Exploring movement of embodied, enacted, and inscribed knowledge through policy consultation: A case study of a mental health policy consultation process in South Africa

Debra Leigh Marais

Durban
February 2018

Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in the Department of Psychiatry, School of Clinical Medicine, University of KwaZulu-Natal

Declaration

I, Debra Leigh Marais, declare that the work contained in this thesis, except where otherwise acknowledged, is my original research, and has not been submitted to the University of KwaZulu-Natal or any other tertiary institution for the purposes of obtaining an academic qualification, whether by myself or any other party.

Signed: 	Supervisor: 	Supervisor: 
Debra Leigh Marais	Professor Inge Petersen	Dr Mike Quayle
Date: 2 February 2018	Date: 2 February 2018	Date: 2 February 2018

Abstract

This study is concerned with the intersection of knowledge and policy in the context of mental health system challenges in a developing country. Its focus is specifically on the way in which different forms of knowledge, from multiple sources, move through a policy consultation process to inform mental health policy. Policymakers tasked with developing mental health policies must balance a number of competing demands, including the need to develop policies that are applicable on a national level, while simultaneously addressing the idiosyncratic and contextual particularities associated with mental ill health at individual and local levels. Marrying the principles of evidence-based policymaking, with its focus on *what works*, with the principles of consultative policymaking, with its focus on *what works for whom*, means finding ways to integrate multiple knowledge inputs to incorporate these into policy decisions. In this sense, policymaking represents something of a knowledge problem for policymakers.

In the South African legislative context, public participation in policymaking is taken as a given, with little guidance specifying how such processes should be conducted, nor whether or how the inputs from such processes are used in policy decisions. The consultation process around South Africa's first mental health policy was the focus of this case study. The aim was to trace the movement of knowledge inputs through the consultation summits into policy outputs. Research suggests that certain forms of experiential knowledge may not be amenable to being captured in policy consultation processes. This study thus used Freeman and Sturdy's (2015a) conceptual schema of knowledge functions in policy as its analytical framework. This schema distinguishes between three phases of knowledge – *embodied*, *enacted,* and *inscribed* – that can be transformed between phases through various kinds of action. It provided a lens through which to trace the enactment and movement of embodied (experiential and evidence-based) knowledge through the consultation process, to determine the extent to which this form of knowledge was transferred into the inscribed knowledge of consultation recommendations and policy outputs.

Data included mental health policy documents, reports and audio recordings from the provincial and national consultation summits, and key informant interviews. Thematic framework and thematic content analyses were conducted using the *embodied-enacted-inscribed* analytical framework. Findings revealed that no substantive changes were made to the mental health policy following the consultation summits, and suggest that the consultation summits had minimal impact on policy. In particular, there do not seem to have been systematic processes for facilitating and capturing knowledge inputs, or for transferring these inputs through increasing levels of summarisation during the consultation process. One of the consequences of this was that much rich contextual detail of participants' embodied

knowledge was not followed through to be incorporated into consultation and policy outputs. The implications of the findings for mental health policy consultation in South Africa are discussed.

This is the first study to document, in depth, a significant part of the consultation process around mental health policy in South Africa, using the *embodied-enacted-inscribed* framework to explore how knowledge inputs informed policy. In doing so, it draws attention to the unique challenges in reconciling the contextual detail of embodied knowledge with the abstract generalisability of inscribed (policy) knowledge – an undertaking that has particular relevance for mental health policy consultation. The study highlights the importance of designing participatory processes that enable optimal use of knowledge inputs in these enacted spaces, in order to align assumptions about the value of policy consultation with consultation practice, as well as to strengthen the policy development-consultation-implementation link.

Acknowledgements

This PhD has been six years in the making and I am grateful for the presence of many people who have walked some or all of the path with me. I extend my sincere thanks to the following people, for contributing in a multitude of ways:

I've been lucky to have the guidance of three supervisors lighting the PhD path for me:
Prof Jonathan Burns, for investing his energy and time in me, giving me the freedom to map out my own path, and offering support and encouragement as I navigated the early, uncertain terrain of this journey. Prof Inge Petersen, for so willingly taking over when Jonathan left to take up a new position abroad. This PhD has benefitted from her vast experience and insightful inputs; I have benefitted from her gentle and ever-present guidance. Dr Mike Quayle, for shining light into dark corners throughout this journey and illuminating what I could not see. All that I have learnt from him requires a thesis of its own. I am grateful for his generosity with his time and remarkable intellect, his calm support, and his careful navigation of the roles of supervisor and friend.

Financial support from the College of Health Sciences (UKZN) doctoral scholarship fund is gratefully acknowledged.

My colleagues and friends at the School of Psychology, UKZN, Pietermaritzburg, for walking the first three years of this journey with me; my colleagues and friends at the Research Development and Support Division (RDSD) at the Faculty of Medicine and Health Sciences (FMHS), Stellenbosch University for walking alongside me for the last three years. I am especially grateful to my RDSD colleagues for their support and encouragement over the last few months (and for never appearing to grow tired of "PhD" being the answer to every "How are you?" question). I am grateful to Prof Nico Gey van Pittius for giving me the space and time to continue to map out my academic path, and for supporting me in this PhD.

Friends and colleagues at the Faculty of Medicine and Health Sciences who have provided much needed words of support and encouragement, cups of coffee, generosity, and kindness. Special mention must go to Kate, Karen, and Phumla, for daily doses of all of these things.

My impromptu PhD support groups in Pmb: Nandisa and Thabo (now Mr and Mrs!), and Tamaryn, Erin, and Hilton. I am grateful to Erin for time and effort spent transcribing endless hours of audio recordings.

The PhD group run by Prof Susan van Schalkwyk at the FMHS, which has been a lifeline over this past year. In Anke Rohwer I have found a fellow traveller to navigate the last leg of this PhD journey with; in Marlette Burger and Charmaine van Merwe I have found gifts of kindness and friendship that continue beyond the closing of this chapter.

It has taken a village of friends and family to sustain me through the duration of this PhD. I am thankful to every one of my friends and family, near and far, who have offered constant encouragement, care, company, and humour to keep me going. Special mention to ever-present lights in the dark: Kel, Ais,

Bronwyn, Lisa, Thabisile, Sim, Amy Jo, Lil, and Haemish. I am grateful to Lil for calm and clever assistance with graphics, and to Haemish for all things technical and for determined commitment to reading these many, many pages, just for fun.

My sister Trace, brother-in-law Frans, Mom and stepdad Dudley, Dad and stepmom Micks: cheerleaders and avid supporters of their how-many-more-degrees-now sister/daughter. I am grateful for their unfaltering belief in me.

My Pietermaritzburg family, Vernon, Lyn, Rachel, Leah and Kelvin: no place has ever felt more like home than yours.

My Cape Town family, the Fürsts, and particularly my dear cousin Caren: for not letting me give up, on anything, ever. I love you for it.

Jael, Rolly, Prisca, Tinashe, Clovis, and Joshua: the staff at Common Ground café who have kept me caffeinated and kept me company over countless hours, days, weeks, and months spent at my perch, looking out over Table Mountain. The value of the safe space that they generously allowed me and my laptop to claim for much of this PhD cannot be measured.

I am deeply grateful to Viv O'Neill for careful and care-filled proofreading and editing of this tome – a labour of love more than of anything else. I am as thankful for her calm containment over the past few months as I am for her keen eye and conceptual insight.

My dear friends Sherran, Nicola, Doug, and Cath forged the PhD path ahead of me and have lent me their maps along the way. This has been an arduous journey and they have been with me in all the light and dark and stuck places. I am grateful for their wisdom, humour, and *knowing* of me which so many times kept me from turning back.

Floss: a path walked together, through so many difficult changes, and still you are (t)here.

Bev, for the holding and the seeing, and for coming to find me no matter how deep the mud.

Susan: a crossing of paths I will never be more grateful for. It is because of you that I am here, with hands on hips and a lifetime of appreciation for your mentorship, wisdom, and care.

Kim, for over twenty years of friendship and navigating this life stuff together. I am grateful for you every day.

F&M, for sitting beside me.

Dedication

This work is dedicated to Susan, mentor extraordinaire, for injections of invaluable guidance, faith, and kindness when I needed them most.

And to my dear friend Kim, for being there in the every-day despite living thousands of kilometres away. Each word of this thesis was written with you at my virtual side.

Table of contents

List of tables

List of figures

Chapter 1: Orientation to the study

This chapter provides a roadmap to the overall study. It includes a rationale for the study and presents the aim, research questions, key concepts, and methods used. It ends with an outline of the structure of the thesis in terms of how the chapters are organised.

1.1 Introduction

This study is concerned with the intersection of knowledge and policy in the context of mental health system challenges in a developing country. Its focus is specifically on the ways in which different forms of knowledge, from multiple sources, move through a policy consultation process to inform mental health policy. Policymakers tasked with developing mental health policies must balance a number of competing demands, including calls for policies to be evidence based, calls for public participation in policymaking, and an increasingly complex burden of disease profile and requisite health system responses. Developing policies that can be universally (nationally) applied whilst simultaneously addressing the idiosyncratic and contextual particularities associated with mental ill health at individual and local levels adds to this complexity. This is especially true in a country like South Africa, which is characterised by substantial sociocultural diversity and socio-economic disparities.

South Africa's *Mental Health Policy Framework and Strategic Plan 2013-2020* (Department of Health, 2013) was adopted in 2013. The development of this policy included an extensive consultation process, involving consultation summits in eight of the nine provinces and culminating in a national consultation summit, where input was invited on the draft policy document. This policy consultation process is the subject of the current study. As such, this research is positioned at the interface between evidence-based and consultative policymaking, focusing on processes through which knowledge is transferred to inform policy, with an emphasis on participation and the integration of multiple forms of knowledge in mental health policy development. In this introduction, the complexity of the knowledge-in-policy problem is described, highlighting the gap that this study aims to address, and outlining the contribution to knowledge that this study makes.

Several reports from the World Health Organization (WHO) have drawn attention to the global burden of mental and neurological disorders (WHO, 2003, 2009, 2011, 2017). Although these disorders currently rank second on the global health priority list, they have largely been a neglected priority on national and international policy agendas (Draper et al., 2009; Jacob et al., 2007; Jenkins et al., 2010; Lund, Kleintjies, Kakuma, Flisher, & the MHaPP Research Programme Consortium, 2010; Shah & Beinecke, 2009; Tomlinson & Lund, 2012; Vigo, Thornicroft, & Atun, 2016). The growing burden of

mental illness in the context of a high prevalence of communicable diseases and demands on increasingly resource-constrained health care systems presents challenges for policymakers. Giving priority to mental health would mean making trade-offs between investments in different public policies (Saxena, Thornicroft, Knapp, & Whiteford, 2007). In the face of scarce resources and competing health priorities, policymakers have to make difficult decisions about allocating limited funds for health care (Shah & Beinecke, 2009), and difficult choices between alternative uses of the same resource (Mangalore, Knapp, & McDaid, 2012).

Ensuring that policy is evidence based is one way of increasing the efficiency and cost-effectiveness of health system responses to disease burden (El-Jardali, Ataya, Jamal, & Jaafar, 2012; Lund, Stein et al., 2008). In low- and middle-income countries (LMICs), it is particularly important that evidence of effective strategies gained through research is used to inform policy so that limited resources available can be put to good use (Ssengooba et al., 2011). This has prompted calls to increase capacities for evidence-based policymaking in these contexts (Lund, Stein et al., 2008). In line with this, there has been a proliferation of knowledge-translation models in recent years, which attempt to facilitate an understanding of how a range of factors interact to 'bridge' the gap between evidence and policy (Bowen & Zwi, 2005; Bullock, Watson, & Goering, 2010; Kothari, Birch, & Charles, 2005; WHO, 2006). However, the efficacy and utility of such models are increasingly being called into question, with growing recognition that one size does not fit all (Bullock et al., 2010; Ward, House, & Hamer, 2009). This is particularly true in developing country contexts, where there are limited resources and capacities to translate evidence into effective policies (Lund, Kleintjes et al., 2008; Pang et al., 2003).

Some have suggested that lack of local research data is one of the factors affecting the lack of effective mental health policies in LMICs (McDaid, Knapp, & Raja, 2008; Ngui, Khasakhala, Ndetei, & Weiss Roberts, 2010; Omar et al., 2010). While there is substantial evidence about the effectiveness of mental health interventions, much of this has been generated in high-income countries, and the generalisability of such information from one context to another has been called into question (Patel et al., 2007; Saxena et al., 2007). In LMICs, and in South Africa in particular, there are specific contextual factors that influence the prioritisation of evidence – such as the HIV/AIDS epidemic, violence, poverty, and pressure to be perceived as in line with international priorities such as the Millennium Development Goals (Burns, 2011; Jenkins et al., 2010). Furthermore, the nature of evidence as generalisable knowledge may limit its ability to respond to contextual idiosyncrasies typical of a diverse country like South Africa, where health system governance is decentralised and there is great variability across provinces in terms of population needs and capacity of the system to respond to these needs (Lund et al., 2010; Naude et al., 2015). It is thus essential that locally appropriate evidence – or, more generally, knowledge – is

generated for countries to find solutions to their own mental health problems (Ebrahim & Smith, 2001; Ndetei, 2008).

Evidence-based policymaking in mental health poses particular complexities. One of the strongest arguments against evidence-based policymaking is based on the privileging of certain forms of knowledge over others, a carry-over from evidence-based medicine and the hierarchy of evidence. The evidence at the apex of the hierarchical pyramid – such as systematic reviews and randomised controlled trials – is typically considered the gold standard output of research. Evidence from qualitative research such as case reports and anecdotal knowledge tends to be placed lower down at the base of the hierarchy. The use of randomised controlled trial methodologies that privilege group-level outcomes over idiographic design, for example, neglects the importance of individual experience and the meanings of health problems for those who live with them (Brosnan, 2016; Pawson, 2006; Rose, Thornicroft, & Slade, 2006; Schorr, 2003). In the mental health field in particular, the danger of a reliance on the kinds of knowledge generated at the top of the evidence hierarchy is that it risks reductively negating the personal and interpersonal significance and meaning of experience (Holmes, Murray, Perron, & Rail, 2006).

However, little attention is paid to whose voices and knowledge were – or were not – represented in the decision-making process (Brock, Cornwall, & Gaventa, 2001). There is thus a need for alternative ways of thinking about knowledge in evidence-based policymaking (Mitton, Adair, McKenzie, Patten, & Perry, 2007). In addition, policy, like evidence, needs to balance the tension between general applicability and local relevance (Freeman & Sturdy, 2015a). This highlights the importance of attending to contextually based knowledge as one way of enhancing policy development and implementation. As such, some have called for a shift in policymaking from an emphasis on *what works* (evidence), to *what works for whom* (evidence-in-context), and argue that attending to different forms of knowledge in the policy consultation arena may provide a link between these two (Greenhalgh & Russell, 2009; Parkhurst, 2016).

It is generally accepted in democratic societies that the public has a right to be fully informed about both the decisions that affect them and the way in which those decisions are made (Rowe & Frewer, 2000). Consulting the public on policy decisions can serve a number of purposes, reflecting principles of openness and transparency, legitimacy and accountability, and effectiveness and efficiency. However, the extent to which the public is involved, and the extent to which their views are incorporated into these decisions, varies considerably. In South Africa, too, public participation in policymaking is taken as a given, without necessarily problematising how such processes should be conducted, nor whether or how the inputs during such processes are used. While it is acknowledged that policy decisions are based

on a complex interplay of local and global factors, if policy consultation is undertaken, there should at least be some demonstration that consultation inputs were used to inform policy, as well as how this was done (Bishop & Davis, 2002; Cook, 2002). This is particularly important when a great deal of financial and human investment has been made in the consultation process, as was the case in the extensive consultation process undertaken in relation to the mental health policy in South Africa.

The policy consultation mandate adds another layer of complexity to the balancing of multiple factors that policymakers must achieve in policy decisions. In the mental health context, a number of developments have further illuminated the importance of involving a range of stakeholders in mental health service planning and policies. In light of the substantial treatment gap for mental disorders, for example, mental health policies globally have increasingly advocated for deinstitutionalisation, thereby shifting the focus away from tertiary care to integrating mental health care into primary health care (Patel et al., 2013; WHO, 2008). This, together with demands on health systems to respond to the growing need for chronic care, places additional responsibilities on primary health care workers, as well as on mental health care specialists responsible for overseeing the task shifting of these roles (Ngo et al., 2013). The success of such approaches is thus largely contingent on those tasked with delivering these services. As such, involving health care professionals in the development of mental health care policies and programmes – always recognised as a key factor in effective policy implementation (Walker & Gilson, 2004) – is arguably more important now than ever. Within the context of South Africa's decentralised health system, it is equally important to ensure involvement of provincial- and district-level managers in policy development, to avoid disjuncture between national-level policy and local-level implementation (McIntyre & Klugman, 2003).

In addition, there is a corresponding shift towards person-centred care and efforts to adopt a recovery approach in mental health care provision, focusing on the uniquely personal experience of mental illness and on an individual's potential to live a meaningful life despite their illness. This is matched by growing calls to enable greater representation of mental health care users and their families in the development of mental health policies (Kleintjes, Lund, Swartz, Flisher & the MHAPP Research Programme Consortium, 2010; Semrau et al., 2016; WHO, 2016). However, the capacity of mental health care users to engage in policy discussions is limited, particularly in developing countries like South Africa (Kleintjes, 2012; Kleintjes, Lund, & Swartz, 2012). Furthermore, inputs from the public during policy consultation are unlikely to be consistently in the form of factual or evidence-based knowledge, but rather as practical or experiential embodied knowledge (Farina, Epstein, Heidt, & Newhart, 2012; Hampton, 2009; Morrison & Dearden, 2013). This may be difficult to codify and therefore capture in documented – and transferable – forms (Abidi, Cheah, & Curran, 2005; Kingston, 2012a; Smith-Merry, 2012).

It is thus important to consider how the public engage with policy during policy consultations, and how their inputs might be used to inform policy. In particular, this will mean finding ways of structuring policy consultation processes to not only enable multiple forms of knowledge to be elicited and receive attention, but also to be moved through the consultation process to inform policy. Procedural considerations may focus, for example, on the training of skilled facilitators, the involvement of mediating bodies, or the presence of decision makers who are responsive to multiple forms of input (Boivin, Lehoux, Burgers, & Grol, 2014; Emery, Mulder, & Frewer, 2014; Li, Abelson, Giacomini, & Contrandriopoulos, 2015). Alternately, such considerations may require rethinking the 'rules of the game' altogether, through finding innovative ways of structuring policy consultation processes that go beyond the usual meeting or microphone management format, to allow for more embodied and emotive expressions of experience as legitimate forms of input (Barnes, 2002, 2008; Young, 2000).

Policy, then, can be conceived of as an inscribed form of knowledge that draws together a multiplicity of knowledges. In this sense, policymaking represents something of a knowledge problem for policymakers (Maybin, 2013). Given that consultation is presumably conducted with the genuine goal of attending to public perspectives on policy, and given that increasing the involvement of mental health care users in policy development will likely increase the extent to which inputs during policy consultation are in the form of embodied knowledge, it is important that policymakers find ways of eliciting and capturing this knowledge. However, the problem identified here is that the movement of embodied knowledge through the policy consultation process to inscribed knowledge is likely to be limited, particularly in more conventional consultation formats such as summits or public hearings (Smith-Merry, 2012). This may be, in part, because this form of knowledge may not be considered as legitimate as input framed as 'evidence', and therefore not receive attention. It may also be because this type of embodied knowledge does not easily lend itself to abstraction and inscription, which is a necessary part of a policy consultation exercise. This study thus set out to trace and classify the types of knowledge that are produced at a consultation event, and to assess whether and how embodied knowledge moved into and between enacted and inscribed knowledge forms.

The aims of this study were (1) to trace the ways in which different types of knowledge are, and can be, utilised in the consultation process and (2) to generate suggestions for how mental health policy consultation in South Africa can be improved. The conceptual and analytical frameworks underpinning this study were based on Freeman and Sturdy's (2015a) theoretical schema for the classification of knowledge, as this provided a useful way of understanding how knowledge functions in policy. Freeman and Sturdy (2015a) distinguish between three phases of knowledge – *embodied*, *enacted*, and *inscribed* – and propose that knowledge can be transformed between phases through various kinds of (inter)action. Embodied knowledge includes both experiential and evidence-based (factual/theoretical)

knowledges that individuals embody. Inscribed knowledge is a codified form of knowledge that is contained in material artefacts – in this study, primarily as words in documents. Enacted knowledge is knowledge-in-action, the observable enactment of the other two knowledge forms. (Refer to section 1.5.3 below for a more detailed description of these knowledge forms.)

This conceptualisation of knowledge was considered particularly relevant for the current study, not only because it highlights the *movement* of knowledge through policy, but also as it does not presume that one form of knowledge precedes or is superior to another, nor is one form associated with a particular kind of actor in the policy space (Freeman & Sturdy, 2015b). As such, it collapses the evidence-based knowledge hierarchy, and allows for due consideration of multiple knowledge inputs which, as highlighted above, is especially important in mental health and developing country contexts.

This study makes a contribution to the field of mental health policy consultation in a developing country context. It is the first study to document, in depth, a significant part of the consultation process around mental health policy in South Africa, which it does by tracing knowledge inputs through the process in order to understand how the consultation informed policy. It applies a new theoretical lens to illuminate how different forms of knowledge (embodied, enacted, and inscribed) move through a policy consultation process in South Africa. In doing so, it draws attention to the unique challenges in reconciling the contextual detail of embodied knowledge with the abstract generalisability of inscribed (policy) knowledge – an undertaking that has particular relevance for policymaking in mental health and, specifically, for policy consultation in developing world contexts. The study highlights the importance of designing participatory processes that enable optimal use of knowledge inputs in these enacted spaces, in order to align assumptions about the value of policy consultation with consultation practices.

