THE UNIVERSITY of EDINBURGH

Edinburgh Research Explorer

Making Knowledge for International Policy

Citation for published version:
Sturdy, S, Freeman, R & Smith-Merry, J 2013, 'Making Knowledge for International Policy: WHO Europe and Mental Health Policy, 1970-2008' Social History of Medicine, vol 26, no. 3, pp. 532-554., 10.1093/shm/hkt009

Digital Object Identifier (DOI):
10.1093/shm/hkt009

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Preprint (usually an early version)

Published In:
Social History of Medicine

OPEN ACCESS

Making knowledge for international policy:

WHO Europe and mental health policy, 1970-2008

Abstract: It is widely agreed that the effectiveness of the World Health Organization (WHO) in international policy derives from its reputation as a source of authoritative knowledge. However, little has been done to show how WHO mobilises knowledge for policy. Commentators tend to assume that WHO is a technocratic organisation, which uses technical expertise to define universally-applicable standards on which to base policy. This paper tells a more complex story. Looking in detail at the efforts of the WHO European Regional Office, since the 1970s, to reform mental health policy across the region, it shows that the organisation's main policy successes in this field were achieved, not by circulating standardised data or policies, but by creating opportunities to share holistic, experience-based knowledge of best practice. We analyse our findings using the idea of 'epistemic communities', which we show can throw new light on the role of knowledge in international policy.

Introduction

The effectiveness of the World Health Organization (WHO) as a policy body has depended from the beginning on its ability to mobilise knowledge. Possessing only limited financial resources, and with no powers to compel member states to adopt any particular course of action, WHO can do little, on its own, to require changes in national or local health policy. Consequently, such success as WHO has had in promoting and coordinating international health initiatives is generally attributed to its reputation as a source of sound and reliable knowledge. As one commentary put it: 'The WHO's recognised strength lies in its biomedical knowledge, its scientific knowledge base, its surveillance and normative regulations, and its data collection ... Its perceived weakness lies in its limited ability to apply this knowledge at country level'.[1] According to another, WHO's influence is due to its ability to deliver a range of 'international public goods', including 'research and development, particularly regarding problems of global importance ... ; information and databases that can facilitate a sustained process of shared learning across countries; harmonised norms and standards for national use and ... for regulation of the growing number of international transactions; and consensus-building on health policy, which can help mobilise political will within each country'.[2]

Such views are broadly consistent with a growing body of academic research that seeks to explain the emergence and influence of an increasingly wide range of

---

[1] Kelley Lee et al., 'Who Should be Doing What in International Health: A Confusion of Mandates in the United Nations?', *British Medical Journal*, 1996, *312*, 302-307, 306.

[2] Dean T. Jamison, Julio Frenk and Felicia Knaul, 'International Collective Action in Health: Objectives, Functions, and Rationale', *The Lancet*, 1998, *351*, 514-517, 512.

international organisations since the early twentieth century. There is widespread agreement that the production and mobilisation of knowledge is central to the way that many international organisations exert an influence in the world. In a widely cited article, for instance, Barnett and Finnemore argue that international organisations derive their power in large part from their ability to '(1) classify the world, creating categories of actors and action; (2) fix meanings in the social world; and (3) articulate and diffuse new norms, principles, and actors around the globe. All of these sources of power flow from the ability of [international organisations] to structure knowledge'.[3] Given this perspective on the power of international organisations, and given WHO's prominence among international organisation, one might have expected that academics would have been quick to look in some detail at the ways in which WHO generates, structures and mobilises knowledge for policy. Surprisingly, this does not seem to have been the case.

This lack of detailed empirical investigation has not prevented commentators from making assumptions about what sort of knowledge politics WHO practices, however. WHO is widely understood to be a predominantly 'technocratic' organisation, in the sense that it looks primarily to technical knowledge as a basis for establishing normative standards of healthcare practice and provision, which are then universally applied and, where possible, enforced across member countries.[4] This assumption,

---

[3] Michael N. Barnett and Martha Finnemore, 'The Politics, Power, and Pathologies of International Organizations', *International Organization*, 1999, *53,* 699-732, 710.

[4] Philip M. Strong, 'A New-modelled Medicine? Comments on the WHO's Regional Strategy for Europe', *Social Science and Medicine*, 1986, *22*, 193-199; John W. Peabody, 'An Organ-

too, is broadly in keeping with the way that academic analysts have tended to think about the power of international organisations more generally. Barnett and Finnemore, for instance, consider international organisations primarily as bureaucratic institutions, which exercise power through '(1) the legitimacy of the rational-legal authority they embody, and (2) control over technical expertise and information'.[5] The kinds of knowledge practices that Barnett and Finnemore identify with this bureaucratic orientation – classification, the fixing of meanings, and the articulation and diffusion of norms – are all equally consistent with a technocratic approach to policy that other commentators attribute to the World Health Organisation.

However, our own findings indicate that this is not the only way that WHO works. A technocratic approach to knowledge and policy may well hold good for large areas of WHO's activities, but we cannot simply assume that it is true of everything the organisation does. In the present paper we look in some detail at how, from the 1970s onwards, WHO's European Regional Office undertook successive initiatives to generate and disseminate knowledge of the organisation and effectiveness of mental health services within the region, as a basis on which to promote reform of those services. To the very limited extent that historians have commented on this aspect of WHO's work, they have assumed that it too was primarily technocratic in character, in that it was aimed at setting universal standards of provision: 'After the

---

izational Analysis of the World Health Organization: Narrowing the Gap Between Promise and Performance', *Social Science and Medicine*, 1995, *40*, 731-742.

[5] Barnett and Finnemore, 'Politics, Power, and Pathologies', 707.

Second World War, the World Health Organization (WHO) played an active part in generating information about the state of mental health care in various countries, largely in order to set international standards for it'.[6] Our own findings, based on detailed examination of WHO documents and on interviews with a number of informants involved in WHO Europe's more recent activities in the field of mental health, show that the story is rather more complicated than this technocratic model suggests.

WHO officers did indeed set out with the aim of collecting standardised data about mental health services and their effectiveness, of a kind that was intended to permit rigorous comparison between different national mental health systems, and that would provide a basis for universal norms and recommendations regarding the kinds of mental health policies countries should pursue. But we show that these initiatives were largely unsuccessful. WHO officers repeatedly failed to establish universally applicable standards, not just for the provision of care, but even for the work of data collection. In consequence, rigorous international comparison proved impossible, as did the technocratic aim of setting universal standards of provision. That does not mean that WHO Europe has been unable to effect significant advances in regional mental health policy; on the contrary, it has achieved some notable successes in this regard. But those successes have been achieved through the production and mobilisation of a very different kind of knowledge: not standardised and comparative,

---

[6] Marijke Gijswijt-Hofstra and Harry Oosterhuis, 'Introduction: Comparing National Cultures of Psychiatry', in Gijswijt-Hofstra et al., eds, *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches* (Amsterdam: Amsterdam University Press, 2005), 9-23, 9.

but case-based and holistic, and rooted in personal experience of the peculiarities of local mental health systems of a kind that proved difficult to reduce to the standardised categories necessary for technocratic policy making.

Our findings thus present an opportunity to reassess how WHO operates as a knowledge-based international policy organisation. We do not presume that our findings can be generalised to areas of health policy beyond mental health; it may well be the case, for instance, that WHO has succeeded in pursuing a technocratic approach to knowledge and policy in more biomedicalised fields of medicine, where technical standardisation is more readily achieved and where there may be much greater consensus both within and among countries about appropriate forms and standards of provision. However, our research makes clear that this is not the only way that WHO is able to operate, and that other forms of knowledge and policy may sometimes prove more practicable or more effective. We therefore need to find ways of thinking about WHO's efforts to produce and mobilise knowledge for policy that do not simply presuppose a technocratic orientation. To that end, we go on to discuss our findings in the light of ideas about 'epistemic communities', as elaborated by Michael Haas and other writers in the field of policy studies, but also – and importantly – as developed within the field of science and technology studies. Our analysis suggests not only that thinking about epistemic communities can throw valuable light on the role of knowledge in the making of WHO policy, but also that policy scholars might benefit from incorporating insights from science and technology studies into their own understanding of epistemic communities.

