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Citation for published version:

Smith-Merry, J, Freeman, R & Sturdy, S 2008, 'Organising Mental Health in Scotland' *Mental Health Review Journal*, vol 13, no. 4, pp. 16-26., 10.1108/13619322200800024

Digital Object Identifier (DOI):

[10.1108/13619322200800024](https://doi.org/10.1108/13619322200800024)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Preprint (usually an early version)

Published In:

Mental Health Review Journal

Publisher Rights Statement:

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This is a pre-print of the authors' final manuscript. To reference, please use Smith-Merry, J., Freeman, R., & Sturdy, S. (2008). Organising Mental Health in Scotland. *Mental Health Review Journal*, 13(4), 16-26.

Organising mental health in Scotland

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Abstract

This paper reports the first phase of a research project on mental health policy in Scotland which investigates the way knowledge is mobilised in the policy process. In this first phase of the project, we have been concerned to map the organisational domain of mental health policy in Scotland, paying attention to the form and structure of agencies and organisations as well as to the relationships between them.

On the basis of an extended series of interviews, we describe a set of organisations in which central government is dominant. But we also note a range of organisational forms and functions, and a diversity of sources of knowledge, expertise and information on which they draw. Our respondents identify a dense network of linkages between agencies, which are realised for the most part in membership of ad hoc groups, as well as a common framework for their activity which is set by a small number of key policy documents. In this way, our analytic focus shifts from organisational units themselves to patterns of dependence and communication between them and the structures that facilitate this.

Introduction and background

How should we characterise public mental health as an organisational field? How do policy makers and practitioners themselves describe it? What do they know about it? What kinds of knowledge are mobilised in working in and on it? This paper engages with these questions by reporting on the first phase of a project conceived to investigate the relationship between knowledge and policy making. This extended case study of mental health in Scotland is one of twelve included in a trans-European consortium funded by the European commission (a parallel study of education in Scotland is a second). The first

twelve-month phase of the project has been concerned with mapping the terrain of mental health policy in Scotland. The results of the first phase of this project have served to delineate the entities and relationships which constitute the system and the documents, networks and organisations which guide its operation. They have also served to highlight a series of new questions which will steer the next phases of our research.

In Scotland, mental health is one of the signal fields of post-devolution policy making. This has been the effect of a slow process of reform beginning in the early 1990s, culminating in the Millan Commission and the legislation which it informed, and sustained both by continued investment and by Government attention to mental health as a policy priority (Cairney, 2007). In the process, a field of public policy has been reformed and reconstituted. Much of what has taken place reflects principles espoused across government, including commitments to partnership, participation and transparency. Much is made of networks, inclusion and the evidence base. By the same token, the new governance of mental health turns on (even consists in) the production and exchange of knowledge, ideas and information. Integral to this exchange are the relationships that allow it to occur. It is these relationships that we focus on in this paper.

Method

The project research team consists of one full-time research fellow and two part-time senior researchers. The research team is advised by a group of four people who have each worked in the mental health policy sphere in Scotland for over ten years.

We interviewed representatives from 16 organisations across the mental health sector in Scotland. In order to determine our interview subjects we drew up a list of organisations involved in policy making for the mental health sector in Scotland. We included in this list all generic mental health organisations not aligned to a specific diagnosis or demographic. The project team then narrowed this list down to 16 organisations which reflected the diverse community involved in mental health policy making in Scotland (appendix 1). We then took this list of organisations to our advisory group who suggested contacts that we might like to approach within each organisation. All organisations approached agreed to be interviewed. Our sample is largely representative of the field as a whole in that it includes, in much the same measure as exists in the sector as a whole: organisations, units and networks based in central government; government agencies operating at both a national and a regional level; and agencies in the non-government sector.