1.2 Description of study context: Mental health system governance in South Africa

Given the increasing global burden of mental illness, it is imperative that mental health services are organised in a coordinated and efficient manner so that treatment reaches those who need it. The importance of good governance through mental health legislation and policies has been recognised as a critical step in the strengthening of mental health care systems to respond to the growing burden of mental illness (Marais & Petersen, 2015; Mugisha et al., 2017; Patel et al., 2016; WHO, 2009). South Africa's unique quadruple disease burden has particular implications for the demand for and supply of health care in the country (Econex, 2009). The health system's response to the chronic disease burden is still sub-optimal, partly due to the demands placed on the system by the overwhelming prevalence of

communicable diseases such as HIV/AIDS and tuberculosis (Bradshaw, Steyn, Levitt, & Nojilana, 2011; Mayosi et al., 2012).

The burden of mental disorders in South Africa has also increased substantially over the past 20 years (Mayosi et al., 2009; Murray et al., 2012). However, competing with multiple pressing health concerns, resource allocation for mental illness in South Africa seems to follow the global trend of being insufficient, inequitably distributed, and inefficiently utilised in relation to need (Burns, 2011; Lund, Kleintjes et al., 2008; Lund et al., 2010; Williams et al., 2008). Without a well-conceptualised national mental health policy, responses to mental disorders are at risk of fragmentation or duplication, and scarce resources are likely to be used inefficiently (WHO, 2005).

It is within this context that South Africa's *Mental Health Policy Framework and Strategic Plan 2013-2020* (Department of Health, 2013) was promulgated in October 2013. With its focus on the mental health policy consultation process undertaken by the Department of Health early in 2012, this study explores one slice of the broader policy development process that unfolded in South Africa following its first democratic elections in 1994. A brief outline of this broader process provides context for the case study.

The 2013 mental health policy built on existing mental health policy guidelines that had been developed in 1997 (Department of Health, 1997). This coincided with the delineation of nine new provinces, and the establishment of new provincial governments in South Africa. Although it was expected that the policy guidelines would inform the development of provincial policies and strategic plans for mental health (Draper et al., 2009), there was ultimately very poor uptake. This was attributed to administrative and capacity constraints, uneven distribution of resources, and the low priority given to mental health by national and provincial health departments compared to other implementation priorities (Lund, Kleintjes et al., 2008; Lund et al., 2010).

Another important development in South Africa's mental health regulatory history was the adoption of the Mental Health Care Act of 2002. Hailed as "one of the most progressive pieces of mental health legislation in the world" (Burns, 2011, p. 100), the Act contained provisions for the decentralisation of mental health care from psychiatric institutions, the development of community-based care, and the integration of mental health into primary health care (Burns, 2011; Lund et al., 2010). However, due primarily to lack of funding and poor planning and preparation, mental health service provision remains chronically insufficient and many of the goals of the Mental Health Care Act have not yet been realised (Burns, 2011; Lund et al., 2010).

It is also important to note the context of health system governance in South Africa. The National Department of Health, through the National Directorate: Mental Health and Substance Abuse, drives the development of national legislation and policies, and provides policy direction to the directorates or sub-directorates for mental health within provincial departments of health that are responsible for policy implementation (Department of Health, 1997; Lund et al., 2010). Health system governance in South Africa is therefore decentralised, but provincial authorities are mandated with implementing national policies and legislation at provincial and district levels (McIntyre & Klugman, 2003).

Within this context, those tasked with developing mental health policies face a daunting challenge. Policymakers must draw on multiple knowledge sources to weigh up policy decisions. These inputs may be drawn from knowledge about feasibility and resource constraints, international norms and standards, human rights principles, competing priorities, evidence-based knowledge, monitoring and evaluation feedback, health workforce needs and capacities, and appeals from service users and their advocates. In South Africa's current socio-political and economic climate, policy decisions are under increasing scrutiny, with growing public demands for government accountability and transparency. Furthermore, with a decentralised health system, policymakers must develop policies that are universally applicable but locally relevant. As such, they need to attend to the unique contextual particularities of provincial health needs and system capacities, while formulating policies that are sufficiently abstracted to provide overarching direction for mental health system governance. It is against this backdrop that the current study is situated.

1.3 Aim and research questions

The aim of this study was to explore how the mental health policy consultation process undertaken in South Africa in 2012 informed policy, by tracing the movement of different forms of knowledge through the consultation process. This was applied to a particular case of policy consultation and, in addressing this aim, the study sought to answer three research questions in relation to this specific case:

1. How were participants' embodied knowledges enacted and captured (inscribed) during the consultation process?
2. How did the consultation process enable or constrain the movement of knowledge from enacted to inscribed forms?
3. How did inscribed knowledge outputs from the consultation move through points of abstraction to inform policy?

These questions were developed in an iterative process of engagement and refinement in moving between theory and data (Maxwell, 2013) to understand how the mental health policy consultation process had generated outputs that might inform policy.

1.4 Study methodology

1.4.1 The point of departure: From what to how to why

This is a qualitative research study. A qualitative approach to research allows for exploring real-world phenomena in "depth, openness and detail" (Durrheim, 2006, p. 47) towards describing and understanding the what, how, and why characteristics of a particular phenomenon (Henning, 2004).

As is often the case with qualitative research, this study did not finish where it was expected to at the start. The initial aim was to conduct an analysis of South Africa's *Mental Health Policy Framework and Strategic Plan 2013-2020*, comparing it to the draft policy that was reviewed during the policy consultation process. Of interest was how the framing of mental health issues during the consultation may have influenced the framing of how these issues were addressed in the final policy. However, preliminary comparative analysis of the draft mental health policy that was reviewed at the consultation summits and the final policy document revealed that there were very few substantive changes to the content of the document following the consultation. This analysis, then, provided the point of departure for this study: exploring *how* the consultation process unfolded – particularly in relation to the movement of knowledge through this process – in an attempt to understand *why* inputs at these summits may not have influenced the policy.

Both the complexity of the case and the non-linear nature of the research process created a number of challenges in the write-up of this case study, including how to present the research in an ordered way without reverting to a chronological approach. It was helpful to conceive of this research as proceeding through three levels of 'reflective' knowledge construction (Mezirow, 1991):

1. Content reflection – describing WHAT happened,
2. Process reflection – exploring HOW it happened, and
3. Premise reflection – understanding WHY it happened, linking back to why this was considered an important issue in the first place (Kreber & Cranton, 2000).

This approach was used as a structuring tool to anchor different elements of the research:

1. WHAT happened – the description of the case (consultation process). This is described in the METHODOLOGY chapter. It also includes the preliminary finding that the policy changed only in relatively minor ways following the consultation process, which is presented as the point of departure for this study in the FINDINGS chapter.
2. HOW it happened – an in-depth exploration of the consultation process towards understanding what happened to knowledge inputs through the process. The *how* informed the specific research questions underpinning the study, and is detailed throughout the analysis presented in the last five sections of the FINDINGS chapter.
3. WHY it happened – a critical and conceptual interpretation of why what happened played out in the way that it did, and what this means in the context of what is known about this issue. This comprises the DISCUSSION chapter.

1.4.2 Study approach and design

As knowledge is a central concern in this thesis, it is important to consider how knowledge is understood ontologically and epistemologically in this study, and to locate the research within a particular philosophical paradigm. The paradigmatic position adopted in this research study was informed by a pragmatic philosophy. Ontologically speaking, reality is understood by pragmatists as fundamentally experiential (Morgan, 2007). Although pragmatists acknowledge that there is such a thing as reality, this reality is constantly changing based on people's actions and their consequences. One can only know what one knows through interacting with one's environments and formulating concepts and categories to make sense of these interactions (DeForge & Shaw, 2012). In pragmatism, then, external reality exists, but comprises an "experiential world with different elements or layers, some objective, some subjective, and some a mixture of the two" (Feilzer, 2009, p. 3). Reality can be known using research tools that "reflect both deductive (objective) evidence and inductive (subjective) evidence" (Creswell, 2014, p. 37), gathered through both quantitative and qualitative approaches.

Given that the current study sought to illuminate the complexity of moving from the particular to the abstract in knowledge and policy, a pragmatic paradigm was considered a particularly good fit, as it is able to connect context with generality, and subjectivity with objectivity (Morgan, 2007). Thus, in a sense, an approach based on a pragmatic paradigm represents a flexible and practical approach that seeks to draw attention away from the paradigm wars between positivism and constructivism, by refocusing on "the problem to be researched and the consequences of the research" (Feilzer, 2009, p. 2), approaching knowledge as that which is "useful, practical and what works" (Creswell, 2014, p. 37).

In keeping with the descriptive, exploratory nature of the questions guiding this inquiry, a single case study research design was adopted. Case study designs fit within the practical, real-world philosophy typical of pragmatic paradigms. Case studies also tend to focus more on process than on outcome (Denscombe, 1998) and are considered appropriate design choices when dealing with how and why questions (Yin, 1994), as they allow for in-depth engagement with the object or subject of study through employing multiple methods to analyse multiple sources of data. As the aim of this study was specifically to consider the movement of knowledge forms through a policy consultation event, as opposed to seeking a holistic understanding of the consultation process, an embedded case study design was employed. The details of the selected case are briefly outlined next.

1.4.3 Selection of the case and data collected

The mental health policy consultation process that was undertaken in South Africa in 2012 was purposefully selected (Maxwell, 2013) as the case for this study. More specifically, the provincial and national mental health consultation summits that took place between February and April 2012 were selected as a temporally bound 'window' on the broader policy development process and its subsequent finalisation and implementation. As such, this was an instrumental case study, whereby the selected case was considered to represent "an exemplar of a more general phenomenon" (Willig, 2008, p. 79). A detailed description of the case is provided in the methodology chapter. The decision to focus on this case specifically was a natural follow-on from the preliminary analysis of the mental health policy that served as the point of departure for this study.

Given that the phenomenon of interest in this study was the movement of knowledge through these consultation events, data were selected that would provide a window on forms of knowledge that were in use during the summits in a way that would address the research questions. In keeping with the imperative to include data from multiple sources in case study inquiry (Yin, 1994), key informant interviews, documents, and audio recordings of summit proceedings comprised the data sources for this study. Seven interviews were conducted with key informants who had participated in various ways in the mental health consultation process. These individual perspectives generated a number of hypothetical "propositions" (Yin, 1994, p. 21) regarding how (and whether) knowledge was used in the consultation process, which both reflected potentially important theoretical issues and informed subsequent decisions regarding data selection (Babbie & Mouton, 2001; Willig, 2008; Yin, 1994).

Several documents were included as data: the pre-summit draft mental health policy document; the final mental health policy document; the national mental health summit programme; and the draft and final summit declarations (output of the national summit). Consultation summit reports were also

requested from the provincial and national departments of health and, where available, were included as data to trace the transfer of knowledge between and within summits. Audio recordings from the entire two-day national summit were obtained, including of the ten topic-driven breakaway group discussion sessions that took place during this summit. These were transcribed and the transcripts formed an integral part of the data analysis.

1.4.4 Data analysis

Due in part to the complexity of both the consultation process and the data it generated, it was important to adopt a conceptual lens through which these could be understood. This conceptual framework evolved during back-and-forth iterations between theory and data, while maintaining an awareness of the unique context within which this consultation process occurred. It provided the knowledge-in-policy focus of this study which, in turn, informed the analytical framework. This, again, is consistent with a case study design, as Yin (1994) suggests that the best analytical strategy is one that relies on theoretical propositions. As such, Freeman and Sturdy's (2015a) knowledge schema formed the analytical framework, making it possible to view the data in terms of how it was functioning as a form of embodied, enacted, or inscribed knowledge. Within each of these overarching thematic layers, a number of thematic analyses were applied.

i) Point of departure: Comparative analysis of policy documents

A preliminary phase of analysis was conducted, towards addressing the original aim of this study outlined in section 1.4.1 above. This involved a comparative thematic analysis between the draft mental health policy document that was reviewed at the consultation summits in 2012 and the final mental health policy document that was adopted in 2013. The finding that policy content changed very little following the consultation summits shifted the focus of the study to the consultation process itself, with the comparative policy analysis thus serving as the point of departure for this case study.

ii) From the inside out: Reviewing the consultation process

The main analysis began at the level of the individual, with the key informants' perspectives on the policy consultation process and policy content. Thematic framework analysis was employed to identify key themes relating to the process of policy consultation, and to policy content as it related to key issues in mental health from the perspective of interview participants. The interview findings are revisited at the end of the analysis and combined with the findings from the analysis of the summit documents and

transcripts, to identify continuities and discontinuities across the data and highlight issues for discussion.

Deductive, thematic content analysis was used for the analysis of documents and transcripts from the policy consultation process. This allowed for both a thematic and a numerical approach to the data that would allow for comparison across multiple data sources within particular content areas, for the purposes of tracing knowledge as it moved from one point in the consultation process to the next. Themes were developed deductively in most cases, while nonetheless allowing for additional themes to be identified within data as analysis progressed. The identification of the deductive themes was guided by the mental health topics that were identified for discussion at the national summit, as well as by the types of knowledge that were identified in the literature as relevant to this study's focus – specifically, embodied (including experiential and evidence-based), enacted, and inscribed forms of knowledge. The deductive themes were applied across multiple layers of analysis, requiring repeated returns to the data to build these layers; these are described briefly below and linked back to the three research questions.

iii) Embodied knowledge enacted

(Addresses question 1: How were participants' embodied knowledges enacted and captured during the consultation process?)

The analysis moved out from the level of the individual (interview) to the enactment and inscription of embodied knowledge at the micro level, that is, within the ten breakaway discussion group sessions at the national summit. The analysis here focused on the use of evidence-based and experiential knowledge claims by participants to support or oppose policy proposals.

iv) Enacted knowledge inscribed

(Addresses question 2: How did the consultation process enable or constrain the movement of knowledge from enacted to inscribed forms?)

The analytic focus then turned to an analysis of the way in which the consultation process at the micro and meso levels may have enabled or constrained the enactment and inscription of this embodied knowledge, and in particular the movement of knowledge from enacted to inscribed forms.

v) Inscribed knowledge transferred

(Addresses question 3: How did inscribed knowledge outputs from the consultation move through points of abstraction to inform policy?)

In the third level of analysis, the knowledge inscribed in documents with increasing degrees of summarisation (abstraction) across the consultation process was compared and analysed for follow-through of inscribed knowledge from the particular (group recommendations) to the abstract (policy document).

vi) From the outside in: Re-viewing the consultation process

(Addresses all three research questions)

This final phase involved returning to the interview findings and integrating these with the findings from the analysis of summit documents and transcripts in order to move towards an understanding of how and why particular forms of knowledge did – or did not – move through the policy consultation process. In this section, a factual synthesis of findings in relation to the three research questions is presented, with particular emphasis on drawing out the connections to embodied, enacted, and inscribed knowledge forms.

The findings chapter begins with the preliminary analysis of the draft and final policy documents, framed as the point of departure for this study. The remaining sections are then structured according to the five analytical layers outlined above.

1.5 Definition of key concepts

The conceptual framework guiding this study draws on bodies of work that, while related, have not typically been considered all together: the forms and functions of **knowledge** at the intersection of **evidence-based policymaking** and **consultative policymaking** in **mental health** in **low- and middle-income country** contexts. Because these concepts underpin the conceptual framework that guided this research, they are briefly explained below.

1.5.1 Context: Mental health and low- and middle-income countries

Mental health: This study is set in a mental health context. Mental health is defined by the World Health Organization as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001, p. 1). It is "an integral part of health and well-being" (WHO, 2013, p. 7). Mental health is determined by individual, social, political, economic, and environmental factors. As the focus of this study is on consultation around mental health policy, the findings are interpreted in

relation to their implications for mental health policy development at an individual, systemic and governmental level.

Low- and middle-income countries: Low- and middle-income countries (LMICs) are defined according to the World Bank as those countries with a gross national income per capita of between less than $1,025 (low-income) and $12,475 (upper middle-income) (World Bank Data Team, 2017). Such countries are thus classified as economically distinct from high-income countries (HICs). South Africa is classified as an upper middle-income country (World Bank Data Team, 2017). However, this categorisation should be interpreted in the context of extremely high inequality, as measured by the Gini coefficient (Lustig, 2016), such that a large proportion of the South African population lives in extreme poverty, despite a relatively high ranking in average terms.

The LMIC term is frequently used interchangeably with *developing countries*, while the HIC-LMIC distinction is also sometimes defined as the global north and global south, or Western and non-Western countries. These distinctions are often employed to highlight the unique challenges within these contexts, as well as challenges in 'translating' policies, concepts, and interventions from HIC to LMIC environments. Although the term *developing countries* is now being used less frequently, it is still used in relation to a number of the United Nation's Sustainable Development Goals (SDGs), which now include mental health targets (Khokhar & Serajuddin, 2015; United Nations, 2017). In this study, therefore, the terms LMICs and developing countries are used interchangeably.

1.5.2 Policymaking: Evidence-based and consultative

Evidence-based policymaking: Evidence-based policymaking is both a conceptual rationale and an operational approach to policy development that is "based on the premise that policy decisions should be better informed by available evidence and should include rational analysis. This is because policy which is based on systematic evidence is seen to produce better outcomes" (Sutcliffe & Court, 2005, p. iii). There are numerous evidence-based policymaking strategies, which differ according to how evidence is defined and how it is incorporated into policy. In relation to this study, evidence-based policymaking has relevance as a particular knowledge-transfer process that adds evidence-based knowledge into the policy development 'mix'.

Knowledge transfer: Knowledge transfer is a term commonly employed in relation to evidence-based policymaking and, as the name suggests, refers to a set of models or practices that aim to increase the uptake of knowledge into policy and practice. Knowledge transfer is often used interchangeably with knowledge translation, research uptake, dissemination, diffusion, knowledge exchange, and bridging the

know-do gap. There is also overlap with knowledge-management strategies characteristic of the organisational literature.

Consultative policymaking: Policy consultation is located within the broader context of public participation, although the terms have also been used interchangeably. It involves an exchange between those who make policy and those affected by policy choices, with varying degrees of participant involvement in the decision-making process at different points in time. Governments engage in consultation around public policies for a number of purposes, ranging from information exchange to an indication of responsiveness to public preferences, to transferring responsibility for the decision to the hands of citizens.

Impact of policy consultation on policy: There is a general expectation in policy consultation that the inputs of those consulted will in some way be used in the development of policy. There is much debate around the issue of impact of consultation on policy, in part due to lack of consistency or clarity in how impact is defined or assessed. Impacted, used, influenced, informed, considered, followed through, taken up, or factored into policy are all terms that are used in relation to how public inputs to a consultation process are managed in relation to policy. 'Informed' is the term used predominantly in this study due to the implication inherent in this term that there is not a direct linear relationship between consultation inputs and policy outputs.

1.5.3 Knowledge: Embodied, enacted, inscribed

These three concepts were developed by Freeman and Sturdy (2015a) in their conceptual knowledge schema described below. They conceived of knowledge forms as analogous to the three phases of matter: liquid (embodied knowledge), gas (enacted knowledge), and solid (inscribed knowledge). These three concepts are central to this study and so are briefly defined here.

Embodied knowledge: Embodied knowledge is a form of knowledge that is "deeply embedded in bodily experience" (Freeman & Sturdy, 2015a, p. 9). It is typically understood as tacit, practical, and experiential. However, Freeman and Sturdy also incorporate explicit, factual, or theoretical knowledge in their definition of embodied knowledge. This more explicit, fact-based type of knowledge has sometimes been defined as *embrained,* and can be seen as representing, among other things, the evidence-based knowledge that individuals embody and are easily able to articulate in verbal form. The premise is that all knowledge, whether verbal or non-verbal, is experienced by and in the physical being of each individual. In this study, participants in the policy consultation process are seen to draw on both evidence-based and experiential knowledge, understood here as embodied within individuals and

requiring enactment to be 'seen' or shared. This is in contrast to knowledge that exists 'out there' in other (non-bodily) forms – specifically, in enacted and inscribed forms held in interactive spaces and in documents/materials, respectively, as described below.

Enacted knowledge: Enacted knowledge captures the action component of knowledge. Like gas is to solid and liquid, enacted knowledge represents the transformation of embodied and inscribed knowledge into a new, active form. Freeman and Sturdy (2015a) recognise enacted knowledge as a distinct form of knowledge which may, in turn, result in the production of new embodied or inscribed knowledge. Like gas, enacted knowledge is transient and only visible through (inter)action. It is a particularly useful concept in relation to this study, as it calls attention to the interactive meeting spaces in which participants' embodied knowledge can be enacted.

Inscribed knowledge: Inscribed knowledge is a codified form of knowledge that is captured and encoded in words or symbols in material artefacts such as documents. Inscribed knowledge represents a 'translated' (encoded and inscribed) form of embodied and enacted knowledge that is stable, easily reproduced, and easily transferable. Inscription of knowledge typically involves some form of abstraction in the codification process. In a policy consultation process, the inscription of knowledge in documents is a critical component of transferring knowledge inputs to policy outputs.

Using the *embodied-inscribed-enacted* framework as an analytical lens in this study made it possible to explore how knowledge moved through the mental health consultation process, and specifically through the national consultation summit, in different forms. It provided insight into how the use and transfer of these different forms may have influenced the potential of summit outputs to inform policy. A common theme in this study is the tension between the particular and the abstract when developing policy in mental health contexts. This knowledge framework allowed for the analysis to be approached in terms of moving from the particular (embodied knowledge) to the abstract (inscribed knowledge). This premise is elaborated on in Chapter 2.

