Working paper: Transformation of a mental health system – the case of Scotland and its lessons for Australia

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The ability of health systems to successfully transform has become a concern for both policy makers and academic researchers over the past five years. This working paper, based on over 50 interviews, observation and extensive document analysis undertaken over a four year period, reviews the transformation of Scottish mental health policy over the past ten years in order to examine processes which led to transformation. In reviewing the Scottish case we find that between 1999 and 2009 the Scottish mental health policy and legislative frameworks for mental health were completely transformed. The main factors contributing to the initial transformation were:

- devolution of the Scottish Parliament which acted as a moment of policy crisis,
- widespread perception of the problematic nature of the current legislative and policy framework,
- publication of dramatic statistics on suicide in Scotland which led to attention in the media and within parliament,
- a focus on openness and consultation,
- high levels of communication within the sector.

Ongoing sustained transformation and innovation within mental health policy in Scotland fostered by:

- ongoing consultation, meetings and other ‘talking events’,
- the establishment of networks for fostering communication within key areas of the system,
- creation of effective routes for the spread of innovation,
- acceptance of policy failure,
- development of a decentralised system where central control is maintained through the use of targets and indicators,
- external validation of the Scottish mental health system through involvement with international actors such as WHO,
- development of an identity for Scottish mental health policy – ‘the Scottish way’ – which motivates action.

The Scottish case provides opportunities for policy learning. Many of the processes and events which took place in Scotland can be adapted to Australian circumstances. Here the paper highlights specifically:

- the exploitation of natural ‘moments of crisis’ for their potential to act as catalysts for transformation,
- the necessity for exploring and developing existing and new channels for organisation and communication,
- the publication of stories and statistics which highlight the need for change and the strategic utilisation of the media in this,
- transformation of the bureaucracy to facilitate communication and to allow new ideas to enter policy.

I invite discussion, comment and critique based on the ideas presented here and hope that this example of policy transformation will add to the debate in Australia about how successful transformation of the mental health system might take place.
Introduction and Paper Aims

The aim of this working paper is to use the case of Scottish mental health policy to examine the way that significant transformation has occurred in a particular health policy context. Over the past ten years the mental health system in Scotland has gone from one characterised by outdated legislation, poor communication and a very limited policy framework to one which has been held out as exemplary by the World Health Organization, the European Commission and other international actors. Scotland plays host to regular international visitors who visit to learn from individual innovations and programs which have been embraced within Scottish mental health policy.

In order to keep the discussion focussed this paper does not discuss the implementation of the new policy and legislative framework. Instead it focuses on the factors which have allowed high level structural change to occur and factors which allow for ongoing transformation through the development of a responsive system where innovation is able to emerge as required. Specifically the paper examines:

- the historical situation of mental health policy in Scotland.
- the structural factors which precipitated change.
- the organisational, communicative and ‘technological’ factors which have allowed major transformation to continue.

The changes that happened in Scotland are not unique to Scotland. The minutiae of the changes themselves were unique but the overall processes were not and may be usefully applied to other policy contexts. I aim to apply this case to the current state of the Australian health system, where my exploration of this case study will add to current debates concerning:

- how such system transformation might meaningfully happen within an Australian context.
- how Australian mental health policy might be developed.

In order to do this I begin by painting a picture of Scottish mental health policy at the start and end points of a ten year period. I ask:

- What was happening in Scotland prior to devolution in 1999?
- What was the situation ten years later in 2009?
- What events and processes led to the changes that took place?

I then examine how these changes have been sustained, and come to some conclusions about system transformation in this context. This leads on to a discussion of how the conclusions made about the Scottish case might be usefully applied to Australian health policy. I invite comment and critique of the working paper and look to contribute to the discussion about how transformation within mental health can occur in Australia.
Data Sources

This working paper derives from reflections on four years of research on Scottish mental health policy which has examined the way particular forms of knowledge have impacted on and derived from this policy environment. This research was undertaken as part of a large, European Commission funded project, KnowandPol, which has spent the past four years examining knowledge and policy across twelve European research sites within eight different countries. This research has produced a large body of material deriving from a ‘policy mapping’ task and a series of in-depth case studies.

The research has drawn on a large data set comprised of over 50 interviews with individuals involved in Scottish mental health policy, in-depth analysis of key policy documents, briefing papers and other relevant documents, and the observation of major policy events and consultation processes.