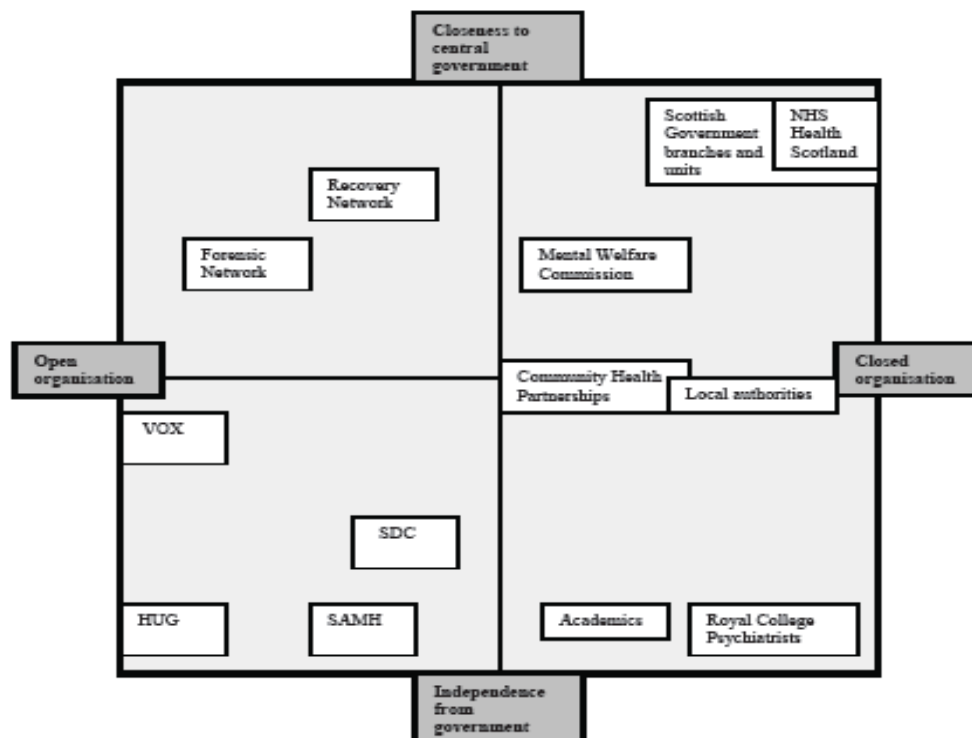
Interviews were conducted in person at the respondents' place of work, and involved either one or two staff members from the responding organisations. Interviews ranged in length between 26 minutes and 1 hour 32 minutes. Interview questions were designed to elicit responses about the form, structure and history of respective organisations, and about their relationships with others. They also referred to the types of knowledge produced within the mental health sector in Scotland, how this knowledge is sourced and formulated, and how it is disseminated and used. Responses were recorded and

summarised, and the summaries were sent back to the interview participants for checking to ensure that their views had been understood correctly. We read through all documents identified by respondents in the interviews. In addition to the interviews we also searched through the websites of all those interviewed and downloaded all relevant knowledge outputs.

Organisations

When selecting the organisations that we chose to focus on for our interviews, we initially tended to think of them as belonging to three distinct categories: government agencies, not-for-profit organisations, and networks. However, it became clear over the course of the interviews that the boundaries between these three categories are not always clear-cut, and that organisations often straddle these boundaries. In fact, it makes more sense to think about these organisations, not in terms of discrete categories, but as located in different positions on a continuum. As a first approximation, we can characterise this continuum as a two-dimensional field (see diagram 1). The (vertical) y-axis of this field represents how close an organisation is to central government; the further down the field, the more remote or independent the organisation from central government. The (horizontal) x-axis represents how open or closed an organisation is. Organisations to the right of the field are relatively closed, with strict controls over membership and over the kinds of interactions they have with other organisations. Organisations to the left of the field are much more open or inclusive, often permitting self-selected membership, and often having an explicit networking function. The organisations we selected for interview can be located on this field as follows:

Diagram 1: Organisations interviewed and their place in the mental health sector in Scotland.



When visualised in this way, the Scottish mental health policy domain plainly includes quite a variety of different kinds of organisations. To grasp this diversity, it will help to say a little more about those we examined directly.

Consider first those organisations that are actually located squarely within the central machinery of the national government of Scotland, the Scottish Government (previously called the Scottish Executive). Of the elected Members of the Scottish Parliament (MSPs), responsibility for mental health is held by the Cabinet Secretary for Health and Wellbeing and by the Minister for Public Health. They oversee the Scottish Government's Health and Community Care Directorate, which includes a Mental Health Division. This in turn comprises three branches and one unit. We interviewed representatives of the following sections of the Mental Health Division:

- The Service and Delivery unit (9 staff), which oversees the delivery of services, particularly the fulfilment of targets and commitments associated with their delivery;
- The Population Mental Health branch (6 Staff), which oversees programs which employ a population-based approach to mental health
- The Law Reform branch (5 staff), which monitors the implementation of the *Mental Health (Care and Treatment) Scotland (2003) Act*.

Additionally, we interviewed members of the National Programme for Improving Mental Health and Well-being (3 staff). This is neither a branch nor a unit; rather, its work sits across all parts of the Mental Health Division and is focussed on identifying and promoting measures to improve mental health and well being at a population level. As discrete, circumscribed agencies of the Scottish government, all these organisations plainly belong in the top right-hand corner of our organisational field.

Actual delivery of state medical services, including psychiatric services, is the responsibility of the National Health Service (NHS) Scotland, which is overseen by the Health and Community Care Directorate of the Scottish Government. NHS Scotland is made up of 14 territorial Health Boards responsible for planning and delivering health care in the Scottish regions, plus a number of centrally located Special Health Boards serving particular functions across NHS Scotland as a whole. We interviewed members of NHS Health Scotland, a special health board responsible for putting in place health improvement programmes which aim to improve the health, including mental health, of the Scottish population as a whole. Located as it is within central government, this organisation, too, effectively belongs in the top right corner of the organisational field.