Methods

The research on which this paper is based was conducted as part of a five-year, multi-centre research project looking at the role of knowledge in policy for health and education across twelve European research sites. One work package within that project set out to examine how a particular regulatory instrument, WHO Europe's 2005 *Mental Health Declaration for Europe* and its associated *Action Plan*,[7] was adopted and implemented in six different European countries. The authors of the present paper were responsible for the Scottish strand of this work package. In addition, we undertook to provide contextual information for all six strands of the work package by researching the circumstances leading up to the drafting and agreement of the *Declaration* and *Action Plan*.[8]

For the latter part of the project, we conducted a review of the secondary social scientific literature on WHO; a review of relevant WHO publications, including all reports, papers and other secondary documents on mental health in Europe that appeared between 1970 and 2008; and a series of semi-structured interviews with ten key actors involved in the production and use of the *Declaration* and *Action Plan* at the international level. Interviewees were identified by referral sampling, and included WHO staff (among them the current and two former Regional Advisers for

---

[7] WHO Europe, *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions*, 2005, WHO EUR/04/5047810/6; WHO Europe, *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions*, 2005, WHO EUR/04/5047810/7.

[8] Richard Freeman, Jennifer Smith-Merry and Steve Sturdy, *WHO, Mental Health, Europe.* Know&Pol Project Report, 2009, available online at

http://knowandpol.eu/IMG/pdf/o31.who.fabrication.pdf

Mental Health), EC officials, project staff, representatives of other international organizations and national officials with particular experience of working at international level. To ensure that interviewees felt able to speak frankly, it was agreed at the outset that the interview data should be anonymised; where used in the present paper, those data are accordingly referenced by the date on which each interview took place.

Data analysis took the form of close textual analysis of the various documents and interview transcripts. Our aim in the first instance was to provide a detailed account of how knowledge of mental health in Europe was gathered, negotiated and agreed in the period immediately before and after the signing of the 2005 *Declaration* and *Action Plan*, with a view to understanding how WHO Europe currently operates as a knowledge organisation. A rather more cursory analysis of the history of WHO knowledge production and mobilisation in this area since the 1970s was included to provide institutional context. In the course of the analysis, however, we agreed that this longer history warranted more detailed attention for the light it throws on tensions between WHO's aspirations and what it has been able to achieve in generating and mobilising knowledge about mental health provision in Europe. Additional research into the published literature was therefore conducted, and the entire corpus of data re-analysed from a historiographical perspective to produce the present paper.

Origins of WHO Europe's approach to mental health

The years following the Second World War saw dramatic growth in international activity around mental health policy,[9] including at the newly-established World Health Organization. In 1948, a Mental Health Unit (initially a 'section' of the Public Health Division) was created at WHO's Geneva headquarters, and an Expert Committee on Mental Health was convened in 1949, meeting more or less annually thereafter. The work of the committee was complemented and supported by the appointment of additional study groups, as well as by various ad-hoc seminars and conferences, often organized jointly with other bodies including the World Federation for Mental Health (formally constituted in London in 1948), ILO, UNESCO and other UN agencies.[10] These activities gave rise to a steady stream of publications including technical reports and conference proceedings, many of which continue to be cited as classics in the field.

From the start, WHO's approach to mental health went far beyond conventional psychiatry. WHO's first Director General was Brock Chisholm, a Canadian psychiatrist and medical statesman who saw the advancement of mental health as part of a broad programme of 'social medicine' that would deal as much with the economic and social dimensions of health and illness as with the biology of disease.[11] This expansive understanding of mental health was reinforced when

---

[9] Gijswijt-Hofstra and Oosterhuis, 'Introduction'.

[10] World Health Organization, *WHO and Mental Health 1949-1961* (Geneva: WHO, 1962).

[11] John Farley, *Brock Chisholm, the World Health Organization, and the Cold War* (Vancouver: University of British Columbia Press, 2008); Ian Dowbiggin, 'Prescription for Survival: Brock Chisholm, Sterilization and Mental Health in the Cold War Era', in James E. Moran

Chisholm appointed Ronald Hargreaves, from the Tavistock Institute in London, to set up WHO's Mental Health Section. According to his obituarist, 'Hargreaves was not concerned so much to establish a division for the furthering of treatment of mental disorder as to ensure that all the preventive measures undertaken by W.H.O. had their due mental hygiene component'.[12] Under the leadership of Chisholm and Hargreaves, WHO adopted a broadly community-based, preventive approach to mental health and mental illness, exemplified by the Expert Committee's third report, the influential WHO Technical Report on *The Community Mental Hospital*, which appeared in 1953.[13] At a time when mental health care in developed countries remained overwhelmingly organised around the confinement of the mentally ill in large psychiatric institutions, WHO's commitment to preventive and public health aspects of mental health was pioneering and distinctly reformist. This approach remains dominant within WHO to the present day.

Seen in wider perspective, however, mental health was a matter of rather peripheral concern within WHO, at least during the organisation's early years. Globally, WHO's attention was principally directed to the pressing health problems of the developing world, and that tendency only became more marked as growing numbers of newly-

_____

and David Wright, eds, *Mental Health and Canadian Society* (Kingston and Montreal: McGill-Queen's University Press, 2006), 176-192.

[12] K.S., 'G.R. Hargreaves, O.B.E., M.R.C.S., L.R.C.P., M.Sc., F.R.C.P.Ed.', *British Medical Journal*, 5 January 1963, 62-63, 62.

[13] World Health Organization, *The Community Mental Hospital. Third Report of the Expert Committee on Mental Health*, WHO Technical Report Series no 73 (Geneva: WHO, 1953).

independent countries joined the organisation through the 1950s and 1960s. For many of these countries, the most urgent issues revolved around implementation of basic sanitary measures, the provision of minimal levels of health care, and efforts to combat infectious disease. As a result, interest in mental health increasingly shifted away from WHO headquarters in Geneva to the organisation's European Regional Office in Copenhagen.[14] As early as 1962, a WHO review of work in the area of mental health noted that 'as the European Office is not so preoccupied with the communicable diseases as the other Regional Offices, it is not surprising that it has given a lead in mental health work of a high standard'.[15] This regional focus was formalised in September 1970, when the European Regional Committee approved a 'long-term programme' in mental health that aimed at replacing narrowly psychiatric approaches to mental illness with 'a new model of care: comprehensive preventive, treatment and rehabilitation services delivered in the community by multidisciplinary teams of health professionals'.[16]

---

[14] Uniquely in the UN system, WHO is divided into six Regional Offices, the Directors of which are primarily accountable to the countries within their respective regions. While the European Regional Office enjoys considerable autonomy over policy, however, the fact that health systems in the member countries are mostly well developed and effectively university means that the Office receives little funding from WHO headquarters. L. Lerer and R. Matzopoulos, R. (2000), '"The worst of both worlds": the management reform of the World Health Organization', *International Journal of Health Services*, 2000, *31(2)*, 415-438.

[15] WHO, *WHO and Mental Health 1949-1961*, 6.

[16] WHO Europe, *Sixty Years of WHO in Europe*, (Copenhagen: WHO Regional Office for Europe, 2009), 20; Hugh L. Freeman, Tom Fryers, and John H. Henderson, *Mental Health Ser-*

May's survey

This orientation towards comprehensive, multidisciplinary, community-based mental health services owed much to the European Office's first Mental Health Officer, a psychiatrist called Tony May. As one of our respondents observed, the effect of May's appointment was essentially 'to give mental health a public health direction … It's not psychiatry we're talking about, it's mental health'.[17] May regarded the collection of systematic information on the state of mental health services as crucial if policy was to be reoriented in this way. He accordingly ensured that the first phase of WHO Europe's 'long term programme' in mental health was devoted to what would later be described as 'a large-scale "intelligence" operation',[18] that was intended to provide the first comprehensive survey of mental health services across WHO's European Region.

