

Scotland, Mental Health and WHO

Jennifer Smith-Merry
Richard Freeman
Steve Sturdy

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Table of contents

1. INTRODUCTION	1
2. THE INSTITUTIONAL RELATIONSHIP BETWEEN SCOTLAND AND WHO	1
2.1 <i>History of Scotland's relationship with WHO Europe</i>	1
2.2 <i>History of the impact of WHO on Scotland and Scotland on WHO</i>	2
3. DOING HELSINKI : SCOTTISH CONTRIBUTIONS TO THE DEVELOPMENT OF THE HELSINKI DECLARATION AND ACTION PLAN	3
3.1 <i>The lead up to Helsinki</i>	3
3.2 <i>The Helsinki meeting</i>	4
3.3 <i>The benefits of Helsinki</i>	6
4. AFTER HELSINKI	8
4.1 <i>Impact of Helsinki</i>	9
4.2 <i>The Baseline study</i>	10
5. WHO, THE EUROPEAN UNION AND SCOTLAND	11
6. DISCUSSION AND CONCLUSION	12
BIBLIOGRAPHY	14

1. Introduction

This report explores the relationship between the World Health Organization's Regional Office for Europe (WHO Europe) and Scotland in the context of mental health. We discuss the historical relationship between the two actors and the official relationships which regulate their interactions. We then examine in detail Scottish involvement in WHO's Ministerial Conference on Mental Health in Helsinki in January 2005 which resulted in the signing of the *Mental Health Declaration for Europe* and its accompanying *Action Plan*. We examine the impact of the relationship between the organisations and find that for each the benefit of their relationship lies in mutual validation.

The findings of this report are based on a literature review and a series of interviews with key informants. The literature review examined documents such as reviews, reports and policy documents related to Scottish mental health policy making for references to WHO. WHO documents were searched for references to Scotland. Academic texts were also systematically searched for evidence of the impact of WHO on Scottish mental health services, programmes and policy. We conducted semi-structured in-depth interviews with nine key informants working within WHO, the Scottish Government, services and NGOs who had been involved in some way with the development of the Helsinki Declaration.

2. The institutional relationship between Scotland and WHO

2.1 History of Scotland's relationship with WHO Europe

Scottish engagement in WHO has for a long time been associated with a Scottish public health tradition and the strength of its Public Health Institutes, including the Usher (Edinburgh), Glasgow, Dundee, Aberdeen, and the Health Education Board for Scotland (300708). This institutional presence and capacity is distinct in organisation and orientation from that in England. Nevertheless, it is the UK, not Scotland as a separate entity with its own health system, which holds formal membership of both WHO and the EU. WHO does, however, collect separate data on Scotland in some instances because the health system is devolved and is affected by different variables to those in the other UK countries.

WHO recognition of the UK rather than Scotland in its own right is a problem that must be carefully negotiated those working in mental health policy in Scotland who wish to take part in deliberations with WHO (161008; 071108; 230708). Significant negotiations have to be undertaken with both England and WHO in order for a Scottish presence to be accepted at meetings. Successful negotiations for a Scottish presence is seen as important because, as one respondent commented, "If you are not at the meetings you do not know what is going on" (071108). Scotland is thus dependent on a sympathetic

administration in either WHO Europe or the UK Government at Westminster for their voice to be heard. This problem is even more significant in Scottish dealings with the European Commission, who see Scotland as part of the UK and have decided that any tensions are for those within the country to deal with (161008; 230708; 040309). The relationship between the Mental Health Division in Scotland and its counterparts at Westminster have not allowed these negotiations to happen easily and consistently. As one respondent commented, Scotland had more influence in international health before devolution, when it was represented through the Scottish Office in London (300708).

The historical relationship between Scotland and WHO Europe has also been maintained through the work of key actors. For example, WHO Europe's third Regional Adviser in Psychiatry (1980-1986) was the Scottish Psychiatrist John Henderson, who was formerly Principal Medical Officer in Psychiatry at the Scottish Home and Health Department in Edinburgh (1972-1976), and then Regional Medical Adviser for Mental Health in WHO's South-east Asia Region (SEARO, 1976-1980). He has been continually involved in work with WHO and was part of the steering group that organised the Helsinki meeting in January 2005.