In addition to the 14 regional Health Boards, Scotland's 32 local authorities also have responsibility for delivering and implementing mental health policy and services at a local level. We interviewed representatives from one local authority involved in delivering mental health services in Fife. This was the Mental Health Team operating within Social Work Services at Fife Local Authority. We have positioned this authority as a closed organisation at some distance from central government, but still relatively close as the services it provides are guided by central legislation and policies.

Local coordination of the health service delivery activities of the regional Health Boards and local government authorities, and integration of those activities with the work of voluntary and other organisations, is the responsibility of Community Health Partnerships (CHPs). Formally part of the NHS, CHPs include representatives from a wide range of health care providers within the region. For our study, we interviewed a representative from the Kirkcaldy and Leven CHP, which fulfils this responsibility within the Kirkcaldy and Leven locality in Fife. On our grid, this organisation is located at a similar remove from central government as the local authorities, but is less closed, reflecting its inter-agency coordinating function.

Also at some remove is the Mental Welfare Commission, which was set up by and is fully funded by the Scottish Government. The Commission comprises four full-time Commissioners and 17 part-time Commissioners appointed through a public appointments process administered by the Scottish Government, plus 55 support staff. The Commission aims to safeguard the rights and welfare of those with a mental illness, learning disability or other mental disorder, and has a number of formal relationships and responsibilities defined through Memorandums of Understanding with the Scottish Government Health Department among other government agencies. It is ostensibly independent from the Scottish Government, so that it can be seen to carry out its duties free from political control, but its duties are defined by the government, and include monitoring the operation of the *Mental Health Care and Treatment (Scotland) Act 2003* and the *Adults With Incapacity Act*, and visiting those subject to this legislation.

Much more remote from government, though still with some governmental responsibilities, is the Scottish branch of the Royal College of Psychiatrists, the professional and educational body for psychiatrists in Scotland. It is part of the UK-wide Royal College of Psychiatrists, which is based in London. Incorporated by Royal charter, it is the official licensing body that oversees admission to psychiatric consultant status in Scotland, as part of a government-sanctioned medical licensing scheme. It also serves as a lobbying and networking group on behalf of its members. Since membership is highly selective, on the basis of advanced academic qualifications and examinations, we have identified it as a relatively closed organisation.

Academic research, from a wide variety of scientific, medical and social scientific disciplines, is often incorporated into mental health policy in Scotland as in other developed countries. We interviewed one academic researcher who we have treated as representative of the place of academics and academic institutions within the mental health sector in Scotland. Academic institutions are relatively closed organisations, though less so than the single-specialty Royal College of Psychiatrists. They are ostensibly strongly independent and autonomous from government, though governed by government charter.

Moving into the realm of what might be called autonomous non-governmental organisations, we interviewed a representative of the Scottish Development Centre for Mental Health (SDC). The SDC provides research, training and evaluation services to the mental health sector in Scotland, and is commissioned by various actors in the sector

to provide these services. There are currently 12 staff working at SDC, with most staff working as researchers and project workers who bring together the commissioned research that SDC carries out. They also have 18 associate consultants who work with them as project needs dictate. As such, the SDC might be considered not just as a non-governmental organisation, but also as a relatively small networked organisation – and hence as belonging not just towards the bottom of our organisational field, but also rather further to the left than the bodies we have considered thus far.

A rather larger non-governmental networking organisation that we included among our interviewees is the Scottish Association for Mental Health (SAMH). SAMH is a very large organisation that has around 900 staff members spread across the organisation, with around 850 working in the provision of services and 50 located in the head office. The main bulk of SAMH's work is in not-for-profit service delivery, although they also have a strong focus on the development of research which aims to change mental health policy and practice. At the top of the SAMH administrative structure sits the CEO and Executive team whose actions are directed by a Board of Directors. In addition to its service delivery role, SAMH is also a membership organisation, whose members comprise mainly service users and carers, but also include trade unions, professionals and journalists. The organisation consults with its members over certain policy decisions.

Our interviewees also included representatives from two voluntary sector networks that are dedicated primarily to networking activities – the Highland Users Group (HUG) and Voices of Experience (VOX). VOX and HUG are mental health service user organisations, and all within the organisations, including staff, are service users. These networks are not for profit and each has only a handful of staff, but draws on the participation of large numbers of members, who direct the actions of the organisation. Staff within these networks tend to have a facilitative role, where they inform members, facilitate member discussion, and take direction from this discussion. HUG is a collective advocacy organisation for people with mental health problems which serves the Scottish Highlands and Islands, and has approximately 360 members. VOX is a national mental health service user network which provides a voice to mental health service users. The aim of both VOX and HUG is to gather members' views and represent them in the development of policy and planning for mental health.

We should not suppose that networking activities necessarily correlate with distance from government however, or that network organisations therefore belong solely in the bottom left-hand corner of our organisational field. On the contrary, we interviewed representatives from two network organisations that had close links to the Scottish Government. First of these was the Forensic Mental Health Services Managed Care Network (Forensic Network), which was set up by the Scottish Government in 2003, and which continues to be funded by the government. Membership is automatically conferred on all those involved in any work that touches on the intersection between the criminal justice system and mental health system in Scotland. Membership thus includes members of the health, police, prison and social work services, as well as other agencies involved in the care of mentally disordered offenders. The role of the Forensic Network is to develop policy and strategies, and offer guidance and support for services and

individuals involved in forensic services, with a view to developing consistency and best practice in forensic mental health practice. Plainly a networking organisation with a loose structure, it nevertheless belongs high on the left-hand side of our organisational field, by virtue of its close connections to central government.