The initial stage of the project consisted in the creation of a multi-dimensional policy ‘map’ where we mapped the organisational entities and individuals involved in Scottish mental health policy, the systems through which they communicated and through which their work was directed, and the knowledge used and created through the interactions between these actors. We then worked on a series of case-studies which focussed on:

- the interactions between Scotland and WHO Europe in the field of mental health
- a consultation process for a new Scottish public mental health strategy, Towards a Mentally Flourishing Scotland.
- the implementation of ‘recovery’ as a guiding principle for the operation of mental health services.
- the use of measurement, indicators and targets within Scottish mental health policy.

A series of six in-depth reports and several journal articles based on this research have so far been produced by the Scottish mental health research team1. Much of the research in this report comes from previous reports made for the KnowandPol project2.

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1 These reports are referenced throughout this working paper and can be accessed via the project website: http://www.pol.ed.ac.uk/public_policy/research_projects/knowledge_and_policy/

2 Throughout the working paper these reports have been cited so that those interested in reading further on the Scottish case can do so. Where interviews have not been referred to in previous KnowandPol reports interviews are referred to by the date on which they occur (e.g. 081009).
Work which explores system transformation has strong policy and academic relevance. In Australia there is growing frustration about existing health reform processes, such as those enacted by COAG and a growing interest in transformation. System transformation has been identified as necessary in several health policy contexts. For example in Western Australia the Health Reform Implementation Taskforce (WA) and the Clinical Senate both list work on health system transformation as aims3. Recent public debate in Australia has frequently presented mental health as an aspect of the health system in desperate need of transformation4.

Academic interest on transformation has focused on what is actually meant by health system transformation and how it can be achieved.5 Much recent literature has specifically reflected on how transformation might take place in mental health systems6. What is still needed within this literature are a significant number of examples of cases where transformation has occurred so that these can be analysed retrospectively to look for the critical steps that have characterised or facilitated change. This paper contributes to addressing this deficit.

Scotland and its health

Scotland is a country of around 5.1 million inhabitants spread across 78,772 square kilometres. While much of the population live in urban centres such as greater Glasgow, which has a population of over 2.2 million, some also reside in the very remote areas of the Scottish highlands and islands7.

Healthcare by the Scottish National Health Service (NHS) is provided free of charge to all UK residents and is funded through general taxation. Scotland has its own NHS separate to that in England. Annually there are 27.4 million general practitioner consultations in Scotland, with an estimated 25% to 30% of these consultations involving depression, stress or anxiety8.

In 1997 the Scottish population voted to establish its own parliament which would have certain areas of legislative power devolved from the UK parliament in Westminster. The new parliament first sat in 1999 and one of its devoted powers was health and through this, mental health.

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5 S. Lewis and S. Leeder (2009) Why health reform? Medical Journal of Australia, 191(5): 270-272; Steven Lewis recently spoke on large system transformation at a Menzies Centre for Health Policy event in Sydney titled Large System Transformation: What is it and can it be done?. A podcast of the event is available at: http://www.menzieshealthpolicy.edu.au/other_tops/AUDIO/recordingleswlis0311.mp3
The mental health of the Scottish population was increasingly poor in the years leading up to devolution. In 2000, the year after the Scottish parliament was established, the Scottish suicide was almost double the rate in England. In 2002 the Scottish suicide rate sat at 17.8 per 100,000 population, with the Scottish male suicide rate at 27.8 per 100,000 and female rate at 8.5 per 100,000 (this is in contrast to a rate of suicide amongst English men of 16.7 per 100,000 and women of 5.0 per 100,000)\textsuperscript{9}. The rate of anti-depressant use in Scotland was also growing at a fast rate by the time of devolution, with prescriptions growing from 1.5 million in 1995-1996 to almost 2.8 million by 2000-2001\textsuperscript{10}.

The policy and legislative situation in 1999

Prior to devolution Scottish mental health systems, policy and legislation were marginalised and outdated. The main piece of legislation dealing with mental health was the Mental Health (Scotland) Act 1984. This replaced an earlier 1960 Act of the same name\textsuperscript{11}. However, the 1984 Act was merely a ‘consolidating act’, which meant that it just re-enacted the 1960 Act along with all of the amendments made since 1960. This meant that there had been no systematic reform of mental health legislation in Scotland since 1960\textsuperscript{12}.