1.6 Structure of thesis

This chapter presents an overview of the study, with the aim of providing a roadmap for the reader to the study components that are addressed in detail in the chapters below. In the next chapter (Chapter 2), the key contexts and concepts around which the research is positioned are unpacked. This review of relevant literature considers how knowledge and policy intersect within a mental health context, both globally and locally. It draws on theories and research relating to evidence-based and consultative

policymaking in order to highlight the complexity of the policymaking process – and specifically the transfer of knowledge through these processes – and, finally, considers how different forms of knowledge intersect with policy. The conclusion of the literature review chapter draws together the tensions between different forms of knowledge in policy decision-making, considering how mental health policymaking represents a unique kind of knowledge problem for policymakers.

In Chapter 3, the methodology of the study is described. This chapter provides the rationale for the qualitative case study design and locates this within a pragmatic paradigm. A detailed description of the case is presented, and the choices made regarding units of analysis, data collection, and data analysis are explained. The classification of knowledge as embodied, enacted, and inscribed was drawn from the conceptual framework to inform the analytical framework. The findings reported in Chapter 4 are thus discussed in relation to this framework. Chapter 5 interprets these findings in the context of existing theory and research on knowledge and policy consultation in a mental health and developing country context and outlines recommendations for practice and for further research. The conclusion (section 5.5) of the discussion chapter highlights how this study has contributed to knowledge of mental health policy consultation processes in South Africa, illuminating gaps in the consultation process that have implications for those organising and participating in such processes in future. The contribution of this study to empirical work on the *embodied-enacted-inscribed* knowledge framework – and specifically its application in developing world contexts – is also outlined.

Chapter 2: Literature review

This study draws on three main bodies of work in conceptualising mental health policy consultation as a knowledge problem. These comprise the three main sections of this chapter: evidence-based policymaking, consultative policymaking, and knowledge-in-policy as embodied, enacted, and inscribed. A brief overview of these sections is presented here.

The first section incorporates literature on evidence-based policymaking to provide a brief review of policymaking processes to give context for the current study. The discussion focuses particularly on the shift towards ensuring that policies are evidence based, outlining knowledge-translation models that have been developed to increase the uptake of evidence into policy. The iterative and interactive nature of both policymaking and knowledge transfer is emphasised in this discussion. The epistemological status of 'evidence' as a form of knowledge is then reviewed, highlighting in particular some of the challenges associated with different kinds of evidence relating to mental health as it moves across contexts – such as from global to local sites, or from the abstract to the particular.

In the consultative policymaking section, principles of and approaches to public participation in government decision-making are discussed. Policy consultation is presented as a form of public participation that tends more towards information exchange between citizens and government officials than to shared decision-making or control. A review of the public participation context in South Africa shows that participatory principles have typically not been realised in practice in the country. The gap between policy development and policy implementation is explored as a particular challenge in this regard.

Process- and outcome-related criteria that have been used to assess the effectiveness of policy consultation are then presented, with particular emphasis on how these criteria might influence the use or influence of policy consultation on policy. The conceptualisation of policy consultation as a knowledge-management process is then discussed – both in terms of procedural aspects, as well as in terms of recognising the legitimacy of different kinds of knowledge contributions and enabling these in participatory processes. Finally, this second section explores policy consultation in mental health as a particular kind of knowledge problem for policymakers, with respect to including, enabling, and capturing mental health knowledge inputs.

In the third and final section of this chapter, the intersection of knowledge and policy – and specifically, policy consultation – is considered in greater detail. The discussion begins by outlining specific functions

that knowledge might serve in policy, and is followed by a brief review of the opportunities and challenges presented by tacit and explicit forms of knowledge, as well as by mechanisms for integrating these. This discussion highlights again how the perceived legitimacy of different kinds of knowledge might affect this. The *embodied-enacted-inscribed* knowledge framework is then presented and described, returning to consideration of key elements of policy consultation processes that might optimise the integration and use of these different knowledge forms. This is considered specifically in the context of mental health policy consultation in the concluding section of this chapter.

2.1 Evidence-based policymaking

This study is situated in the larger body of work regarding how public policies come to be developed and implemented. In particular, this study is about the use of knowledge in policy consultation in terms of its transfer in different forms through a consultation process. As such, it is located within the broader context of policymaking and positioned in relation to another area of policymaking in which the role of knowledge and its transfer has had a significant impact: evidence-based policymaking. A broad overview of the evidence-based policymaking movement is thus presented in this section, providing a contextual and theoretical backdrop to the knowledge-policy interface intrinsic to consultative policymaking. The discussion in this section focuses on the interaction of one particular type of knowledge – 'research evidence' – with policy, to foreground later discussions on the points of divergence between evidence-based policymaking and consultative policymaking. It also highlights the complexities of the very nature of what constitutes this 'evidence-based knowledge' when it comes to mental health, and the challenge for policymakers when moving this knowledge between different contexts.

2.1.1 Policymaking and the evidence-based shift

2.1.1.1 The policymaking process

At a general level, policymaking can be understood as a series of decisions, undertaken through a variety of methods, that effect varying degrees of change (Jones, Jones, Shaxson, & Walker, 2012). The making of policies – from agenda setting to implementation – is one element within any country's political system and governance process. The nature of this system will influence how policies are made, who has a say in these policies, and the extent to which the policymaking process is open or closed to the direct or indirect involvement of a wide variety of potential voices (Walt, 1994). This helps to orientate public policymaking as a political process; thus, it is "not simply a problem-solving process: it is a process

of negotiation, bargaining, and the accommodation of many different interests, which reflect the ideology of the government in power" (Walt, 1994, p. 73).

Health policy development – and, by extension, mental health policy development – has been described as complex, multi-level, continuous, and driven, to varying degrees, by government, the public (including interest groups), and foreign agencies (Buse, Gilson, Dickinson, & Murray, 2008; De Vries & Klazinga 2006; Hyder et al., 2007; Walt & Gilson 1994). The product of policymaking in mental health should be a mental health policy document, which has been defined as an organised set of values, principles, objectives, and areas for action that provides the overall direction for improving the mental health of a population (WHO, 2005, 2009). The likelihood of the policy being contextually appropriate will depend on the processes by which it was developed, and in particular, the degree to which it has included key stakeholders within this process (Walt & Gilson, 1994), as well as whether it took relevant data regarding the mental health care needs of the population into account (Flisher et al., 2007). In the implementation of policy, the existence of an appropriate policy may be a necessary condition for improved services, but is, of course, not sufficient. Mental health policies may draw on evidence and international best practices but, as will be shown in this section, need to be tailored to local needs and conditions.

A number of models specifically relating to the policymaking process have been developed, ranging from rational normative models which mostly prescribe how policy *should* be made, to incremental models that more closely reflect how policy is *actually* made (for an overview of these models, see Buse et al., 2008; Buse, Mays, & Walt, 2012; Walt, 1994). In addition to these conceptualisations of policymaking, several theories have been proposed to further understandings of how and why policy change occurs (Buse et al., 2008; Kingdon, 2003; Kuruvilla & Dorstewitz, 2010; Lipsky, 1980; Sabatier, 1988, in Buse et al., 2008; Shiffman & Smith, 2007). What these models demonstrate is that policymaking is a complex, iterative interaction between content, process, and actors within particular political contexts. Research and researchers are among the many influences on policy; the ('lay') public and their inputs and preferences are another.

Policymakers may use evidence in policy towards particular goals, just as public participation in policymaking might achieve certain others. Certainly, the complexity of policymaking seems to require a specific kind of (expert) knowledge, which generally seems to lie in the hands of a small, elite minority. However, in democratic societies, the right of the public to participate in decisions that affect them is an important factor in public policymaking (Kuruvilla & Dorstewitz, 2010). The role of evidence-based knowledge in policymaking is the focus of this section; the role of public consultation in this process is considered in later discussions. As will be seen in later sections, balancing the different requirements of

each of these processes, and the knowledges they generate, adds to the challenge for policymakers seeking multiple inputs to inform policy in ways that balance inclusiveness with effectiveness.

2.1.1.2 The shift to evidence-based policymaking

Recognition of the value of evidence-informed decision-making in medicine sparked similar changes in the policymaking field (Buse et al., 2012). Evidence-based policies have been argued to be better informed about what will work and what will not, to allow for a broader range of policy options, to be more effective and more cost-effective, to increase confidence in decisions taken, to improve implementation, to result in better outcomes, and to improve the quality and longevity of life (Bowen & Zwi, 2005; Court & Young, 2004; Hanney, Gonzalez-Block, Buxton, & Kogan, 2003; Strydom, Funke, Nienaber, Nortje, & Steyn, 2010; Sutcliffe & Court, 2005). In low- and middle-income countries (LMICs), it is particularly important that evidence of effective strategies gained through research is used to inform policy so that limited resources available can be put to good use (Bennett & Jessani, 2011; Ssengooba et al., 2011; Swartz, Tomlinson, & Landman, 2004). With increasing recognition of the importance of grounding health and mental health policies in evidence about best practices in prevention and treatment (Lund, Stein et al., 2008) came calls for governments to focus efforts on finding ways to maximise the uptake of evidence into policy (El-Jardali et al., 2012).

Initially, the role of research in policy was assumed to be a means to solve pre-identified policy problems, or to generate new knowledge that pointed to the need for new policies (Buse et al., 2012). This approach mirrored the rational, linear models of policymaking mentioned above. As with policymaking, however, there has since been a move away from these more linear approaches to recognise the complexity of the relationship between research and policy. Research has been used in policy in a number of ways, and research evidence has relevance at many points in the policymaking process, including in agenda setting, policy formulation, implementation, and evaluation. Several models have been developed to better understand how and why research-generated knowledge might be used to inform policy at various stages in the process. These are discussed in more detail below. What these models demonstrate is that knowledge does not easily move from one domain (research) to another (policy). Knowledge transfer requires careful attention to a number of factors that may increase or decrease the likelihood that evidence-based knowledge finds its way into policy.

2.1.1.3 Models of evidence-based policymaking: A 'transfer' of knowledge

The shift to evidence-based policymaking foregrounded the important role of evidence-based knowledge in policy, as well as of the processes through which this knowledge might be transferred

between the research and policy domains. These knowledge-transfer processes are outlined in this section.

In recent years, there has been a proliferation of conceptual knowledge-translation models which aim to promote an interactive, reciprocal process of knowledge exchange between research producers and research users (Bowen & Zwi, 2005; Bullock et al., 2010; Graham et al., 2006; Kothari et al., 2005; WHO, 2006). A number of terms have been used to capture the process of getting research results into policy (and practice) – *bridging the know-do-gap*, *knowledge translation*, *research utilisation* or *uptake*, *diffusion*, *dissemination*, *knowledge transfer*, *knowledge exchange*, and *evidence-based policymaking*. Many of these terms have been used interchangeably, or as sub-components of one another; in other instances, the same terms are used to refer to different processes. For simplicity, the term 'knowledge translation' will be used throughout this section, to refer to the complex set of processes that occur in the development of evidence-based policy.

Knowledge translation is about "creating, transferring and transforming knowledge from one social or organisational unit to another … it is a complex interactive process that depends on human beings and their context" (Landry, Amara, Pablos-Mendez, Shademani, & Gold, 2006, p. 597). This latter element highlights the importance of adapting knowledge to context, and therefore the need for translation. Knowledge translation has generally been differentiated from the more passive processes of knowledge utilisation, dissemination, and diffusion, highlighting that the transfer of research to policy is an interactive process that must be actively managed, not only through packaging knowledge to be more amenable for uptake, but through creating the conditions that will facilitate dialogue between key actors (Jones, Datta, & Jones, 2009; Sedlačko & Staroňová, 2015). As will be seen later, attention to these factors is also important for optimising the transfer of knowledge in policy consultation.

A multitude of frameworks or models have been developed that attempt to facilitate an understanding of how a range of factors interact to bridge the 'gap' between evidence and policy. Each of these models attends not just to whether research is used in policy, but *how* it is used – whether instrumentally, conceptually, or symbolically (Mitton et al., 2007). Such functions may become more or less relevant at different stages of the policymaking process, for example, during agenda setting or during implementation. These functions of knowledge and their role in policymaking are picked up again in later sections (see section 2.3). Weiss (1979) has been particularly instrumental in providing ways of conceptualising this process, proposing six models to shed light on the pathways along which research might travel to policy: problem-solving models (push and pull), strategic models (political and tactical), the enlightenment model, and the interactive model. These are briefly outlined in this section.

Initially, knowledge-transfer models were primarily concerned with outlining how products from the research community might be transferred to the policymaking one, and came to be known as rational, or linear, models of evidence-based policymaking. Such models tended to see policymaking as a largely rational, problem-solving process which took place through a series of stages. Knowledge-driven, or push models (Weiss, 1979), proposed that researchers approached policymakers with a range of information (evidence) that might assist in developing (better) policies. In problem-solving, engineering, or pull models (Weiss, 1979), policymakers are seen as active seekers of information from researchers that could solve current policy problems.

The overemphasis of these early models on the rational, linear nature of the evidence-based policymaking process led to the development of incrementalist models, which attempted to capture more accurately the complex, real-world process of policymaking and the role(s) of research within this. Incrementalist models – including Weiss's (1979) enlightenment and interactive models and Lindblom's (1959) muddling through model – acknowledged that both research and policy decision-making take place in parallel with a number of other social processes, which interact to create different functions for and impacts of research on policy and policy on research (Almeida & Bascolo, 2006). These incrementalist models also highlight that the transfer of knowledge is as much dependent on an interactive process of exchange between people as it is on other factors. The specific ways in which this transfer might be effected – that is, through dialogue or written policy briefs – are considered in later sections on the micro-processes of knowledge transfer.

Recognising that research can be – and frequently is – used for strategic purposes, Weiss (1979) proposed two further models of knowledge translation: in the political model, research is used to legitimise pre-determined policy decisions and advance particular (political) agendas; in the tactical model, research is used for other political means, such as increasing perceptions of responsiveness among the public or even justifying delaying policy change (Almeida & Bascolo, 2006; Buse et al., 2012; Sedlačko & Staroňová, 2015). These models highlight the importance of ongoing contact between researchers and policymakers, such that policymakers become part of the research process in some way.

The discussion in this section has outlined several approaches to understanding the relationship between research and policy in the context of evidence-based policymaking. Each approach highlights different aspects of the evidence-policy interface. A key conclusion that can be drawn from the knowledge-translation literature is that the relationship between research and policy is neither linear nor direct. The process is contingent not just on the (political) context in which it occurs, but on numerous individual, inter-individual, and institutional elements that intersect in different ways, at

different times in the policymaking process, in relation to different policy issues. While attending to one element – such as the appropriate packaging and communication of research results – might be a necessary condition for increasing the likelihood of uptake, no one factor is in itself sufficient.

Importantly, the models described above that emphasise context and complexity highlight that research evidence is also just one among many sources of information, or knowledge, that policymakers need to and do draw on when making policy decisions (Jones, 2009; Jones & Walsh, 2008). The conclusion reached by Jones (2009, p. 29) following a review of knowledge-to-policy literature was that "the message that is emphasised over and over again is that [knowledge-translation strategies] are more of an art than a science, requiring considerable amounts of judgement and luck" – for researchers and policymakers alike. In addition, much of the research on evidence-based policymaking has focused on increasing the use of research evidence, taking this use "as an a priori positive outcome" (Smith, 2013, p. 23, in Parkhurst, 2016, p. 24). As will be seen in the discussion below, critiques of knowledge translation extend beyond challenging the limitations of the process to disputing the epistemological status of evidence itself.

2.1.2 Evidence-based policymaking in mental health as a knowledge problem

In the previous sections, the process of evidence-based policymaking was considered from the point of view of 'transferring' knowledge at the research-policy interface – in other words, the *how* of evidence-based policymaking. The discussion above made some implicit assumptions about the nature of the knowledge – or evidence – that was to be transferred. In this section, the complexity of the notion of 'evidence' – the *what* of evidence-based policymaking – will be explored. It therefore focuses on the knowledge element of knowledge transfer. In particular, it considers how contested notions of what constitutes evidence in mental health complicate the movement of knowledge across different contexts, including from the abstract (objective) to the particular (subjective), from global to local, and from 'evidence' as it is positioned at the apex of the evidence hierarchy to 'experience' as it is positioned at the base. As will be seen later, these tensions between these epistemological and contextual dimensions are mirrored in the policy consultation space, where policymakers are faced with the increasingly complex task of integrating multiple knowledge inputs while balancing the abstract with the particular, the global with the local, and scientific expertise with on-the-ground experience.

2.1.2.1 Moving from abstract-objective to particular-subjective

While the value of evidence in increasing the effectiveness and efficiency of policy interventions is hard to refute, the dominance of the evidence-based approach in both policy and practice has been called into question. A number of criticisms have been levelled against the notion of evidence-based policymaking and the assumptions on which it is based. This section will outline critiques that highlight the dangers of uncritical allegiance to evidence as the most comprehensive, unassailable knowledge base for making sound policy decisions. Some of these critiques have been tempered in more recent years, with the recognition even among advocates of evidence-based policymaking that "what we can expect from evidence – even at best – is a supporting role in the policy-making process" (Bedard & Ouimet, 2016, p. 2). Nonetheless, the rationalist perspective of this approach endures, despite decades of critical analyses (Russell, Greenhalgh, Byrne, & McDonnell, 2008).

The notion of evidence-based policymaking seems to be based on a number of assumptions about the objectivity of knowledge, the unproblematic separation of knowledge from those who generate it and those who use it, and the rationality of the decision-making process in policymaking (Greenhalgh & Wieringa, 2011; Sedlačko & Staroňová, 2015). In its purest form, evidence-based policymaking is a technocratic style of policymaking, bound up in (questionable) assumptions of positivism and what Greenhalgh and Russell (2009, p. 307) call "naïve rationalism": the idea that research evidence is value-free and context-neutral, and can offer solutions to most, if not all, policy problems. As such, resolving the ethical and moral dilemmas that policymakers face is posited as a case of finding the best evidence to determine the best course of action.

However, even advocates of evidence-based policymaking acknowledge that "evidence, in itself, even when valid and relevant, is hardly enough to justify a particular course of action … And, even when trying really hard, you are likely to face a lack of evidence to inform you on a given subject" (Bedard & Ouimet, 2016, p. 3). A broader range of methodological approaches have "made possible a shift from 'what works' to 'what is the nature of the problem,' 'why does it occur,' and 'how it might be addressed' (Nutley, Walter, & Davies, 2007, p. 13). However, while cause-and-effect knowledge might be applicable in the medical sciences, the possibility of achieving reliable causal knowledge of social processes for the purpose of designing societal interventions is being questioned (Deaton, 2009; Sanderson, 2000).

Precisely the methodological rigour that elevated scientific knowledge to its current position is part of its downfall – controlling variables and being able to specify causal factors do not have the same application in real-world contexts where there are multiple sources of influence (Head, 2010). In addition, the issues are complex and systemic, and there may be underlying value conflicts (Head, 2010).

There may also be a mismatch between the sort of information that researchers produce and its salience to policy decisions due, in part, to divergent timescales and priorities, and in part to the narrow focus of randomised controlled trials (RCTs) and systematic reviews on 'impact' (Jones, Jones, & Walsh, 2008). This limits what can be known about the effectiveness of interventions in the real world, unless pragmatic clinical trials are conducted, and is unlikely to provide conclusive evidence on how to prioritise issues or funding decisions, for example.

As previously discussed, much of the research on evidence-based policymaking has concerned itself with the (instrumental) use of knowledge to inform suitable policy solutions. This assumes not just the neutrality but also the stability and uniformity of evidence (Little, 2003). However, there may be multiple evidence-based solutions to every problem, as well as multiple ways of interpreting 'the evidence'. Furthermore, the evidence-based policymaking discourse tends to portray research findings as "stable, fully formed 'objects,' travelling from their point of production to their recipients in policy" (Sedlačko & Staroňová, 2015, p. 22). As such, a focus on evidence-based policymaking may overemphasise the role that scientific knowledge plays in policy decisions (Freeman, 2000), implying that if enough empirical research is conducted, the answers to all policy questions will be found. Challenges against this approach are based, in part, on the reductionist and acontextual nature of evidence, and in part on the paradox that the more that is discovered about social issues, the more apparent are the gaps and limitations in knowledge about these issues (Head, 2010).

Furthermore, research findings are often contradictory and inconsistent, thereby complicating policy choices rather than simplifying them and creating uncertainty where certainty is sought (Grundman & Stehr, 2012). If there ever comes a time when 'all the evidence is in', then this may "not be a time of certainty but one of conflict" (Little, 2003, p. 180). Researchers' recommendations tend to include a number of caveats, and are qualified with statements of uncertainty and risk, which is "in conflict with the need for quick and secure procurement of reliable information for policymaking purposes" (Jones et al., 2008, p. 90). This may be partly why some policymakers have suggested that while there is an abundance of evidence highlighting the scale of the problem ('what is'), "convincing approaches to solving the problem ('what is to be done') are often conspicuous in their absence" (Petticrew, Platt, McCollam, Wilson, & Thomas, 2008, p. 7).