Scotland's relations with WHO in the field of mental health prior to Helsinki were thus characterised by informal relationships between individual actors which needed to be continually and carefully negotiated and maintained.

2.2 History of the impact of WHO on Scotland and Scotland on WHO

Prior to the release of the 2005 Declaration and Action Plan WHO appeared in only limited ways in Scottish mental health policy making. The then UK Scottish Office's 1997 draft *Framework for Mental Health Services in Scotland* made no mention of WHO. The Millan Committee, whose 2001 report *New Directions. Report on the Review of the Mental Health (Scotland) Act, 1984* was principally concerned with mental health legislation, made reference to the Hague Convention on the International Protection of Adults, the European Convention on Human Rights and the Council of Europe White Paper on Psychiatry, but not to WHO. Reflecting WHO's cross-national work on suicide Scotland's national strategy for suicide prevention (*Choose Life*) used WHO figures for international comparison (Scottish Executive 2002, app 1, p 43).

While there has been little reference to WHO evident in the development of mental health services and legislation, a stronger relationship has been built between WHO and Scotland in the field of public mental health. When Scotland's National Programme for Improving Mental Health and Wellbeing started to be developed in 2001 there was an ambition by those working on the project to have Scotland in the top three or four in the world for pursuing mental health promotion work (071108). The development of a

strong relationship between WHO and Scotland in mental health was part of the strategy for making this happen. Those planning the Programme went out to deliberately meet with the European Commission and WHO to signal to Europe that Scotland could make an impression, separate to that of the UK (071108; 140408). In a nice circularity, the main driver for this action was the successful promotion of the National Programme within Scotland. The reasoning here was that if people in Europe said that Scotland was doing well, then people in Scotland would take more notice of the work that was getting done. External validation is the marker of internal success and promotes further investment in work in this area. The National Programme, with its focus on mental health promotion rather than services, remains the main context in which the relationship between Scotland and WHO is manifest within Scotland.

3. Doing Helsinki : Scottish contributions to the development of the Helsinki Declaration and Action Plan

Respondents emphasised that participation by Scotland in the development of the Helsinki meeting and inclusion as a delegation at the meeting was part of a deliberate strategy (140408; 071108; 030308). This strategy relied primarily on the involvement of Scotland in all the deliberations leading to the conference and its outcomes and was facilitated through presence at meetings, development of written documents and personal connections between key actors.

3.1 The lead up to Helsinki

Participation at meetings was viewed as central to asserting Scottish influence on the development of the Helsinki conference and the resulting Declaration and Action Plan (140408; 071108). One respondent reflected on this in depth and commented that Scotland was getting known in the area "...because people like me were going along to meetings and talking about it" (071108). This preparatory groundwork meant that when it came to the Helsinki meeting Scotland could then take part and promote their agenda for mental health. This respondent detailed the way he engineered his participation in the UK delegation that went to Brussels as part of a key pre-Helsinki meeting in 2004. This meeting was the last chance for UK governments to say what they wanted to achieve through Helsinki and to draft the Declaration that would then be signed off at the January 2005 meeting. Early Scottish participation in the preparations for Helsinki was also important in order to achieve Scottish ministerial presence at the meeting. This was because the Minister would not want to be involved in a meeting in which Scotland did not have a significant presence.

Respondents discussed the importance of the "behind the scenes stuff" that take place prior to international meetings like Helsinki in corresponding with and getting to know

key staff, lobby groups and individuals (161008). The following quote represents this well:

“Its relationships. You are listening to what’s going on and dropping two or three significant pieces of messaging, rhetorical messaging that you are just saying over and over again.” (071108)

This correspondence involved reassuring actors with very different agendas for mental health that the agenda Scotland was suggesting did not take away from the work that they were doing, but rather complemented it.