Alongside out-dated legislation there was a lack of policy direction to guide the work of the system. Policy on mental health was disparate and there were few official policy directives issued, with the Scottish Grand Committee lamenting a “lack of formal policy objectives for mental health” in Scotland\textsuperscript{13}. As a result the policy document, Framework for Mental Health Services, was released by the Scottish Office of the UK Government at around the same time as the 1997 vote for devolution. While this document was in many ways lacking in innovation and, like the 1984 legislation mainly brought together in one document the previous disparate directives, it provided a focus for the mental health community through their support or critique of the document\textsuperscript{14}.

\textsuperscript{9} ScotPHO (2010) Suicide: UK. Online document (view individual charts for men and women and then click to reveal underlying data): http://www.scotpho.org.uk/home/Healthwell-beinganddisease/suicide/suicide_data/suicide_uk.asp
\textsuperscript{10} ISD Scotland (2009) Medicines used in mental health - BNF Section 4.3 Antidepressants http://www.isdscotland.org/isd/servlet/FileBuffer?namedFile=BNF4.3_Data_File_92_09.xls&pContentDispositionType=attachment
\textsuperscript{13} J. Loudon and D. Coia (2002) The Scottish Scene, Psychiatric Bulletin, 26: 84-86. The Scottish Grand Committee is a committee of the Westminster Parliament which comprises of all of the Scottish based MPs who met regularly prior to devolution to debate legislation directly affecting Scotland. It has met only rarely since devolution.
The period up to devolution saw growing momentum for change with a number of large conferences and other events being held which called for action on mental health reform. In the mid 1990s two conferences, Slow Train Coming and Slow Train Still Waiting, were held in Glasgow in order to press for action on mental health reform. Other seminars occurred in Edinburgh in the mid 1990s alongside the development of a more vocal consumer movement. However apart from the 1997 Framework document, which was far from comprehensive, there had been little action on mental health policy change.

The policy and legislative situation in 2009

Ten years after devolution, the mental health policy framework in Scotland was very different. Policies and programs for mental health services and public mental health had been devised and enacted and there was a new piece of mental health legislation. The main components of this framework have been the:

Mental Health (Care and Treatment) Act, 2003

The development of this act was as a direct response to the findings of an extensive consultation and a major review of mental health in Scotland by the Millan Committee. The Act defines the roles and responsibilities of all those involved in the care and treatment of those experiencing a mental health problem and is underpinned by ten principles:

- equality,
- non-discrimination,
- respect for diversity,
- reciprocity (safe and appropriate services for those in care and after discharge),
- informal care (compulsory powers as last resort),
- participation,
- respect for carers,
- least restrictive alternative,
- child welfare,
- benefit.


The Act identifies roles and organisations and explains their responsibilities in relation to consumers, carers and other service providers. Another piece of legislation with peripheral responsibility for mental health created in this time was the *Adults with Incapacity (Scotland) Act 2000* which was designed to uphold the rights and welfare of those who are unable to make decisions on their own behalf.

**National Programme for Improving Mental Health and Well-being**\(^\text{17}\). The first major policy document in mental health released after devolution was the 2003 Action Plan driving the first iteration of the Scottish Executive’s population mental health strategy, the National Programme for Improving Mental Health and Well-being (the National Programme). The rise of the National Programme signalled the ascendance of a new way of thinking about mental health, where mental health was understood as a multi-faceted and subtle concept which was nevertheless of equal importance to work on mental ill-health\(^\text{18}\). The National Programme has directed its action towards\(^\text{19}\):

- “Raising awareness and promoting mental health and well-being
- Eliminating stigma and discrimination
- Preventing suicide
- Promoting and supporting recovery.”

These goals have been enacted through the development of a range of projects and agencies, such as the Scottish Recovery Network, which promotes recovery, the anti-stigma program, ‘see me’ and the suicide prevention program Choose Life. Since the launch of the National Programme in 2001 there have been three different policy documents guiding its progress, including action plans released in 2003 and 2006, and the 2009 policy *Towards a Mentally Flourishing Scotland*.

For the Scottish Government the National Programme was seen as fully one half of the mental health equation and mental health services as the other\(^\text{20}\). Its establishment as an equal partner with mental health services, signified a significant redirection for mental health policy in Scotland. Investment by the government in the National Programme signified a recognition of mental health and its determinants as multi-faceted and complex, determined by social factors far removed from the traditional ‘mental health system’\(^\text{21}\).

