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Reciprocal Instrumentalism

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Reciprocal instrumentalism: Scotland, WHO Europe, and mental health

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Abstract: This paper explores the relationship between the World Health Organization's Regional Office for Europe (WHO Europe) and Scotland in the context of mental health. Since devolution Scotland has gained autonomy as a constituent country of the UK and has developed a reputation for progressive mental health policy. Scotland has also become increasingly involved in WHO, notably in the development of the *Mental Health Declaration for Europe*. In this paper we examine the interactions that regulate the relationship between these two actors in order to determine how and why the relationship was built. Our analysis draws on interviews with individuals involved in the development of the *Declaration* and its accompanying *Action Plan* alongside an analysis of related texts. We observe that the relationship between Scotland and WHO was created and perpetuated through personal communication, meetings and the joint production of documents, in a way that mutually validated the policy aims and agenda of both actors.

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1 Introduction

In January 2005 the World Health Organization's Regional Office for Europe (WHO Europe) hosted a Ministerial Conference for Mental Health in Helsinki (WHO, 2005c). The conference was attended by Ministers and Ministerial representatives from each of its 52 member states. Within the delegation attending from the UK were a large number of representatives from Scotland, including the Deputy Minister for Health and Community Care, Rhona Brankin. Scotland played a prominent role in the preparations for and the proceedings of the Ministerial Conference and in the events leading on from it. In this paper we examine how and why Scotland, as a non-state and thus non-member of WHO Europe, developed a prominent position in WHO Europe's deliberations around mental health. Focussing on the development of the Helsinki Ministerial Conference and the *Mental Health Declaration for Europe* and *Action Plan* (hereafter referred to as *Declaration* and *Action Plan*) which were agreed upon at the conference, we examine the development of the relationship between the two actors in this setting (WHO, 2005a, 2005b). We explore this developing relationship through data derived from interviews with key informants and an analysis of documents relating to mental health work in both Scotland and WHO Europe.

We introduce our paper through a discussion of the history of Scotland and WHO Europe's relationship to work in mental health and their relationship with each other. We then look in detail at Scotland's involvement in the development and performance of the Helsinki Ministerial Conference and the associated *Declaration* and *Action Plan*, and at the impact of this involvement in Scotland. We end the paper with a discussion of the benefits of the relationship for both actors.

2   Methodology

The findings of this report are based on a literature review and a series of interviews with key informants[1]. The literature review examined documents such as reviews, reports and policy documents related to Scottish mental health policy making for references to WHO. The content of WHO Europe documents relating to the *Declaration* and *Action Plan* were analysed 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. Our purposive sample comprised individuals working within WHO Europe, the Scottish Government, mental health services and NGOs who had been closely involved in some way either with Scottish participation in the Helsinki Conference or in the development of the *Declaration* and *Action Plan*, or both. We asked our respondents to 'tell the story' of the relationship between WHO and Scotland in respect of mental health: interview questions related to the role of each in the conference and the development of the *Declaration* and *Action Plan*. Each interview was recorded in digital audio, and all data entered into the qualitative data management programme NVIVO. Data was hand-coded according to theme.

We approached our data principally from the perspective of narrative analysis and set out to construct a coherent narrative of the events and processes through which Scotland interacted with WHO, and of the consequences of these interactions for Scotland and WHO (Abbott, 1992; Gotham and Staples, 1996). Based on this narrative, and drawing on the statements provided by our informants, we then sought to infer the more generally strategic orientations and interests that informed the activities of the different participants in those interactions. Finally, by triangulating our study against the work of other scholars investigating the activities of international regulatory organisations like WHO, we were able to draw more general conclusions about the nature of WHO's regulatory activities and about the role of regional as well as national actors in furthering those activities.

3   Scotland and mental health policy

Until 1999 Scottish mental health policy was directed by the UK Parliament at Westminster through the Home and Health Department of the Scottish Office. The 1999 devolution of power from Westminster to the Scottish Parliament meant that Scotland took on the authority to make independent decisions over many areas of policy, including health and mental health. The development of a strong mental health policy was a political priority for the newly devolved Scottish government (called the Scottish Executive until September 2007 and the Scottish Government thereafter).