Secondly, the Scottish Recovery Network was set up by the Scottish Government's National Programme for Improving Mental Health and Well-being in late 2004 as a 'vehicle for learning and sharing ideas around recovery'; like the Forensic Network, it receives continued funding from the Scottish Government. While calling itself a network, however, it is not clear that it offers a very active networking role to its members. Rather, with only four staff, it appears to serve more of an information-sharing role, with the aim of promoting the idea of recovery from mental illness. As it states on its website, 'The Network itself is comprised of a loose affiliation of organisations and individuals, from varied backgrounds, who all share an interest in efforts to promote recovery' (Scottish Recovery Network, 2007). As such, it might perhaps be better thought of as a quasi-autonomous dissemination branch of the Scottish Government Mental Health Division than as a genuine networking organisation. We therefore locate it relatively high on our organisational field, and towards the mid-line, reflecting its close links to central government, and its limited networking activities.

In our initial map of the mental health policy field in Scotland we are thus looking at a diverse variety of organisations, fairly evenly distributed around our two-dimensional organisational diagram both in terms of their closeness to or distance from central government, and in terms of the relative openness or closedness of their membership and their networking activities. A similar diversity and lack of clear-cut categories is apparent if we consider the functions that those organisations fulfil. Thus we interviewed two respondents from organisations whose remit is mainly to represent users, five from predominantly service-focussed organisations, three from organisations primarily concerned with knowledge sharing through networks, two from agencies oriented towards improving population health, and two actors from organisations whose mental-health policy activities primarily involve research. While many of these organisations have a primary focus such as service delivery or training, however, in most cases they also carry out a variety of other roles. For example while SAMH might be viewed as a service provision organisation if we look solely at the declared roles of its staff and at its funding arrangements, it also has lobbying and policy development as a key focus, and makes a significant impact in this area. Further, all the organisations that we interviewed carry out or are involved in research of one form or another. Functional diversification is thus a characteristic of many of the organisations involved in the Scottish mental health policy field, as well as of the field as a whole.

Knowledge in organisations

Meanwhile, what kinds of knowledge are carried by these different organizational forms and functions? Those working across the mental health sector in Scotland bring with them knowledge gained through formal education, through practical experience gained in

the course of their careers, and from personal experience outside education and work. The routes by which individuals come to work in the field of mental health policy differ widely. These diverse personal backgrounds shape the types of knowledge that individuals value and what they then do with the different kinds of knowledge available to them. Such factors may have an important impact on policy outcomes and implementation.

Diversity of knowledge and experience was typical within individual mental health policy organisations, as well as across the field as a whole. Starting with the Scottish Government, our interviews revealed that those working in the various sections of the Mental Health Division and in the National Programme have come to their roles from a wide variety of backgrounds and that there is no particular educational, career or life experience which is universally valued over others. Rather, individuals are selected according to the roles that need filling in a particular context. Many have been career civil servants while others have worked within academia, service delivery, communications and marketing. There is also a programme of secondment in operation where practitioners such as psychiatrists, social workers and teachers are seconded into the Government when their expertise is needed for the creation of a specific policy.

Those currently working around mental health within NHS Health Scotland tend to have experience and qualifications in public health, health improvement and sociology. Nonetheless, it was emphasised in the interview that staff could come into roles in NHS Health Scotland from a very wide variety of backgrounds and that there was no particular qualification that was the norm. At a local level, those working in the Mental Health Officer team in Fife local authority are all social workers with specific qualifications in mental health, while most of the staff of the Kirkcaldy and Leven CHP have previously worked in the local NHS Health Board.

Among those organisations ostensibly independent from but with firm links to government, Mental Welfare Commissioners come from a range of backgrounds including psychiatry, psychology, social work, law and advocacy. Mental health and learning disability service users and carers are also represented. The Royal College of Psychiatrists is the most educationally and occupationally homogeneous of the bodies we investigated, all members of the College having medical qualifications and advanced specialty training in psychiatry. However, the administrators employed by the Scottish branch of the Royal College of Psychiatrists come from administrative backgrounds not related to mental health. Academic researchers in the field of mental health policy generally hold higher academic qualifications, but in a notably diverse range of disciplines; the researcher we interviewed has qualifications in social policy and sociology and has worked in mental health research for 30 years.

The background of staff within the network organisations is very varied within and between organisations. Within SDC all staff except those working in administration have degrees and many have a Masters or PhD; most staff come from a social sciences background. Within SAMH most staff within the head office have degrees in the social sciences. For those working within VOX and HUG their knowledge and experience as

mental health service users was highlighted by respondents as the most significant experience that they bring to their positions. Most of those employed in the Forensic Network are practitioners such as psychiatrists or nurses with a background in forensic mental health. Most of the staff working for Scottish Recovery Network come from a social science background.