The role of knowledge in policy, then, is more complex than drawing on available evidence to solve problems. Insofar as knowledge constructs or frames the very problems to be solved, it may also be employed for political uses, including establishing or contesting authority and control over policy choices (Bacchi, 2009; Daviter, 2015). There is therefore the possibility of the politicisation of science, where evidence may be manipulated for political gain, as well as the 'scientisation' of politics, where evidence

is used to justify political ends (Jones et al., 2008). Thus, the focus of evidence-based policymaking on what works risks disguising political agendas as science (Greenhalgh & Russell, 2009) and obscures the fact that even 'hard' science is socially constructed, portraying knowledge translation as a "politically neutral exercise in the transmission of facts" (Greenhalgh & Wieringa, 2011, p. 503). By camouflaging the political nature of policymaking in idioms of objectivity, neutrality, and rationality (Shore & Wright, 1997), the recourse to evidence "introduces a somewhat naïve and dangerous expectation of conclusiveness and impartiality" (Sedlačko & Staroňová, 2015, p. 17). It also ignores the fact that the 'gaps' that evidence is meant to fill are not voids, but "crowded spaces already filled with moral values and preconceptions" (Shore & Wright, 1997, p. 21), and that policy is shaped not just by information but by interests, ideology, and institutions (Weiss, 1999).

Questions around the contextual applicability of research evidence to society's 'wicked' problems – those that resist clear solutions (Head, 2010) – have also highlighted the role of values and uncertainty in policymaking. While all questions require evidence, Greenhalgh and Russell (2009, p. 310) argue that "an answer to the question 'what should we do?' will never be plucked cleanly from massed files of scientific evidence. Whose likely benefit is worth whose potential loss? These are questions about society's values, not about science's undiscovered secrets". Such questions about balancing one group's likely benefit against another group's likely loss are questions about society's values, and will never be answered by throwing more science at the problem. This suggests that policymaking may be less about a rational process of deciding between available options and more a process of debating between different value-based possibilities, values that themselves are contextually rooted.

Policymaking therefore involves making value-based choices between multiple options in setting priorities and allocating scarce resources (Parkhurst, 2016), a reality that the notion of evidence-based policymaking obscures. Parkhurst (2016, p. 19) suggests that the 'what works' language of evidence-based policymaking "confuses certainty of effect with desirability of outcome", failing to recognise that what works **here** might not work **there**. This is particularly important when it comes to clinical trials and the real-world applicability of these findings. While there is evidence from trials that task shifting in mental health care is effective, for example, there is little evidence that it works at scale due to capacity and resource constraints (Burgess, 2016; Eaton et al., 2011). This points to the importance of drawing on evidence that has relevance for the contexts in which evidence-based policy will be implemented. As will be discussed in the next section, there are a number of challenges in generating and using locally applicable evidence in developing countries, as well as in transferring evidence from global to local contexts, particularly with respect to mental health.

2.1.2.2 Moving from global to local

The problem of local evidence

An inadequate supply of locally-relevant evidence is argued to be one of the obstacles to evidence-informed policymaking in developing countries (Omar at al., 2010). For policymakers to prioritise mental health, they need to first be convinced that effective interventions for mental health exist, and that investing in such interventions is cost effective. Many LMICs, however, have insufficient data to guide policy decisions (Saxena & Maulik, 2003; Wang et al., 2007). The types of evidence available also tend to be limited to clinical interventions, which does not address how such interventions might be implemented effectively even as part of a well-functioning mental health system (Minas & Cohen, 2007; Omar et al., 2010; Saraceno, 2007; Swartz et al., 2004). In LMICs, it is particularly important that evidence of effective strategies gained through research is used to inform policy so that limited resources can be optimised (Araya, 2009; Mari et al., 2006; Ssengooba et al., 2011). However, the bulk of economic analysis about cost-effective mental health interventions has been conducted in high-income countries, and cost-effectiveness evidence translates poorly across different contexts (Khandelwal et al., 2010; Saxena et al., 2007). It is thus essential that locally appropriate evidence is generated for countries to find solutions to their own mental health problems (Ebrahim & Smith, 2001; Ndetei, 2008).

However, if resources for health care are limited, they are even more limited for health research, particularly in LMICs (Barsdorf, 2012; IJsselmuiden, Marais, Becerra-Posada, & Ghannem, 2012; Volmink, 2005). Mental health research has to compete for resources with other health research priorities (Araya, 2009) and, in general, mental health research and the infrastructure needed to support such research in LMICs are grossly inadequate (Mari et al., 2006; Saxena, Maulik, Sharan, Levay, & Saraceno, 2004). The limited capacity of health research systems in LMICs to generate the evidence needed to address health problems has been identified as a potential obstacle to the development and effective implementation of health policies (Lund et al., 2008; McDaid et al., 2008; Ngui et al., 2010; Omar et al., 2010). Despite widespread acceptance that mental health research is critical for effective service provision and policy planning, it is generally acknowledged that there are insufficient resources for mental health research in South Africa relative to the burden of mental illness (Chipps & Ramlall, 2012; Freeman, 2000; Razzouk et al., 2010).

In addition to gaps in mental health research capacity, there are also insufficient mechanisms, resources, and capacities for ensuring the effective translation of evidence to policy in South Africa (Cronin & Sadan, 2015; Naude et al., 2015; Senkubuge & Mayosi, 2012). Resources are required for all

stages of the policymaking process (Omar et al., 2010), including the uptake of evidence into policy (Young, Garner, Clarke, & Volmink, 2016); however, in many LMICs, there is limited capacity on both sides of this process. For a number of reasons, there is poor transfer of knowledge between the research and policy processes (Lund, Kleintjies et al., 2008; Pang et al., 2003), with the result that available evidence is under-utilised and has limited impact on policy (Aikins et al., 2010; Omar et al., 2010). Research and policy priorities are usually poorly integrated (Chipps & Ramlall, 2012), and there are poor linkages between researchers and policymakers (National Health Research Committee [NHRC], 2011). There is a need for researchers to understand the process of policy development and implementation, and to develop strategies for communicating with policymakers (Naude et al., 2015; Young et al., 2016). Similarly, there is a need for policymakers to understand the research process and the implications of research evidence, as well as to develop the expertise to utilise research outputs effectively (Lund, Kleintjes et al., 2008).

This section has highlighted systemic challenges with respect to producing locally relevant evidence as a result of capacity constraints in both the research and research-to-policy systems. In the absence of well-developed local information systems, mental health research infrastructure, and capacity for knowledge transfer in policymaking, policymakers in developing countries must find ways of integrating limited locally generated evidence with 'global' evidence. However, in the mental health field in particular, uncritical application of evidence from high-income country contexts is potentially problematic. Some of the challenges in moving from global to local knowledges in mental health are discussed next.

The problem of mental health evidence

Much of the evidence about the effectiveness of interventions has been generated in high-income countries, and the generalisability of such information from one context to another has been called into question (Patel et al., 2007; Saxena et al., 2007). For one thing, global research agendas and the funding behind them can perpetuate cultural biases and exclude socially disadvantaged groups (Crowther, Lipworth, & Kerridge, 2011). For another, "economic and political forces shape the production, interpretation, and impact of evidence" (Kirmayer & Pedersen, 2014, p. 768). In addition, what is understood as mental health globally versus locally is a matter of discourse and ideology, which frame how problems are seen and therefore addressed (Jakubec, 2004). Understanding the uptake of evidence into policy, then, is also a case of understanding how and why particular ways of thinking about, measuring, and intervening in mental health issues gain ascendancy in policy dialogues (Brock et al., 2001). Some of the tensions between global and local understandings of mental health are explored in

this section, focusing on the global mental health 'movement' and the issues it throws up around diagnosis, culture, and the medicalisation of mental health.

Around a decade ago, some of the international efforts to respond to the global burden of mental illness were drawn together under the umbrella of the global mental health movement (Horton, 2007; Lancet Global Mental Health Group, 2007; Patel et al., 2011). This movement is based on the notion that everyone with mental illness, anywhere in the world, deserves attention (Rinehart, 2016; Whitley, 2015) and was in part a response to the low priority that mental health had typically been given (Jacob et al., 2007). There is clearly great value in seeking to address the previously neglected issue of mental illness by drawing attention to a universally shared burden and the human rights implications of leaving this burden unaddressed. However, the global mental health movement has also been criticised on a number of grounds. The discussion that follows outlines some of these critiques in order to illuminate complexities inherent in notions of 'evidence-based knowledge' as it applies to mental health. These complexities contribute to the challenges facing policymakers in these settings, as they must navigate these tensions when integrating multiple knowledges into evidence-informed and locally relevant mental health policies. Three dimensions of the critiques against the global mental health movement – and, more broadly, the transfer of mental health evidence from global to local contexts – are described here: the medicalisation of mental health, assumptions underlying diagnostic classification systems, and the influence of culture on human experience.

Medicalisation refers to the way in which mental distress has come to be framed in medical or neurobiological terms, and the tendency to categorise and classify psychiatric disorder in disease-like terms (Kirschner, 2013). Medicalisation has, in one sense, been a way of destigmatising mental illness, framing it as a 'real' disease, as opposed to a moral or personal failing. This has, in part, been the mission of the global mental health movement (Clark, 2014). Some have argued, however, that this approach is at risk of biological reductionism, making explicit assumptions about the biological basis of mental illness. For one thing, there is still debate about the biological basis of some of these disorders, for example, post-traumatic stress disorder (Clark, 2014; Stein, Seedat, Iversen, & Wessely, 2007; Tribe, 2014). Critics also argue that the evidence base for biological causes of and treatments for mental illness is far from comprehensive and uncontested (Bentall, 2009; Fernando, 2012; Ingleby, 2014; Summerfield, 2012).

Another consequence of the biological focus inherent in the medicalised approach is that it risks masking the effects of the social determinants on mental health. It is well known that "a considerable amount of the social and mental suffering experienced in developing countries can be attributed to adverse social conditions, structural violence, poverty, war, famine and inequality" (Whitley, 2015, p.

289). A psychological response of distress under such circumstances might be considered a normal human response to abnormal conditions (Summerfield, 2008). As such, the global mental health movement is "perceived to be providing medical solutions to non-medical problems, thereby unwittingly acquiescing in the social status quo" (Whitley, 2015, p. 289). Furthermore, biomedicine and psychiatry are themselves cultural institutions and, as such, Kirmayer and Swartz (2014, p. 44) suggest that "the cultural institutions and practices that constitute local ways of life actually create and maintain the social arrangements that give rise to these social determinants in the first place". While the global mental health movement acknowledges the social determinants of mental illness, Fernando (2012) argues that the movement's main impetus is scaling up health care services using a Western biomedical model, with a notable lack of attention to culture and its relationship to mental health.

Asserting a biological basis of mental disorder also makes implicit assumptions about the universality of mental illness. This is problematic in part because disease categories are socially and historically constructed (Clark, 2014; Small, 2006). Social constructionists argue that the way in which diagnostic taxonomies such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) construct mental disorder effectively constructs normality, such that the 'disorder' largely lies within the individual, and other ways of being outside of the dominant psychiatric discourse remain unseen or unacceptable (Aho, 2008; Crowe, 2000). Because these classification systems originated within a Westernised framework, they tend to assert an individualised, rationalistic notion of 'normality', which can be seen as a form of cultural imperialism (Whitley, 2015). Despite widespread acceptance of the influence of culture on mental health, "in the search for generalisable knowledge, evidence on mental disorders tends to downplay or ignore cultural variations" (Kirmayer & Swartz, 2014, p. 53).

Fernando (2012) argues that the global mental health movement has also been a large driver of the research agenda, using the global burden of mental illness – based on Disability-Adjusted Life Years (DALYs) – to support advocacy for scaling up mental health care services. However, this perpetuates a more individualistic approach to disease, without taking into account that "community distress is greater than the sum of the distress of its individual members, particularly in collectivist cultures" (Fernando, 2012, p. 400). This points to another difficulty with transporting Westernised diagnostic concepts and treatment systems to other (cultural) contexts: differing notions of selfhood across cultures and the effects of this on human experience. While Western psychological theories tend to be individualistic in orientation, people in many non-Western cultures around the world have a more interpersonal worldview (Mpofu, 2002). Here, personhood is most often defined and experienced relationally (Bakhurst & Sypnowich, 1995; Guisinger & Blatt, 1994; Mkhize, 2004; Tangwa, 2000), such that the meaning of being ill is interpreted within a socially and culturally constituted frame of reference

(Kleinman, 1980; Petersen, 1998). The challenge, then, is to integrate 'mainstream' Westernised theories and treatment systems with non-Western indigenous systems (Hoppers, 2002; Mpofu, 2002). This, in turn, entails incorporating alternative forms of evidence that can account for the meaning and lived experience of mental illness. This is explored further below.

2.1.2.3 Moving from evidence to experience

Hierarchies of evidence, with RCTs as the gold standard, may seek to distinguish harmful from effective interventions, but they may also mask the fact that many other types of knowledge can, do, and should inform decisions (Bowen & Zwi, 2005; Davies, Nutley, & Walter, 2008; Venn, n.d.). In recent years, there have increasingly been calls for the evidence-based movement to expand its conception of what counts as reliable knowledge (Pope, 2003), which includes expanding the range of methodologies that might generate this knowledge (Hutchinson & Rogers, 2012). There is growing recognition, for example, of the value of both practical or professional knowledge about what works under what conditions, as well as the experiential knowledge of service users and ordinary citizens in informing policy decisions (Collins & Evans, 2002; Glasby & Beresford; 2006; Head, 2010; Rose et al., 2006).

This, in turn, has led to greater attention to qualitative research methodologies and acknowledgement that the objectivity so revered as a prerequisite for high quality research might be moderated by the practical and ethical benefits that proximity to the object being studied (a characteristic of feminist and participatory methodologies) might offer (Williams & Glasby, 2010). Parkhurst (2016, p. 29) argues that while the evidence hierarchy and RCTs are not inherently flawed, "they are being incorrectly applied … if they are used to prioritise policy choices". Indeed, even the knowledge generated by RCTs is probabilistic rather than absolute (Hutchinson & Rogers, 2012). Evidence that a particular treatment is efficacious does not provide an answer as to "whether such a treatment should be pursued in a particular setting" (Crowther et al., 2011, p. 869), nor whether it should be prioritised over other treatments, unless RCTs have been specifically designed for direct comparison. This suggests that no single research design can answer every question, and that there needs to be greater engagement between policymakers and researchers to ensure that appropriate research designs are matched with particular policy-relevant questions going beyond considerations of effectiveness (Bedard & Ouimet, 2016; Davies et al., 2008).

Furthermore, the use of RCT methodologies that privilege group-level outcomes over idiographic designs may be limited in their ability to account for the importance of individual experience and the meanings of health problems for those who live with them (Brosnan, 2016; Holmes et al., 2006; Pawson, 2006; Rose et al., 2006). In the mental health field in particular, the centrality of meaning and

experience is reflected in the shift from biomedical to recovery-based approaches, and from symptom reduction to living in a way that enables management of the condition in the context of an individual's ongoing life (Davidson, Drake, Schmutte, Dinzeo, & Andes-Hyman, 2009; Oades, 2011; Parker, 2014; Thomas, Bracken, & Timini, 2012). What this shares with the person-centred approaches that are also becoming characteristic of general health care (and mental health care in particular) (Storm & Edwards, 2013; WHO, 2008, 2016), is the shift away from the expert as sole authority on the best decisions; this locates the centre of authority somewhere more in the middle, where the voices of patients have greater space and weighting in decision-making. In research, too, narrative accounts can make the implicit and explicit experiential knowledge of mental health service users salient in a way that provides decision-makers with valuable information about health research priorities (Caron-Flinterman, Broerse, & Bunders, 2005).

This, in turn, implies that evidence as it is conventionally understood – as scientific knowledge, organised in a hierarchy of validity and quality – is only one component in evidence-based decision-making, whether that is at the level of treatment decisions or policy decisions. Glover (2005, p. 2) argues that a recovery-based principle is "just as relevant at the policy framework level as it is at the clinical coal face of service delivery", and this entails "examining, honouring and embracing [integrating] the knowledge base that principally informs recovery-based service delivery – the lived experience of those who have triumphed and struggled over mental illness". Experiential or situated knowledge, then, has value for its instrumental or informational role alongside the more technical, abstract evidence employed in policy (McDonough, 2001). This calls for alternative, more qualitative, methodologies based on interpretive and phenomenological approaches that can articulate the subjective experience of living with mental disorders (Aho, 2008; Kirschner, 2013; Petersen, 1998; Russo & Beresford, 2015).

Not only can experiential knowledge make important informative contributions to policy, the flexibility of this kind of evidence "at the boundary between science and its publics can offer opportunities for participation and engagement" (Moore & Stilgoe, 2009, p. 654). Roberts (2014) explores the relationship between evidence, engagement, and participation in policymaking. He asserts that consultation can serve the purpose of adding information to the evidence base informing policy. A second fundamental purpose of consultation is to allow for participation and representation of a wide range of views and experiences, which, in turn, requires balancing scientific evidence with experiential evidence. Roberts (2014) suggests that different kinds of competence, knowledge, and experience will be relevant at different stages of policy consultation.

Following this argument, knowledge does not have to be viewed in binary terms as expert evidence or lay experience. Rather, different individuals or groups bring different kinds of knowledge that has

relative value at different points in the policy development process. While not negating considerations of methodological quality which contribute to the robustness of evidence-based conclusions, Davies et al. (2008, p. 189) argue that "we cannot tighten our definitions of evidence to exclude that which is hard to assess or challenging to integrate … Such integration may require unlearning as part of the re-ordering of knowing".

2.1.3 Evidence-based policymaking: Conclusion

This section has presented an overview of evidence-based policymaking as a process of knowledge exchange between researchers and policymakers. In outlining knowledge-translation frameworks within the policymaking context, it has highlighted the complexity of this transfer process. In addition to the necessity of moving evidence-based knowledge across the research-policy interface, this discussion has also considered the complexity of the very nature of evidence itself. It has shown that evidence for mental health policy is contested in various ways, particularly as it moves from one context to another. Policymakers must integrate multiple knowledge inputs while balancing tensions between the abstract and the particular, between global and local, and between evidence and experience. In the end, they have to make practical decisions about what to prioritise and what to fund.

It should be clear from the above discussion that evidence-based policymaking is a complex process involving the weighing up of multiple factors. The challenge in moving towards a democratisation of knowledge (Jones et al., 2008) in policymaking is to shift focus from the bidirectional relationship between evidence and policy to an understanding of how many different forms of knowledge might be integrated to inform policy decisions. Governments are increasingly expected to implement effective policies as well as to meet the participatory mandate of democracy by involving citizens in the decision-making process (Kuruvilla & Dorstewitz, 2010). Reconciling the complex process of (scientific) knowledge generation with the complex process of public decision-making is no easy task. In addition, in determining policy priorities and solutions, policymakers are tasked with integrating research evidence, as one form of knowledge, with other knowledge forms. This is particularly evident as one moves from technocratic to democratic decision-making, in which public participation plays a key role. In the sections that follow, public participation in policymaking and its implications for the role of different forms of inputs in policymaking are discussed.

2.2 Consultative policymaking

Policy consultation is an important element of the policymaking process, which might be viewed from macro (governance), meso (policy development), or micro (participatory processes) perspectives. In this study, policy consultation is understood as a mechanism for public participation in policymaking. Framing consultative policymaking in this way foregrounds the tension between the democratic imperative to involve the public in policy decisions, and the technocratic imperative to formulate policies that are evidence based and effective. It also highlights the need to balance or integrate multiple knowledge inputs during policy development.

In this section, policy consultation is explored along a number of dimensions. First, it is contextualised within the broader field of public participation, in order to foreground the participatory elements of the process and understand the purposes for which policy consultation might be undertaken. The extent to which mandates for public participation in South Africa have been realised are briefly explored. The effectiveness of policy consultation approaches is then elaborated on, focusing on process and outcome criteria. The impact of policy consultation is one criterion against which effectiveness is assessed, and it is discussed in detail here as the influence of policy consultation on policy is a key component of the current study. Then, the role of knowledge in policy consultation is discussed. As the current study is concerned with how knowledge inputs are elicited, captured, and transferred through a policy consultation process, the challenges in achieving this in the context of mental health are presented.

2.2.1 Public participation in policymaking

Policy consultation is located within the broader context of public participation, although the terms have often been used interchangeably. The impetus for greater citizen engagement through participation represents a shift from representative democracy to participatory democracy, with participation lying somewhere between administrative fiat and direct democracy (Barnes, Knops, Newman, & Sullivan, 2004; Bishop & Davis, 2002). As such, public participation is considered to be a fundamental element of democracy (Briand, 2007; Mullen, Hughes, & Vincent-Jones, 2011; Roberts, 2004), based on the implicit assumption that more participation is better for democracy (Pratchett, 1999, in Catt & Murphy, 2003). Understanding the rationale for public participation in government decision-making, as well as the degree of public involvement, provides context for this study. In particular, the discussion in this section highlights that while participation might imply influence on decisions, it does not guarantee it. As such, exploring the processes and outcomes of public participation in policymaking can provide insight into how these factors impact on whether and how participants' contributions are used to inform policies.

2.2.1.1 Purposes of public participation

In terms of the democratic rationale, there are clear positive reasons for involving the public in government decision-making; there are also negative consequences to *not* involving them. Rowe and Frewer (2004) suggest that the shift towards greater public participation is linked to the decline in public confidence and trust in the people and processes through which policy decisions have traditionally been made. Similarly, it has been linked to calls for greater government transparency and accountability (Abelson & Gauvin, 2006; Organisation for Economic Cooperation and Development [OECD], 2010). Public participation, then, has the potential to build public trust (Grimmelikhuijsen, 2012; Wang & Wart, 2007). However, this implies that the rationale for conducting public participation may sometimes be more to pacify the public than to truly engage with their views (Buccus & Hicks, 2011; Rowe & Frewer, 2004), which, according to the International Association for Public Participation's (IAP) core values of participation, should be a fundamental element of authentic public participation (IAP2, 2007). These core values are outlined in Table 2.1.