Post-devolution mental health policy in Scotland presents a clear break with that which was in place before. It has centred around the development of the *Mental Health (Care and Treatment) Scotland Act 2003*, a new framework for services outlined in the policy document *Delivering for Mental Health*, and population mental health work carried out through the National Programme for Improving Mental Health and Wellbeing. Smith-Merry et al. (2008, p.16) note that the development of this new framework for

mental health has been built on government principles of "partnership, participation and transparency" that bring together a diversity of statutory and non-governmental healthcare providers. The creation of policy in line with these principles has been coupled with the importation and development of innovative policy responses which seek to balance provision of services for the mentally ill with novel public mental health initiatives that seek to promote positive mental health and wellbeing among the entire population (Smith-Merry, 2008). These policy developments have meant that Scotland has been acknowledged by WHO and others as internationally progressive in its recent approaches to mental health policy (Cairney, 2009; Smith-Merry, 2008; Hunter et al., 2008). However, there is still a concern that mental health policy within Scotland is not prioritised to the extent that it should be (040309[2]).

While Scotland has historically had links with various parts of WHO Europe in the field of mental health, prior to the 2005 *Declaration* and *Action Plan* these relations were characterised by informal connections between individual actors or organisations which needed to be continually and carefully negotiated and maintained. These connections reflect a wider pattern of Scottish engagement in WHO Europe that owes much to a long and distinctively Scottish tradition of public health work more generally, associated with the internationally recognised Public Health Institutes in Edinburgh (the Usher Institute), Glasgow, Dundee and Aberdeen, as well as the Health Education Board for Scotland (300708). This institutional presence and capacity, distinct in organisation and orientation from that in England, provided the basis for a historical relationship with WHO that was maintained through the work of key individual 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).

Since devolution there has remained a degree of uncertainty and tension about Scottish autonomy in matters of health, and about the manner in which Scotland, as a constituent country of the UK, should perform as an international actor. While the main concern of other national actors has been the normative implications of the programme being promoted by WHO, for Scotland it has been the ill-defined nature of its relationship with the international organisation which has seemed most problematic. It is the UK government, not Scotland, which holds formal membership of WHO Europe. Our respondents discussed this as a 'problem' that must be carefully negotiated by those working in mental health policy in Scotland who wish to be involved with WHO Europe (161008; 040309; 071108; 230708; 030308). Significant discussions have to be undertaken with both the UK Government at Westminster and WHO Europe in order for a Scottish presence to be accepted at meetings and for Scottish data to be collected separate to that of the rest of the UK. Successful negotiations for a Scottish presence are 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 both WHO Europe and the UK Government for its voice to be heard. The ongoing relationship between the Mental Health Division in the Scottish Government and its counterparts at Westminster has not allowed these negotiations to happen easily and consistently. In consequence, Scotland's voice is often not heard on an international stage. Indeed, one respondent went so far as to suggest that Scotland had more influence in international health before devolution, when it was represented through the Scottish Office in London (300708).

4   International organisations and regional actors

In contrast with the extensive literature on why and how state actors become involved in the work of international organisations such as the United Nations and the European Union (e.g., Lane and Maeland, 2006; Barnett and Finnemore, 2004; Kratochwil and Ruggie, 1986; Abbott and Snidal, 1998), there is a surprising lack of authoritative research on how and why regional actors like Scotland pursue similar involvement. Recent literature that does address this issue deals almost entirely with the work of the EU (e.g., Moore, 2008; Marks et al., 2002; MacNeill et al., 2007). Such research has questioned in particular why regional actors might want to be involved with the EU despite a declining regional focus by the EU itself. Scotland is a case in point, with a long history of engagement at the EU level and representation by several regional offices in Brussels who coordinate this engagement (Marks et al., 2002). A recent study by Moore (2008, p.525) has found that for the devolved governments of the UK the main purpose of this engagement has been in "…raising their profile as constitutional regions in Brussels circles".

   Even less scholarly effort has been devoted to understanding how and why regional actors like Scotland might seek involvement with international organisations such as WHO, which have limited regulatory powers, or why international organisations such as WHO might want to be involved with regional or non-state actors that are already aligned with their agenda. The lack of research in this area is particularly surprising given the increasing academic interest in 'global' rather than 'international' health, with its focus on non-state actors such as corporations rather than the centrality of the nation state in health work (Brown et al., 2006; Leeder et al., 2007; Kickbusch and de Leeuw, 1999).