As this data shows, amongst the organisations that we focussed on the most prevalent academic background of employees is the social sciences, and most staff have undergraduate qualifications. Practitioner knowledge is important in many of these organisations, as demonstrated through the program of secondment in operation in the Scottish Government and the presence of practitioners amongst the Mental Welfare Commissioners as well as within the Forensic Network and Royal College of Psychiatrists. The knowledge gained through service user experience is also valued, as evidenced by the operation and participation of HUG and VOX and the participation of service users and carers as Mental Welfare Commissioners.

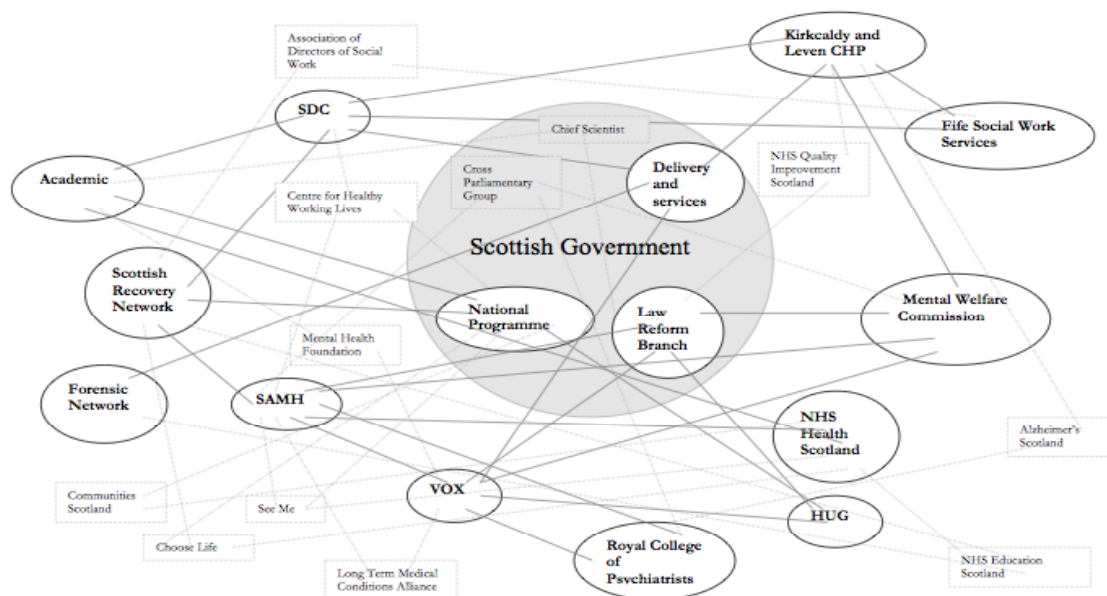
Organisation, knowledge and networks

On investigating the activities of these organisations it became clear that the field as a whole is characterised, not just by organisational diversity, but by a high degree of interconnection and interaction between different organisations. The field of mental health policy is itself organised as a network, sustained and articulated by a dense matrix of formal and informal linkages. All the organisations that we interviewed are formally and informally linked with many other organisations within the mental health policy sector in Scotland. Much of this interconnectedness is achieved through joint knowledge production and exchange activities, while these activities are in turn sustained and to an extent directed through various institutional mechanisms including key policy document, flows of money and formally constituted groups and committees.

Several organisations were engaged in project collaboration and commissioner/provider relationships. The Mental Welfare Commission also has a number of very formal reporting relationships defined through Memorandums of Understanding, for example with the Scottish Government Health Department. In addition to these formal relationships all interview respondents emphasised the significant informal relationships they have with other organisations within the mental health sector in Scotland. In diagram 2, below, we have visually represented the linkages between the organisations that we interviewed and other Scottish-based organisations identified by the respondents. The organisations that we interviewed are highlighted in bold. We have also included several other organisations that were mentioned in the interviews – but only those that were mentioned more than once, since to include all of the organisations mentioned would have been visually confusing. This diagram demonstrates clearly the dense web of knowledge-based interactions that link together the various organisations active the mental health policy field in Scotland is interconnected. It makes clear, moreover, that such interlinkages spread freely across the diversity of organisational types that

characterise the Scottish mental health policy landscape, and across both government and non-government bodies.

Diagram 2 linkages between organisations within the mental health policy community in Scotland.



Additionally, all the organisations that we investigated apart from the Kirkcaldy and Leven CHP mentioned knowledge links to international organisations, networks, or knowledge in their work. The most frequently cited international link was with the International Initiative for Mental Health Leadership (IIMHL) whose involvement was specifically cited by nine of those interviewed. Other significant inter-country links were with researchers working in recovery and peer support in the USA, and with user, research and service delivery organisations in New Zealand, Australia and Canada. Several organisations also cited the use of knowledge produced by the European Union and the World Health Organisation.

