Knowledge, Policy and Mental Health

WHY WE MIGHT THINK ABOUT KNOWLEDGE

There is always a variety of knowledge at play in any given policy domain; in our case, that of mental health, this includes medical science, technical understandings of law and accounting and the practical wisdom of professionals and administrators, as well as the 'evidence of experience' held by service users and their carers. Meanwhile, the use of knowledge as an instrument of governance has increased, as exemplified in consultations, indicators and other instruments of performance management. This suggests that one of the tasks of government (both national administrations and international organizations) is to synthesize and integrate different kinds of knowledge. Yet policy makers are made uncertain not only by conflicts of interest but also by incommensurable epistemologies or ways of knowing: not only do people want different things; they also *know* different things.

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WHAT DO POLICY MAKERS KNOW?

This briefing summarises the findings from our five-year study of mental health policy making in Scotland and in Europe. We set out to identify and understand the cognitive roots of public policy, to explore the ways of thinking which inform government. We were interested in three aspects of the relationship between knowledge and policy:

- *What do policy makers know and how do they know it?*
- *How do they use what they know from different sources in making decisions?*
- *How do they use different kinds of information to govern mental health?*

In order to answer these questions, we collected data from the documents produced by government and other organizations, by observation of meetings and other events, and through interviews with public officials, practitioners, service users and other representatives of networks, organizations and groups.

A EUROPEAN PROJECT

Our work was part of the bigger, integrated European project KNOWandPOL, which investigated health and education policy in eight countries at local, national and international levels. The project was funded by the European Commission and directed by the Centre for Interdisciplinary Research on Solidarity and Social Innovation at the Catholic University of Louvain, Belgium.

MAPPING THE TERRITORY

We began by surveying the ground, mapping the territory of mental health in Scotland.[1] We wrote what we called a 'policy morphology', trying to describe its institutional shape. We located both organizations and individuals, asking specifically about the sources of their expertise. We identified a thick canopy of committees and groups, as well as frequent 'talking events' such as conferences and consultations.

[1] Smith-Merry, J, Freeman, R and Sturdy, S (2007) *Scottish mental health policy: context and analysis*, report to the European Commission Integrated Project 0288848-2 KNOWandPOL, Louvain-la-Neuve: Université Catholique de Louvain

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These served as a means of reciprocal information and education among those involved. The mental health 'system' seems to exist to the extent that it generates and disseminates knowledge about itself.[2,3,4]

'If you miss a meeting you miss out.'

POLICY: COLLECTING, SORTING AND DISTRIBUTING KNOWLEDGE

We then focused on the National Programme for Improving Mental Health and Wellbeing, and the consultation exercise which led to the government's strategic statement *Towards a Mentally Flourishing Scotland*.[5] This allowed us to explore the way the policy process works to collect, sort and distribute knowledge, and sometimes to generate new knowledge, too. It became clear that different actors deployed different kinds of knowledge at different stages of the policy making process, and that a key function of government is to organize and express it in coherent and intelligible form. In doing so, some elements are highlighted and others excluded. In this way, we began to think of the policy making process as a collective learning process; by the some token, however, it was clear that some actors were more able to create and exploit new knowledge than others.

We noted the existence and evolution of a particular pattern in the production and use of knowledge, in which performance indicators have become increasingly significant. At the same time, however, the emergence of a new terminology - of well-being, for example - serves to create new objects of thought and discussion. These become points of orientation for both social and political mobilisation.[6] Meanwhile, there seem to be differences between what is talked about in meetings and conferences and what is written in policy documents. At consultation events, professionals and practitioners trade stories and everyday understandings, interpreting and operationalizing the language of policy.[7] The experience not only of delivering but in particular of using services, meanwhile, seems elusive, difficult to write down. As policy is processed from one site to another in and through documents, this knowledge evaporates.

'As well as evidence we need to listen to what practitioners have said through the process, which may not be evidence based.'