Table 2.1: International Association for Public Participation core values of participation

1. The public should have a say in decisions about actions that could affect their lives.
2. Public participation includes the promise that the public's contribution will influence the decision.
3. Public participation promotes sustainable decisions by recognising and communicating the needs and interests of all participants, including decision-makers.
4. Public participation seeks out and facilitates the involvement of those potentially affected by or interested in a decision.
5. Public participation seeks input from participants in designing how they participate.
6. Public participation provides participants with the information they need to participate in a meaningful way.
7. Public participation communicates to participants how their input affected the decision.

Source: IAP2 (2007, p. 1)

Public participation has often been used interchangeably with other terms, including public engagement, public involvement, and public representation (Brackertz & Meredyth, 2009; Shipley & Utz, 2012). Similarly, the public has been widely defined – as citizens, consumers, users, lay persons, community members, patients, or practitioners (Conklin, Morris, & Nolte, 2012), as well as in individual or collective terms (Barnes, 2009). In this study, 'the public' will denote those affected by policy decisions, including providers and users of health care services. Public participation or involvement has

also been sought across a range of contexts, including policymaking, service planning, priority setting, and health care decision-making.

Bishop and Davis (2002) define participation as giving citizens a voice in policy choices. This definition has value in this study because 'having a voice' can be conceptualised as both a process and an outcome – citizens should be given the opportunity to reflect (use their voices) on policy choices, but their voices should also be reflected in policy choices. This is consistent with Pratchett's (1999, in Catt & Murphy, 2003) classification of public participation approaches according to how they enhance democracy. He identifies two dimensions of participation: representativeness and responsiveness. Representativeness concerns both opportunities for participation and how participants are equipped to participate meaningfully. Responsiveness is determined by the extent to which policymakers hear participants' views, as well as how explicit they are about the way these views were included in the final decision(s) (Pratchett, 1999, in Catt & Murphy, 2003). Both of these dimensions underpin the rationale for this study in terms of whether and how consultation spaces enable participation, and whether and how inputs in these spaces are used to inform policy.

Although understandings of public participation and corresponding methods of engagement vary widely, all approaches rely to a greater or lesser extent on an exchange of information between citizens and government (Rowe & Frewer, 2005). It is generally accepted, then, that in democratic societies the public has a right to be fully informed about both the decisions that affect them and the way in which those decisions are made (Rowe & Frewer, 2000). The extent to which the public is involved, however, and in particular, the extent to which their views are incorporated into these decisions, varies considerably. Approaches to public participation, based largely on degrees of public involvement, are outlined in the next section.

2.2.1.2 Approaches to public participation

When the public are invited to participate in an event such as the mental health policy consultation summit in South Africa, a number of assumptions around public inputs and influence are implicit in this process. These are explored here. Early approaches to public participation represented participation on a continuum of greater or lesser public involvement in government decision-making. These drew largely on Arnstein's (1969) influential ladder of participation, where the bottom rung denotes manipulation, and the top rung citizen control (see Figure 2.1). Arnstein's focus was thus on participation as a form of power exchange between citizens and government. She argued that any form of participation that did not involve transfer of control to citizens was merely token.

Along similar lines, Pateman (1970, in Bishop & Davis, 2002, pp. 17-18) distinguished between pseudo, partial and full participation, from "processes which offer the full comfort of voice without real substance, through to those rare instances in which each participant can influence the outcome". There is a value judgement in these continuum approaches, then, that is critical of tokenistic efforts at information exchange and suggests that active involvement of citizens in decision-making – even handing over decision-making control – represents optimal public participation.

Degrees of citizen power	**Citizen control**
	Delegated power
	Partnership
Degrees of tokenism	**Placation**
	Consultation
	Informing
Non-participation	**Therapy**
	Manipulation

Figure 2.1: Arnstein's (1969) ladder of citizen participation

Although the most influential, the continuum model is based on an assumption that the full range of participatory approaches are available to policymakers, when in reality this may be limited by the policy issue on the table, among other things (Bishop & Davis, 2002). Other approaches have put forward a more nuanced understanding of what type of participation approach might be most suitable for particular types of policy issues. For example, Thomas (1990, 1993) conceptualised participation as different forms of decision-making processes, with varying degrees of public input depending on the policy issue under consultation. These range from autonomous managerial decisions to segmented or unitary public consultation, to public decisions (Thomas, 1990). Similarly, Shand and Arnberg (1996, in Bishop & Davis, 2002) combined the continuum approach with linking particular participation models to particular policy problems. This continuum also ranges from minimum to maximum participation but, like Thomas's approach above, it is not hierarchical; the participation approach is explicitly linked to the objectives for seeking public input (see Figure 2.2).

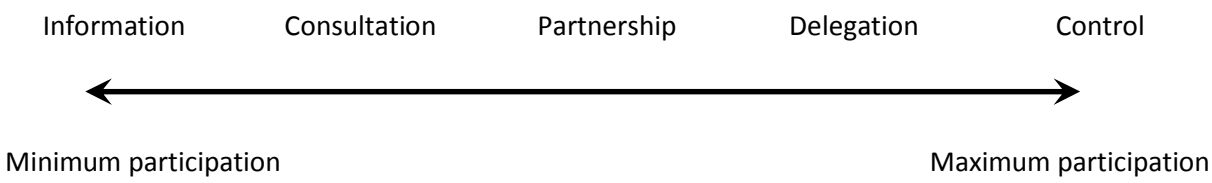


Figure 2.2: Shand and Arnberg's (1996, in Bishop & Davis, 2002) participation continuum

To varying degrees, participation in this model involves an exchange of information and an exchange of control. At the minimum participation end, policymakers seek information from the public to make a decision. Consultation, the next point along the continuum, involves more of a two-way exchange of information, but policymakers retain control over the decision. Partnership, in contrast, implies an exchange of information in a collaborative decision-making process. Delegation involves policymakers handing control over choosing policy options to citizens and/or citizen representatives. At the maximum participation end of the continuum, the public as a whole makes decisions directly. This represents direct democracy and is operationalised through referenda, for example.

The International Association for Public Participation (IAP2, n.d.) adopts a similar approach to classifying approaches to participation, linking these to particular participatory techniques or methods. This continuum also focuses on degrees of public involvement, but defines this specifically as impact. They explicitly link the approaches and methods to the goals towards which public input is sought, as shown in Table 2.2 below. Participation thus entails processes that inform, consult, involve, collaborate with, and/or empower citizens.

There are thus a number of different ways of approaching public participation in government decision-making. There are also several mechanisms for operationalising the objectives of public participation. Just as public participation lacks uniformity in definition and in purpose, *methods* of engagement also vary widely. What they do all seem to share is a starting point on the ladder of participation, as they all rely to a greater or lesser extent on an exchange of information (Rowe & Frewer, 2005). Although they may diverge on the degree of public involvement in the decision-making process, it is clear that the methods employed must be clearly linked to objectives if public participation is to be successful (Conklin et al., 2012; Florin & Dixon, 2004). Florin and Dixon (2004, p. 160) argue that "without this link, public involvement is unlikely to be translated into a decision that is representative of the public view or indeed meaningful". In addition to identifying clear objectives, decisions about public participation typically involve decisions about who should be involved, and how they should be involved, that is, in

what capacity, and through what mechanism. This may involve trade-offs between the breadth of involvement (inclusivity) and depth of involvement (quality) (Mullen et al., 2011).

Table 2.2: International Association for Public Participation public participation spectrum

Minimum public impact → Maximum public impact

Inform	**Consult**	**Involve**	**Collaborate**	**Empower**
Public participation goal	*Public participation goal*	*Public participation goal*	*Public participation goal*	*Public participation goal*
To provide the public with the balanced and objective information to assist them in understanding the problem, alternatives, opportunities, and/or solutions	To obtain public feedback on analysis, alternatives, and/or decisions	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered	To partner with the public in each aspect of the decision, including the development of alternatives and the identification of the preferred solution	To place final decision-making in the hands of the public
Promise to the public	*Promise to the public*	*Promise to the public*	*Promise to the public*	*Promise to the public*
We will keep you informed	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible	We will implement what you decide

Other dimensions along which methods might be selected include the location in which input is sought, the type of knowledge that the process of participation seeks to access, the degree of power sharing allowed for in participation opportunities, and the level at which change might be achieved (Barnes, 2009). Catt and Murphy (2003) suggest that if the purpose of participation is to gather information on public perspectives and preferences, then who is included in that process should be as wide-ranging as possible across the general public. In many cases, however, the rationale for public participation might require the inclusion of more specific types of interest groups, groups with particular types of expertise,

or marginalised or minority groups. This will involve the selection of methods from a different set of participatory techniques than in situations where the focus is on information-gathering. Common methods of public participation discussed in the literature (see, for example, Bishop & Davis, 2002; Catt & Murphy, 2003; Davis, 1996, in Davis, 1997; Degeling, Carter, & Rychetnik, 2015; Florin & Dixon, 2004; Shipley & Utz, 2012; Williamson & Fung, 2004) are identified in Table 2.3, which links particular methods with the broader approaches to public participation outlined by Shand and Arnberg (1996, in Bishop & Davis, 2002) and the IAP2 (n.d.).

Table 2.3: Participatory methods associated with different approaches to public participation

Public participation approach	**Participatory methods**
INFORM/INFORMATION	Public polling Surveys Public information campaigns Fact sheets Websites
CONSULT/CONSULTATION	Public comment/calls for submissions Interest group meetings Town hall meetings Focus groups Public meetings/public hearings
INVOLVE/PARTNERSHIP	Advisory committees Policy communities Workshops Citizens panels
COLLABORATE/DELEGATION	Impact assessment studies Consensus building/consensus conferences Collaborative forums
EMPOWER/CONTROL	Citizens juries Referenda Ballots

The next section will discuss public consultation in policymaking in more detail, as one approach to public participation.

2.2.1.3 Policy consultation as public participation

The above discussion implies that public participation is not a single procedure that is conducted for a singular purpose; there is a wide range of rationales and possible methods for engaging the public, depending on the degree of public participation desired. Policy consultation, the focus of this study, is one form of public participation. Shand and Arnberg's (1996, in Bishop & Davis, 2002) and the IAP2's

(n.d.) classifications of participation offer a useful means of locating policy consultation within the broader context of public participation. Like participation more generally, consultation involves an exchange between those who make policy and those affected by policy choices and, like participation, consultation occurs with varying degrees of involvement in policy decisions (Davis, 1997). As suggested by the definition of consultation in Shand and Arnberg's (1996, in Bishop & Davis, 2002) model, consultation is weighted more strongly on the information exchange side than on the power exchange side of public participation. Catt and Murphy (2003, p. 415) argue that "consultation, by definition, is not decision making" but go on to suggest that not all decision-making processes in a democracy need to involve a direct level of citizen involvement, as was proposed by Arnstein (1969). They suggest that in particularly technical or sensitive issues, only certain forms of consultation would be appropriate, and that meeting democratic ideals would simply require being transparent and accountable in the process.

This is supported by Kane and Bishop (2002) who assert that efforts at public consultation should never imply that the public's contributions will *determine* policy decisions. Importantly for this study, however, while it may be accepted that adopting a consultation model of participation leaves control over the decision with policymakers, there is nonetheless an assumption of reciprocity in the consultation process:

> It is predicated on an acceptance by policy makers that those being consulted have the capacity not only to comment, but to influence the final disposition of the policy proposal. Consultation collects voices and ensures they are heard when choices are made, but does not assume any fundamental shift in ultimate responsibility for the decision. (Bishop & Davis, 2002, p. 22).

These decisions will be determined by the purpose for which public input is sought at different points in the policymaking process. The purposes of policy consultation are explored next.

As mentioned in the first chapter, consulting the public on policy decisions can serve a number of purposes, reflecting principles of openness and transparency, legitimacy and accountability, and effectiveness and efficiency. While these are broadly aligned with democratic imperatives underlying public participation, the purposes of consultation may be at odds between policymakers and citizens (Jones & Newburn, 2001; Martin, 2009; Shipley & Utz, 2012). To some extent, this reflects a tension that often exists in consultation objectives between better responsiveness (increasing opportunities for participation and attending to citizens' perspectives), and better outcomes (improving the quality, acceptability, and legitimacy of decisions) (Barnes, 2009; Barnes, Newman, Knops, & Sullivan, 2003; Theron, Ceaser, & Davids, 2007). Martin (2009) suggests that this is a tension between democratic objectives that prioritise participation and technocratic objectives that focus on improving quality and effectiveness. Reasons for involving the public in policy decision-making, then, might be located

somewhere between these two objectives, although in practice, policy consultation might be undertaken to achieve a number of goals that combine both democratic and technocratic rationales.

Involving the public in policy and service planning, then, is seen as a (democratic) way of enabling those affected by these decisions to have a role in shaping them, as well as a way of being responsive to the needs of the individuals and communities that policies aim to serve (Florin & Dixon, 2004). This links to the notions of representativeness and responsiveness, outlined above, that underscore public participation (Pratchett, 1999, in Catt & Murphy, 2003). Thus, one goal of policy consultation is to elicit and incorporate public perspectives and preferences into government decision-making. Policy consultation may also be conducted to assess public opinion around particular issues, and to gain a better understanding of the needs of communities (Conklin et al., 2012). This, in turn, may improve the policy process by increasing the information or range of perspectives available to policymakers (Catt & Murphy, 2003). These goals position policymakers as recipients of information which they may incorporate into policies to a greater or lesser degree. The policy consultation process can also be a mechanism for channelling information from policymakers to the public, that is, using consultation to educate or inform the public around particular policy decisions (Jones & Newburn, 2001), or perhaps to persuade the public on certain issues (Walters, Aydelotte, & Miller, 2000) and thereby reduce conflict (Beierle, 1998).

Policy consultation might also serve the purpose of raising the profile of particular issues and demonstrating government's commitment to addressing them, as well as signalling a broader commitment to public accountability (Arnstein, 1969; Barnes et al., 2004). As such, one of the objectives of engaging in policy consultation would be to build public trust (Beierle, 1998; Wang & Wart, 2007). Following on this, consultation can also be used to legitimate policy decisions (Barnes et al., 2003; Walters et al., 2000), as well as to enhance the perceived legitimacy and integrity of public institutions (Martin, 2009; Wang & Wart, 2007). Policy consultation may also be used as a means of garnering public support for policy decisions that have already been made – what has been referred to as "choreographed public consultation, aimed at achieving predetermined goals" (Cheeseman & Smith, 2001, p. 84). There is an inherent risk in this, however, that if policy consultation is conducted without incorporating into policy any of the input it gathers, it may simply serve to "provide policymaking with a veneer of legitimacy" (Burall, 2012) and prove counterproductive to its democratic goals, leaving the public feeling angry, frustrated, and betrayed (Manor, 2004; Motala et al., 2016; Theron et al., 2007).

Engaging in authentic consultation, on the other hand, can promote public support and cooperation around implementation (Clapper, 1996; Jones & Newburn, 2001). It can also increase the effectiveness of the policy and its implementation by enhancing citizen ownership over consultation outcomes and by

adapting the policy, based on essential information that would not be available without consultation (Arnstein, 1969; Beierle, 1998; Cronin & Sadan, 2015). By extension, policy consultation can enhance policy implementation by involving key stakeholder groups on whom successful implementation of policies at local levels may depend (Irvin & Stansbury, 2004; McGee & Norton, 2000; Piper & von Lieres, 2008).

The objectives outlined so far speak to the value of policy consultation as a means to particular ends. From another perspective, policy consultation may be seen as a valuable end in itself. Arguments for the intrinsic value of consultation focus on its potential for creating a more informed, empowered, and active citizenry, which is considered a cornerstone of better democracy (Barnes, 2009; Conklin et al., 2012), particularly when consultation includes the voices of those who have previously "gone unheard or been actively silenced" (Barnes et al., 2004, p. 93). One of the challenges to optimising these intrinsic benefits, however, lies in reconciling goals of inclusivity with goals of efficiency.

This tension was alluded to earlier in this discussion. Cook (2002) argues, for example, that the empowerment rationale conflicts with the shift in policymaking towards evidence-based objectives, which imply a narrowing of decision-making to particular (expert) inputs. Nonetheless, there is a general expectation that consultation should, at the very least, provide feedback to participants about the process, including the "results of the exercise, the action that was taken as a result and, if the action they recommended was not taken, reasons why not" (Cook, 2002, p. 528). Similarly, Kane and Bishop (2002) assert that participants want to feel as though their views have been genuinely considered, regardless of whether these views were incorporated into the final decision.

It is reasonable to assume, then, that the extent to which participants in and organisers of consultation processes might differ in terms of their expectations about the process is also likely to affect the extent to which they deem the process to have been successful. As the above discussion has demonstrated, the objectives underlying policy consultation will determine, among other things, who is consulted and how they should be consulted. The availability of options for achieving these objectives will also to some extent depend on the political system within which public input is sought. In the following section, approaches to public participation in South Africa will be briefly outlined.

2.2.2 Public participation in South Africa

The current study is concerned with a policy consultation process within a South African setting. To contextualise this, this section outlines some of the formalised approaches taken by government to public participation in South Africa, as well as some issues with its implementation. There are, of course,

a number of means by which the public (broadly defined) might engage with or influence government decision-making, ranging from top-down "invited spaces" such as national elections or ward committees, to bottom-up "invented spaces" such as mass demonstrations and protests (Cornwall, 2002, p. 17). These are comprehensively covered elsewhere (e.g. Buccus, Hemson, Hicks, & Piper, 2008; Funke, Nienaber, & Henwood, 2011). This section will provide a brief overview of the extent to which legislative mandates around public participation in South Africa have been realised in practice.

South Africa, a representative democracy, has followed international trends in terms of showing increased government and public attention to public participation in recent years (Buccus et al., 2008). There are constitutional and statutory mandates for public participation at various levels of governance, as principles of participatory democracy are espoused in South Africa's constitution (Republic of South Africa, 1996). In parliament, the nine provincial legislatures are constitutionally required to elicit public participation in decision-making and policy processes (Buccus & Hicks, 2011; Nyalunga, 2006), with a number of provinces developing guidelines and programmes to put this into effect (Buccus et al., 2008). In addition, the National Policy Framework for Public Participation (Department of Provincial and Local Government, South Africa, 2007) outlines the rationale for public participation and offers standardised guidance for local government regarding community participation in decision-making.

These legislative mandates notwithstanding, there is increasing recognition that insufficient attention has been paid to mechanisms for public participation at various levels of governance in South Africa (Buccus et al., 2008). This is especially so at provincial and national levels (Buccus et al., 2008). In many spheres of government, such as health and social welfare, public service planning and delivery is decentralised (McIntyre & Klugman, 2003). As such, local government is required to institute formal mechanisms for promoting citizen participation in service delivery planning and implementation, including, for example Integrated Development Plans, *imbizo* (traditional forums), ward committees and public hearings (Buccus et al., 2008; Motala et al., 2016; Mubangizi & Gray, 2011). These have been implemented at local levels with varying degrees of success (Mbuyisa, 2013; Piper & von Lieres, 2008; Smith, 2011).

The general expectations of participatory processes in South Africa seem to follow global trends, that participation should attend to the "experiential and grounded perspectives" of the public (Sebola, 2016, p. 57), and that such participation should have demonstrable results, which, in turn, requires that there is adequate follow-through after public events (Buccus et al., 2008). In practice, however, Buccus et al. (2008, pp. 300-301) assert that "public participation is limited to forms of consultation, usually around needs, rather than any real empowerment in political decision-making", and that "invited spaces for public consultation (have) largely been ceremonial and without bearing on the urgent issues of the

moment". These and other authors highlight that the political will for public participation in South Africa is not reflected in its implementation, with many consultation exercises used as endorsements for pre-determined decisions, without meaningful deliberation, follow-up, or change (Theron et al., 2007). There are indications that this may be, in part, because of "time pressures, resource constraints, and capacity limitations" (Fortin, 2009, p. 11). It may also partly be because the formulation of most policy processes at the national level removes them from the provincial and local administrative structures tasked with implementing them, as well as from the communities who might participate in them (Buccus & Hicks, 2011).

In national policymaking in particular, there are also indications that the ruling political party is moving towards greater centralisation of powers, and that there is a tendency to minimise public participation when controversial policies are formulated (Funke et al., 2011). In the context of South Africa's decentralised health system, this is particularly problematic. There is evidence to suggest that provincial and district-level planners and managers are not sufficiently involved in health policy development, which creates a disjuncture between "policymaking authority of higher levels of government and the implementation capacity of service provision levels" (McIntyre & Klugman, 2003, p. 108). The implementation gap between top-down consultation on national policies and the mandate for implementation at provincial levels in South Africa has been well documented (Brynard, 2007; Buccus & Hicks, 2011; Burgess, 2016) and mirrors global trends discussed above.

Other research has also exposed a number of common practices that have left participants in such processes feeling excluded and disempowered, as well as having insufficient opportunities to participate meaningfully in policymaking processes. These include not receiving feedback, not seeing recommendations being taken up or having noticeable impact, feeling co-opted into processes which already had pre-determined outcomes, and only being asked for input at late stages of policy formulation, suggesting that consultation was merely to secure political buy-in (Buccus & Hicks, 2011; Ditlopo, Blaauw, Penn-Kekana, & Rispel, 2014; McIntyre & Klugman, 2003; Scott, 2009; Walker & Gilson, 2004). Even in instances where efforts have been made to engage in more deliberative participatory processes, success has been limited, with evidence that protest and litigation might be more effective than discourse at influencing policy change (Baccaro & Papadakis, 2008). There is thus clear divergence between the goals of public participation and its effects in practice in the South African context, and a need to identify means and mechanisms through which public inputs might have a meaningful impact on policy decisions.