5   WHO, WHO Europe and mental health

Academic literature referring to the work of WHO generally focuses on the use of their indicators and definitions, or the extent to which the ideas expressed in WHO declarations and action plans are taken up by individual countries (e.g., Henderson, 2007; Xiangyang et al., 2003; Vega et al., 2009; Manifold and Marshman, 2009). Less attention has been paid to why countries or regions choose to maintain or foster relationships with WHO, or the ways in which these relations are maintained (Kickbusch, 2003). Our interest here focuses in on questions related to this latter topic and examines how and why the relationship between the supranational WHO Europe and the new Scottish government is maintained. Specifically we ask: Through what instruments is the relationship created and enacted? Could theirs be called a regulatory relationship? What does a regional actor gain from their relationship with WHO? And, conversely, what does WHO gain from this involvement?

   WHO has been described as a knowledge-based organisation whose expertise lies in promotion, coordination and use of research (Stenson and Sterky, 1994; Lee et al., 1996). Jamison et al. (1998) delineate two main functions performed by WHO: a core function and a supportive function. The core function includes the 'promotion of international goods' through 'shared learning', 'consensus building' and the development of "harmonised norms and standards for national use" [Jamison et al., (1998), p.515]. The supportive function is one specifically addressed toward states that are unable to manage their own way out of health crises as a result of political instability, economic constraints

and so forth. It is easy to imagine why countries might want to be involved with WHO if they can benefit from its supportive function. It is less clear why a regional actor from an advanced liberal democracy might want to be involved in the work of WHO Europe, but the reason presumably lies in WHO Europe's 'core function'. In this respect, it is notable that WHO Europe's work on mental health has mainly involved precisely the kind of 'core' activities identified above. These include the generation of "consensus on specific problems and issues to identify and promote best practice, and …exercises to survey mental health services and policies in member countries" (Freeman et al., 2009).

Such activities have only developed quite recently. Given the relatively high levels of access to healthcare in this region, WHO's authority in the European region is largely restricted to the promotion of population strategies. Mental health, long conceived primarily as an individual rather than a population problem, tended to fall outside this purview, and did not develop as a central focus for WHO Europe until the late 1990s when a growing focus on the burden of disease attributed to mental ill-health, along with a personal interest in mental health on the part of the new WHO Europe Regional Director, Marc Danzon, combined to push it to the fore (Freeman et al., 2009). This new attention to mental health was also apparent in the work of WHO internationally, culminating in the designation of 2001 as the Year of Mental Health, and the release of the *World Health Report 2001*, titled *Mental Health: New Understanding, New Hope*. This was accompanied by the release of a Mental Health Atlas which mapped mental health resources in each of the WHO member states. WHO Europe had significant involvement in the development of the 2001 *World Health Report* and released in the same year a set of country reports on the mental health situation in Europe (Rutz, 2003; Freeman et al., 2009).

In September 2003 the WHO Regional Committee for Europe meeting in Vienna featured the agenda item 'Mental Health in WHO's European Region'. This agenda item reviewed the demographic and social patterns of mental ill-health across Europe and WHO Europe's work in the area. Its discussion at the meeting led to the agreement of a resolution requiring the development of a ministerial conference on mental health to be held in Helsinki in January 2005. The conference was developed through collaboration and cooperation between a number of key actors including the European Commission who also have a growing competency in public mental health in Europe (080730; European Commission, 2009; Di Fiandra, 2009; Kelly, 2008).

Table 1 Mental Health Declaration and Action Plan for Europe

Declarations and action plans are non-binding statements created by WHO Europe in order to bring member states together to promise action on a specified issue. The *Mental Health Declaration for Europe* and its accompanying *Action Plan* defines and sets the scope for mental health work in Europe and lists a set of actions and responsibilities for different actors. It prioritises work on "promotion, prevention, treatment and rehabilitation, care and recovery", anti-stigma work and the involvement of service users and carers, thereby aligning itself with a holistic approach focusing on both services for mental illness and the promotion of mental health (Freeman et al., 2009). The action plan lists possible actions states might take in fulfilling the aims of the *Declaration* and sets a series of milestones which should be 'moved toward' by 2010.

Preparations for the conference involved a series of meetings between these key actors which led to the development of a succession of 19 draft versions of the *Declaration* and *Action Plan* and a set of 14 briefing papers. The briefing papers functioned to provide a background for conference delegates on various issues in mental health and served to set

the context in which the *Declaration* and *Action Plan* would be situated. The *Declaration* and *Action Plan*, as devised by WHO Europe before the conference, was agreed without further changes at the Ministerial Conference. Table 1 provides a summary of the contents of the *Declaration* and *Action Plan*.