KNOWLEDGE: EMBODIED, INSCRIBED, ENACTED

It was now possible, even necessary, to develop a more formal conceptual scheme of what we understood as 'knowledge' in policy. Drawing a simple analogy with the three phases of matter - solid, liquid and gas - we argue that knowledge, too, exists in three phases, which we characterise as embodied, inscribed and enacted.[8]

[2] Smith-Merry, J, Freeman, R and Sturdy, S (2008) 'Organizing mental health in Scotland', *Mental Health Review Journal* 13 (4) 16-26
[3] Smith-Merry, J (2008) 'Improving mental health and wellbeing in Scotland: A model policy approach' *Advances in Mental Health* 7 (3) 176-185
[4] Smith-Merry, J, Freeman, R and Sturdy, S (2011) 'Transformation of a mental health system – the case of Scotland', draft paper
[5] Smith-Merry, J, Freeman, R and Sturdy, S (2009) *Towards a mentally flourishing Scotland: the consultation process as public action*, report to the European Commission Integrated Project 0288848-2 KNOWandPOL, Louvain-la-Neuve: Université Catholique de Louvain
[6] Sturdy, S, Smith-Merry, J and Freeman, R (2010) 'Stakeholder consultation as social mobilisation: framing Scottish mental health policy', draft paper
[7] Smith-Merry, J (2010) 'Consulting with practitioners for policy: knowledge, education and implementation', draft paper
[8] Freeman, R and Sturdy, S (2011) 'Knowledge in policy: embodied, inscribed, enacted', draft paper

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Embodied knowledge is that held by persons as they go about their activities in the world; it is sometimes written down or *inscribed* in texts, tools and instruments; whether embodied or inscribed it is only realised in action, in being *enacted*. Just as matter may pass from one phase to another, we have tried to capture the way in which knowledge can be transformed, through various kinds of action, between phases.

WHO KNOWS

We used this scheme in our study of WHO Europe's work in mental health.[9] We identified WHO as a distinctively knowledge-based organization, and described its typical activities in this field over three decades, 1970-2000. We explored the way in which working groups work, as well as successive attempts to conduct comparative surveys of mental health services across European countries. We then focused on the *Mental Health Declaration and Action Plan* for Europe made and agreed at WHO's ministerial conference in Helsinki in January 2005.[10]

We analysed the way in which the organizing committee assembled both documentary evidence and embodied expertise. We traced the way in which the knowledge captured in and for the conference was elaborated in the discussion and development of the European Commission's subsequent Green Paper on mental health (2005) and in WHO's own baseline study of progress against the goals of the *Declaration*. We then reflected on the interdependence of different forms of knowledge, and on the way in which, over time, the act of comparison makes things comparable.[11, 12]

'The first thing was to take stock of what the major mental health problems in Europe were'

KNOWLEDGE REGIMES

We and our partners conducted parallel studies of the impact of the *Declaration* in selected European countries. This brought out more clearly the relationship between knowledge, interests and institutions as the Declaration was used to different ends in different 'knowledge regimes'.[13] In some countries, the concentration of authority in government may provide a focus for new ideas and information but may also represent an almost insuperable obstacle to them. Policy change, if implemented, is likely to extend across a system although – by the same token – it may never be made. Where authority for mental health policy is more dispersed, the number of opportunities and entry-points for change agents is that much greater. Change is more likely, but also more likely to be partial, uneven and uncoordinated.

[9] Freeman, R, Smith-Merry, J and Sturdy, S (2009) *WHO, Mental Health, Europe*, report to the European Commission Integrated Project 0288848-2 KNOWandPOL, Louvain-la-Neuve: Université Catholique de Louvain
[10] Freeman, R (2009) 'Articulation, assemblage, alignment: the project in/of EU governance', draft paper
[11] Freeman, R (2010) 'Comparison and performance', draft paper
[12] Sturdy, S (2010) 'Making knowledge for international policy: WHO Europe and mental health policy, 1970-2008', draft paper; Freeman, R (2011) 'Reverb: policy making in wave form', draft paper
[13] Freeman, R, Smith-Merry, J, and Sturdy, S (2009) *Regulation, knowledge and the international organization: WHO's Mental Health Declaration for Europe*, report to the European Commission Integrated Project 0288848-2 KNOWandPOL, Louvain-la-Neuve: Université Catholique de Louvain

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RECIPROCAL VALIDATION

In Scotland, we identified an interesting process of reciprocal validation between national and international authorities: while Scottish policy makers drew on external interest and approval in developing mental health initiatives in Scotland, these in turn served as useful demonstration sites for WHO's work elsewhere.[14,15] We found the relationship between the national and the international to be slow, iterative and circular, which we described as 'recursive' rather than 'multilevel' governance.

'The world is watching what we do.'