“You say ‘this isn’t about taking away the need to totally transform mental illness services in the eastern bloc countries. This isn’t about stopping the move to deinstitutionalisation. It’s about doing both at the same time.’ ” (071108)

It was also viewed as important to get Scottish work in mental health written into documents such as the 14 briefing papers which were created to inform the discussion at the conference (140408). Scottish initiatives were mentioned as examples of ‘good practice’ in mental health work in several of these briefing papers, including those dealing with suicide (Briefing 7), prevention and promotion (Briefing 8) and stigma and discrimination (Briefing 10). Scottish policy makers were then able to justify ongoing investment in mental health by highlighting these citations as indicative of the respect with which international actors.

3.2 The Helsinki meeting

‘Doing’ the Helsinki meeting for the Scottish delegation involved the ‘right’ people meeting, talking and hearing in the ‘right’ ways. This process was carefully orchestrated. As one respondent commented, “I know how to operate in these rooms” (071108).

Scotland sought to establish itself as a significant presence at Helsinki and did this by having a big team in attendance and by erecting a stall which showcased the main initiatives in mental health being promoted in Scotland. The strategy being employed was that every time someone met the Minister they then took them up to the stall so that they could see that the rhetorical arguments that Scotland were making for a particular direction in mental health policy were reflected in practical examples of current work in the area (030308; 071108; 140408).

“It was blatant self promotion but with a purpose. You go anywhere in Europe and ask them who is doing good work in MH and Scotland will be within the first three to five names mentioned.” (071108)

In Helsinki the Scottish delegation were lobbying for a Scottish agency or programme to be selected as a WHO Collaborating Centre (071108). Negotiations prior to the

conference led to Scotland being considered as the lead agency for work on stigma. The presence of Linda Dunion who was the campaign Director for the anti-stigma campaign 'see me' and a presentation at Helsinki by the Scottish delegation on their anti-stigma work emphasised the appropriateness of Scotland as a Collaborating Centre in this area. Inclusion of a Scottish presentation on the meeting agenda further established Scotland as a significant presence at the meeting.

The respondents discussed how important it was that the right people attended and participated at Helsinki (030308; 071108). Attendance at the meeting by Rhona Brankin, the then Deputy Minister for Health and Community Care in Scotland who had direct responsibility for mental health, was seen as very important for the success of the meeting for Scotland. As one respondent commented: "She made a presentation, she met with other people and she committed Scotland to achieving these goals" (071108; 030308). In terms of Scotland's international presence these were all very significant things for the Minister to be doing as they helped raise the nation's profile as a distinct institutional identity within WHO and forged new relationships for collaborative mental health work. The Minister was invited to attend by the UK Government, after negotiations between Scotland and Westminster over who would attend (030308).

Ministerial participation in Helsinki was also viewed as advantageous for the profile of mental health work within Scotland (071108). There were two main reasons for this. The first reason was that participation at the meeting provided an opportunity for the Minister to become informed about the overall agenda for mental health that the meeting drew together. The second reason was that participation by the Minister implied a degree of commitment to that agenda, and that she would then have to deliver on the agenda when she returned to Scotland. Both of these outcomes had a direct benefit for those developing mental health work in Scotland in that it validated Scottish work already being done and kept it on the agenda. Policy makers found it beneficial to keep referring to the Ministerial involvement in the meeting in order to highlight their continuing work in the area. As one respondent commented, "We spun lots of press from that" (071108). An example of this can be seen in a 2005 edition of the National Programme's magazine *Well?* where Rhona Brankin was quoted as saying:

"I was delighted to be able to take part and to learn more about mental health issues across Europe. It was also a great honour for me to share with our European partners some of the work we're doing here in Scotland. We should be proud of what we've started in Scotland and although we still have a long way to go to achieve our vision for Scotland's mental health we are well on our way to meeting the actions called for in the WHO declaration." (Rhona Brankin in *Well?* 2006, p.26)

It was felt that such was the value of the Minister's involvement in Helsinki that even now they should be referring to the WHO Declaration on all documents with an additional

mention of the Minister having been present at that time and having witnessed the signing (071108).