May's approach to data collection was typically technocratic in its aims. In 1970, a working group on the classification and evaluation of services had concluded that 'only lip-service was being paid to the scientific planning of mental health services

---

vices in Europe: 10 Years On (Copenhagen: World Health Organization Regional Office for Europe, 1985), 2.

[17] Interview, 23 July 2008.

[18] Freeman, Fryers and Henderson, *Mental Health Services in Europe*, 14.

through the collection of suitable statistics'.[19] May agreed that 'Efficient organization depends on the collection and analysis of uniform data',[20] and he accordingly drew up a detailed questionnaire that was eventually sent to each of the thirty countries that made up the European Region at that time. The survey was conceived as a way of 'documenting aspects of WHO's long-term programme in mental health', and was intended to identify developments in particular countries 'which could be useful for the Region as a whole'.[21]

In retrospect, May's survey has assumed considerable historical significance: according to one of our interviewees, 'It was a seminal document in WHO… a tabulation of mental health services in Europe', which demonstrated for the first time the need 'to know where you're starting from … There were your gaps, there were your challenges'.[22] However, May himself saw his survey as falling rather short of what he had hoped. Specifically, it failed to produce the kind of standardised data that would enable him to compare the organisation and effectiveness of mental health systems in different countries. His questionnaire was designed to ask for no more than the minimum information that he considered necessary for effective administration of mental health services. But even basic information was often unavailable. A preliminary study conducted among eight countries quickly revealed

---

[19] Ibid.

[20] Anthony R. May, *Mental Health Services in Europe. A Review of Data Collected in Response to a WHO Questionnaire* (Geneva: WHO, 1976), 12,

[21] Ibid., 1.

[22] Interview, 23 July 2008

that 'there were many gaps in the kind of data which planners might reasonably expect to have at their disposal',[23] and this judgement was confirmed when the revised questionnaire was eventually sent out to all thirty countries in the region.

Moreover, such data as were generated by the survey were more effective in demonstrating the incommensurability of different national mental health systems than in providing a basis for comparing them. Despite May's care in drawing up the questionnaire, and in following up his respondents in the hope of clarifying their reports, the data were vitiated by a lack of consistent criteria and terminology of reporting. Consequently, the results precluded any possibility of rigorous comparative analysis.[24] Later commentators sought to construe May's survey in a more positive light: not only had it demonstrated that international surveys were possible, but 'A series of imprecise yet recognizable patterns had emerged, which could provide the basis for future policy statements and inquiries'.[25] On their own, however, such imprecise generalisations were an inadequate basis for technocratic policy interventions.

Henderson's survey

In 1980, May retired from the post of Regional Advisor in Mental Health, and was replaced by John Henderson, another psychiatrist with a strong commitment to

---

[23] May, *Mental Health Services in Europe*, 1.

[24] May, *Mental Health Services in Europe*, 1-2.

[25] Freeman, Fryers and Henderson, *Mental Health Services in Europe*, 27.

community-based mental health services. Henderson shared May's conviction that data collection was the key to reform of mental health services, and in 1982 he initiated his own survey to assess what progress had been made in the ten years since May had undertaken his study of mental health services in Europe. He was joined in this endeavour by Hugh Freeman and Tom Fryers, who had pioneered the provision of community mental health services in the deprived northern English city of Salford during the 1960s.[26]

Initially, Henderson, Freeman and Fryers sought to revive the kind of explicitly comparative and normative approach that May's survey had failed to achieve. They were ambitious to design a survey instrument that would produce data that would be 'consistent' and 'comparable', and they hoped that their survey would 'not only illustrate service development – or lack of it – between the beginning of the 1970s and the beginning of the 1980s, but will also help to show the way to make it easier to undertake a similar review of progress by the beginning of the 1990s'.[27] Like May before them, however, they quickly realised that patchy data and lack of standardised reporting criteria would make rigorous comparison of different national systems impossible. Inconsistency in the available data in turn reflected deeper differences in the conceptual basis of mental health policy in different countries, they observed; attempts at comparison would inevitably be confounded by, among other

---

[26] Valerie E. Harrington, 'Voices Beyond the Asylum: A Post-war History of Mental Health Services in Manchester and Salford' (unpublished PhD thesis, University of Manchester, 2008).

[27] Freeman, Fryers and Henderson, *Mental Health Services in Europe*, 4.

things, divergent ideas about 'mental health', prevention, and the respective roles of mental health service staff, psychiatric hospitals and community mobilisation.[28]

Consequently, they decided instead to tailor their methods to make the most of such data as were readily available. In place of direct measurement, they set out to identify 'general "indicators" of progress in mental illness care'[29] of a kind 'that are theoretically susceptible to measurement in terms of the accessible information'.[30] The measures they adopted – including metrics such as 'Reducing the number of mental hospitals with more than 1000 beds', 'Decreased length of inpatient stay', and 'Changes in the numbers of nurses' – reflected their presuppositions about what constituted good mental health care, and much of their final report consisted of lengthy tabulations of data under these and other heads. Even these surrogate measures of mental health care proved difficult to interpret, however. Consequently, the authors admitted: 'To try to gain instructive generalizations for many of the 'indicators' ... we have used various summations, averages, proportions and ratios that could not be accommodated in the tables'.[31] Repeatedly, they lamented that their data were 'far from complete' and 'insufficient to permit comparison', 'not consistent', incapable of being 'satisfactorily ... interpreted', 'misleading' and 'variable

---

[28] Ibid., 3, 44, 97.

[29] Ibid., 4.

[30] Ibid., 29.

[31] Ibid., 30.

in quality'.[32] In consequence, only the most limited comparison between countries

had been possible.[33]

Henderson and his co-authors were also pessimistic about the likelihood that such

problems would be overcome in future. While urging that 'the improved collection of

information on mental health services is an activity deserving collaboration, for which

WHO is the most appropriate international agency',[34] they saw serious obstacles in

the way of such initiatives. National governments often lacked the capacity to return

adequate data, or failed to recognise the value of 'international knowledge of mental

health' for national planning.[35] Even where effective information systems existed,

governments were often reluctant to harmonise them with one another. Resistance

to WHO efforts at technocratic standardisation had been voiced as early as 1979,

when mental health advisers from a number of countries had discussed the

implications of May's report. While agreeing that the report was a useful 'yardstick in

measuring and comparing services in different countries', 'At the same time, the

advisers expressed their resistance to having national information systems bound by

any system established by WHO'.[36] Faced with such barriers, and conscious of the

shortcomings of their own survey, Henderson and his colleagues concluded that

_____

[32] Ibid., 31, 49, 55, 64, 65.

[33] Ibid., 71.

[34] Ibid., 4.

[35] Ibid., 97.

[36] Ibid., 98-99.

there was little point in attempting to pursue further comparative data-gathering initiatives.

Pilot study areas

Given the impediments facing comparative surveys, Henderson and his co-authors now proposed that WHO Europe's investigations into mental health services should instead concentrate on a 'different approach' based on the study of so-called 'pilot study areas'.[37] They were referring to a separate programme of investigations that began as early as 1973, when May had suggested that, in addition to surveying mental health provision across the region's member states, it would also be worth undertaking more detailed, in-depth investigations of much smaller areas.[38] The proposal was subsequently taken up by a WHO Europe working party,[39] and the study was eventually expanded to include a total of 21 'pilot study areas' in 16 countries.[40]

---

[37] Ibid., 101.

[38] WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a Working Group* (Copenhagen: WHO Regional Office for Europe, 1973); WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study* (Copenhagen: WHO Regional Office for Europe, 1987), vii.

[39] WHO Europe, *Changing Patterns in Mental Health Care. Report on a WHO Working Group* (Copenhagen: WHO Regional Office for Europe, 1978).

[40] WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study*.