Clarifying objectives upfront will also communicate to all involved what is (and can be) expected in both process and outcome terms. Success or failure might then be assessed on the degree to which these

objectives were met. As will be seen in the discussion below, evaluating effectiveness might also be influenced by whether the focus is on the process or the outcome of the consultation.

2.2.3 'Effectiveness' of policy consultation: Process, outcomes, and impact

As mentioned previously, whether policy consultation is effective or not depends to some extent on what the objectives were for consulting – in other words, what it will be measured against. This again points to the importance of clarifying these objectives upfront. Indeed, being clear about the purpose of consultation might be seen as an indicator of effectiveness in and of itself (Kane & Bishop, 2002). Policymakers and public participants may also have different expectations regarding the consultation activity and, therefore, different ideas about what would be considered a 'successful' process. Despite a growing body of evaluation studies and the importance of ensuring that policy consultation has an impact (however defined), there still seems to be little clarity regarding how to assess this. This section will focus on the criteria that have typically been used in evaluating public participation, followed by more detailed consideration of outcome criteria and, in particular, how the influence of policy consultation on policy decisions might be determined. Throughout this section, consultation is used interchangeably with engagement, participation, and involvement, although it is acknowledged that each of these may imply different degrees of involvement (and indeed of influence on the decision-making process).

In general, effectiveness of public consultation has been assessed along two main dimensions – process and outcome. In their comprehensive review of studies that evaluated public participation exercises, Rowe and Frewer (2004) noted that most of the studies listed outcome criteria, while about half identified both process and outcome criteria. Few studies focused only on process. Some have suggested that if a process is considered fair, the outcome will also be perceived as being fair and, similarly, if the outcome is considered acceptable, the process employed in reaching that outcome will be assumed to have been a good process – such that evaluating one may be seen as a good enough surrogate for evaluating the other (Gross, 2007; Lauber & Knuth, 1999; Rowe & Frewer, 2004). Others have argued that participation can only be deemed authentic if attention is paid to both process and outcome, and that both should therefore be included in evaluative work (King, Feltey, & O'Neill Sussel, 1998). Nonetheless, the policy consultation evaluation literature has tended to focus on one or the other element. In the discussion that follows, it is worth noting inputs to policy consultation processes have tended to be subsumed in reviews of both process-related and outcome-related factors. The relative neglect of the importance of (knowledge) inputs to such processes is a central premise of this thesis and one of the gaps that this study aimed to address.

2.2.3.1 Assessing process

Abelson and Gauvin (2006) reviewed articles that had conducted scoping or systematic reviews of public participation evaluation studies. They found that "process matters, and that different types of public participation processes should be designed for different types of issues, decision-making conditions, and groups of participants" (Abelson & Gauvin, 2006, p. 19). Even in instances where decision outcomes are contested, these are more likely to be accepted if the procedures followed in reaching these decisions are perceived favourably (Beierle & Cayford, 2002, in Abelson & Gauvin, 2006). This highlights the importance of attending to process in public consultation. Research focusing on process evaluations has identified a number of criteria linked to successful public participation, while recognising that contextual and environmental factors will interact with process and thereby influence effectiveness (Abelson et al., 2004; Rowe & Frewer, 2000). These criteria are listed in Table 2.4.

Table 2.4: Criteria for evaluating participation *process*

Representativeness	Fairness	Competence
Early involvement	Process flexibility	Human resources
Inclusivity	Resource/information accessibility	Material resources
Continuity of participation	Openness of process	Task definition
Comfort	Transparency	Adequate time
Satisfaction	Neutrality	Structured decision-making
Convenience	Independence	Effective methods
Clear communication about purpose	Feedback	Legitimacy
Incorporation of values/beliefs into discussion	Identifiable links between process and decision outcome	Interaction
Consideration of participants' knowledge	Accountability	Deliberation
		Identification of common good

Adapted from Abelson et al. (2004); Abelson & Gauvin (2006); Brown (2014); Rowe & Frewer (2000, 2004).

In some cases, authors have sought to classify evaluation criteria into overarching categories linked to different aspects of the process. These can be roughly differentiated according to the fairness or acceptability of the process, and to procedural proficiencies that enhance effective decision-making. Webler (1995) defined the former as fairness and the latter as competence; others have distinguished these as acceptance criteria and process criteria (Brown, 2014; Rowe & Frewer, 2000). These each speak to different dimensions of the rationale for public participation – fairness to the democratic rationale, and competence/procedural effectiveness to the technocratic rationale. This is consistent with Barnes' (2009, p. 62) assertion that "evaluation questions need to incorporate the pragmatic concerns of those who want to improve the practice of citizen participation, as well as a broader and more theoretical

purpose in understanding what such developments mean for the relationship between state and citizens".

A number of these elements are worth briefly elaborating on in the context of the current study. The importance of processes that are inclusive, representative, and fair has particular relevance in the context of policy consultation in mental health. These concepts are explored further in later discussions around increasing the legitimacy of inputs to mental health policy consultation. The chosen format or technique of consultation is also likely to affect opportunities for participants not just to speak and be heard, but also the extent to which their inputs are likely to influence final decisions. Public meetings, for example, have been largely ineffectual in influencing policy decisions, while more deliberative methods such as focus groups and citizen juries have more potential in this regard (Shipley & Utz, 2011). It is therefore essential to attend to consultation methods in terms of how these might enable or constrain interaction between participants and engagement with the policy proposals on the table (Catt & Murphy, 2003). However, Shipley and Utz (2011, p. 8) argue that "a good deal of theoretical writing does not make a distinction among methods, inferring in some ways that consultation is a single entity rather than a broad range of techniques".

The format and organisational structure of the consultation method chosen will both influence and be influenced by considerations regarding time allowed, ways in which inputs are elicited, the opportunity for interaction and deliberation, and the means through which contributions will be recorded. Giving due consideration to participants' knowledge requires skilful facilitation, adequate time, and creative tools for both eliciting and capturing knowledge inputs (Gramberger, 2001; Shipley & Utz, 2011). More interactive forms of consultation are therefore likely to be more resource intensive, but are more likely to reach the goals of participation as a genuine dialogue around policy (Cook, 2002).

Horlick-Jones, Rowe, and Walls (2007, p. 261) argue that despite widespread recognition of the need to integrate multiple types of knowledge inputs in citizen engagement, and the importance of managing information, knowledge, and communication in the effectiveness of such processes, little work has "considered closely the overall management of information and knowledge during such exercises". There are two immediate implications of this. The first is the importance of facilitation, but in particular, the ways in which knowledge is managed and integrated through the process. Knowledge brokering has arisen in response to the need for systematic management of knowledge across different interfaces in policymaking (Ward et al., 2009). Knowledge brokers or intermediaries can, in turn, use tools like boundary objects – maps, pictures, models, reports, and so on – that span boundaries across bodies of knowledge (Jones et al., 2012). Boundary objects have been found to be of particular value in

integrating different viewpoints and improving the use of citizen and other types of knowledge inputs in policy (Jones et al., 2012). This concept is explored in more detail in later sections.

The second implication of the need for management of information and knowledge during policy consultation is linked to a number of other process criteria listed above: transparency, feedback, accountability, and ensuring identifiable links between process and decision outcomes. Understandably, those consulted would want to know that their time and energy have been worthwhile. As such, they are entitled to receive feedback on the results of the consultation, and the reason that action is either taken or not taken as a result of public inputs (Cook, 2002). Petts (2008, p. 830) argues that while it is not always possible to determine tangible effects on decisions, it should "at least be clear to the public which elements of the debate they have been involved in have been taken on board in the decision, and which elements have not and (most importantly), the reasons why this is the case". This is linked to the manner in which inputs are recorded and incorporated into final policy decisions, which is explored further in the section below.

2.2.3.2 Assessing outcomes

Outcome criteria identified across a number of studies are listed in Table 2.5. Many of the studies reviewed by Rowe and Frewer (2004) stated impact or influence as one of the outcome criteria for assessing effectiveness. However, this impact has been variably defined and measured. Evaluation studies that have focused on outcome have tended to focus more on the impact of the process on participants (rather than on the impact on organisers /policymakers), on the policy decision, and on policymaking more generally (Abelson & Gauvin, 2006; Conklin et al., 2012). This may in part be because of the difficulties inherent in assessing outcomes of public participation, and in part because, while these effects are highly context dependent, context is seldom assessed in evaluation studies (Abelson & Gauvin, 2006).

Abelson and Gauvin (2006) and Rowe and Frewer (2004) outline a number of challenges in assessing outcome, including how and when to define the endpoint of an outcome (e.g. at the end of a participation exercise, or through to policy implementation), how long impacts would have to last in order to be considered effective, and difficulties teasing out the impact of the participation process from other influential variables. The latter is also linked to challenges in tracking government decision-making processes and identifying the specific influence of participation recommendations which, as discussed above, requires mechanisms for recording and reporting on the consultation process. It is perhaps not surprising, then, that "robust evidence of the impact of public involvement remains scarce" (Conklin et al., 2012, p. 159), despite attempts to distinguish between short-term outputs (resulting directly from

the participation process), and longer-term outcomes (relating more to the rationale for involving the public in political decision-making) (Brown, 2014).

Table 2.5: Criteria for evaluating participation *outcomes*

Policy or decision influence Interaction with lay knowledge Time to develop regulations Responsiveness to participants' recommendations Public views incorporated into decision-making Specific changes to policy and practice Compatibility of participation recommendations and policy decisions	Participant satisfaction Improved/restored trust Increased knowledge and understanding Impact on general thinking Participants' values/opinions changed Increased self-efficacy Improved capacity for political engagement/activity Increased civic engagement Individual empowerment Social impact Cohesive community identity Social connectedness	Effect on staff and planning process Staff awareness Impact on training/learning Improved decision-making Relationship/network building Conflict resolution Cost effectiveness

Adapted from Abelson and Gauvin (2006); Conklin et al. (2012); Rowe and Frewer (2004).

A number of these elements are linked to the process of knowledge management mentioned in the section above. In particular, i) policy or decision influence, ii) responsiveness to participants' recommendations, iii) incorporation of public views into decision-making, iv) specific changes to policy and practice, and iv) compatibility of participation recommendations and policy decisions all depend to some extent on the mechanisms for recording and reporting on consultation inputs. This, in turn, links to record keeping and access to information regarding public participation in policy decisions, including information about how these decisions were made. As Mendizabel (2013, p. 8) argues:

> bad decisions we can live with – it's part of the democratic process; but bad decision-making processes are unacceptable. And worse still is keeping these decision-making processes out of sight. How else can the citizens of a country hold their politicians and civil servants to account if influence happens behind closed doors and policy is discussed in terms that exclude the majority of the population?

It is also important, therefore, to "have a paper trail regarding how these decisions were made and how the public was consulted" (Marais, Quayle, & Burns, 2017, p. 40). As will be seen in this study, there is an absence of policies or guidelines in South Africa regarding "how consultation processes should be recorded, what forms these records need to take … and how access to such records should be managed" (Marais et al., 2017, p. 41). This is likely to impede efforts to determine how consultation inputs were incorporated into policy decisions.

There is another important outcome of policy consultation, however, that is not linked to decision influence. This relates to the impact of the process on participants themselves. While the emphasis above is on how knowledge moves through the process in documented form, knowledge interactions between participants at such events also facilitate knowledge transfer between individuals. Not only does this imply that participants emerge from the process with new or different knowledge (Smith-Merry, 2012), it also has the potential for a number of positive outcomes for individual participants, such as increased empowerment, social connectedness, self-efficacy, and civic engagement. The value of such outcomes for mental health care users in particular is discussed later in this section (see, for example, Kleintjes, 2012; Restall, 2013). This speaks to the performative value of consultation in itself (Hajer, 2005; Turnhout, van Bommel, & Aarts, 2010). It also highlights that participants are likely to have diverse experiences of consultation, which, in turn, will affect their perceptions of the effectiveness of the process (Abelson & Gauvin, 2006; McCluskey, Deshpande, Shah, & McLeod, 2004; Rowe & Frewe, 2000; Webler, Tuler, & Krueger, 2001).

Common to many studies on participants' perspectives of effectiveness seems to be participants' desire to know that their input is being used in some (tangible) way to inform policy decisions, as opposed to merely legitimating pre-determined outcomes. Indeed, some studies have identified degree of public influence on decisions as *the* indicator of effectiveness in public participation (Boivin et al., 2014). In Restall and Strutt's (2008) study of mental health care users' perspectives on meaningful engagement, for example, activities that participants perceived to be more strongly weighted towards information exchange than collaborative decision-making were seen, at best, as a waste of time and, at worst, as exploitation. Participation therefore also has the potential to have negative impacts, such as a sense of dissatisfaction and frustration among participants, and decreased trust in government institutions (Licht, 2011). This could particularly be the case where participants feel they are not being heard, or their opinions are not taken into account in the final decisions.

Many have argued that authentic participation in policy processes should allow for citizens to have an impact on policy decisions (King et al., 1998; Morrison & Dearden, 2013). Lauber and Knuth (1999) demonstrated that the degree of influence that participants had over final policy decisions was strongly linked to their perceptions of fairness, while McCluskey et al. (2004) found that citizens' perceived ability to influence policy decisions was strongly linked to the likelihood that they would participate in political decision-making processes. This is also true for those who are expected to implement policy decisions, although there is evidence to suggest that in many cases, these role players are simply expected to passively comply with "policy decisions that they have not had any significant role in shaping, [and] which do not draw on their understanding and experience or their perceived needs"

(Cronin & Sadan, 2015, p. 7). Similarly, others have shown that participatory processes "fall far short of their promise to give people a say and some control over policies and practices that affect their lives" (Aronson, 1993, p. 368). Public participation is frequently only invited after policy decisions have been made, so that "only superficial changes are made as a result of public input" (Wang & Wart, 2007, p. 267).

This again highlights the problem with assuming that good process results in good outcomes because eventually "someone in a position of influence will make a decision about whether or not to incorporate the public's input into the public policy process, regardless of whether or not the processes was deemed to be good or bad" (Abelson & Gauvin, 2006, pp. 13-14). Even in cases where an explicit objective of public consultation has been to achieve actual influence on decisions, success has appeared to be marginal (Conklin et al., 2012). As the focus of the current study is on tracing the movement of knowledge through a consultation process to assess how these inputs informed policy, it is worth exploring the notion of policy impact in more detail.

2.2.3.3 Assessing impact on policy decisions

The discussion above highlighted that impact on policy decisions is considered by public participants in particular to be an important indicator of effectiveness. Effectiveness might be achieved, in part, by designing processes in such a way as to optimise follow-through and uptake of recommendations. However, there are significant challenges in determining whether and how policy consultation recommendations have been used, and in identifying what aspects of the process might increase the likelihood of influence. Missing from many evaluation approaches to public participation is an assessment of the circumstances under which consultation inputs are or are not used in the final decision-making process (Emery et al., 2014). Emery et al. (2014) suggest that it is therefore difficult to discern whether lack of evidence of impact is a result of genuine lack of impact, or of inadequate measures to assess impact. The notion of impact is unpacked further in this section.

Part of the difficulty with assessing influence of consultation on policy may stem from lack of clarity about what *using* public inputs actually means, which limits attempts to identify how this occurs. Li et al. (2015) explored the concept of *use* as it pertained to government-initiated public consultation processes, and identified a number of other terms that have been employed interchangeably with *use* in relation to the impact of public participation on public policies: *influenced*, *incorporated*, *considered*, *factored in*, and *taken into account*. Participants in their study had problems with the term *use* in its potential to create false impressions regarding the degree of impact of public inputs on policy decisions and to suggest that it is the driving force in policy decision-making. *Influence* was perceived to be closely

connected with *use* and its resultant connotations; it was also linked to empowerment in its implication that participants have the power to produce effects on both policymakers and policy decisions.

Problems with the concepts of *use*, *influence*, and *impact* have also been noted in other studies. Joly and Kaufmann (2008), for example, proposed using the notion of *policy resonance*, as opposed to *impact*; they assert that this is more consistent with the non-linearity of public participation in policymaking in that it suggests the possibility of influence rather than a tangible and measurable impact. Even where public participation appears to have had an influence, it may simply have confirmed what policymakers were already going to do (Abelson & Gauvin, 2006). This highlights a further difficulty with assessing decision impact: determining how public participation inputs have been integrated with other forms of policy information, evidence, and inputs (Emery et al., 2014; Li et al., 2015). This tension is a key factor underlying the rationale for the current study.

Nonetheless, it would still be useful to identify what factors might increase the *likelihood* of influence, and a number of studies have attempted to do so. Boivin et al. (2014) conducted the first randomised trial of collective priority setting for health care improvement, with and without public involvement. They found that decisions made with public involvement differed significantly from those made by (policy) professionals alone. They explored components of the participatory process which might explain the variations in public influence. These included participants' "ability to display rational arguments, their use of collective speech strategies, and the establishment of strategic alliances with professionals" (Boivin et al., 2014, p. 336). They also found that an experienced, objective moderator who attended more to process than to content was more effective in eliciting public views than one who held multiple roles, for example, as moderator and participant.

Li et al. (2015) considered the issue from a slightly different angle, exploring how *use* of public inputs in policy decisions might be determined. They identified three factors that seemed to be indicative of *use.* Firstly, willingness to listen was a signal to participants of intent to use, as well as of a potential openness to change as a result of public inputs. Genuine listening as a precursor to *use* was an important dimension in avoiding falling into the trap of using public involvement simply as a symbolic gesture to rubber-stamp predetermined decisions. The second factor was the involvement of mediating bodies that could facilitate the exchange of ideas between public and policymaker, as well as translate public inputs into forms that would make them amenable to policymakers. This relates to the concept of knowledge brokering mentioned earlier. The third element was some form of response or feedback to the public regarding whether (and how) their recommendations were incorporated or acted on, in other words, a transparency and accountability dimension. Although the nature of this response varied considerably, all approaches included some form of reporting back to the public which, in turn, required

some form of tracking of public inputs through the decision-making process. The importance of recording and reporting on these processes was also highlighted in discussions regarding outcome criteria above.

A number of factors that seemed to increase the likelihood of impact were also identified by Emery et al. (2014). These included: i) linking local-level engagement to local policy impact; ii) skilled facilitation; iii) explicit integration of the participatory exercise into the policymaking process through, for example, the direct engagement of policymakers in the activity; iv) timing the activity to coincide "with a relatively short window in which information is assessed in advance of a policy decision" (Emery et al., 2014, p. 16); and v) forging relationships through informal interactions as a mechanism for being listened to – "capturing hearts and minds rather than putting something on the agenda" (Emery et al., 2014, p. 14). This latter point highlights the critical role of individual policymakers in what might get followed through into policy decisions.

Emery et al. (2014) found, for example, that impact was not only strongly dependent on those who made the ultimate decisions regarding what information should be used. The perceived credibility (in the eyes of these policymakers) of the chosen participatory approach also seemed to affect impact. In addition, the way in which inputs were framed influenced the extent to which they received attention. This suggests that what policymakers perceive as legitimate (or not legitimate) in terms of both process and content may affect the likelihood that policy consultation recommendations are used to inform policy. Other studies have demonstrated similar effects (Aronson, 1993; Boivin et al., 2014). Participants may frame their inputs in ways that differ from the language of policymakers and policymaking. As such, there tends to be an expectation that participants need to turn their experiential knowledge into concrete proposals or suggestions in order to be heard. Findings from Aronson's (1993, p. 371) study showed that this put "the onus on consultation participants to translate their experiences out of everyday terms and into actionable, bureaucratic vocabulary – from the terms of their unique perspectives to the terms of service delivery", which had a direct influence on the extent to which participants influenced policy decisions.

This suggests that one reason that the influence of consultation inputs on policy decisions is hard to ascertain is that such inputs may come in a form that is difficult to translate into policy (Smith-Merry, 2012), which affects their perceived legitimacy. In addition, Barnes et al. (2003, p. 380) argue that "different forms of participation create very different circumstances and opportunities for people to take part"; this highlights the importance of attending to process in order to optimise the potential for inputs to be heard and perhaps used. Towards this end, Harvey (2009) launched a critique of (quantitative) attempts to operationalise evaluation of public participation in policymaking in terms of

technical criteria, arguing that this goes against the very rationale driving greater participation, that is, as a move against the "scientization of the policy process" (Harvey, 2009, p. 146). He argues that this technocratic approach has, ironically, come to dominate the participation evaluation literature, such that this has the potential to exclude and alienate participants in the process, as well as the knowledge they bring.

These criticisms highlight that public participation processes may constrain or enable particular forms of input which, in turn, may affect the perceived legitimacy of consultation outcomes. This is also likely to influence whether the process and/or outcomes are considered effective by different role players in the process. As this section has shown so far, assessments of public participation's success or failure depend to some extent on the rationale for engaging the public in policymaking. If, for example, it is to achieve democratic objectives of greater participation by citizens in government decision-making, success may be evaluated according to how fair and inclusive the process was. Common to many of these objectives, and the methods employed to operationalise them, is the importance of transparency in whether and how inputs to policy consultation are used. As such, policy consultation might be conceptualised as an exercise in knowledge management, both in terms of explicit, process elements, as well as in terms of recognising and enabling different kinds of knowledge contributions. This is explored further in the next section.