Attending the meeting with Rhona Brankin was Geoff Huggins, the newly appointed Head of the Mental Health Division within the then Scottish Executive. Attendance at the meeting was seen as important in educating the new mental health policy lead, whose background was not in mental health, about how mental health work happened at the WHO Europe level and what the issues were (071108). For those new to mental health work in Scotland, such as Geoff Huggins and Rhona Brankin, the meeting thus had an educative function.

The other members of the Scottish delegation included:

- Gregor Henderson and Wendy Brock from the National Programme
- Linda Dunion who was the campaign Director for the anti-stigma campaign 'see me'
- Emma Hogg from NHS Health Scotland (the health promotion branch of the National Health Service in Scotland)
- Anne Clark from the Glasgow Centre for Population Health
- Caroline Farquhar from the Anti-suicide programme Choose Life

A separate delegation attended from England but not from Wales or Northern Ireland. According to one of our respondents the English and Scottish delegations got on well during the meeting (071108).

Personal connections between individuals was an important factor in facilitating Scottish influence on the development of the Helsinki meeting, Declaration and Action Plan. For example, several of our respondents mentioned specific connections between themselves and WHO that had been facilitated by personal connections they had with Matt Muijen, the current WHO Regional Advisor for Mental Health who was previously chief executive at the Sainsbury Centre for Mental Health in England (230708; 071108; 230309). There is also a family connection between Gregor Henderson, who attended as part of the delegation in his role as director of the National Programme, and his father, John Henderson, former Regional Advisor and part of the steering group for the Helsinki meeting.

3.3 The benefits of Helsinki

Both Scotland and WHO Europe found benefit in the participation of Scotland in the Helsinki meeting and the deliberations leading up to it.

For WHO the benefit of Scotland's participation in the Helsinki meeting was in the way that the existence of Scottish programmes could validate the WHO agenda. WHO needed to be able to demonstrate that the agenda that they were promoting could work in practice when implemented within member states. As one respondent commented, "WHO can't say a lot of the things in its declarations without being able to point to places that were doing things. So we gave them that security" (071108). In the Helsinki report and the briefing papers that preceded it Scottish programmes were thus identified as examples of good practice.

For Scotland, the validation that WHO offers is more subtle and multifaceted. WHO's reference to and inclusion of Scotland in Helsinki meetings and documents was seen to greatly enhance the profile of Scottish mental health work. The logic was that if a respected international body like WHO included Scottish work as an example of good practice and aligned its aims for mental health across Europe with that already being undertaken in Scotland, then this validated the Scottish approach. As one respondent commented:

"In any international collaboration that we do... we want it to reflect positively on Scotland... we know that if other countries look at what we do, then the impact of that is that the people in Scotland think it's more valuable... a positive endorsement from the States or from the World Health Organization is worth gold to us" (030308).

Another respondent spoke of his hopes for Helsinki in fulfilling this role, commenting on how important it was that the Helsinki declaration included something on promotion, prevention and social inclusion as this was the focus policy was taking in Scotland: "What I wanted, of course, was for WHO to say exactly [the same as] what we were doing here." This would then enable them to point out to Scottish Ministers: "Scotland's direction is totally in line with the direction of the WHO declaration....Well, of course it was in line. We made sure it was." (071108)

The meetings were viewed as offering Scotland a "networking" and "showcasing opportunity" which helped them connect with other work being done in mental health across Europe (140408). This contact was seen as beneficial because it built further opportunities for validation of Scottish work as that work became promoted in other forums. This created opportunities for the 'Scottish approach' to mental health to be adopted in other countries, thereby building a network of countries supporting each other in doing the same types of work. This networking and showcasing function also opened up further possibilities for gaining funding for Scottish work on mental health through international collaborative work.

4. After Helsinki

“People are still talking, as a result of Helsinki, about things they wouldn’t otherwise talk about.”(030308).

For our respondents the most significant outcomes of Helsinki for Scotland, besides the general validation gained for the Scottish mental health agenda, were the appointment of NHS Health Scotland as a WHO Collaborating Centre for Health Promotion and Public Health Development and the appointment of a specific Scottish Counterpart for mental health (140408, 071108).