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21  I have expanded more on the establishment of the National Programme in the article J. Smith-Merry (2008) Improving mental health and wellbeing in Scotland: A model policy approach, Advances in Mental Health, 7(3).
Delivering for Mental Health

The policy document *Delivering for Mental Health*, which sought to define the direction for Scottish mental health services, was released in late 2006. Delivering for Mental Health includes 12 commitments which cover different key aspects of mental health service delivery. These key aspects include the development of recovery within mental health services, peer support, psychological therapies, integrated care pathways, crisis standards, acute inpatient forums and improvements in child and adolescent mental health and dementia services.

For those in the government the document was viewed as “significantly more ambitious” than the *Framework* document which it replaced because “for the first time in mental health, this was a policy document backed by a focused delivery plan”. Most of the commitments in *Delivering for Mental Health* contain specific targets which state that the commitment will be achieved within a certain time-frame. Often the targets also outline a specific rate at which improvement must take place, for example a 50% reduction in the admission of children to adult beds by 2009. These targets are monitored by central government and results shared amongst health board areas in order to inspire health boards to implement innovative changes which will act to improve services in line with the policy objectives.

A number of important reviews of the mental health system also took place during this time, including, most prominently the review of mental health nursing, *Rights, Relationships and Recovery*. There has been an ongoing processes of reviewing and evaluating programs, policies and agencies implemented whose results have been used in reforming practice.

Together these policies, projects, agencies and legislation have created a completely new structure for the Scottish mental health system which is gradually bringing about the desired changes in services and population mental health.

Change in the air: using the devolution effect for policy transformation

As the contrast between 1999 and 2009 shows, the mental health system in Scotland went from a situation in 1999 in which it relied on legislation dating back to the 1960s and one scant policy document. This was transformed by 2009 into a system guided by a full range of policies targeting both services and population mental health, new legislation, and new agencies and networks for administering the policies.

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The years around devolution therefore became a significant transformative moment for the Scottish mental health system and the fact that this ‘moment’ happened around the time of devolution was no coincidence. Devolution acted as a critical event or ‘moment of crisis’ for policy making in Scotland. Such ‘moments’ serve to disrupt the normal flow of policy and its implementation and allow new ideas to enter the policy domain. Instances of policy problematisation, where existing policy approaches are called into question, provide an opportunity for researchers to visualise processes of system transformation. Fairclough\(^{26}\) refers to these instances of problematisation as ‘moments of crisis’ where processes of governing are exposed. Moments of policy crisis work to problematise existing policy frameworks and allow for novel solutions to arise as the existing order is destabilised. They can be planned, foreseen (as in the case of devolution) or sudden as a result of a sudden crisis (as in the case of the Virginian mental health system in the US)\(^{27}\).

**Processes facilitating change**

There are a number of critical events and processes that we can highlight which took place around devolution which facilitated transformation:

**Communication**

With devolution and a new Scottish Parliament change was in the air and there was a great deal of public interest in how change could happen. Getting people together to talk about mental health was perhaps the most crucial step in transforming mental health policy in Scotland. In the lead-up to devolution groups of individuals in key roles discussed the problems with the current mental health framework and what they wanted the mental health system to look like\(^{28}\). These talking events developed a momentum for change and harnessed the good-will of those working in mental health, getting them ‘on board’ for change.

**Publication**

Publication of suicide statistics highlighting poor mental health in Scotland was of critical importance in drawing attention to mental health. The publication of statistics indicating the high levels of suicide in the Scottish population, especially in relation to the much lower figures for the rest of the UK, drew attention to mental health in the media. This attention meant that it was taken up and debated in the Scottish parliament. Debate in the media and parliament revealed how out of date the current policy and legislative framework for mental health was and forced the government to act.


\(^{28}\) e.g. ‘see me’ (2005), ‘see me’ so Far: A Review of the first 4 years of the Scottish Anti-stigma Campaign. http://www.seemescotland.org.uk/images/pdfs/1.6.seemesofar.pdf
A new parliament

The Scottish parliament was new and was looking for flagship policies which it could own, take action on and demonstrate action. Mental health became a good candidate for this because of the highlighting of significant levels of need demonstrated by the suicide and depression statistics and the very limited policy and legislative framework available to deal with the problem. Prioritising mental health meant significant funding was given over to supporting the development of an holistic mental health system.

