health and mental ill-health rather than create public dialogues around a contentious aspect of policy.

The knowledge created through the operation of this policy does get articulated in the wider public sphere through public marketing campaigns, the media, culture-based events and programmes, publications such as advice booklets, programmes within the school curriculum, via the operation of the health system and through the creation of public 'champions' who speak publicly about their own experiences of mental health and ill-health.

The statistics that are used to drive policy change, such as those on suicide, mental wellbeing or anti-depressant use are prominently discussed in the media when they are released. This is important because the use of these statistics by the media is key to the issue being acted upon by the government. The bigger the fuss made by the media, then the better the reaction by the government and associated actors.

7.7 How do local actors directly and indirectly influence the central decision making process?

For the National Programme in general local actors are most actively involved via the local implementation of national initiatives such as Choose Life, in which there is scope for the work of a national initiative to take on a local 'flavour'. There are also mechanisms for local practice to become 'nationalised' through several programmes, (e.g. *Evidence into Action* run by NHS Health Scotland) which aim to evaluate local area initiatives in order to develop the knowledge base around 'what works' in mental health promotion. During its most recent review the National Programme was criticised for not engaging enough with local areas.

In the *TAMFS* consultation process local actors were most obviously involved in influencing the process at the consultation event stage. During the process of synthesising the consultation event dialogue into response documents these individual,

local voices, were largely lost because of the nature of the practices surrounding these types of document.

7.8 International knowledge in the public action

In the consultation process there were references made to policies of other countries, but in a limited way. Some references were made to supranational policies by WHO Europe and the EU in order to demonstrate that the policy approach taken by Scotland was supported more generally. Government representatives promoted the work of the National Programme by referring to international actors using the Scottish policy as an example of good practice.

The final *TAMFS Policy and Action Plan* did include reference to the work of WHO Europe. The final page of the policy document listed the aims of the 2005 Mental Health Declaration and Action Plan for Europe. It drew attention to the way in which the aims for the next stage of the National Programme aligned with the aims of the WHO Declaration and Action Plan.

Annex: Documents used

The following is a list of documents analysed in depth for this research:

- *Towards a Mentally Flourishing Scotland*. Consultation document.
- Greenspace Scotland consultation response
- Lanarkshire consultation response
- Greater Glasgow and Clyde consultation response
- Highlands consultation response
- Report of the National Dialogue event, Glasgow
- Report of the National Dialogue event, Perth
- *An analysis of the responses to the national consultation on Towards a Mentally Flourishing Scotland*. Consultation response synthesis.
- *A Review of Scotland's National Programme for Improving Mental Health and Wellbeing 2003-2006*. Review of the National Programme.
- May 2008 draft of the TAMFS policy and action plan
- August 2008 draft of the TAMFS policy and action plan
- *Towards a Mentally Flourishing Scotland Policy and Action Plan, 2009-2011*. Final Policy and Action Plan for the next stage of the National Programme.
- Concepts and Definitions paper by Keith Tudor distributed to the National Reference Group
- 'Towards a Mentally Flourishing Scotland: A short briefing document' by Phil Hanlon distributed to the National Reference Group.

In addition to these documents we read through and conducted some auto-coding of all 76 consultation documents.

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