In its role as a Collaborating Centre NHS Health Scotland has taken up WHO's post-Helsinki work on mental health and stigma. This work has created ongoing links between Scotland, WHO and the other WHO member states and serves as a further point of validation for Scottish work in this area (140408). The work of the collaborating centre was a three year programme (now complete) consisting in developing a policy briefing, a guide book on stigma and hosting the conference *APPROACHES: taking action against stigma across Europe* in Edinburgh in April 2008 (NHS Health Scotland, 2008a; NHS Health Scotland, 2008b).

In addition to the appointment of the Collaborating Centre it was also seen as very significant that Scotland now had an official Counterpart in Geoff Huggins who is the Head of the Mental Health Division in the Scottish Government (WHO, 2007b). This was seen by our respondents as a direct outcome of the series of Helsinki-related meetings and makes Scotland unique in its relations to WHO Europe in that as a ‘region’ of the UK it has been granted its own Counterpart for mental health (071108; 030308). Counterparts are usually appointed by member state governments and are individuals who, as WHO describes it, have “...a thorough knowledge of the mental health field in their countries and are in a position to influence processes regarding mental health, e.g. development of national mental health plans” (WHO, 2007a). They meet regularly with other WHO Counterparts and facilitate the work of WHO Europe in their own countries. It is significant that in Scotland the role of Counterpart has not gone to a psychiatrist as it may have done in countries operating under a predominantly medical model of mental health, but to an administrator. The existence of a Scottish Counterpart as separate from that assigned to UK as a whole was seen by our respondents as a very significant development for Scotland (071108; 030308). It was viewed as both giving Scotland a voice in WHO proceedings and in sustaining mental health promotion work at a national level.

These developments formalised Scottish relations between Scotland and WHO which had hitherto been highly informal. This served to validate Scotland as an international actor separate to the rest of the UK.

4.1 Impact of Helsinki

References to the Helsinki meeting, Declaration and Action Plan do not appear in the Scottish Executive's children and young people's mental health strategy of 2005, its 2006 review of mental health nursing, *Rights Relationships and Recovery* or its major commitment to service development, *Delivering for Mental Health*, made the same year. The Declaration and Action Plan were however used as a principal frame of reference for the independent review of Scotland's National Programme for Improving Mental Health and Wellbeing which reported in January 2008 (Health Scotland 2008, pp 29-30). The Review concluded that:

"Scotland is well known in WHO and the European Union as an exemplar of policy development and implementation in public mental health and has influenced policies in other countries... The National Programme has been in the vanguard of international policy development in mental health improvement and has influenced development in WHO, Europe and the European Union" (Health Scotland 2008, p 12, p 29).

WHO was referred to more widely in the consultation process for *Towards a Mentally Flourishing Scotland (TAMFS)* in early 2008 which sought to refine the next stage of the National Programme. At several consultation events Scottish Government speakers commented on the alignment of WHO's agenda as evidenced in the Declaration, with that being undertaken in Scotland (Highlands Consultation Event 050308; Lanarkshire Consultation Event 180208; Universities Scotland Consultation 290208).

None of our respondents were willing to say that the Declaration and Action Plan themselves had a great deal of impact on people's work in mental health in Scotland or that they referred to it to any great extent in policy documents. It was seen as offering little to people 'working on the ground' in Scotland in mental health services and programmes either because it worked at a level of abstraction far beyond what was useful to these organisations or because "...it's not as radical as some of the things on the ground in Scotland can be" (071108). They did, however, see that it was a useful thing to talk about in a presentation in order to contextualise Scottish work by acting as a precedent and backdrop for action, and also as an educative tool. This is evidenced in its use in the *TAMFS* consultation, discussed above. One respondent believed that part of the reluctance of the Scottish Government to actively refer to WHO documents such as the Declaration and Action Plan was that WHO were very guarded about the use of their name and logo which "...makes local actors nervous of using and referencing WHO material." (030308). Respondents were quick to reassure us that the lack of direct use of the documents on the ground did not equate to a failure of the Declaration, but that they saw its use in the Scottish context more in terms of promotion and validation rather than as a way to change or impact on policy directly (071108; 030308).