2.2.4 Policy consultation as a knowledge management process

This study is primarily concerned with how knowledge moves through policy consultation processes in order to at least have the *potential* for influence on policy, as discussed above. This underscores the importance of knowledge 'management' in policy consultation, which includes attending to how knowledge contributions might be elicited, captured, and transferred during such processes. The challenge facing policymakers is that policy consultation, by its nature, involves a wide range of diverse kinds and forms of knowledge contributions, which must be balanced against different – sometimes competing – policymaking objectives. In order to optimise the value that each of these knowledge inputs might hold in enhancing policy outputs, the legitimacy of different kinds of knowledge contributions must be recognised. Policy consultation processes must therefore be designed in such a way as to enable these kinds of inputs. This section will briefly explore each of these elements.

Limits on the degree to which policy consultation processes might impact on policy have been outlined above. In earlier discussions, policy consultation was situated on the information exchange end of the public participation continuum, implying that participants in consultation exercise may retain little control over final policy decisions. Nonetheless, the democratic rationale for consulting the public has

clear implications for the importance of authentic participation, while the technocratic rationale points to the value of inputs to such events in terms of, for example, enhancing policy implementation. What is evident from these discussions is that policy consultation should involve at the very least, careful attention to the ways in which knowledge inputs will be managed through these processes.

Rowe and Frewer (2005, p. 251) have provided the clearest overview of policy consultation from a knowledge or "information flow perspective". They highlight how a number of process and outcome mechanisms that have been linked to effectiveness can be harnessed to optimise the information exchange that takes place during policy consultation exercises. Essentially, then, they define an effective policy consultation process as one in which "full relevant information is elicited from all appropriate sources, transferred to (and processed by) all appropriate recipients, and combined (when required) to give an aggregate/consensual response" (Rowe & Frewer, 2005, p. 251). Managing such a process efficiently would entail maximising all relevant information from the maximum number of participants and transferring it, with minimal information loss, to those who must process it in making policy decisions.

Rowe and Frewer (2005) identify two engagement mechanisms in participatory processes that they believe to be critical for the effective management of inputs to these processes. The first is the "presence or absence of adaptive facilitation" to elicit individual inputs (Rowe & Frewer, 2005, p. 269). Rowe and Frewer argue that participants in consultation only represent *potential* sources of information – potential which remains latent unless participants are engaged with in such a way as to enable and maximise their inputs. This links to earlier discussions on the importance of skilled facilitation in participatory exercises. Rowe and Frewer (2005) identify several variables relating to the design and facilitation of participatory processes that might enable or constrain the elicitation of participant inputs. One of these is the extent to which the elicitation mechanism is open or closed. In other words, allowing for free responses, as might occur in focus groups or breakaway group discussions (i.e. open mechanisms), is "likely to elicit more of the relevant information from participants than closed ones", such as referenda or surveys (Rowe & Frewer, 2005, p. 269).

Although they acknowledge that open mechanisms might also elicit a great deal of irrelevant information, Rowe and Frewer (2005, p. 269) contend that open mechanisms, like open-ended questions in social science research, are "predicated on the assumption that they will yield richer data than will closed questions". This links to the second mechanism that Rowe and Frewer (2005) perceive as key to effective engagement, which resembles what is described elsewhere as knowledge brokering (Jones et al., 2012). Once individual inputs have been elicited, a different form of facilitation is needed to process and aggregate these inputs. Even if participant inputs have been elicited optimally, the

effectiveness of the consultation exercise can be compromised if processes are not in place to "merge various participants' knowledge or opinions into some composite response that accurately combines all relevant information from those participants" (Rowe & Frewer, 2005, p. 273). Extending the concept of policy consultation as knowledge management, Meessen et al. (2011) argue that improper management of knowledge collected from relevant stakeholders is also a barrier to policy implementation in many LMIC contexts.

Underlying this conceptualisation of policy consultation as a form of information or knowledge management are questions of legitimacy – specifically, recognising the legitimacy of diverse knowledge contributions and how these might be enabled. While the goal of public participation in policymaking is not to replace the voices of experts or other stakeholders, there should at least be meaningful opportunities for the public to influence decision-making and to complement these other knowledge inputs (Abelson & Gauvin, 2004). Towards this end, Morrison and Dearden (2013, p. 180) suggest that "achieving meaningful participation requires not only providing opportunity to participate but also facilitating participants' ability to do so by addressing the mismatch of knowledge bases" (i.e. the greater credibility of scientific knowledge over experiential knowledge).

Morrison and Dearden (2013) argue that building the capacity of participants to enable them to contribute in ways that might receive attention is an untenable solution to this problem. This professionalisation of participants risks reinforcing the dominance of scientific or expert knowledge over experiential knowledge. They suggest instead that attention be paid to the methods of engagement so that participants are enabled to express themselves in familiar ways. This speaks both to explicit mechanisms for gathering and optimising such inputs, as outlined above, as well as to more implicit mechanisms that may act to enable or constrain different kinds of contributions. If the principles of public participation are to be achieved, then, it is necessary to expand on both the nature (expertise) and the form (rhetorical style) of knowledge inputs that citizens bring to participatory processes.

This, in turn, requires some insight into how participants engage in consultation debates. However, the ways in which participants in consultation exercises actually make knowledge contributions in face-to-face policy negotiations has received little attention. While research on deliberative methods goes some way towards understanding how participation at this individual level might be optimised, such methods have tended towards the normative (Papadopoulos & Warin, 2007b). As such, they have been criticised for positioning public participation as a rational endeavour that might be exclusionary to those who are not familiar with these normative prescriptions (Barnes et al., 2003; Young, 1990, 2000), or who may be more comfortable with less rationalistic, more expressive, forms of engagement (Barnes, 2002, 2008; Papadopoulos & Warin, 2007a).

This implies that the design of methods for public engagement requires careful attention, as do the implicit 'rules of the game' that particular participatory mechanisms might communicate to participants. When engaging in face-to-face dialogue, for example, there are certain conversational norms which participants might be motivated to – or feel compelled to – subscribe in order to garner support for their positions on particular issues. For example, rhetorical devices such as reason-giving or claim-backing might be employed to convince or persuade others involved in the debate, for example (Cheng & Johnstone, 2002; Polletta & Lee, 2006) or to establish legitimacy as part of a shared community of practice (Adams, 2014; Antaki & Leuder, 1990). These conversational devices might, in turn, serve to sanction or constrain other forms of input that do not subscribe to normative conventions. To the extent that participatory processes involve language 'games' that "govern how and when people can speak and what they can say" (Wittgenstein, 1953, p. 592, in Morrison & Dearden, 2013, p. 181), legitimising diverse forms of contributions may include changing the 'rules of the [consultation] game' (Barnes, 2002) that require participants to contribute in particular ways and to make particular contributions in order to be considered legitimate in these spaces.

Effective deliberative processes may therefore place very high demands on participants (Abels, 2007), as well as on facilitators or organisers of such processes; the latter need to be skilled in communicative processes (Martin, 2012) as well as the management and processing of knowledge contributions, as highlighted by Rowe and Frewer (2005) above. Barnes et al. (2004) showed that simply bringing policymakers and citizens together does not guarantee that their discussions will encompass the principles of participation. There needs to be an awareness of the conditions that enable argumentation and challenge and, in particular, that allow for recognition and legitimation of different types and sources of knowledge, as well as different modes of expression (Barnes et al., 2004). As mentioned above, this would require rethinking the 'rules of the game' (Barnes, 2002) which affect not only who can participate in policy consultation processes, but how they are enabled to participate.

In certain policy areas, such as in mental health policy consultation, inclusivity and fairness are inextricably linked not just to opportunities for participation, but also to the ways in which participation is enabled during consultation processes. This is essential for ensuring that participating members of the public, however defined, have equal opportunities to be heard, as well as for these inputs to be optimised towards enhancing policy. In the next section, then, legitimising different inputs as well as mechanisms for enabling these in mental health policy consultation are discussed.

2.2.5 Consultative policymaking in mental health as a knowledge problem

The discussion above has highlighted the profound challenges of creating participatory forums that allow for a "plurality of views" (Petts, 2008, p. 825) and a "multiplicity of styles of discourse" to be heard (Martin, 2012, p. 179). Policymakers need to find ways to design such processes so that they fulfil the mandates of both policy effectiveness and participatory fairness. The unique complexities in the mental health field – of its knowers and its knowledges – add a layer of intricacy to this task. This section considers the complexities of including, enabling, and capturing knowledge contributions in mental health policy consultations.

2.2.5.1 Including mental health knowledge inputs

Policy consultation in mental health must include a diverse set of voices in order to be truly representative. The importance of including the perspectives of mental health service providers and mental health care users is outlined in this section.

Mental health care practitioners' knowledge

With the growing dual burden of disease in LMICs and the demands this will place on health care resources (Unwin et al., 2001), it is critical that mental health interventions are treated as an integral part of primary health care services (Lund et al., 2012; Patel et al., 2016). The focus of South Africa's *Mental Health Policy Framework and Strategic Implementation Plan 2013-2020* (Department of Health, 2013) is on the decentralisation of mental health care through primary health care re-engineering, and the development of district (community-based) mental health services, with an emphasis on task shifting (Petersen et al., 2016). These health system changes will place additional demands on primary health care workers who are now on the frontlines of responding to the acute and chronic needs of their patients, including common mental and neurological disorders (Ngo et al., 2013). It also requires mental health care specialists to take on roles of training and supervision as task shifting of mental health care from specialists to generalists and to community health care workers is now the order of the day (Department of Health, 2013; Petersen, Lund, Bhana, & Flisher, 2012). The centrality of human resources to the successful implementation of this policy provides an impetus for growing calls for the involvement of health care professionals in the development of the policies that they are tasked with implementing (Brophy & Savy, 2011; Ditlopo et al., 2014; Walker & Gilson, 2004).

The tension between policy and practice has been well documented in terms of the know-do gap (Bennett & Jessani, 2011; WHO, 2006). Brophy and Savy (2011) argue that there is a disconnect between

the rationalist, positivist (and 'evidence-based') aims of policymakers, and the professional ideals of mental health care practitioners. In particular, the dictates of policy may serve to restrict or constrain the work of people on the ground, who work far more with uncertainties than with the certainties sought by policy and policymakers. Baillergeau and Duyvendak (2016) also emphasise the uncertainty facing mental health practitioners in their everyday work, and argue that experiential knowledge is an important resource in coping with this uncertainty and complexity. They suggest that responses to such uncertainty resemble a bricolage of experiential and expert knowledges, whereby understandings of particulars must be integrated with understandings of universals (Malterud, 2001, in Baillergeau & Duyvendak, 2016). Bottom-up approaches to policy development have also been argued to be particularly important in the social and health care services, "because those providing the services must have discretion in taking decisions that allow them to respond effectively to variable client needs" (Walker & Gilson, 2004, p. 1252). Issitt and Spence (2005, p. 64) assert that in the relational or caring professions, professional practice includes both theory and empirical evidence, as well as a "knowing which springs from the experiences of everyday interventions and association with service users".

This lends support to calls for expanding on what is considered 'evidence' to incorporate the multiple perspectives and knowledges that practitioners draw on in providing care (Brophy & Savy, 2011; Isitt & Spence, 2005). However, some studies have shown that having professional status does not necessarily mean that one is accorded expertise and authority to speak to or participate in policy development (Phaladze, 2003). In a recent South African study on the involvement of nurses in various policy developments, Ditlopo et al. (2014, p. 4) found that many nurses felt that their limited involvement was because of the "failure of policymakers to recognise the importance of their clinical knowledge and expertise in informing policies". This echoed the findings of Walker and Gilson's (2004, p. 1259) study, where nurses "were asked to implement a policy about which they had not even been informed, let alone consulted, and whose immediate consequences for their daily practice were largely ignored". Importantly, Walker and Gilson (2004) showed that the implementation of policy was influenced by practitioners' values and experiences, such that policy interventions were adapted at the site of intervention and, in some cases, had unanticipated consequences. Given the substantive shift in mental health care service provision to primary care, and emphasis on task shifting of specialist roles to non-specialists, not taking the perspectives of these health and mental health care practitioners into account in policy development is likely to have a significant impact on policy implementation.

However, little research has been conducted on the ways in which practitioner knowledge is actually used (how it functions and moves) in and across policy consultation processes (Smith-Merry, 2012). Smith-Merry (2012) asserts that the value of the experiential knowledge of mental health care practitioners is the very reason they are consulted in the first place, but that it is precisely this kind of

knowledge that makes it difficult for their inputs to have an impact on policy. In her study, this was in part because experiential knowledge was considered less legitimate as a source of knowledge for policy development in comparison to more traditionally valid forms of evidence. In addition, the lack of impact was also because the nature of this knowledge meant that it did not move easily into codified forms of knowledge, such as in policy documents, and therefore into the next stage of the consultation process. As such, there was a "gradual lessening of the use of practice/experiential knowledge of practitioners the further it progressed through the chain of consultation events and texts … [such that] the personal, experiential nature of the data, which gave it much of its power, was lost" (Smith-Merry, 2012, p. 140). It is important, therefore, not just to find ways of increasing the perceived legitimacy of such knowledge, but also to attend to how this knowledge can best be used during policy consultation processes.

Mental health care service users' knowledge

Calls for greater inclusion of mental health care practitioners in policy development are paralleled by the growing recognition of the importance of involving mental health service users in service and policy planning (Thornicroft & Tansella, 2005). However, in LMICs in particular, there is generally poor service-provider involvement, and even poorer service user involvement in the development of mental health policies and plans (Petersen et al., 2017). Shifts in the focus of mental health service provision and in advocacy movements that emphasise *nothing about us without us* (Trivedi, 2014) underscore the impetus to include service users in policy consultation processes. These shifts will be briefly explored in this section.

The shift to integrated mental health care outlined above has corresponded with an increasing move towards person-centred care (Storm & Edwards, 2013; WHO, 2008, 2016). Parallel to the integration of mental health services into primary care in South Africa has been the adoption of an integrated chronic disease management model; this has been a response to the growing need for chronic care services at primary health care level (Asmall & Mahomed, 2013; Mahomed & Asmall, 2015). These developments have required a reorientation of the health system "from a biomedical model of symptom management to a patient-centred model of holistic care" (Asmall & Mahomed, 2013, p. 11). Person-centred care is a holistic approach that not only seeks to respect what matters to patients about their experiences of health care, but also represents a reaction to what has traditionally been a disease-centred and staff-centred system of health care (Entwistle & Watt, 2013; Harding, Walt, & Scrutton, 2015).

With respect to mental health care in particular, valuing patients' perspectives has stemmed, in part, from the impetus of the recovery approach, which emphasises the idiosyncratic nature of illness experiences, the meaning that each individual attaches to these experiences, and the importance of

hope and self-determination (Glover, 2005; Hummelvoll, Karlsson, & Borg, 2015; Parker, 2014). This again underscores the value of attending to local and experiential sources of mental health knowledge, seeing these as particular "truths based on personal experience with a phenomenon" (Borkman, 1976, p. 445, in Baillergeau & Duyvendak, 2016, p. 411); these can, in turn, enhance approaches to mental health care. Baillergeau and Duyvendak (2016) highlight a number of valuable features of this knowledge, including the experience of having lived through care institutions and/or treatment, the experience of social consequences of having a condition framed as problematic, the experience of advocacy, and the experience of recovery itself.

Person-centred care recognises the importance of giving patients a voice, not just in their own treatment decisions but in policy and programme decisions that affect their lives (Gask & Coventry, 2012). Apart from the value it places on service users' experiential 'expertise', policy consultation with mental health care service users and their families can also facilitate a sense of empowerment, belonging, and participation as citizens among these typically marginalised groups (Kleintjes et al., 2010; Kleintjes et al., 2012; Mezzina et al., 2006). Noorani (2013) has argued that self-help and recovery groups that have typically been seen as sites of 'health', should be re-viewed as sites for advocacy and activism. In this way, experiential knowledge can gain its own authority and convey messages that are not available through more formal mechanisms such as textbooks. In addition, this can "bring a unique perspective to mental health policy through [the] experience of mental illness" (Kleintjes et al., 2010, p. 571). This highlights the importance of capacity-building initiatives that enable service users to participate in policy development, as well as of expanding the capacity of policymakers to integrate multiple sources and forms of knowledge into policy decisions.

However, the capacity of mental health care users to become involved in policy consultation in South Africa is limited (Kleintjes et al., 2012), as it is in other LMICs (Abayneh et al., 2017; Gurung et al., 2017). In addition, the mental health service-user advocacy movement is still relatively under-developed in South Africa, creating a challenge for policymakers in finding such groups to consult (Kleintjes et al., 2010; Kleintjes, Lund, & Swartz, 2013). Outside of being affiliated to advocacy-driven NGOs or service-user representative groups, mental health service users have few opportunities to participate in policy development (Kleintjes et al., 2010). While studies in high-income countries have suggested that efforts to include mental health service users in policy development remain tokenistic (Ocloo & Matthews, 2016), the limited evidence in LMICs on service-user involvement at the systems level (Semrau et al., 2016) means that there is "no conceptual framework to inform effective involvement of service users and caregivers" (Abayneh et al., 2017, p. 10).

Other barriers to service-user participation in policy consultation include stigmatising or negative perceptions towards service users as legitimate partners in the development of mental health policies (Kleintjes et al., 2010). In addition, even where service users are involved, there are barriers to their participation because they are still perceived as not possessing the right kind of knowledge (Enany, Currie, & Lockett, 2013; Martin, 2008). Enany et al. (2013) showed that service-user participants in policy consultations aligned themselves with a particular kind of 'expert' knowledge in order to distinguish themselves from service users with merely 'lay knowledge', thereby increasing their legitimacy. There was also a sense among service users in this study that they should "learn boardroom jargon and management process so they can be involved and work alongside professionals" (Enany et al., 2013, p. 28).

However, as argued in earlier discussions, increasing the capacity of service users to enable them to have the right kinds of knowledge with which to engage with policy and policymakers risks co-opting them into professionalist discourses, thereby reinforcing the dominance of expert or professional knowledge over experiential knowledge (Demszky & Nassehi, 2012; Harvey, 2009; Morrison & Dearden, 2013). Some have argued that the onus should instead be on policymakers to organise policy consultation processes that can accommodate the kinds of knowledges that mental health service users have to contribute (Morrison & Dearden, 2013; Summerfield, 2012).

This echoes calls for policymakers to improve their own capacity to understand and engage respectfully and appropriately with service users (Carter, Beech, Coxon, Thomas, & Jinks, 2013; McDaid, 2009; Kleintjes et al., 2010). In turn, this adds to the dilemma for policymakers, who, in addition to having to weigh up the validity and value of different kinds of knowledge inputs, need to balance the typically urgent need to implement solutions with the need to consult, leaving little time for building capacity pre-consultation (Kleintjes et al., 2010). In this context, it may be more apt for capacity to be developed during participation (Tritter & McCallum, 2006). Either way, it implies that attention should be paid to the 'rules of the game' in policy consultation, as a means of optimising service-user input. This is further explored in the next section.

2.2.5.2 Enabling mental health knowledge inputs

While the democratic value of policy consultation is often taken as a given, the way in which such processes are implemented may in fact exacerbate tensions between government and the public (Quick & Feldman, 2011). As has been shown above, even where service users and service providers are included in policy consultations, possibilities for authentic participation in decision-making are not automatically guaranteed (Elberse, Caron-Flinterman, & Broerse, 2011; Roberts, 2014). There is thus a

need for creative, enabling approaches to public participation in policy formulation (Marres, 2007; McCunn & Robinson, 2009), particularly if more marginalised or vulnerable groups are to be included (McCellan, 2012; Morrison & Dearden, 2013; Young, 2000). There are also "challenges in designing engagement processes that enable service users to contribute on their own terms, while giving due weight to other evidence" (Roberts, 2014, p. 955). As such, Barnes et al. (2004, p. 106) argue for the "importance of micro-level analyses of the processes of exchange that take place within participative forums if we are to develop a better understanding of the frustrations as well as the achievements of public participation". In particular, the task is to structure policy consultation processes in ways that both enable authentic participation and allow for the integration of multiple forms of knowledge as authentic inputs to the process.

More conventional forms of participation may be exclusionary to those who do not have the skills to interact in these kinds of settings, which places "serious limits on a mutual exchange of knowledge" (Morrison & Dearden, 2013, p. 180). For one thing, the tendency in policy consultation has been towards the normative, whereby participants are expected to deliberate on issues in a rational manner, giving reasons to justify their arguments that others can accept as persuasive by virtue of their appeal to universal values (Elster, 1998; Habermas, 1984). By definition, this focus on reasoned discourse excludes more emotive, less rational inputs and, *ipso facto*, the people and groups who find expression through these forms of talk (Barnes, 2002, 2008; Young, 2000). Other exclusion mechanisms that may serve to limit participation include the setting, the behaviour of facilitators and participants, chosen methods of communication, and speaking time granted (Elberse et al., 2011). This has led to efforts to find ways both to legitimise a wider range of inputs in policy consultation spaces (Epstein, Heidt, & Farina, 2012; Hampton, 2004; Polletta & Lee, 2006), as well as to design participatory processes that take potential exclusion mechanisms into account (Cook, 2002; Elberse et al., 2011; Roberts, 2014).