5.1   *Scotland and WHO Europe: building the relationship*

When Scotland's National Programme for Improving Mental Health and Wellbeing was initiated in 2001 there was an ambition by those working on the project to have Scotland placed "in the top three or four in the world for pursuing mental health promotion work" (071108). The development of a strong relationship between WHO Europe and Scotland was viewed as an important part of the strategy for making this happen. Those planning the programme consciously went out to meet with both the European Commission and WHO Europe to signal to Europe that Scotland could make an impression, separate to that of the UK (071108; 140408). In a nice circularity, a key motivation behind this action was to promote the National Programme within Scotland: if people in Europe said that Scotland was doing well, those in Scotland would take more notice of the work being done there (030308). External validation thus became a marker of internal success and a means to promote further investment in work in the 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 Europe is maintained.

6   **The development of the Helsinki Ministerial Conference and the *Declaration* and *Action Plan***

The relationship between Scotland and WHO Europe was deliberately fostered by Scottish actors through their involvement in all the deliberations leading up to the Helsinki Ministerial Conference. Respondents emphasised that participation by Scotland in the development of the *Declaration* and *Action Plan* and inclusion as a delegation at the conference was engineered as part of an intentional strategy to promote Scottish inclusion in mental health work at an international level (140408; 071108; 030308). Three key mechanisms were singled out by respondents as important in the development of the relationship between Scotland and WHO Europe:

•   the cultivation of personal connections between key actors

•   participation in the development of written documents

•   participation in meetings.

Fostering connections between key individuals was highlighted as essential in achieving a Scottish presence at international meetings like the Helsinki Ministerial Conference. Respondents discussed the importance of the "behind the scenes stuff" involving corresponding with and getting to know key staff, lobby groups and individuals that needs to take place prior to meetings such as these (161008; 140408). Long-standing personal contacts were important. For example, several of our respondents mentioned specific interactions between themselves and WHO Europe 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).

The joint writing of documents and inclusion in publications was viewed as another key part of the Scottish strategy, ensuring that Scottish work in mental health was written into key documents (140408). An example of the 'success' of this strategy was the inclusion of Scottish knowledge in several of the 14 'briefing papers' written to inform discussion at the Helsinki Conference, including those dealing with suicide (Briefing 7), prevention and promotion (Briefing 8) and stigma and discrimination (Briefing 10). These briefing papers set the scene for those at the conference by articulating the issues and providing examples of 'good practice' in order to contextualise the actions outlined in the *Declaration* and *Action Plan*. The inclusion of these examples of Scottish good practice in documents was also important for WHO Europe. As one respondent commented, "WHO can't say a lot of the things in its declarations without being able to point to places that are doing things. So we gave them that security" (071108). Reference to Scottish examples of good practice in the areas of mental health work covered by the *Declaration* and *Action Plan* thus served to validate the WHO Europe agenda for mental health.

Participation at meetings was also seen as a central tool for asserting Scottish influence on the development of the Helsinki Ministerial Conference and the resulting *Declaration* and *Action Plan* (140408). 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). Participation at meetings served the dual purpose of influencing the form and content of the *Declaration* and *Action Plan* while highlighting Scotland as a valid actor within WHO Europe. One respondent detailed the way that he worked to engineer his participation in the UK delegation that went to Brussels as part of a key pre-Helsinki Ministerial Conference meeting in late 2004. This meeting was the last chance for UK governments to say what they wanted to achieve through the Ministerial Conference and to draft the *Declaration* and *Action Plan* that would then be signed off at the January 2005 meeting. A careful and subtle discourse was used in order to create and maintain relationships and ensure that the Scottish 'message' was heard. The following quotation represents this well:

> "It's 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 discourse involved reassuring actors with very different agendas for mental health that the agenda Scotland was suggesting did not detract 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)

The preparatory groundwork built up through fostering key relationships, involvement in meetings and joint document writing meant that when it came to the Helsinki Ministerial Conference Scotland could then take part and promotes their agenda for mental health. It also meant that Scottish policy makers would be able to justify ongoing investment in mental health by citing their involvement with WHO as indicative of the respect with which international actors regarded Scottish mental health work.