While the *content* of the Declaration and Action Plans may have had little direct impact, the *process* of being involved in the ongoing deliberations around its implementation were seen to be of continued significance for Scotland. Valuable relationships between Scotland and WHO which functioned to further validate Scottish work in mental health were viewed as being maintained through continuing participation in meetings (140408; 030308; 071108). After Helsinki Scotland participated in a series of meetings and events including (140408; 181108; 030308):

- Barcelona (2007) – meeting of WHO mental health Counterparts
- Edinburgh (2007) – release of the preliminary Baseline study figures (discussed below)
- Edinburgh (2008) – Stigma event hosted by WHO and the NHS Health Scotland Collaborating Centre
- Utrecht (2008) – meeting of Collaborating Centres
- Brussels (2008) – high level EC-WHO meeting which established the European Pact for Mental Health and Well-being

Participation in these meetings was seen as important for keeping mental health on the agenda in Scotland and sustaining international interest in Scottish work on mental health. It was emphasised by our respondents that for the meetings to be worthwhile Scotland had to keep presenting work that they were doing now, and not rest on their previous laurels (071108; 181108). An example of this can be seen in Geoff Huggins' presentation of Scottish work on indicators at the 2008 Utrecht conference, which was seen to influence ongoing work by WHO Europe in developing mental health indicators (181108).

4.2 The Baseline study

The decision to develop a baseline study, which aimed to assess the state of mental health work amongst the WHO Europe Member States, was agreed upon at a Counterpart meeting in Chania in Crete in 2006. The baseline study sought to assess the nature of mental health work before work on the aims of the Declaration and Action Plan was implemented so that progress against these aims could be gauged. The National Institute for Mental Health in England (NIMHE) was to make a UK return the baseline study. However, the study also included a direct and separate return from Scotland.

Scotland's inclusion in the baseline study was seen as a result of both their enthusiasm for the task and negotiations with England (181108). If they had not wanted to appear in the study then they would not have and the results from Scotland would have been subsumed into a larger UK-wide return (181108). Significantly Wales and Northern

Ireland, who also have devolved responsibility for health and social care did not lodge a separate return. The only other country to include separate 'regional' returns was Spain. Scotland were involved in the development of the questionnaire and piloted it.

5. WHO, the European Union and Scotland

It is revealing to compare Scotland's relationship with WHO Europe to that it has with the European Union – another supranational body which also does work in mental health in Europe. Respondents noted a significant difference in the status of WHO Europe and the EU which differentially effected Scotland's relationship with each of them. WHO was viewed as being authoritative but lacking in resources, whereas the EU was seen as well resourced but lacking in authority. As one respondent noted:

“WHO has an element of status and grandness. The EU has money but is tainted by impenetrable politics; it is open to questioning. It is a big machine that people are not quite sure of the benefit of. In the field the EU has money and is therefore powerful... WHO has authority and EU has power.” (071108)

It was therefore important for our respondents that they create connections between Scotland and the EU in order to receive funding, but important to be recognised and included in work by WHO because of the validation brought by association with their authority (161008; 071108).

The relationship Scotland has with the EU is sustained through official institutional relationships. An example of this is the position of two Scottish organisations - the Scottish Development Centre for Mental Health (SDC), a research, training and development organization based in Edinburgh; and NHS Health Scotland - as lead partners (with STAKES, Helsinki) in the EC's SUPPORT project. SUPPORT is funded for three years, 2006-2009, to provide technical and administrative support to the Commission in its development of an EU mental health strategy (Support Project, 2009). For our respondents this was seen as an important link between Scotland and the EU as it meant that many key documents produced by the Commission on mental health would have NHS Health Scotland and SDC's logos on them (071108; 161008). Through this Scotland would thus be strongly associated with any work that came out of the EU. This was viewed as being important as much of the work that the EU does in the area is seen as consisting in “getting people together to write documents.” (071108). In recent briefing sheets that the Europa website has released on mental health policy and services in different countries, Scotland is not seen as a separate entity, but the UK report includes a separate section for Scotland (European Union, 2008). Inclusion and participation of Scottish interests at meetings was also viewed as being central to the relationship between the EU and Scotland (161008).