RECOVERY AND REFLEXIVITY

We conducted two further case studies of mental health policy in Scotland. The first focused on the idea of Recovery. We noted its origins in discussions abroad, and identified its points of entry to Scottish thought and practice. In moving from one country to another, the idea underwent a degree of interpretive translation, and then more explicit domestication as its advocates sought to appeal to a local audience. Its implementation constituted a further shift, from the shared understanding of a social movement to the more regulated domain of public policy.[16] We noted the array of knowledge-based technologies, including narratives, indicators, planning and peer support through which the concept of recovery is realised in practice.[17] Each is geared to induce new levels of reflection and reflexivity among service providers and service users.

'There is a lot of recovery oriented work going on but it is really hard to evidence it because paperwork and the way we document things doesn't reflect that.'

MUTUAL INTERROGATION

Our final case study reflected our interest in the knowledgeable practices of policy making as much as any specific object or topic. We sought to understand the use of an array of indicators, targets and benchmarks in mental health policy in Scotland, including those for Recovery, suicide, anti-depressant prescribing and population mental health and well-being.[18] We found that indicators and other means of performance measurement served to set questions for the policy community and not, or at least not only, to hold it to account. They seemed effective to the extent that they make for 'collective puzzling', or a pattern of mutual interrogation by actors both of the data and of each other. Interestingly, therefore, these new 'knowledge technologies' seemed to be set in or surrounded by elements of uncertainty, anxiety and trust, or what we might otherwise think of as the antitheses of knowledge.

[14] Smith-Merry, J, Freeman, R and Sturdy, S (2009) *Scotland, mental health and WHO*, report to the European Commission Integrated Project 0288848-2 KNOWandPOL, Louvain-la-Neuve: Université Catholique de Louvain

[15] Smith-Merry, J, Freeman, R and Sturdy, S (forthcoming) 'Reciprocal instrumentalism: Scotland, WHO Europe, and mental health', *International Journal of Public Policy*

[16] Smith-Merry, J, Freeman, R and Sturdy (2010) *Recovering mental health in Scotland: recovery from social movement to policy goal*, report to the European Commission Integrated Project 0288848-2 KNOWandPOL, Louvain-la-Neuve: Université Catholique de Louvain

[17] Smith-Merry, J, Freeman, R and Sturdy, S (2011) 'Implementing recovery: an analysis of the key technologies in Scotland', *International Journal of Mental Health Systems* 5(1)

[18] Smith-Merry, J, Sturdy, S and Freeman, R (2010) *Indicating mental health in Scotland*, report to the European Commission Integrated Project 0288848-2 KNOWandPOL, Louvain-la-Neuve: Université Catholique de Louvain

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KNOWLEDGE EXCHANGE

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

One of the key themes of our study has been that policy makers produce and use knowledge in interaction with others. In this spirit, we have sought to engage with the policy community in a number of ways. We have been guided by a project advisory board which included a mental health promotion officer, a member of a specialist mental health research and training organization and a civil servant as well as a university colleague in public health sciences. Apart from our reports and academic publications, we have made presentations at national and international conferences; we have issued newsletters and contributed to others; we have used dedicated websites to promote our work. We have delivered feedback sessions to invited audiences of policy makers and representatives of a range of interested organizations, and provided inputs to professional training both in mental health and in knowledge exchange. We have joined a Scottish government reference group and a WHO working group, and contributed to their discussions. We have hosted a series of 'Mental Health Conversations' at the University of Edinburgh, which provide an opportunity for members of the policy community to think and talk in new ways.[19]

THE RESEARCH TEAM

Dr Richard Freeman teaches theory and method in the Graduate School of Social and Political Sciences, University of Edinburgh, where he is also Director of the Public Policy Network.[20]
Dr Steve Sturdy is Deputy Director of the Genomics Forum at Edinburgh. His research has chiefly been concerned with the relationship between medical science, medical policy and medical practice in nineteenth- and twentieth-century Britain.
Dr Jennifer Smith-Merry was Research Fellow on this project from 2007 to 2011; she is now Senior Lecturer in Qualitative Research in the Faculty of Health Sciences, University of Sydney. Her current research focuses on mental health policy and patient safety.

All the reports cited here are freely available from our project website at
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[19] See the website at www.publicpolicynetwork.ed.ac.uk
[20] www.richardfreeman.info