The methodology employed to study these areas was quite distinct from that adopted in the very broad national and international surveys attempted by May and Henderson. 'Pilot study areas' were generally quite small – often as small as a single municipality or district – permitting detailed description of the organisation and operation of mental health services in each area. Rather than looking for broad comparisons between areas, those involved in the pilot study area project were more interested in developing a deep understanding of how each area-based service functioned in its own right: 'The focus of enquiry, in short, was to be fixed not on national trends but rather on a number of selected local experiments which might serve as demonstration models for future development'.[41] This kind of insight into the detailed workings of local services could not be gleaned from a standardised survey instrument such as a questionnaire. 'The only way to get to know how a psychiatric service functions is to work in it for a period of time', one participant observed. 'Written descriptions, even visits, will not convey the nuances and subtleties of administration, organization and function that give each service its unique character'.[42]

This kind of holistic, case-based knowledge of local services did not lend itself to standardised forms of comparison between different areas. Indeed, the pilot study area project served to underline that even when apparently similar methods of record-keeping were employed in different areas, differences in how those records

---

[41] WHO Europe, *Changing Patterns in Mental Health Care*, 2.

[42] D. Walsh, 'A Typical Pilot Study Area', in WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study*, ch. 4, 73.

were used and interpreted often meant that they were not strictly comparable.[43]
Freeman and Fryers concluded: 'With such a wealth of data, and with the range of
human experience encompassed by mental health services, it is not surprising that
general, overall comparisons of areas were found impossible'. Far from regretting
the impossibility of general comparisons, however, Freeman and Fryers now saw it
as confirming what they regarded as an important message about mental health
service planning: 'this [i.e. the failure of comparison] reinforced the very proper
mistrust of the idea of a "blueprint" for services'.[44] Increasingly, they were moving
away from a technocratic approach to mental health policy, towards one which
supposed that services should be organically tailored to meet local needs and
opportunities.

This also entailed rather different methods not just of collecting but also of circulating
the kind of knowledge on which policy should be based. Technocratic approaches to
policy making tended to suppose that the necessary information could be collected
and analysed centrally, and that the results could then be disseminated in the form of
standardised data and policy documents. By contrast, the kind of deep personal
knowledge of local circumstances that Freeman and Fryers had come to prefer
resisted easy communication in documentary form. Consequently, advocates of the

---

[43] A. Dupont, 'Mental Health Information Systems', in WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study*, ch. 2.

[44] Hugh L. Freeman and Tom Fryers, 'The Pilot Areas Study and the Context of Mental Health Care', in WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study*, ch. 7, 157.

pilot study areas project urged that publication of written reports should be supplemented by opportunities for individuals to meet and share the personal knowledge and experience that they embodied: 'An important feature of the project was the regular, approximately annual meetings of the pilot study area directors and/or their representatives and collaborators,' which provided 'an important forum for the exchange of information about psychiatric care under greatly varying sociocultural and economic conditions, largely inexpressible in statistical terms'.[45]

Participants in the scheme had little doubt that such exchanges had led to real improvements in their respective mental health services, even if they could not produce statistics to prove it. The work of describing each area 'must have' caused team members to assess the structure and function of those services, while also making them aware of developments elsewhere, insisted one participant;[46] while Freeman and Fryers argued that 'the evidence suggests that the study itself has contributed significantly to progress in most of [the areas]'.[47] WHO Europe's efforts to reform mental health by technocratic means might have foundered, but some actors, at least, were persuaded that more permissive, personally-mediated methods of learning by sharing examples of good practice had proved successful.

The International Classification of Mental Health Care

---

[45] R. Giel and J.U. Hannibal, 'From Phases I and II to Phase III', in WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study*, ch. 1, 9,11.

[46] Walsh, 'A Typical Pilot Study Area', 74.

[47] Freeman and Fryers, 'The Pilot Areas Study and the Context of Mental Health Care', 160.

One final attempt was made during the late 1980s to generate standardised, comparable data about different national mental health systems within WHO's European region. The impetus on this occasion came not from the Regional Office but from the central office in Geneva, who wished to improve knowledge of mental health provision worldwide. Knowing how much work had already been done to describe the state of mental health services within the European region, in November 1988 WHO convened an expert meeting in the Department of Social Psychiatry of the University of Groningen, one of the WHO Europe Collaborative Centres that had participated in the pilot study areas programme.[48] The meeting acknowledged the shortcomings of previous efforts to compile comparative data on mental health service provision: May's and Henderson's surveys had generated 'detailed and reliable' information that provided a 'general picture' of mental health services in the countries surveyed, but had failed to achieve the kind of 'standardization' of data necessary to permit comparison between countries. What was needed, the meeting declared, was 'a classification of services in mental health care that would facilitate comparisons between care provided in different institutions and regions'.[49]

---

[48] WHO Europe, *The WHO International Classification of Mental Health Care. Report on a WHO Meeting, Groningen, Netherlands, 2-3 November 1988* (Copenhagen: WHO Regional Office for Europe, 1990); A. de Jong, 'Development of the International Classification of Mental Health Care (ICMHC)', *Acta Psychiatrica Scandinavica*, 2000, *102* (*Suppl. 405*), 8-13.

[49] WHO Europe, *The WHO International Classification of Mental Health Care*, 1.

The meeting suggested that such a classification might be achieved by supposing that mental health services were made up of discrete 'modules of care'. The nature and identity of such modules could not be assumed in advance, since mental health care differed so markedly from one locality to another. But it could be defined empirically, for each location, by looking at how staff were organised to deliver particular kinds of care. A standardised protocol might then be drawn up to ensure that the same kinds of data were collected about every module of care.[50] However, the meeting recognised that this standardisation would be harder to deliver in practice than on the page, noting that 'It is not really possible to give strict rules for the actual subdivision of an institution into modules of care'. Rather, standardisation would depend heavily upon the judgement, skill and experience of the observer. Consequently, 'To guarantee the standardization of the description of mental health care services using the classification and because this concerns a complex matter requiring expertise, the application should be performed by a trained assessor'.[51] Even then, the assessor would probably not have a sufficient understanding of any particular institution to ensure accurate classification, and so would need in addition to draw on the knowledge and experience of 'representatives of the institution to be classified' such as service managers.[52] And since local representatives would be concerned to ensure that their institutions were seen in the best possible light, 'Great

---

[50] Ibid., 4.

[51] Ibid.

[52] Ibid., 5.

care should then, however, be taken in guarding the objectivity of the assessment',
the authors warned.[53]

Following the meeting, the challenge of drawing up a workable and reliable protocol
for data collection was passed to the Groningen team, who in 1996 published what
they called the International Classification of Mental Health Care (ICMHC). The
ICMHC specified that, for the sake of convenience, modules of care might most
effectively be equated with administrative units of service provision, while the data to
be collected were categorised into ten possible 'modalities of care'. Each module of
care was to be scored in terms of the range and specialisation of the interventions it
provided under each of those modalities. Field trials showed that the ICMHC
produced reliably comparable descriptions of services when used by assessors
familiar with the services they were assessing.[54] Other researchers agreed that the
ICMHC was 'one of the most highly developed of the instruments available for
classification and description of aspects of services. It allows comparisons between

---

[53] Ibid., 6.

[54] A. de Jong, *International Classification of Mental Health Care. A Tool for Describing Services Providing Mental Health Care* (Groningen: Department of Social Psychiatry, WHO Collaborating Centre, University of Groningen, 1996); de Jong, 'Development of the International Classification of Mental Health Care'.

catchment areas and between countries of the interventions and activities available within mental health facilities'.[55]

However, there were clear limits to the applicability of the ICMHC. 'The instrument is highly developed as a means of assessing the content of the "package of care" provided by a mental health facility, but less developed as a means of classifying services into basic types and of describing the set of services available in a catchment area', noted one group of reviewers.[56] In this regard, the ICMHC might be better seen as adding a comparative dimension of the kind of detailed local studies undertaken under WHO Europe's pilot study areas programme than as a means of generating broadly comparative knowledge of mental health service provision in different countries. Another limitation was acknowledged by the Groningen team themselves. In compiling the instrument, they had to make certain compromises in order to deliver a workable protocol. Most notably, they had decided to exclude from their purview 'those social services which were seen to work more and more closely in the community with mental health care services in the process of delivering care', since attempting to bring them within the scope of the instrument 'would have required resources that were lacking'.[57] The ICMHC thus explicitly excluded one of the aspects of mental health provision that most interested policy

---

[55] Sonia Johnson, Luis Salvador-Carulla and the EPCAT group, 'Description and Classification of Mental Health Services: A European Perspective', *European Psychiatry*, 1998, *13*, 333-41, 339,

[56] Ibid., 340.