7   At the Helsinki Ministerial Conference

As with Scottish involvement in the conference preparations, 'doing' the Helsinki Ministerial Conference for the Scottish delegation involved the 'right' people meeting, talking and hearing in the 'right' ways (030308; 071108; 140408). This process was carefully orchestrated. As one respondent commented: "I know how to operate in these rooms" (071108). Respondents highlighted two tactics used to establish a Scottish 'presence' at the conference: attendance at the conference by the right people and high visibility of the Scottish team. This latter tactic was achieved by sending a large delegation, by making presentations, and by erecting an information stall to exhibit Scottish innovations in mental health work.

It was important that the right people attended and participated at the Helsinki Ministerial Conference (030308; 071108). The Scottish delegation included the Deputy Minister for Health and Community Care, the head of the Mental Health Division of the Scottish Government Health Directorate, and representatives from the National Programme, the anti-stigma programme 'see me', National Health Service (NHS) Health Scotland (the health promotion branch of the NHS in Scotland), the Glasgow Centre for Population Health and the anti-suicide programme Choose Life. A separate delegation attended from England but not from Wales or Northern Ireland.

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 valuable for the success of the meeting for Scotland (030308; 071108). As one respondent commented: "She made a presentation, she met with other people and she committed Scotland to achieving [the conference] goals" (071108). In terms of the development of Scotland's international presence these were significant things for the Minister to be doing as they helped raise the nation's profile as a distinct institutional identity within WHO Europe. Ministerial participation in the Helsinki Conference was also viewed as advantageous for the development of the profile of mental health work within Scotland (071108). Participation by the Minister implied a degree of commitment to the Scottish mental health agenda, which she would then have to deliver on when she returned to Scotland. Following the conference policy makers thus found it beneficial to keep referring to the Ministerial involvement in the meeting in order to highlight their continuing work in the area. For example a 2005 edition of the National Programme's magazine *Well?* featured an interview with Rhona Brankin on the conference [Scottish Executive, (2006a), p.26]. As one respondent commented: "We spun lots of press from that" (071108).

Promotion of Scottish mental health work at the conference relied on the performance of a highly visible Scottish team that worked together strategically. Through presentations, such as that given by the Minister or the Scottish anti-stigma programme 'see me', the Scottish team promoted the Scottish population mental health agenda as an example of good practice. They reinforced this through the erection of a stall which they staffed and to which they would direct anyone they spoke with (030308). Scottish delegates involved in both the preparation for the Helsinki Conference, and at the conference itself, used their involvement instrumentally as a mechanism for self-promotion. One respondent emphasised how important this self promotion was:

> "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)

The next sections of the paper examine the impact of the conference and *Declaration* and *Action Plan* in Scotland and the reasons why, for Scotland, participation and high visibility in the conference and associated events and documents were so important.

7.1 The impact of the Declaration and Action Plan

The impact of the *Declaration* and *Action Plan* within Scotland was distinctly mixed. Notably, references to the Helsinki Ministerial Conference and *Declaration* and *Action Plan* have not appeared in a large number of Scottish policy documents concerned primarily with the provision of services for the mentally ill. They did not appear in, for example, 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*, which was published the same year (Scottish Executive, 2006b, 2006c). This reflects the fact that the activities of WHO Europe, and Scottish involvement in those activities, are primarily restricted to population mental health work rather than services.

By contrast, the *Declaration* and *Action Plan* have figured prominently in Scottish initiatives around population mental health. They were used, for instance, 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 [Hunter et al., (2008), pp.29–30]. As a result of the prominence of Scotland within the process and documents associated with the development of the *Declaration* and *Action Plan* 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" [Hunter et al., (2008), pp.12, p.29].

The work of WHO Europe was also widely referred to 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 Europe's agenda, as evidenced in the *Declaration* and *Action Plan*, with that being undertaken in Scotland (Highlands Consultation Event 050308; Lanarkshire Consultation Event 180208; Universities Scotland Consultation 290208). The resulting *TAMFS* Policy and Action Plan, released in April 2009, dedicated one page to listing the aims of the 2005 *Declaration* and *Action Plan* and noted: "This [*TAMFS*] policy and action plan demonstrates Scotland's ongoing commitment to addressing these European priorities in a Scottish context" [Scottish Government, (2009), p.50]. This statement endorses the work of the National Programme by placing it within the context of a larger European project.

None of our respondents were willing to say that the *Declaration* and *Action Plan* themselves had a great deal of impact on mental health work in Scotland or that it figured in decisions about policy. 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). Our

respondents did, however, see that it was a useful thing to talk about in a presentation in order to provide a precedent and context for Scottish work, and also as an educative tool, as evidenced in its use in the *TAMFS* consultation, discussed above. Respondents were quick to reassure us that the lack of explicit use of the documents 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 Plan* 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.