Policy documents

A small set of key policy documents appears crucial in facilitating coordinated action and interaction between different organisations involved in Scottish mental health policy making. Our interview respondents named several such documents as embodying the official overarching priorities guiding the Scottish mental health sector as a whole. Most of these documents were put together by the Scottish Government. Eleven interviews identified *Delivering for Mental Health*, which outlines specific actions and targets to delivered in order to improve the mental health of the Scottish population, as a key document in this respect. Four identified *Delivering for Health* (the Kerr Report), which has the same focus as *Delivering for Mental Health*, but applies to the operation of the health system as a whole. Five identified the *Mental Health (Care and Treatment)*

(Scotland) Act 2003, which guides through law the priorities, rights and responsibilities of all those who either have a mental illness or are involved in the care of the mentally ill. Six identified the population-health-based approach articulated within the *Action Plan 2003-06* of the National Programme for Improving Mental Health and Well-being. Another document identified by two respondents was *Rights, Relationships and Recovery: The National Review of Mental Health Nursing in Scotland*, which is viewed as having changed the culture of mental health nursing, and through this the operation of the whole system. Other documents mentioned as guiding the work of individual organisations and actors were: the *Adults with Incapacity (Scotland) Act 2000*, which is designed to uphold the rights and welfare of those who are unable to make decisions on their own behalf; NHS Health Department Letter (HDL) (2006) 48, which guides the development and operation of forensic mental health services; the *Framework for Mental Health*, put together by the Scottish office prior to devolution and which outlines the principles which should underpin the delivery of mental health services in Scotland, with an emphasis on joint planning for mental health; the HEAT targets, which guide the operation of the NHS; and the mental health priorities published by the Chief Scientist's Office within the Scottish Government.

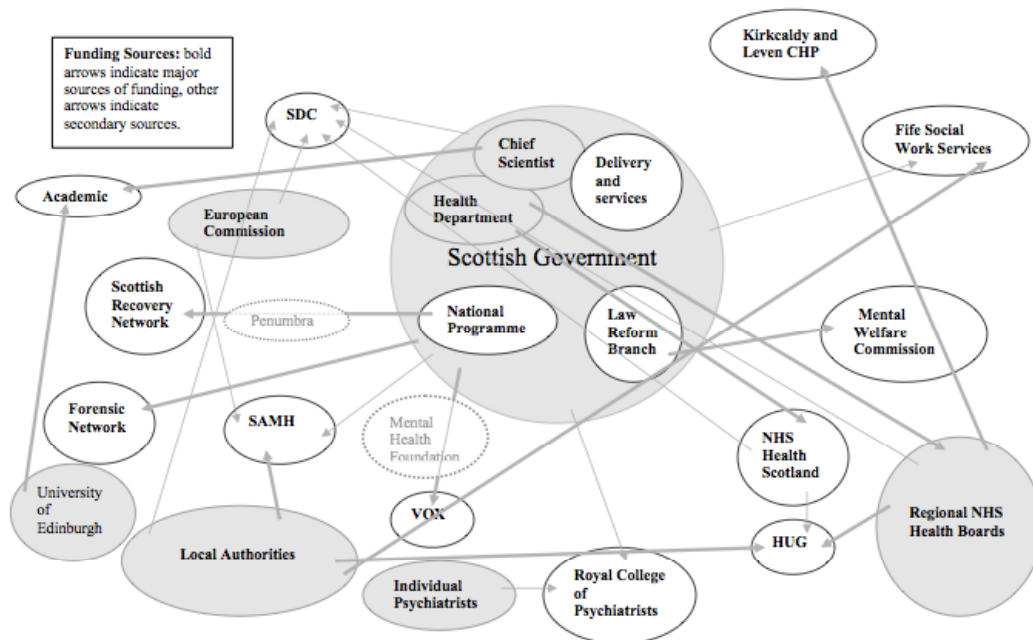
Very few respondents criticised the Scottish Government priorities reflected in these documents and those criticisms that were mentioned were focused more on operational issues in relation to these documents rather than the overarching policy priorities expressed. Publication of policy documents does not of course ensure assent in itself, let alone bring about interaction or collaboration between different policy organisations. However, it is striking how far the various actors operating within the Scottish mental health policy field do assent at least to the policy priorities as expressed in these key documents, and do take them as a basis for pursuing further collaborative activities, and particularly for activities concerned with further knowledge production.