[57] de Jong, 'Development of the International Classification of Mental Health Care', 9.

makers at WHO Europe, namely the shift from a predominantly curative approach to mental health care towards one characterised by a community-based and preventive approach to public mental health.

These limitations are evident in the way that the ICMHC has since been put to use. While it has proved serviceable as a means of conducting detailed comparison between local services of a similar kind[58] or in similar localities,[59] it does not appear to have been employed in large-scale international surveys of mental health service provision more generally. Notably, it was not used in WHO's own later surveys of mental health provision either within Europe or globally (see below).

The National Counterparts

For much of the remainder of the 1990s, the focus of WHO Europe's mental health programme was diverted away from efforts to survey mental health service provision across the region, and towards more immediately pragmatic needs.[60] Conferences and working groups continued to meet and report on a variety of topics, but their

---

[58] For instance C. Wright et al., 'Assertive Community Treatment Teams in London: Models of Operation. Pan London Assertive Community Treatment Study Part I', *British Journal of Psychiatry*, 2003, *183*, 132–8.

[59] Grigory Rezvyy et al., 'The Barents project in Psychiatry: A Systematic Comparative Mental Health Services Study Between Northern Norway and Archangelsk County', *Social Psychiatry and Psychiatric Epidemiology*, 2007, *42*, 131-139.

[60] Interview, 19 January 2009

activities were guided primarily by the Health For All targets set by WHO in Geneva,[61] and by the urgent need to redress the state of mental health services in many of the Eastern European countries newly opened up to Western scrutiny and influence.[62] By the end of the decade, however, a number of factors would come together to stimulate renewed efforts to build a Europe-wide strategy to review and reform mental health services.

One factor was the appointment, in 1998, of the Norwegian ex-Prime Minister, Gro Harlem Brundtland, as Director General of WHO. Mental health reform was high on Brundtland's list of concerns, and as Director General she would call repeatedly for the development of a more preventive, community-based approach to mental health worldwide. In keeping with this vision, WHO devoted the World Health Report for 2001 to an urgent statement on *Mental Health: New Understanding, New Hope*,[63]

---

[61] On the meaning and context of the Health for All targets, see Ilona Kickbusch, 'The Contribution of the World Health Organization to a New Public Health and Health Promotion', *American Journal of Public Health*, 2003, *93*, 383-388.

[62] World Health Organization, *Evaluation of Community-based Mental Health Care Systems: Establishment of a Data Bank. Report on a WHO Consultation, Warsaw, 23-24 August 1990* (Geneva: WHO, 1992); World Health Organization, *Quality Assurance Indicators in Mental Health Care. Report on a WHO Consensus Meeting, Stockholm, 30-31 August, 1993* (Geneva, WHO, 1994); World Health Organization, *Patient Outcome Measures in Mental Health. Report on a WHO Consensus Meeting, Stockholm, 23-24 November, 1995* (Geneva, WHO, 1996).

[63] World Health Organization, *World Health Report 2001. Mental Health: New Understanding, New Hope* (Geneva: WHO, 2001).

accompanied by an atlas detailing the distribution of mental health resources across the world.[64] Meanwhile, concern at the burden of mental ill health was also growing outside the WHO, notably within the European Union, and in 1999 a prominent Conference on the Promotion of Mental Health and Social Inclusion was hosted by Finland during its tenure of the European Presidency.[65] The need for WHO Europe to respond to these pressures was implicitly acknowledged in the following year, when Marc Danzon was appointed Regional Director. Danzon had a clinical background as a child psychiatrist, and before being appointed overall Regional Director of WHO Europe had served as Regional Director of Communications and then of Health Services, where he was responsible for overseeing the mental health programme. On his appointment, Danzon persuaded the Finnish government to co-sponsor what would become the first ever WHO European Ministerial Conference on Mental Health, to be held in Helsinki in January 2005.

The Ministerial Conference provided an opportunity to make a major statement about the direction of mental health policy in Europe. In preparing for the Conference, however, WHO Europe was once again confronted with the paucity of information

---

[64] World Health Organization, *Atlas: Mental Health Resources in the World, 2001* (Geneva: WHO, 2001); World Health Organization, *Project Atlas: Information and Evidence for Better Decisions* (2009), http://www.who.int/mental_health/evidence/atlasmnh/en/index.html, accessed 28 February 2010.

[65] V. Lehtinen, *Action for Mental Health. Activities co-funded from European Community Public Health Programmes 1997-2004*, report prepared for the European Commission, Health and Consumer Protection Directorate-General (Luxembourg: European Commission/STAKES, 2004).

about the current state of mental health services in different member countries. Fortunately, steps to fill the gap were already being taken by Wolfgang Rutz, who in 1998 had joined WHO Europe as Regional Advisor in Mental Health. Rutz had set about compiling information on the condition and effectiveness of mental health services within the region. Llike other Regional Advisors before him, he had quickly discovered that systematic comparative data were extremely difficult to come by.[66] Rather than attempt to conduct yet another survey of services, however, Rutz instead instituted a network of national 'counterparts' – individuals from each country within the region who were responsible for liaison between their respective countries and the WHO Regional Office.[67] The national counterparts met twice a year to discuss the development of mental health services across Europe, and their meetings provided a further opportunity to share personal knowledge and experience of mental health services in different national settings.

The nature of the knowledge shared by the national counterparts is apparent from the compendium of 'country reports' that they wrote to supplement the World Health

_____

[66] He did, however, manage to compile provisional figures on the incidence of mental illness in different countries, using the Health For All database: Wolfgang Rutz, 'Mental Health in Europe: Problems, Advances and Challenges', *Acta Psychiatrica Scandinavica*, 2001, *104* (*suppl. 410*), 15-20.

[67] WHO Europe, *Mental Health in Europe. Country Reports from the WHO European Network on Mental Health* (Copenhagen: WHO Regional Office for Europe, 2001); WHO Europe, *WHO European National Mental Health Counterparts*, 2007, http://www.euro.who.int/mentalhealth/CtryInfo/20030717_2, accessed 28 February 2010.

Report of 2001.[68] These were two- to three-page 'briefing contributions', intended

primarily for the use of the Regional Adviser and their fellow counterparts, which

provided 'unpretentious and informative' accounts of mental health planning,

legislation and service provision as well as 'areas of progress' and issues of concern

in each of the countries in the region. Like the earlier pilot study area reports, the

country reports eschewed any attempt at rigorous international comparison, opting

instead for 'an impressionistic review describing the relevant efforts and

shortcomings as experienced by the counterpart'.[69] Once again, in the absence of

comparative data about mental health services in different countries, WHO Europe

had opted for a more case-based, holistic understanding of effective service delivery.

This kind of knowledge would be crucial to the success of the 2005 Ministerial

Conference in setting the agenda for mental health policy in Europe.