To an even greater extent than between Scotland and WHO, the relationship between Scotland and the EU was seen to be hampered by the official relationship with the EU being made through the UK government at Westminster (040309; 161008; 140408). Because of these institutional arrangements respondents believed that they had less ability to gain a profile within the EU than within WHO Europe. Negotiations for Scottish attendance at meetings had to be made with Westminster and this was seen to be a major stumbling block to the development of the relationship (040309).

6. Discussion and Conclusion

Working relationships between Scotland and WHO Europe in respect of mental health appear to be:

- *partial*, to the extent that they are predominantly concerned with public mental health rather than mental health services;
- *limited* to information, advice, consultation and dissemination, that is to communicative rather than legislative or financial instruments, and
- *contingent* on particular opportunities taken by individuals and organizations.

In so far as this forms a regulatory relationship, it is one conducted by peers rather than 'from above', in which the mutual reinforcement of symbolic authority remains a key concern.

The most prominent message that came through our interviews was that for both Scotland and WHO the primary benefit of the relationship was one of validation. For Scotland validation by an authoritative international body such as WHO legitimised their mental health agenda in a way that made those within Scotland take notice. Scottish policy makers and ministers were seen as far more likely to support the Scottish mental health agenda if it were validated through discussion at international meetings or included in international documents (071108). The importance of international validation is thus that it has local effects and sustains further international interaction which will then create further positive local effects.

For WHO Europe Scottish involvement in meetings and inclusion in documents validates their agenda through demonstrating that the goals they specify are possible. Scottish examples thus make tangible WHO's abstract agenda. Their participation also works to further authorise WHO's voice in Europe as WHO authority would break down if the member states were not interested or involved in the agenda.

Relationships between individuals and institutions were viewed as very important. It was important for Scotland to have official connections with WHO. Respondents repeatedly expressed concerns resulting from WHO's primary official connection being through the

UK Westminster government in London (140408; 071108). Many of the 'strategic' steps that they described were aimed at addressing this in order to give Scotland a voice or identity in the proceedings. The appointment of a Scottish Collaborating Centre and Counterpart were viewed as making a big difference in that they formalised the relationship between the two actors. These roles served to open the door to Scottish attendance and participation at meetings and inclusion in documents. Participation in these technologies was viewed as the main mechanism for the development and maintenance of the Scottish relationship with WHO (071108; 161008; 140408). For our respondents problems expressed about the relationship between Scotland and international organisations like WHO related to not being heard or not being understood. At a macro level this was about the inclusion of Scotland as an official actor. At a more micro level it concerned things like language. For example, one respondent commented at length about the language problems inherent in the multi-language settings in which these meetings take place and documents created. He states that there is "...no common definition of terminology in mental health and how it translates. Recovery is a good example. Recovery is translated as 'cure' in many European languages, which is the opposite of what the recovery concept represents" (161008).

The way in which work in Scotland informs an international position against which it is subsequently assessed may be described as circular, but it is also progressive. The circle of policy making never returns to the same point t , but to $t+1$. As one of our respondents described it, for example, the reworking of the National Programme in the *TAMFS* consultations has developed an increasingly clear categorization of support, prevention and promotion activities (140408). This has been implicit in Scottish thinking for a long time, thinking which informed but was better expressed in the Helsinki documents. This re-assertion of Scottish thinking in an international forum in turn re-informed and was re-expressed in *TAMFS*.

In brief, we find the relationship between Scotland and WHO, as expressed through the regulatory effect of the processes associated with the creation and implementation of the Declaration and Action Plan to be slow, iterative and circular. We suggest a process of recursive, rather than multilevel, governance, in which regulation – at least in this case – appears to be a process of mutual adaptation and mutual validation. This seems to conform better to systems thinking about regulation as a process of interaction rather than the model of action and reaction found in political science. In this way, WHO represents a regulatory *resource* for policy makers as much as (if not more than) a regulatory pressure. Scotland in turn provides a regulatory resource for WHO insofar as it exemplifies the kinds of principles and practices that WHO aims to foster.

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