Money

Such cohesion appears to be derived in part from the extent to which the entire Scottish mental health policy field depends upon and is sustained by a single central source of funding. As diagram 2 demonstrates, much of the organisational activity in this field is underwritten by government funding. The Scottish Government funds fully the day to day work of NHS Health Scotland, the Kirkcaldy and Leven CHP, the Mental Welfare Commission, VOX, the Scottish Recovery Network and the Forensic Network. It partly funds the work of Fife Social Work Services, the Scottish Association for Mental Health, and HUG. It regularly commissions most of the research work done by the academic researcher and SDC. The only organisation that we interviewed that is not funded to any great extent by the Scottish Government is the Royal College of Psychiatrists. The Scottish Recovery Network and VOX are funded through 'parent' organisations (the charities Penumbra and the Mental Health Foundation respectively) which administer their Scottish Government funding for them. The purpose of these parent organisations is two fold: firstly it means that these small organisations do not have to manage their own

funding; and secondly, it introduces a degree of managerial independence into the relationship between the organisations and Scottish Government.

Diagram 3: Funding relationships amongst interview participants.



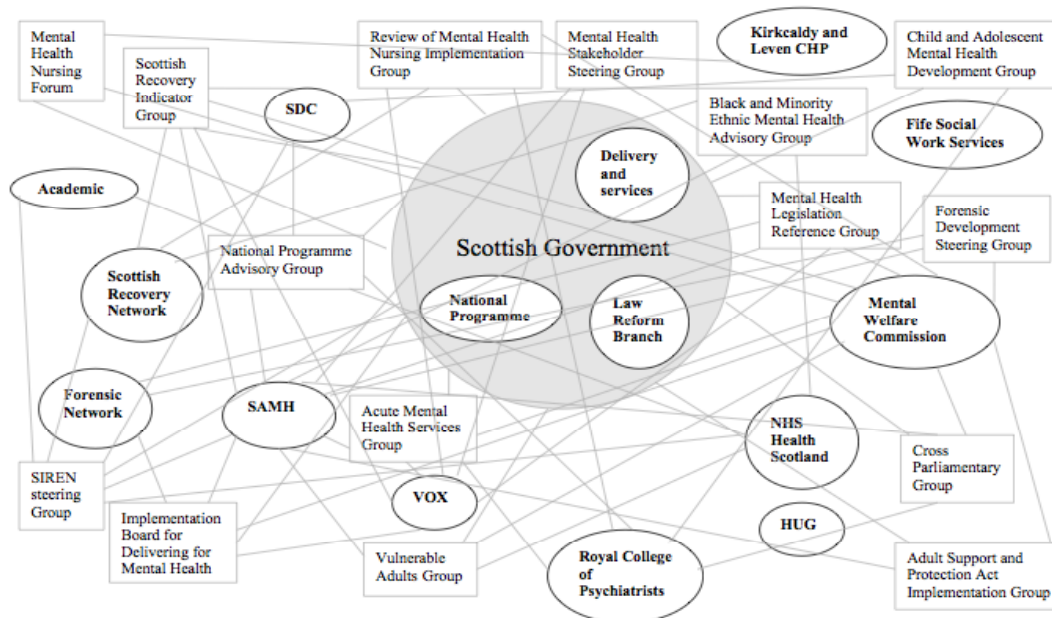
The overwhelming pervasiveness of Scottish Government funding throughout Scotland's otherwise diverse mental health policy field does not of course imply that government acts directly to require collaboration and other forms of interaction between funded organisations. Indeed, the fact that government funding bodies maintain an arms-length relationship with organisations such as VOX and Scottish Recovery Network suggests that they are anxious to be seen not to interfere in the running of voluntary bodies such as these. Nonetheless, since government is plainly in a position to specify the purposes for which funding will be granted, it seems likely that there will at least be a degree of congruity between different organisations as to aims and methods. While the funding regime may not necessitate the high degree of collaboration and interaction between Scottish mental health policy organisations, it certainly helps to create conditions under which such interaction is more likely to occur.

'Group' membership

More active government measures to promote inter-agency interaction and collaboration proceed through the establishment of a wide variety of working groups and committees. The interviews revealed a complex web of committees and groups in which representatives of different organisations participate. Diagram 4, below, illustrates the groups and committees that respondents mentioned they were involved in, and the connections that are formed by actors through their membership of these groups. This is

a complex diagram and is not meant to be read as such, but to illustrate the highly complex nature of interactions and relationships that come into being through these groups.

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



Based on our interviews, we can make several basic comments about the nature of group membership in the organisation of the the mental health sector in Scotland. The actors most frequently active within these groups are the Scottish Government, VOX, the Mental Welfare Commission, the Royal College of Psychiatrists and SAMH. These groups thus represent the administrators, the service users, the quality controllers, the medical experts and the service providers within the sector. The Scottish Government sits on all groups. Those organisations that do not take part in any groups are regional rather than national organisations. The most important committees, at least as indicated by the frequency of membership amongst our interview respondents, are the Implementation Board for Delivering for Mental Health, the National Programme Advisory Group and the Mental Health Legislation Reference Group, and the SIREN (Suicide Information, Research and Evidence Network) steering group. The first three of these advise, respectively, on the work of the three main Mental Health Branches of the Scottish Government. All of the groups identified in diagram 4 above are national groups but many of the same groups are also in existence at regional levels; for example there are localised recovery groups which bring together the NHS, local authority, CHPs, practitioners, user groups and service providers at a regional level, thus enforcing national action at a local or regional level.