The Ministerial Conference

The Ministerial Conference of 2005 might be seen as the apotheosis of the case-

based approach to developing mental health policy. Central to the proceedings of

the Conference were two documents: the *Mental Health Declaration for Europe* and

the *Mental Health Action Plan for Europe,* both of which were prepared before the

Conference and simply approved there without amendments. The form of these

documents is worth noting. The *Declaration* was basically a reassertion of WHO's

long-standing commitment to community mental health, including the importance of

---

[68] WHO Europe, *Mental Health in Europe.*

[69] Ibid., i.

mental health promotion and other preventive measures, the superiority of community-based services over large psychiatric institutions for the mentally ill, and the value of NGOs and service user organisations in providing both preventive and recovery-oriented services. It stressed the need for member countries to develop policies 'aimed at achieving mental well-being and social inclusion of people with mental health problems',[70] and committed ministers to pursue implementation of the *Action Plan* across the European Region 'in accordance with each country's constitutional structures and policies and national and subnational needs, circumstances and resources'.[71] The *Action Plan* in turn listed twelve 'challenges' and a wide range of 'actions to consider' as means of addressing those challenges, plus a short list of 'milestones' against which progress could be measured.[72] Both documents were relatively short: the *Declaration* only six pages in length, and the *Action Plan* just twice that. Strikingly, neither the *Declaration* nor the *Action Plan* cited any evidence in support of the public mental health perspective or the particular lines of action that they recommended. Rather, the two documents read more like a statement of shared aims and values than an example of evidence-based policy.

This absence of evidence was partially mitigated by a set of fourteen 'briefing papers' presented to the Ministerial Conference.[73] These papers served to back up

---

[70] WHO Europe, *Mental Health Declaration for Europe*, 3.

[71] Ibid., 4.

[72] WHO Europe, *Mental Health Action Plan for Europe*.

[73] Available at http://www.euro.who.int/mentalhealth/Publications/publications, accessed 29 March 2010.

the recommendations of the *Declaration* and *Action Plan* by providing empirical information on a range of topics, including the mental health of children and young people, stigma and social exclusion, and suicide prevention. Insofar as the briefing papers cited statistical or other quantitative evidence, this was predominantly either epidemiological or concerned the availability of psychiatric and other kinds of mental health care across the European region. By contrast, information about the nature and content of mental health services was chiefly case-based and qualitative in character, including brief descriptions of particular initiatives under way in different countries. The briefing documents thus did not set out to provide systematic evidence for the effectiveness of any particular form of intervention. Rather, the initiatives they described served simply to exemplify the kinds of practical ways in which the challenges identified in the *Declaration* and *Action Plan* might be addressed; in effect, they were instances of good practice that other countries might wish to emulate or adapt for their own purposes. To that end, they were selected principally for the way that they embodied and exemplified the general aims and values on which the *Declaration* and *Action Plan* were founded.[74]

The way in which these examples of good practice were selected is also worth noting. The briefing papers were themselves the outcome, not of any systematic review of the available evidence, but rather of a whole series of committees, working groups and ad hoc meetings that brought together a wide range of interested parties. Much of the responsibility for planning the conference was delegated to a Steering

---

[74] Jennifer Smith-Merry, Richard Freeman and Steve Sturdy, 'Reciprocal Instrumentalism: Scotland, WHO Europe, and Mental Health', *International Journal of Public Policy*, in press (accepted for publication 14 July 2010).

Committee, which met every two or three months from 2002 to 2004, either in Brussels or Copenhagen. In the course of its preparations, the Steering Committee commissioned and reviewed various working papers and engaged with several other projects, meetings and networks. It drew in particular on a number of 'expert committees' that Rutz, as Regional Adviser on Mental Health, had established on topics such as children and young people, depression and suicide, alcoholism, and stigma and social exclusion. Several of these topics were also explored in a series of developmental 'pre-conferences' to which representatives of member states were invited in the months leading up to the Ministerial Conference itself.[75]

The whole process was concerned as much with securing a degree of common understanding and common purpose between the representatives of different national mental health systems as with formulating a rigorous, evidence-based policy framework. Agreement needed to be reached on such fundamental ideas as what a preventive, public-health approach to mental health policy might look like, or how community-based mental health services might be organised. As Matt Muijen, who replaced Rutz as Regional Adviser in May 2004, later recalled: 'An area that required attention at the drafting stage was the scope of mental health care. It proved necessary, considering the expansion of responsibilities of mental health well beyond the traditional roles of psychiatry in hospitals and outpatient settings, to clarify boundaries and to determine priorities'.[76]

---

[75] Freeman, Smith-Merry and Sturdy, *WHO, Mental Health, Europe*.

[76] Matt Muijen, 'Challenges for Psychiatry: Delivering the Mental Health Declaration for Europe', *World Psychiatry*, 2006, *5*, 113-117.

Face-to-face meetings, and the opportunity to exchange knowledge of exemplary mental health initiatives, were crucial to this process. In the absence of any pre-agreed model of what constituted an appropriate mental health intervention, practical on-the-ground experience of particular initiatives was far more useful than centralised, technocratic knowledge of health systems. Indeed, practical experience of working examples of community-based mental health care proved to be valuable currency in this regard: Scotland, which as a constituent country of the United Kingdom did not have official representation within WHO Europe, was able to leverage a space in the planning process, and ultimately at the Ministerial Conference, on the grounds of having pioneered a number of particularly noteworthy lines of community-oriented mental health work.[77] Practical, experience-based knowledge of mental health service delivery was thus central to the policy process that led to the signing of the *Mental Health Declaration* and *Mental Health Action Plan for Europe*,

The baseline survey

At the same time, however, participants in the Ministerial Conference also reiterated a desire for more systematic knowledge of mental health provision, of a kind that would permit a more technocratic approach to policy. 'In spite of rapid development, the evidence base on preventive activities is still small and needs to be expanded',

---

[77] Smith-Merry, Richard Freeman and Steve Sturdy, 'Reciprocal Instrumentalism'.

declared one of the briefing papers.[78] 'Unfortunately, to date, there has been little implementation of evidence-based approaches to promotion and prevention across Europe', lamented another.[79] The *Mental Health Action Plan for Europe* therefore suggested that relevant data should be collected 'in order to assist in the effective planning, implementation, monitoring and evaluation of an evidence-based strategy'.[80]

Contributors to the Ministerial Conference were especially concerned that such evidence should be of a kind that would permit comparison between different countries and different kinds of interventions. The *Declaration* accordingly endorsed the need to 'Produce comparative data on the state and progress of mental health and mental health services in Member States'.[81] WHO Europe quickly took steps to implement this recommendation. The Regional Office did not have funds of its own for this work, so turned to the European Commission for assistance. At the Helsinki conference, Matt Muijen had explored with Markos Kyprianou, the European Commissioner responsible for Health and Consumer Protection, the possibility that

---

[78] WHO Europe, *Mental Health Information and Research*, Briefing Paper 4, 2005, http://www.euro.who.int/document/MNH/ebrief04.pdf, accessed 30 March 2010.

[79] WHO Europe, *Mental Health Promotion and Mental Disorder Prevention*, Briefing Paper 8, 2005, http://www.euro.who.int/document/mnh/ebrief08.pdf.

[80] WHO Europe, *Mental Health Action Plan for Europe*.

[81] WHO Europe, *Mental Health Declaration for Europe*.

the Commission might support a survey of mental health provision in Europe; funds for this purpose were subsequently written into EC grant funding for mental health.[82]

Preparation of the survey questionnaire was led by the European Regional Office. However, it is notable that the initial design of the survey questionnaire was not based on the ICMHC, which as we saw above had been developed by WHO Europe to permit strict comparisons between specific mental health services within the region. Rather, it was based on the Assessment Instrument for Mental Health Systems, developed by WHO in Geneva as a tool to identify and assess the main components of mental health systems in low and middle-income countries.[83] Evidently the Regional Office recognised that efforts to gather the kind of fine-grained data specified by the ICMHC were likely to be self-defeating, and a more broad-brush approach should be adopted, at least in the first instance.

A key concern throughout the drafting process was the desire to generate viable indicators by which different national systems and different interventions could be measured. As one of our informants put it, the drafting process was informed by consideration of 'what is it that can be turned into a variable and to an indicator

---

[82] Interview, 18 November 2008.