Consultation: Innovation

A new parliament whose key stated focus was openness and consultation. Public participation has been a key focus for the post-devolution Scottish Government, with multiple public consultations taking place on a wide range of topics, from genetic information to a national dialogue around education. The new Scottish parliament sought to mark itself out from the previous London-controlled decision making which had left Scotland feeling out in the cold. They did this by developing a strong emphasis on consultation and new ideas. For mental health this meant that all processes, such as that for the new mental health act, included extensive consultation with a very wide range of actors. This became a mechanism for innovation to enter the policy environment and shape a new direction for mental health.

A new bureaucracy

A new bureaucratic structure within the Scottish Executive allowed for mental health to be organised as a significant, free-standing area with multiple branches. This placed attention not just on mental health, but on its constituent components, the most significant of which was the establishment of population mental health as its own separate section, designed to promote positive mental health within all of the parts of the Executive. New roles in the mental health division – such as the appointment of a director of the National Programme who was not a public servant but a mental health expert – allowed for innovative ideas to circulate amongst the bureaucracy.

The utility of each of these events for enacting policy transformation was dependent on each of the other steps – it was a range of interconnected strategies and effects that made the change happen. In Scotland changes to the mental health system thus took place as a result of both circumstance and strategy. Particularly it was the enactment of strategies which made the most of convenient circumstances. The particular circumstances of devolution made change more likely, but it was the strategic use of these circumstances which allowed change to be driven. This allowed innovation to enter the mental health system in multiple ways that brought about systemic change.

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Performance of the new system according to key indicators.

I include this section because I realise that people will ask the (reasonable) question ‘but what was the impact on the mental health of the Scots?’ However, while there have been improvements evident in the mental health of the population since devolution, the effectiveness of the transformation will not be fully known for many years to come because of the long lead time that many of the measures need in order to show responsiveness. It is also difficult to measure progress on many of the areas for action because these measures, such as those measuring the wellbeing of the population, have only been developed since devolution, so no comparison can be made. The most frequently used measure of effectiveness has been the suicide rate, but this is a very crude rate for which there is limited understanding about what changes in the rate can actually be attributed to. It is included here at Table 1, below, as the government, nevertheless, uses suicide as one of its indicators of performance. Table 1 shows how the rate of suicide has fluctuated since devolution.

**Table 1: Age-standardised suicide rate, Scotland 2002-2007**

<table>
<thead>
<tr>
<th>Year</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age standardised suicide rate (Men)</td>
<td>27.8</td>
<td>23.7</td>
<td>24.9</td>
<td>22.4</td>
<td>24.0</td>
<td>24.9</td>
</tr>
<tr>
<td>Age standardised suicide rate (Women)</td>
<td>8.5</td>
<td>8.2</td>
<td>8.6</td>
<td>8.1</td>
<td>6.5</td>
<td>8.2</td>
</tr>
<tr>
<td>Age standardised suicide rate (all genders)</td>
<td>17.8</td>
<td>15.7</td>
<td>15.4</td>
<td>15.0</td>
<td>15.0</td>
<td>16.3</td>
</tr>
</tbody>
</table>

This table shows that there has been some reduction in the suicide rate since devolution and that the rate that had been steadily increasing until 1999 started to decrease after this time. The most recent suicide data - which is collected as a three year rolling average - (2006-2008) shows a suicide rate of 14.2 per 100,000 compared to a base rate of 17.4 per 100,000 (2000-2003), which is a reduction rate of 11.4%. This meets the government’s suicide reduction target.

An indicator of the success of the work of the National Programme is a reduction in the level of stigma towards people experiencing mental ill-health. Stigma increased in both England and Scotland during the 1990s and early 2000s. While some levels of stigma have remained steady, most have improved with significant improvements, for example, in the extent to which people experiencing mental ill-health are dangerous, which has almost halved since 2003.

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31 150909.
33 Adapted from ScotPHO (2010) Suicide: UK. Online document (view individual charts for men and women and then click to reveal underlying data): http://www.scotpho.org.uk/home/Healthwell-beinganddisease/suicide/suicide_data/suicide_uk.asp
As this data shows, for suicide and according to other measures mental health in Scotland has improved since devolution. However it still remains an area of need which necessitates a responsive system able to adapt to provide an effective mental health system.