> "People are still talking, as a result of Helsinki, about things they wouldn't otherwise talk about." (030308)

For Scotland, the validation that WHO Europe offered was subtle and multifaceted. WHO Europe's reference to and inclusion of Scotland in documents and at the conference was seen to greatly enhance the profile of Scottish mental health work. The logic was that if a respected international body like WHO Europe 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 commented on how important it was that the *Declaration* and *Action Plan* included something on promotion, prevention and social inclusion as this was the focus mental health policy was taking in Scotland: "What I wanted, of course, was for WHO to say exactly [the same as] what we were doing here" (071108). Those attending the conference wanted to be able to go the Scottish Ministers and present them with this validation and, as demonstrated in the data presented above, engineered this as much as possible: "We [wanted to say] that 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 conference and associated meetings also offered an opportunity for Scottish initiatives to be introduced to a much broader audience. These 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 (071108; 140408). 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 was seen as beneficial because it built further opportunities for validation of Scottish work as that work became promoted in other forums (140408). It also opened up further possibilities for gaining funding for Scottish work on mental health through international collaborative work which would, in turn, lead to a further 'spread' of Scottish mental health knowledge.

A valuable consequence of Scottish participation in the processes surrounding the Helsinki Ministerial Conference was the way that it worked to develop 'official' links between Scotland and WHO Europe. At the conference the Scottish delegation lobbied for a Scottish agency or programme to be selected as a WHO Collaborating Centre

(071108)[3]. The presentation at the conference by the Scottish delegation on their anti-stigma work emphasised the appropriateness of NHS Health Scotland as a Collaborating Centre in this area. Having secured that designation, they became active in taking forward WHO Europe's post-Helsinki Conference work on mental health and stigma, producing a three-year programme on mental health involving the development of a policy briefing, a guide book on stigma and a conference, *APPROACHES: taking action against stigma across Europe*, held in Edinburgh in April 2008 (NHS Health Scotland, 2008a, 2008b). The importance of this work for Scotland has lain not so much in the work itself, but in the way it has created ongoing links between Scotland, WHO Europe and the other WHO member states, which has served as a further point of validation for Scottish work in mental health (140408).

Another significant result of Scottish involvement in the Helsinki-related meetings was that Scotland was granted an official Mental Health Counterpart (WHO, 2007b; 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. Scotland is unique in its relations to WHO Europe in being a 'region' of the UK that has its own Counterpart for mental health. The appointment of a Scottish counterpart was viewed as giving Scotland an 'official' voice in WHO Europe proceedings (071108; 030308).

As discussed above, the relationship prior to the conference had to be perpetually re-negotiated through constant careful dialogue between Scotland, the UK Government and WHO Europe. The appointment of NHS Health Scotland as a WHO Collaborating Centre and the appointment of a specific Scottish Counterpart for mental health established official bi-lateral links between Scotland and WHO Europe for the first time, and provided a firmer basis for continuing Scottish involvement in WHO Europe (140408; 071108). Any possible costs deriving from this firmer relationship are limited to the extent to which Scottish mental health policy conforms with the normative programme being promoted by WHO – a programme with which Scotland is already strongly aligned.

8   Concluding discussion

We began this paper by asking why Scotland, a regional actor from an advanced liberal democracy, might want to be involved in the mental health work of WHO Europe, whose substantive work as an organisation appeared to be largely directed at developing countries. Through telling the story of Scottish involvement in the development of the Helsinki Ministerial Conference and its accompanying *Declaration* and *Action Plan* we have illuminated some of the factors contributing to the development of the relationship between the two actors and revealed the strategies and instruments through which the relationship is maintained.

The most prominent message that emerged from our interviews was that for both Scotland and WHO Europe the primary benefit of the relationship was one of mutual or reciprocal validation. Scotland has limited institutional presence as an international actor in mental health given its position as a constituent country of the UK. Since devolution in

1999, however, Scotland has pursued an increasingly distinctive approach to mental health policy. 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. For the Scottish actors involved in the production and performance of the Helsinki Ministerial Conference a major outcome was the appointment of a Scottish Collaborating Centre and Counterpart. This was viewed as significant in that these roles formalised the relationship between the two actors. These 'official' roles served to open the door more widely to Scottish attendance and participation at WHO meetings and inclusion of Scottish work in WHO documents.