[83] Michelle Funk, Natalie Drew and Benedetto Saraceno, 'Global Perspective on Mental Health Policy and Service Development Issues: The WHO Angle', in Martin Knapp et al., eds, *Mental Health Policy and Practice Across Europe* (Maidenhead: Open University Press, 2007), 426-440; Shekhar Saxena et al., 'WHO's Assessment Instrument for Mental Health Systems: Collecting Essential Information for Policy and Service Delivery', *Psychiatric Services*, 2007, *58*, 816-821.

eventually'.[84] Considerable care was therefore taken to design the instrument so as

to produce comparable results when applied in different national and regional

settings. Language was one obvious concern, and most countries translated the

questionnaire into their own languages. But technical vocabulary posed an

additional challenge; consequently the questionnaire was accompanied by a

glossary drawn from a range of other WHO documents, specialist publications and

expert advice. It was also crucial that the questionnaire should be equally applicable

to different national mental health systems. Consequently, national counterparts

were closely involved in the later stages of drafting the questionnaire, scrutinising

and amending the questionnaire at two consultative meetings in March and October

2006. A participant recalled that at the second of these meetings, 'We again had the

text of the questionnaire on the big screen and went through it question by question,

participants made comments that were added with track-changes and after the

meeting we produced an updated questionnaire incorporating the comments'.[85] The

outcome was a significantly enlarged questionnaire, running to nearly 50 pages and

covering approximately 1,000 variables. The final version was ready for distribution

to national coordinators – usually the counterparts themselves – in March 2007.

In all, forty two member states took part in the survey; of the ten that did not, seven

were newly independent states in Eastern Europe, while the remainder – Iceland,

Monaco and Andorra – were very small. The survey generated an enormous

amount of data. Making sense of those data remained a challenge, however, as the

---

[84] Interview, 18 November 2008.

[85] Interview, 25 February 2009.

resulting report made clear. The report was frank about the difficulties that confronted any attempt to survey mental health services across so diverse a region, acknowledging from the start that 'A challenge in its own right was whether this survey could meaningfully be conducted and what the next steps should be'.[86] The authors were particularly circumspect about the possibility of drawing any clear comparative conclusions, dwelling at some length on the tension between diversity and convergence in comparative observation. Gaps in the available information were exacerbated by difficulty in developing common definitions and internationally compatible data. Perhaps surprisingly, comparison had proved particularly difficult in the most developed Western European countries, where de-institutionalisation and diversification of services had progressed furthest: 'Services in the EU 15 countries [i.e. not including the mainly Eastern European countries that have joined since April 2004] appear to be so differentiated that any comparison is haphazard'.[87]

The report was also cautious about the normative conclusions it felt able to draw. There are indications within the survey instrument itself that WHO initially hoped to be able to define a minimum standard of provision that countries might be expected to achieve. Thus the preamble to the survey instrument stated that 'This is a WHO benchmarking project supported by the European Commission', and that 'This questionnaire will offer us an insight into the activities of Member States at this point in time, and a benchmark point as compared to milestones in the Declaration and

---

[86] WHO Europe, *Policies and Practices for Mental Health in Europe: Meeting the Challenges* (Copenhagen: WHO Regional Office for Europe, 2008), 2.

[87] Ibid., 89.

Action Plan'.[88] As preparations for the survey progressed, however, participants

became increasingly cautious: 'We didn't feel that we were in the position to

establish benchmarks already – we needed to have a baseline first'.[89] The survey

instrument was accordingly circulated as a 'Baseline Assessment Questionnaire',[90]

and the final report avoided any suggestion that it was concerned with

benchmarking, presenting itself simply as a first step towards a more comparative

assessment of progress in the reform of mental health provision: 'This report is the

first stage, a baseline'.[91] Nearly forty years after Tony May embarked on the first

systematic survey of mental health services in Europe, hopes of generating the kind

of data that would permit rigorous comparison of different countries, and that might

provide a basis for setting international standards, continued to be deferred.

Discussion

Since the 1970s, WHO's European Regional Office has repeatedly attempted to

compile the kind of data on mental health services that would permit rigorous,

systematic comparison between different national systems and different kinds of

mental health intervention. The impetus behind such efforts has been essentially

---

[88] WHO Europe, *Baseline Assessment Questionnaire: based on milestones, responsibilities and actions in the WHO Mental Health Declaration and Action Plan* (Copenhagen: WHO Regional Office for Europe, 2007).

[89] Interview, 18 November 2008.

[90] WHO Europe, *Baseline Assessment Questionnaire*.

[91] WHO Europe, *Policies and Practices for Mental Health in Europe*, 2.

technocratic – rooted in the expectation that such knowledge would ultimately make possible the establishment of universal, normative standards of provision against which different countries could be measured and judged. In the event, the necessary knowledge has so far proved elusive: the disparate ways in which mental health systems have evolved in different countries, and the different understandings of mental health care that obtain in those settings, have defied reduction to the kinds of standardised categories that would permit direct comparison and universal standard-setting.

This does not mean that WHO Europe has failed in its aim of generating and mobilising knowledge as a means of developing and promoting new mental health policies; on the contrary, it has been quite successful in achieving that aim. But our study makes clear that the kind of knowledge that has proved most effective as a basis for WHO Europe's policy initiatives in the area of mental health consists, not of standardised comparative data about national systems of mental health care, but rather of case-based knowledge of particular local interventions. As we indicated in our introduction, this sits uneasily with the widely-held view of WHO as a technocratic institution which exercises power through the diffusion and enforcement of universal norms and standards. It also challenges us to reconsider the way that academics have tended to think about the role of knowledge in the work of international policy organisations more generally. As we have seen in the case of the widely-cited work of Barnett and Finnemore, much academic thinking in this field assumes a similarly technocratic or beureacratic perspective, attributing the influence of international organisations in large part to their control over the epistemic work of classification, the fixing of meanings, and the articulation and

diffusion of norms.[92] If we are to understand WHO Europe's success in the field of

mental health policy, it appears that we need to expand the way we think about the

role of knowledge in the development of international policy beyond this narrowly

technocratic frame.

One way of doing so is by looking at how policy knowledge originates in and is

mobilised by particular epistemic communities. The idea of epistemic communities

has its roots in the sociology of scientific knowledge, where it has developed as a

useful tool for of thinking about the collective nature of the work of scientific

knowledge production, and about the social organisation of the communities of

practitioners who undertake that work.[93] But it has been adopted with particular

enthusiasm by scholars of international policy, beginning with Peter Haas in a much-

cited 1992 paper on how epistemic communities help to secure international policy

coordination.[94]

---

[92] Barnett and Finnemore, 'Politics, Power, and Pathologies', 707.

[93] For a useful recent review, see Morgan Meyer and Susan Molyneux-Hodgson,

'Introduction: The Dynamics of Epistemic Communities', *Sociological Research Online*,

2010, *15 (2)* 14.

[94] Peter M. Haas, 'Epistemic Communities and International Policy Coordination',

International Organization, 1992, *46*, 1–35; see also Mai'a K. Davis Cross, 'Rethinking

epistemic communities twenty years later', *Review of International Studies*, *FirstView* Article,

DOI: 10.1017/S0260210512000034, published online 11 April 2012.

Like many with only passing familiarity with the sociology of scientific knowledge, however, Haas tends to think of knowledge production and mobilisation, and the epistemic communities that conduct it, in primarily intellectualist terms. Thus he defines epistemic communities as 'networks of knowledge-based experts' whose 'control over knowledge and information' enables them to shape policy by 'articulating the cause-and-effect relationships of complex problems, helping states identify their interests, framing the issues for collective debate, proposing specific policies, and identifying salient points for negotiation'.[95] And he emphasises the shared normative and causal beliefs, criteria for judging epistemic validity, and ideas about the framing of policy problems that he takes to be constitutive of 'community'.[96]

However, work in science and technology studies (STS) also highlights other aspects of epistemic communities that may be valuable for thinking about the role of knowledge in policy. Thus STS scholars make clear that the work of knowledge production depends not just on shared intellectual commitments, but also on the establishment of agreed practices and agreed forms of social order, including shared conventions for collaboration, communication, and the distribution of authority and credit. Crucially, work in STS also emphasises that all these aspects of the intellectual, practical and social organisation of knowledge production may differ quite markedly from one field of science to another.[97] This appreciation of the

---

[95] Ibid., 2.

[96] Ibid., 3.