Ongoing transformation

Changes to the Scottish mental health system did not happen in one step – it has been an ongoing process underpinned by principles and processes which make an adaptive and responsive policy framework more likely. Key to the system’s ability to adapt are several processes:

**Ongoing consultation, talking events and networks**

The mental health system in Scotland is characterised by ongoing high levels of consultation and strong structures for communication. An extensive committee system which manages and reflects on the implementation of policy initiatives provides regular meeting points in which bureaucrats, managers, practitioners and consumers can communicate with each other. Ongoing consultation for new policy and within policy reviews and evaluations also keep the dialogue going. New national networks such as the consumer network Voices of Experience (VOX) and the Forensic Network have been developed by the government as specific tools to facilitate ongoing communication. The Forensic Network is a good example of this. The Forensic Network was developed in order to provide focus to any work that sits at the junction between the mental health system and the criminal justice system. It is a network that all are included in – there is no opt in – and it is well supported by an administrative staff and appointed leads. The Network has specialist working groups and meets for an annual conference and other smaller meetings throughout the year. It has developed new standards and taught programmes in forensic mental health. Most importantly it has drawn attention and action to this area which was viewed as very neglected only five years ago.

**Routes for the spread of policy innovation**

Innovation is a key goal for the mental health division of the Scottish Government. It encourages innovation by local areas, who are then encouraged to document and evaluate innovations in a systematic way so that new knowledge is produced which can be shared through those communication mechanisms discussed directly above. NHS Health Scotland has a program of teaching competency in evaluation within local services in order to get programs and local areas to continuously document the progress of innovative work areas. Evaluation and documentation are essential if innovation is to be shared around the system.

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An example of a specific avenue for this to occur is through the work of the Mental Health Collaborative. The Collaborative is led by the Mental Health Division and includes three regional teams which work to support NHS Boards. Their motto is “Applying quality improvement science to performance challenges.” It is focused on culture change within Health Boards so that “front-line staff” are better able to use information to improve services by analysing current practices and in designing, implementing and evaluating change. Through the work of the Collaborative local areas are encouraged to be innovative in the development of new indicators. Local areas develop their own new indicators, processes and targets, test them in their own work and then share them with other health boards. This develops a culture of working with indicators which comes from the local level. The local areas have become implicated in the culture of measurement and are thus much more likely to take it on than if it had been imposed by central government. Through processes such as these the mental health division creates avenues for responsive continuous transformation within the system.

Acceptance of policy failure

Fear of policy failure limits transformation when government actors are not willing to take action that might not lead to a tangible policy ‘success’, as assessed against a stated, measurable objective. Fear of policy failure means that innovative and possibly highly productive policy goals are not tried because, being innovative, they are inherently more prone to policy failure. Some innovative aspects of the Scottish system, such as the work of the National Programme, and some of the service delivery targets risked policy failure. Indeed several aspects of the policies could be deemed to have ‘failed’. An example of this is the anti-depressant prescribing target which was introduced as one of four ‘HEAT’ targets designed to track the performance of the NHS with respect to mental health.

As discussed above, the rate of anti-depressant prescribing in Scotland is high and was growing at a very fast pace at the time of devolution. The HEAT target aimed to: “Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10 and put in place the required support framework to achieve a 10% reduction in future years (2009/10)”

Table 2: Number of anti-depressants across Scotland 2003-2009.

<table>
<thead>
<tr>
<th>Year</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of prescribed items</td>
<td>3,401,945</td>
<td>2,477,416</td>
<td>3,529,668</td>
<td>3,654,128</td>
<td>3,826,624</td>
<td>4,005,603</td>
</tr>
<tr>
<td>Defined daily dose per 100 population</td>
<td>8.10</td>
<td>8.35</td>
<td>8.49</td>
<td>8.84</td>
<td>9.32</td>
<td>9.72</td>
</tr>
</tbody>
</table>

43 HEAT is an acronym for Health improvement, Efficiency, Access and Treatment. Other HEAT targets for mental health are suicide, early diagnosis of dementia and a reduction in acute readmissions. Since April 2010 the anti-depressant prescribing target was replaced by a psychological therapies target.
As table 2 demonstrates in crude data terms this target was not successfully met. However, instead of seeing this as a ‘failure’ the mental health division has viewed the target as successful in terms of the way that this target has produced a range of new knowledge about depression and anti-depressant use and prescribing. The target – whether it was met or not – meant that this valuable knowledge was produced. The government now knows much more about the issues involved and is able to move its attention to work that will have a more significant impact on depression. The performance of the Scottish government with respect to this policy ‘failure’, was not just about spinning a negative result, but its ability to turn ‘failures’ around and make them a process of learning. Instead of burying its failures it is now building on the new knowledge about depression to create a psychological therapies target which will better work to deliver the action that they want.