WHO Europe, too, needs its policies to be validated and legitimised. As an international agency with limited executive powers, WHO Europe's influence within Europe is relatively weak compared with that of the other major European international organisation, the European Union. For WHO Europe, the benefit of Scotland's participation lay in the way that the existence of Scottish programmes could validate the WHO Europe agenda. WHO Europe needed to be able to demonstrate that the agenda that they were promoting could work in practice when implemented within member states. Stone (2011, p.184, 556) observes that, like national actors, non-state actors are often included in the work of international organisations because they "provide essential services for decision makers by acting as resource banks". This can be clearly seen in the relationship between Scotland and WHO Europe in the field of mental health. Scottish examples make tangible WHO Europe's abstract agenda by demonstrating that the goals they outline are possible, while Scottish participation in WHO Europe authorises WHO Europe's position within Europe by demonstrating that relevant governmental actors in mental health share the WHO Europe agenda. Moreover, the fact that Scotland is a regional rather than a state actor serves to legitimise a further dimension of WHO action. WHO representation largely occurs at the nation state level: it is nation states who are WHO Europe members and sign WHO treaties and declarations. But in a world where the site of health action is increasingly 'global' and less determined by the actions of an individual nation state, WHO has difficulty in enacting their agenda at a regional level where much work on WHOs priorities must occur (Kickbusch and de Leeuw, 1999). This is especially problematic in federal states such as the USA, Australia or Germany, or in the devolved states of the UK where devolved governments routinely have responsibility for health (Wilson et al., 2006). A greater involvement of regional governments such as Scotland in the work of WHO therefore makes sense as it facilitates and legitimates WHO activities at this level.

As a result of this joint need for validation, the relationship between the Scotland and WHO Europe has developed as a process of 'reciprocal instrumentalism', in which both actors seek to develop their own profile through the authority of the other. This in turn has implications for how we should think about the role of WHO as a regulatory agency. Insofar as the relationship between WHO Europe and Scotland constitutes a regulatory relationship, we have seen that it is one conducted by peers rather than 'from above', in which the mutual reinforcement of symbolic authority remains a key concern. Yamey (2002) states that WHO's authority lies in its "near universal representation" and its ability to mobilise expertise. Kickbusch elaborates on this, describing an "international learning process" pursued through "a myriad of meetings, consultations, publications and other formal and informal mechanisms" [Kickbusch, (2003), p.385]. Our study of

Scotland's interactions with WHO Europe in the preparations and performance of the Helsinki Ministerial Conference exemplifies just such a process. Indeed, this process of communicative and regulatory interaction has continued after the Ministerial Conference, both through Scottish participation in various events and through their involvement in the development of the 'Baseline study' which assessed progress towards fulfilling the goals of the *Declaration* and *Action Plan* [140408; 181108; 030308; see Freeman et al. (2009) for a further discussion of the baseline study]. In effect, the relationship between Scotland and WHO Europe in the field of mental health is continually being remade through the development of personal relationships, participation and presentation at meetings, and the joint production of documents.

Our study points to a regulatory relationship which is careful, subtle and, crucially reciprocal. It suggests that, in the sphere of European mental health policy at least, WHO's role as a regulatory agency is achieved through a process of recursive, rather than multilevel, governance, in which regulation appears to be a process of mutual validation. WHO Europe 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 Europe insofar as it exemplifies the kinds of principles and practices that WHO Europe aims to foster. Further work on the role of WHO across other fields will bear out the extent to which this claim can be generalised upon. It would appear that the policy actors we interviewed clearly had a practical appreciation that this was the case. It is less clear how widely this perspective is shared among other policy actors or, importantly, among policy academics. Wider understanding of the recursive and mutualistic character of international regulation in complex areas might therefore be of value to the policy process itself, in making explicit the fact that those regulated are as much agents in the regulatory process as the regulators as the regulators themselves, and in underlining the constructive as well as the restrictive aspects of regulation. For policy academics, meanwhile, this implies that international regulation needs to be understood, not just in terms of the construction and imposition of regulatory regimes on national and regional actors, but also in terms of mutual relationships and processes of validation.

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Notes

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2   Interviews are identified by the date on which they occurred.

3   WHO Collaborating Centres are usually research organisations within member states which take forward research to support the work of WHO. They have a designated networking function. More information on their shape and purpose is available at: http://www.who.int/collaboratingcentres/en/.