[97] See for instance Peter L. Galison and David J. Stump (eds), *The Disunity of Science: Boundaries, Contexts, and Power* (Stanford: Stanford University Press, 1996); Karin Knorr-

diversity of epistemic cultures, and hence of the epistemic communities that those cultures serve to constitute, can be particularly valuable in helping us to understand the very different ways in which knowledge may be organised in relation to policy.

Of course, policy-oriented epistemic communities will often – perhaps even usually – tend to evolve in concert with technocratic approaches to policy, or in connection with policy issues that lend themselves to technocratic interventions.[98] Indeed, the present paper documents the efforts of WHO Europe to create just such a technocratically-oriented epistemic community in the field of mental health policy. Specifically, it shows how WHO officers repeatedly attempted to build an international network of mental health experts, united by shared use of standardised data collection instruments, and reporting to a single central authority that would ensure the quality of the resulting data then use it to create a single coherent body of comparative knowledge of mental health provision across Europe.[99]

To date, as our study makes clear, this project has been seriously compromised by serious technical and practical difficulties. However, our study also shows that WHO Europe has been considerably more successful in fostering the development of a rather different epistemic community in this area of mental health policy,

_____

Cetina, *Epistemic Cultures: How the Sciences Make Knowledge* (Cambridge: Harvard University Press, 1999).

[98] Cross, 'Rethinking Epistemic Communities', 9.

[99] Cf. Saul Halfon, 'The Disunity of Consensus: International Population Policy Coordination as Socio-technical Practice', *Social Studies of Science*, 2006, *36.5*, 783-907.

incorporating very different practices of knowledge production and forms of work organisation. This alternative epistemic community has evolved around the production and circulation, not of standardised forms of data, but of context-sensitive knowledge of particular cases of exemplary mental health interventions. Moreover, that knowledge is in large part generated, not through the deployment of centrally managed and standardised survey instruments (though survey data may sometimes be employed in building such knowledge), but through face-to-face discussion, negotiation and sharing of personal experiences and understanding of relevant interventions.

Over the past forty years, WHO Europe has created a wealth of opportunities for such discussions to take place: at the workshops organised under the pilot study areas scheme, through the regular meetings of the national counterparts and, most visibly, at the many workshops and conferences that culminated in the Ministerial Conference in Helsinki and the signing of the *Mental Health Declaration* and *Mental Health Action Plan for Europe*. In so doing, WHO Europe has done much to create the conditions under which the emergent epistemic community has been able to negotiate and define its own objects of knowledge and standards of knowledge production.

That is not to suggest that WHO officers did not play an active role in determining what kinds of interventions would be considered appropriate for study, or what aspects of those interventions should receive particular attention. Nonetheless, the degree of decentralised autonomy enjoyed by the various parts of this epistemic community stands in marked contrast to the kind of strict centralised disciplinary

control that WHO Europe sought to exert in its efforts to generate systematic comparative knowledge of mental health provision. In terms of the standards and practice of knowledge production it employs and the way the work of knowledge production is organised, the epistemic community that has grown up around the production and circulation of case-based knowledge of exemplary mental health interventions is thus very different from that which WHO initially sought to build around the conduct of systematic surveys.

This decentralised approach to epistemic authority is also apparent in the particular style of policy making that WHO Europe adopted when it decided to create the *Mental Health Declaration* and *Action Plan*. Given the difficulties they had encountered in trying to conduct systematic surveys of mental health provision across Europe, WHO officers were well aware that mental health systems had evolved in different ways and faced different opportunities and constraints in different national settings. If it was impossible even to establish universal standards of measurement and comparison across these different settings, there was plainly little to be gained by trying to define, let alone impose, universal standards of service provision. Instead, in organising the Helsinki conference, the WHO officers and their European Commission colleagues engineered a situation in which policy actors from across Europe were able to agree on a rather general orientation and set of values that they felt should inform mental health practice, and on a wide-ranging set of examples of good practice that they regarded as embodying and exemplifying those values. And by inscribing those values and examples, not in a set of precise technical standards of performance, but in the much more open-ended format of the *Declaration* and *Action Plan*, WHO gave national and local policy makers and

service providers considerable interpretative freedom to decide just what kinds of initiatives might be regarded as successfully implementing WHO policy.

In the event, insofar as the WHO policy has actually led to action, much of the work of interpreting and implementing it has been undertaken or at least championed by members of the same epistemic community of practitioners and policy makers as was responsible for drafting the *Declaration*, *Action Plan* and associated briefing documents; and it has involved much the same kind of discussion and negotiation of what counts as appropriate action in particular contexts as characterised the selection of the exemplary cases that were incorporated in those policy documents. In effect, the work of implementing WHO Europe's policy on mental health can thus be seen as a direct continuation of the work of formulating that policy. Moreover, WHO itself has had very little involvement in such decisions about how to implement that policy as have been taken at national or local level. At most, its presence in those decisions appears to be chiefly symbolic, with the *Declaration* and *Action Plan* being invoked to lend additional authority to a wide range of national and local policy initiatives, many of which were already under way or mooted well before the Helsinki conference.[100] This is a long way from a technocratic or bureaucratic approach to

---

[100] Smith-Merry, Richard Freeman and Steve Sturdy, 'Reciprocal Instrumentalism'; Freeman, Smith-Merry and Sturdy, *WHO, Mental Health, Europe*, 67f; Didier Vrancken, Frédéric Schoenaers and Gaëtan Cerfontaine, 'The WHO in Belgium: Cross-level Networking', Know&Pol Project Report, 2009, http://knowandpol.eu/IMG/pdf/o31.who.belgium.pdf; Gunnar Vold Hansen, Marte Feiring, Marit Helgesen, Helge Ramsdal, 'Norway, Mental Health and WHO', Know&Pol Project Report, 2009, http://knowandpol.eu/IMG/pdf/o31.who.norway-2.pdf; Bori Fernezelyi and Gábor Eröss, 'Lost

policy. WHO's aspirations may have been technocratic, as indeed may those of many who have contributed to the development of its mental health policy; but it would appear that the field of mental health does not lend itself to technocratic intervention, and WHO has consequently had to pursue a very different policy style.

This in turn requires us to rethink the nature of the relationship between WHO's European Regional Office and the epistemic community that has grown up around that Office's mental health policy initiatives. WHO has played an active role in the creation and orientation of that epistemic community, by identifying individuals with roughly similar interests in mental health, creating opportunities for networking and communication, setting a general agenda for discussion, and granting the imprimatur of WHO policy to the outcomes of those discussions. But in terms of making knowledge for policy, and in terms of deciding how to implement that policy, the resulting epistemic community has in large part been left to exercise its own collective judgement, independently of official interference from WHO influence. Indeed, in this respect, that epistemic community might perhaps be better regarded as a network of practitioners and policy makers united by a set of general values and an interest in mutual learning about best practice in mental health than as an organ of WHO policy. Happily, the concerns and interests of WHO Europe and those of the members of the epistemic community that it has fostered are generally in alignment with one another, to the extent that it makes little sense to ask if the epistemic community has developed to serve WHO's policy purposes or vice versa.

_____

in Translation: From WHO Mental Health Policy to a non-Reform of Psychiatric Institutions',
Know&Pol Project Report, 2009, http://knowandpol.eu/IMG/pdf/o31.who.hungary.pdf

Whether similar conclusions might be drawn about other areas of WHO policy, or indeed about the work of other international policy organisations, is a matter for empirical investigation. Mental health is clearly a particularly diverse and contested area of social and medical provision, and may represent an especial challenge to technocratic forms of policy. Whatever the specifics of the case, however, there is a more general conclusion that we can draw from our study of WHO Europe's efforts to make knowledge for mental health policy – namely: that policy studies has much to gain from recognising that epistemic communities are characterised as much by the particular epistemic practices and forms of social order they embody as by generalised forms of expertise and authority. As our case study demonstrates, attention to the particular ways in which specific epistemic communities are constituted in the field of policy can also throw valuable light on the different ways in which policy itself may be pursued.