**Decentralised, central system**

On paper the Scottish mental health system looks highly decentralised, with responsibility for mental health shared between local authorities (the equivalent of local councils) and health boards (the equivalent of area health services) through entities called Community Health Partnerships. There are also a plethora of Quasi-autonomous government agencies and other non-government organisations through which mental health work is done. However this apparent autonomy is illusory if you reflect on the funding of the system and the extensive use of indicators and targets attached to specific policy goals. Diagram 1, reproduced in appendix A, demonstrates the extent to which the system is dependent on central government funding. The other mechanism for government control is through the use of indicators and targets.

The Scottish application of targets is less of the terror and threats variety, which has so characterised the use of performance measurement in the English NHS. Instead Scottish targets are applied as a tool for use by local areas so that they can improve their own performance by introducing innovative practices and by comparing theirs to performance within other areas and learning from practices in other areas. The Scottish Chief Psychiatrist has described the Scottish manner of using targets in the following way:

“We have recognized that, used inappropriately, targets can distort systems. So we have tried to use them in an intelligent way, always focusing on the underpinning improvements that the target is seeking to deliver, rather than viewing the target as an end in itself. This intelligent use of targets has enabled us to keep clinicians engaged throughout the process and is leading to an increased use of information to drive improvement….Crucially, a culture of trust over the proper use of information has been established in Scotland. Maintaining this trust will be the key to our ongoing use of information to drive improved outcomes.”

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Innovation emerges as local areas strive to improve their own performance. There is a competitive element to this as areas aim to have the best outcome for a particular target. Local areas compete with each other and improved performance comes from competition between health boards and services rather than at the end of a big government stick. The Scottish way of doing central government control is thus about maintaining the system through a use of indicators which allows for the development and spread of innovation.

**International promotion**

Proactive cooperation and collaboration with international actors has given credibility to Scottish mental health policy and strengthened it internally. The mental health division has set out to deliberately promote Scottish mental health policy on the world stage in order to strengthen and validate the policy. It has done this through being a proactive partner in international organisations such as the World Health Organization and the European Commission. Scottish actors have actively lobbied and set up avenues of participation within these organisations – a task made difficult, and perhaps more important, because Scotland is not an official partner of these organisations.49

The importance of engagement with international actors lies in the validation that they give the Scottish mental health program. This is because if the Scottish Government becomes known internationally for doing something well then they want to continue to foster this work to sustain this positive reputation. External validation through a positive endorsement of Scottish policy initiatives by powerful international actors thus boosts investment by the Scottish government in mental health policy.50

**Mental health policy – ‘the Scottish way’**

Transformation necessitates motivation and commitment from actors at all levels of the system. The Scottish mental health system is characterised by high levels of agreement – what our research has termed a progressive consensus - about the path the government should be taking with respect to mental health.51 This is significant because the extent to which change can be sustained hinges on the fact that a majority of those involved in the system want to be involved and follow the path that the government has set. Were the progressive consensus which pervades Scottish mental health policy to become somehow undermined then the Scottish way of doing mental health would no longer work.52 Local areas would become resistant to the targets and other indicators set by government and the networks, committees and other meeting points set up for communication would cease to function. This is a delicate balance which must be carefully respected by the government.

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49 This is because it is the UK as a whole who has membership with international organisations, not Scotland who is considered a sub-state actor.


But what makes people involved in mental health in Scotland want to act to improve the system? There is not one simple answer to this question. However, one of the reasons that we have considered in our work is that they believe that they are involved in something good – a ‘Scottish way’ of doing mental health which is better than that which is practiced elsewhere. There is a strong belief amongst those that we have interviewed that in Scotland the mental health system is more consultative, more involving of consumers, less hierarchical and more open to new ideas. The ‘more’ here is usually always contrasting Scotland to England. Paul Cairney\textsuperscript{53} has written that the “image of the UK government style” as top down, and non consensual has “influenced narratives of ‘new politics’ in Scotland” where actors believe “The process is more ‘open and consultative’ and groups point to the ease of access, with civil servants (and often ministers) a ‘phone call away’.” \textsuperscript{54} He writes, “The assumption from most interviewees is that this contrasts with a top-down UK government style in which the process is more formal, ministers and senior civil servants are more aloof, and more policy is pushed through in the face of opposition.” This assumption is very true of Scottish mental health policy and, despite being an assumption rather than something that is necessarily true in practice, is very powerful because actors assume that they are doing something unique and good and this motivates them to work towards developing the system. As Cairney notes, the anti-UK government narrative is a powerful one and may in part explain what has motivated Scottish actors to forge a transformative path for mental health.