Some general comments can also be made about the nature of these groups. Firstly, while many have what appears to be a typical committee structure, they are never referred to as committees, but rather as ‘groups’ or sometimes as panels, boards or

forums. There are ‘steering groups’, ‘reference groups’, ‘implementation groups’, ‘interest groups’, ‘advisory groups’, ‘development groups’ and ‘working groups’. Many of the groups exist as ‘short life working groups’ which is a term the government uses to discuss a group that has been created for a specific purpose and disbands once that purpose has been fulfilled. Another form of group that seems to be common in the sector is one that changes form through the course of development of a project, document or policy. Such groups may start life as an advisory group or steering group for the development of an idea into a project, document and policy. This group will then morph into an implementation group, and finally into a reference group which advises on how the policy or project is working in practice and on continuing work in the area. The group name will change and members will be lost as those with the most relevant skills for the particular stage of development of the project are seconded to the group. Examples of this are the Review of Mental Health Nursing Implementation Group and the Mental Health Legislation Reference Group.

Participation in such groups will not necessarily lead to further collaboration or interaction between the various member organisations. But they do provide a valuable opportunity for participants to learn about one another’s interests and capabilities. Moreover, the fact that such groups are in most instances concerned with developing or overseeing specific practical goals or projects is likely to foster a more pragmatic attitude among the various participants, at least where they are inclined to agree on the practical ends to be achieved. Careful selection of group members from among the various Scottish Government-funded policy organisations may be a powerful means of ensuring such agreement.

Concluding discussion

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

The first thing that can be noted is the centrality of the Scottish Government within the system. When examining the list of organisations, networks and groups that contribute to the mental health system in Scotland it looks on the surface to be a decentralised system with many actors. Diagram 3, however, which specifies the funding relationships between those that we interviewed, demonstrates that in one key respect – that of finance – the Scottish mental health policy domain is far more centralised than it might at first

appear, heavily reliant as it is on Scottish Government funding. The centralisation of the sector is not merely apparent in funding structures. It is also evident in the influence that Scottish Government exerts over the system as a whole through the appointment of a wide variety of inter-organisational groups to direct or oversee specific goals and projects.

The second point to note is the remarkably high degree of consensus demonstrated in the interviews over policy priorities reflected in government documents such as *Delivering for Mental Health*. As discussed earlier, there was little conflict over legislation, the goals of the sector, or its administration and funding expressed in the interviews. This is surprising given that conflict of this nature plagues many other mental health systems, such as England which has seen disruptive and highly emotive debates about the mental health sector which have impeded progress in policy and legislative change (Darjee & Chrichton, 2004). This sparks the question as to how such a consensus has been achieved within the Scottish system. This question will be further explored in the next phase of our research.

Thirdly, as diagram 2 above indicates, the world of Scottish mental health policy agencies and institutions is in fact a world of networks and groups. Actors are relevant only to the extent that they maintain multiple relationships with others: it is this that gives the 'system' its systemic quality. By the same token, the capacity to act is predicated on 'knowing the system'. The interviews demonstrated that one of the key ways that the system becomes known is through the complex web of groups which bring organisations and individuals together. These groups are sites for policy development, and involvement in the policy process thus necessitates being known and included in this system of interlinked groups. 'Knowing', 'system', and 'policy' thus become to a large extent coterminous.

Within this system, a special place may perhaps be given to the various 'groups', panels, boards and other ad hoc bodies constituted by Scottish Government and bringing together representatives of other policy organisations to steer or oversee particular policy initiatives and developments. As discussed earlier, the groups in which the interview respondents participated most frequently were those concerned with advising on the policy and legislative work of the Scottish Government. The presence of so many organisations on these Scottish Government advisory groups may in part explain why organisations are happy to support and go along with the work of the Government: because they are part of the process of policy development and review, they feel more connected to the policies when they are also required to implement them. As Freeman (2006) notes when discussing the collective development of policy documents: "the collective engagement entailed in creating such works – a process of suggestion, negotiation, and experiment – in effect creates the community, which is in turn required to produce them." The same may hold true when overseeing a policy programme as when creating a policy document. As one respondent noted when talking about participation in such groups:

"We are very, very serious about membership because we want to influence as much as we can... (I)f you miss a meeting you miss out."

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Appendix One: Organisations interviewed

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

Scottish Government - Mental Health Delivery and Services unit

Scottish Government - Mental Health Law Reform branch

Scottish Government – Population Health Branch

Forensic Mental Health Services Managed Care Network (Forensic Network)

Mental Health Team within Fife Local Authority Social Work Services

Academic researcher, University of Edinburgh.

NHS Health Scotland

Mental Welfare Commission (MWC)

Highland Users Group (HUG)

Scottish Development Centre for Mental Health (SDC)

Royal College of Psychiatrists (RPsych)

Scottish Recovery Network (SRN)

Voices of Experience (VOX)

Scottish Association for Mental Health (SAMH)

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