Conclusions: lessons for Australia

Scotland is not perfect – and transformation has not been done perfectly. There are still many problems that can be identified in the Scottish mental health system and many of the innovations implemented after devolution will not bear fruit for many years yet. But what is striking about the case of Scottish mental health is the extent to which the system has transformed over a relatively short period of time. Also significant is the way the system has been developed around mechanisms that allow for continuous adaptation to innovation targeted at key areas within the system.

Scotland has borrowed many of its innovations from elsewhere and several of its programs – such as Mental Health First Aid training – have been influenced by or borrowed from Australia. What Scotland has done is to create a coherent and holistic policy framework which implements these programs consistently. Australia, on the other hand, is high in innovation but lacks committed governing regimes through which policy can be implemented effectively.

How might we apply some of these Scottish ‘lessons’ described above to an Australian context? On the face of it Scotland and Australia are very different places, but this should not limit our ability to learn from the Scottish case – we can take from it what is relevant and useful and leave what is not. Here I highlight some of the areas where Australia may be able to engage in elements of the processes I have described above:

Moments of crisis: While devolution is not likely to occur in an Australian context, there are natural moments of crises that might be utilised as opportunities for transformation and renewal. As discussed above, the particular circumstances of devolution made change more likely, but it was the strategic use of these circumstances which allowed change to be driven. Elections and the publication of controversial inquiries or reports, if fully harnessed can serve as similar impetus for change.

Organisation and communication: Change will not happen on its own and for these moments of crisis to be effectively utilised there needs to be forethought and planning from a group of actors who take up strategic positions across the system. The actions of such a group will only be successful if there is good communication across the mental health system already. It is important that this communication does not only take place within professional silos. The groups organising for change in Scotland were made up of a very wide group of actors which included consumer activists, nurses, practitioners, bureaucrats and those working in NGOs. Cross-system communication means that change will be holistic and taken up across the system rather than being confined to specific professional groupings.

Although new channels of communication and organisation can be developed from the ground up, it would be more successful if emphasis would be placed on developing those channels already in existence. This necessitates careful mapping of both existing channels and the impediments that limit the flow of knowledge through these channels.

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55  e.g. M. Petticrew, S. Platt, A. McCollam, S. Wilson and S. Thomas (2008) “We’re not short of people telling us what the problems are. We’re short of people telling us what to do”: An appraisal of public policy and mental health, BMC Public Health, 8(314). This article describes that because of structural barriers the goals of mental health policy have in some respects failed to be integrated with and taken up within other policy areas.

56  Mental Health First Aid training was developed by Betty Kitchener and Professor Tony Jorm at the Centre for Mental Health Research at ANU in 2001. It has been widely implemented in Scotland.
Conclusions: lessons for Australia continued

Publication and media attention: In Scotland the alarming rate of suicide in Scotland compared to elsewhere in the UK was very effective in drawing attention to the need to transform the mental health system. In Australia mental health already has a high profile in the media. Using the media to highlight how bad things are needs to be sustained.

Transforming bureaucracy: One of the most effective strategies for bringing about the development of Scotland’s public mental health program was the employment within the Scottish Executive of Gregor Henderson, an external consultant. Henderson was a transformational leader already well respected within the mental health community whose motivational presence inspired others to contribute to the successful development of the National Programme policies. The inclusion of these atypical positions within the bureaucracy can serve to disrupt bureaucratic workings in a positive way and allow new ideas to enter policy. Likewise an ‘open’ bureaucracy which fosters easy avenues for communication will allow new ideas to enter government and for change to happen more effectively.

Australia will take its own path in the transformation of its mental health system, but an understanding of the way that transformation has occurred in other contexts will add to the public debate about how this should happen. I invite discussion and critique of what is presented here.

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**KnowandPol website** This website has information on all aspects of the European-wide KNOWandPOL project including research reports from the other research sites. http://www.knowandpol.eu/
Appendix A: Government funding of actors in the Scottish mental health system

This diagram was originally used as part of a KnowandPol Scotland report which mapped the mental health system in Scotland. We undertook interviews with a significant number of individuals representing different parts of the mental health system. As part of this we asked respondents who funded their organisations and roles. This diagram is derived from this data.

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