Research on participatory design has started to open up possibilities for meaningful participation, enabling mental health care service providers and users to make contributions in familiar ways (Morrison & Dearden, 2013). In particular, deliberative technologies, defined as "the hardware and software supporting all kinds of social interactions and information communication" (Sandfort & Quick, 2017, p. 4) hold potential for policy consultation. These technologies represent the enactment of a number of elements in the policy context, including characteristics of the facilitator and participants, types of communication techniques, material objects, and conceptual frameworks that "support a broad-based conversation among affected citizens" (Sandfort & Quick, 2017, p. 4). Participatory technologies such as Open Space Technology (OST) can help to address some of the inevitable trade-offs between fairness and effectiveness described earlier in this section (O'Connor, 2005; Sandfort & Quick, 2017). OST was developed by Owen (1993) as a "large group facilitation method [for] tapping into the

collective wisdom of communities of interest … underpinned by … the belief that everybody has something to contribute that needs to be heard" (O'Connor, 2005, p. 2). It is a low-cost, practical, and effective method of engaging stakeholders and, as such, is increasingly being recognised by policymakers for its potential in policy consultation (O'Connor, 2005).

As an innovative method that can build bridges between participants with diverse forms of knowledge, OST may be a deliberative technology that has particular value in mental health policy consultation. Recognising that consultation processes must be carefully designed to optimise the pooling of popular, expert, and experiential knowledge, O'Connor (2005) argues that OST can pull together knowledge around a particular problem or issue. Indeed, one of the valuable aspects of OST in the context of the policy consultation challenges identified in this section is the use of material objects or artefacts as bridges across different communities or bodies of knowledge. These artefacts have been compared to the boundary objects employed in knowledge-transfer processes discussed earlier in this section (Sandfort & Quick, 2017). They represent a mechanism for both eliciting and capturing diverse forms of knowledge, and as such, may be particularly useful in the context of mental health policy consultation. This is explored further in the section below.

2.2.5.3 Capturing mental health knowledge inputs

There are at least two challenges with respect to policy consultation in mental health. Firstly, this is a context in which knowledge inputs may be in more experiential or embodied forms, and therefore difficult to codify and capture (Goldner, Jenkins, & Fisher, 2014). Secondly, the consultation space brings together diverse groups of participants, with diverse ways and forms of knowing. This requires a particular kind of knowledge transfer, one that can incorporate different knowledges, while allowing them to retain their key characteristics. Experiential knowledge can complement other, more formal, kinds of knowledge in these spaces, but this requires not just mechanisms for eliciting such knowledge, but also for integrating and capturing such contributions (Demszky & Nassehi, 2012; Epstein et al., 2012; Fazey, Fazey, Salisbury, Lindenmayer, & Dovers, 2006; Goldner et al., 2014). In particular, drawing experiential knowledge into the policy consultation space requires that it goes through a process of formalisation, generalisation, and abstraction, such that it risks losing its contextually useful character (Agrawal, 2002; Demszky & Nassehi, 2012). It is therefore important that mechanisms are identified that can facilitate the integration of these kinds of knowledges in consultation spaces, while still preserving the contextual value that they hold for policy development.

The notion of a boundary object was first identified by Star and Griesemer (1989) to represent a material artefact to which all members of diverse groups can relate and which draws together

information from these groups into an integrated form. Importantly, boundary objects are malleable enough to enable people to contribute to them, but structured enough to be used in decision-making, as well as transportable outside of the participatory space. Examples include stories, maps, diagrams, pictures, and props – physical or material objects that can be adapted and added to by participants as they share their knowledge (Morrison & Dearden, 2013). Boundary objects can enable both informational and relational work in deliberative spaces (Yeh, 2013) and therefore hold the potential for optimising both meaningful participation, as well as the integration of multiple knowledges. They can "provide a common focus for different ways of knowing" (Feldman, Khademian, Ingram, & Schneider, 2006, p. 95), thereby helping to move beyond tokenistic participation in policy planning (Morrison & Dearden, 2013).

Linking boundary objects with participatory design in policy consultation draws attention not just to how the 'rules of the game' are set up, but also to the mechanisms and medium of consultative discussions (Morrison & Dearden, 2013). In addition, it highlights the importance of understanding how forms of knowledge function and how such knowledge can be transferred from one form to another, as well as from one context to another. The reality is that knowledge in policy consultation spaces must be elicited and captured in ways that facilitate its movement outside of those spaces, such that these knowledge contributions might inform policy.

2.2.6 Consultative policymaking: Conclusion

This section has explored a number of elements of consultative policymaking that have relevance for the goals of the current study. It has presented various process and outcome criteria that are considered to increase the effectiveness of policy consultation, depending on the objectives of the consultation and on the perspectives of those who participate. In doing so, it has also highlighted the challenge for policymakers in balancing participation in policy decision-making with the effectiveness of policy decisions. The influence of policy consultation on policy has been explored, with a particular focus on how consultation contributions might be traced through the process to determine follow-through into policy. This, in turn, has foregrounded the role of knowledge in policy consultation. Strategies for including, enabling, and capturing knowledge inputs, specifically in the mental health policy context, have been discussed. The forms, functions, and transfer of knowledge in policy development are elaborated on further in the next section, with a particular focus on the value of tacit, experiential knowledge and how this form of knowledge might be elicited and transferred in the policy consultation process.

2.3 Knowledge in policy: Embodied, enacted, inscribed

Throughout the discussions in previous sections, policymaking has been conceptualised as something of a knowledge problem for policymakers. Within the contexts of evidence-based policymaking and consultative policymaking, several challenges with regard to balancing various knowledge forms and contents in policy decision-making have been explored. In this chapter, the intersection of knowledge and policy is considered in greater depth. It starts with a more general description of the different forms and functions of knowledge in policy, problematising the notion of *using* knowledge in policy consultation in particular. It presents the *embodied-enacted-inscribed* knowledge framework as a useful way of conceptualising knowledge in policy consultation. Recognising that the policy consultation space is one in which these diverse forms of knowledge come together, the discussion then focuses on how more tacit, embodied forms of knowledge can be transformed into enacted and inscribed forms, in order to facilitate the transfer of knowledge beyond the consultation space.

2.3.1 Using knowledge in policy

There are many different forms of knowledge and many ways of knowing. This section will discuss the role of knowledge in policy in particular. It will consider the purposes for which knowledge is drawn on in policymaking; this both determines and is determined by what sources and forms of knowledge count as legitimate. The challenge for policymakers is to understand how to reconcile knowledge inputs in the political space with knowledge inputs from the scientific/technical space, and, increasingly, knowledge inputs from the consultation/citizen engagement space. Ultimately, this requires a better understanding of the role of knowledge – and of multiple knowledges – in policy, as well as the "multiple points of access [of knowledge] within the policy system" (Weiss, 1999, p. 480). This study is particularly concerned with the role of experiential knowledge from the consultation space as one of these points of access, and how this might supplement knowledge from the evidence/science space.

2.3.1.1 Functions of knowledge in policy

Knowledge has been conceived of as serving a number of functions in policymaking. These are explored here with a view to understanding the purposes for which participant knowledge might be used in policy consultation. The focus of knowledge-transfer models in evidence-based policymaking has typically been on the *instrumental* function that knowledge has as a problem-solving tool in addressing policy problems or answering policy questions. In this instrumental role, knowledge is seen as objective and rational (Grundman & Stehr, 2012), and policymakers seen as problem solvers who draw on this knowledge to aid in improving policy (Jones et al., 2012). Beyond this problem-solving function, Weiss

(1999) proposed that knowledge can also serve a *conceptual* or *enlightenment* function, offering new ways of understanding or insights into policy issues. This kind of learning – through the conceptual use of knowledge (Sabatier, 1987) – occurs in a more diffuse way over a longer period of time than the instrumental use of knowledge, in a process which Weiss (1980, in Daviter, 2015) referred to as knowledge creep.

In the instrumental and conceptual functions of knowledge in policymaking, then, emphasis is on the content value of knowledge. However, consistent with the recognition that policymaking takes place within a complex socio-political context, knowledge has also come to be seen as having other more symbolic or strategic functions in policy; for example, it may be employed more for its potential political function than for its substantive content (Grundman & Stehr, 2012; Nutley, Walter, & Davies, 2003; Sedlačko & Staroňová, 2015; Weiss, 1998). Boswell (2008) distinguishes between two symbolic functions of knowledge in policymaking: first, to back up or justify certain policy decisions, which she refers to as a *substantiating* function, and second, to claim policy authority by drawing on 'expert' knowledge that frames policy problems in particular ways; this is seen as a *legitimising* function.

Knowledge, then, has at least four functions in policymaking: instrumental, conceptual, substantiating, and legitimising. Different forms of knowledge – such as evidence-based or experiential knowledge – may be drawn on to achieve these goals. It is important to point out, however, that these conceptualisations of the functions of knowledge in policymaking have generally been used to refer to the role of expert scientific or technical knowledge in policy, and have not been explicitly extended to other, more tacit, forms of knowledge. This parallels the focus in the knowledge-translation literature on how explicit, scientific evidence might be transferred or taken up into policy, as was discussed in the evidence-based policymaking section.

Arguably, however, these other (practical and experiential) forms of knowledge may be employed in policymaking in similar ways to those outlined above. Practical or experiential knowledge might be drawn on for instrumental purposes when, for example, there are evidence gaps regarding how to solve particular problems. Inputs from practitioners or the public may also contribute in substantive conceptual ways when these experiential and practical forms of knowledge improve understandings of policy problems, or in strategic conceptual ways when they change what is thought about or counts as a problem.

Policy actors or organisations might also align with citizens' experiential knowledge in concrete symbolic ways to give themselves democratic legitimacy, as well as to legitimise their predetermined policy decisions. Atkins and Finlayson (2013), for example, showed how reference to anecdote in political

speech has been increasingly employed by politicians wishing to align themselves with the everyday knowledge of their citizens; this is done to enhance their credibility as 'ordinary people', as well as to legitimate policy choices by associating them with claims about reality. If experiential and practical forms of knowledge serve similar functions to explicit scientific knowledge, it follows that these forms of knowledge are vulnerable to the same risks – such as being used to reinforce or legitimate hegemonic policy narratives.

The primary focus in the current study is on the value of knowledge for its instrumental function. This case study of policy consultation provided an opportunity to explore, retrospectively, how knowledge contributions moved, primarily in documented or inscribed form, through a consultation process. As such, it focuses on the points of exchange between individuals in consultation discussions, and between different chronological components of the consultation summit as documents were transferred from one point to the next. It therefore follows a more linear trajectory than is typical of policymaking itself; throughout the analysis, the limitations of conceptualising knowledge and knowledge transfer in this more instrumental, linear way are highlighted.

Identifying what *forms* of knowledge are appropriate for particular purposes might help to clarify the functions that knowledge could serve in policy(making), as well as point to what processes or mechanisms might be most appropriate for its transfer in various contexts. In particular, linking tacit forms of knowledge to specific sources – to professional practitioners or to lay members of the public, for example – could illuminate the contributions that these forms of knowledge may make at different stages in the policymaking process. The discussion now turns to the specific ways in which tacit forms of knowledge might intersect with explicit knowledge to contribute to policy.

2.3.1.2 Using multiple forms of knowledge in policy

To gain an understanding of how knowledge functions in policy(making), it is important to understand how the forms of knowledge more generally have been understood. Knowledge has been conceptualised along a number of dimensions, including where it is held, in what form it is held, and what function it has in different contexts. Lam (1998) suggests that knowledge can be analysed along two dimensions – epistemological and ontological. The forms of knowledge, or ways in which it is expressed, are located on the epistemological dimension. This includes distinctions between tacit and explicit knowledge, theoretical and practical knowledge, and experience and expertise. The ontological focus is on the locus of knowledge, that is, where it is located; in this regard, Lam (1998) also distinguishes between whether knowledge is individually or collectively. This section focuses on the epistemological dimension, with a discussion of different ways in which various forms of knowledge

have been conceptualised in relation to one another. The ways and places in which knowledge is 'held' are explored later in section 2.3.1.4, which introduces Freeman and Sturdy's (2015a) classification of knowledge as embodied, enacted, and inscribed. This is used to anchor the latter discussion, as this provides the basis of the analytical framework employed in the current study.

At the broadest level, knowledge can be understood as either explicit or tacit. It is generally understood that knowledge can be articulated explicitly (explicit knowledge) or manifested implicitly (tacit knowledge) (Lam, 1998). This distinction is relevant for the current study for two reasons. First, it adds to understandings of how different forms of knowledge have come to be seen as more or less legitimate than others. Second, it has implications for how these forms of knowledge might be accessed and transferred to other forms or other contexts.

One of the first attempts to classify tacit knowledge came from Polanyi (1967, p. 4), who observed that "we know more than we can tell". Such knowledge is hidden or implicit and may be difficult to articulate, although we are not necessarily unaware of it. By definition, explicit knowledge can be captured or coded, in symbols, which allows it to be communicated in verbal or written form. Once it is codified in this way, it no longer requires the "knowing subject" in order to be understood (Popper, 1972, in Lam, 1998, p. 6). Tacit knowledge, on the other hand, is subjective and contextual and exists in an intuitive, unarticulated form (Jones et al., 2012; Lam, 1998). It is, by definition, not easily captured or transferred. In crude terms, then, the distinction between these two forms of knowledge is made according to ease of access and transfer.

It is clear, then, that these two types of knowledge will be accessed and shared – where this is possible – in very different ways. Importantly, this also has implications for whether and how these forms of knowledge can be aggregated or generalised:

> Since explicit knowledge can be easily codified, it can be aggregated at a single location, stored in objective forms and appropriated without the participation of the knowing subject. Tacit knowledge, in contrast, is personal and contextual. It is distributive knowledge that cannot be easily aggregated and stored in objective forms; it can only be appropriated through direct application. The realisation of its full potential requires the close involvement and cooperation of the knowing subject. (Lam, 1998, p. 7)

The tacit-explicit knowledge distinction has been applied to various other forms of knowledge. Explicit knowledge has been linked with theoretical, abstract, or expert knowledge, all of which are considered a kind of *know-that* (Ryle, 1949). In contrast, tacit knowledge is linked with more practical, experiential, and situated knowledge forms – a kind of *know-how* (Ryle, 1949). These distinctions have had

implications for how different forms of knowledge have come to be seen as more legitimate than others, with more explicit forms of knowledge typically being accorded a higher status than tacit knowledge forms.

This echoes earlier discussions on the ways in which evidence-based and experiential knowledges differ in their perceived legitimacy. Although the concept of evidence has been expanded to include a variety of knowledge forms, the predominant focus of evidence-based policymaking, as discussed in a previous section, has typically been on explicit scientific knowledge. However, in the broader context of political decision-making, scientific knowledge is only one input to policy, among many. For example, the section on consultative policymaking showed the importance of practical and experiential expertise as sources of knowledge for policymakers. The consequences of the increasing recognition of the legitimacy of other knowledge forms for use in policy are explored further here. The focus is on linking the notion of tacit knowledge with forms or sources of knowledge that play a role in policymaking, in particular, which leads to consideration of how multiple forms of knowledge might be integrated and, more specifically, how tacit forms of knowledge might be transformed into useable forms.

Before proceeding with this discussion, however, it is important to acknowledge the inherent risks involved in indiscriminately using tacit experiential knowledge. The evidence-based movement is built on recognition of the dangers of subjective decision-making that can neither be verified nor replicated in systematic ways. The evidence-based practice literature is also replete with studies demonstrating that deeply embedded tacit knowledge may serve as a barrier to instituting more effective, research-based practices (Kothari et al., 2012). This type of knowledge might also be vulnerable to subversion for the purposes of furthering dominant agendas (Jones et al., 2012) or may obscure structural inequalities by taking such knowledge at face value or being uncritical of the types of knowledges permitted into the policymaking space (Sedlačko & Staroňová, 2015). Not all tacit knowledge is good tacit knowledge, then, and Kothari et al. (2012) argue that such knowledge, like research-based knowledge, should be subjected to critical appraisal in order to differentiate between sense and non-sense information.

Some have proposed a pragmatic approach in this regard, whereby all knowledge is considered to be contextual knowledge. The value or validity of knowledge is thus assessed according to the purpose for which it is to be used (Caron-Flinterman et al., 2005; Williams & Glasby, 2010), while acknowledging that "there will always be a trade-off in utility between the extremes of generic knowledge, and local knowledge specific to context" (Ekblom, 2001, in Nutley et al., 2003, p. 131). In addition, a great deal of work is still needed to determine the extent to which using more tacit experiential knowledge does indeed contribute to the effectiveness and efficiency of policymaking and policy implementation (Caron-Flinterman et al., 2005). One way of facilitating this would be for the decision-making processes involved

in policymaking and policy consultation to be made more transparent, allowing for potentially greater insight into the flow and uptake of different forms of knowledge into policy, as provided in the current case study.

Jones et al. (2012) provide a comprehensive guide to understanding how explicit and tacit knowledge may be used in policy. They draw together explicit and tacit conceptualisations of knowledge into broader categories that are linked to particular sources of this knowledge as they pertain to policymaking. These sources are broadly defined as research-based knowledge, practice-informed knowledge, and citizen knowledge. Jones et al. (2012) assert that these pragmatic categorisations are consistent with key trends in the developing country-oriented literature and in the 'knowledge-in-policy' field as a whole. What is important for the purposes of the current study is that Jones et al. (2012) acknowledge the crucial role of all three of these forms of knowledge in policymaking, and outline the risks in simply substituting one form for another, or allowing one type of knowledge to dominate.

Jones et al. (2012) also highlight that the knowledge-policy interface is not just affected by political context or the actors involved, but is also "clearly influenced by the contributions each of the different types of knowledge can make" (Jones et al., 2012, p. 120). As alluded to in the discussion above, the use of practice-informed and citizen/lay knowledge in policy holds both a great deal of value and a number of challenges. Nonetheless, Jones et al. (2012, p. 121) assert the importance of "enhancing the legitimacy, saliency and credibility of each of the different types of knowledge" in inclusive and transparent ways to enable policymakers to make "reasoned judgements on how to move forwards".

Jones et al. (2012) therefore argue that, although evidence-based knowledge continues to dominate policymaking, this needs to be complemented with practical and local experiential knowledge. The use of such knowledge in policymaking is demonstrated in Sturdy, Freeman, and Smith-Merry's (2013) case study of the World Health Organization's (WHO) formulation of mental health policies and practices. Starting out with the assumption that, as a technocratic organisation, the WHO's objective is to produce normative, universal best-practice guidelines, Sturdy et al. (2013) theorised that the role of knowledge in the WHO's policymaking around mental health would be primarily technical or instrumental. They found, however, that the WHO's success in influencing regional mental health policies was achieved not through technocratic mobilisation of standardised knowledge, but through an approach that was "case based and holistic … rooted in personal experience of the peculiarities of local mental health systems" (Sturdy et al., 2013, p. 3), thereby showing that other forms of knowledge (i.e. context-based experiential) may sometimes prove more practical and effective in policymaking. Much of this knowledge seemed to be generated through "face-to-face discussion, negotiation and sharing of

personal experiences and understanding of relevant interventions" (Sturdy et al., 2013, p. 21), rather than through empirical information or data gathering.

The importance of attending to situated experiential knowledge was also demonstrated by Healey (2007) in an in-depth case study of urban spatial planning. Asserting that all knowledge – including scientific knowledge – is a form of story acquired through living in the world, Healey (2007, p. 249) proposes that policymaking is an iterative process in which a new story is formed through "encounters between multiple stories". The explicit language of science and validated scientific findings, however, smooths away these lived dimensions of knowledge, which risks "making all kinds of assumptions about cause-and-effect relations that have little grounding in what is actually going on" (Healey, 2007, p. 247). Situated experiential knowledge is thus a key resource for policymakers to integrate with technical expert knowledge, which Healey (2007, p. 26) describes as a process in which "imaginative conceptions of 'what could be' are confronted with diverse kinds of knowledge about 'what is going on'". A potential use of situated experiential knowledge in policy(making) then, is the illumination of how the implementation of a policy may unfold in specific situations and contexts.

However, the legitimation of more practical and situated forms of knowledge in policymaking poses challenges with respect to reconciling knowledge from these diverse sources – from research, from practice, and from the 'lay public'. Williams and Glasby (2010) suggest that decisions about the use and integration of these forms of knowledge will depend on what we want to know, referring back, then, to the different functions that different knowledges might serve. The challenge for policymakers is how to integrate local experiential and situated knowledge with other forms of knowledge inputs to policy. This challenge is briefly considered next.

In drawing attention to the importance of situated knowledge in policy, Healey (2007) calls for policymaking to be seen less as a form of closure and more as a process of discovery, which suggests the need for more participatory and interactive forms of policymaking to replace or supplement more traditional problem-solving models (Colebatch, 2006). Jones et al. (2012, p. 108) acknowledge that creating these spaces within policy "to draw on and combine multiple types of knowledge in an integrative manner" poses particular challenges for policymakers that go beyond making decisions about the right kinds of knowledge to fill the know-do gap. The complexities of certain policy problems exceed the capacities of science alone, such that policymakers require a broader, less positivist, and more interpretivist epistemology – what Healey (2007, p. 243) calls ''epistemological consciousness", and Freeman and Sturdy (2015a, p. 6) refer to as "epistemic versatility". This requires both individual and institutional capacity to elicit and integrate multiple forms of knowledge. Although this might lead to better policy outcomes, Sedlačko and Staroňová (2015) argue that integrating these forms of

knowledge is by no means automatic or straightforward, and there is little theoretical or empirical guidance for conceptualising or effecting such knowledge transfer.

However, the fact that knowledge is both created in, and moves through, social interaction poses both a challenge and a potential solution to the integration of knowledge. Building on the epistemological consciousness required of policymakers in this regard, Healey (2007) suggests that integrating multiple knowledge forms is less about technical skill, and more about the capacity to interact with others in multiple ways and to hear what various stakeholders are saying. This is supported by Ashwood et al. (2014), who showed that the distinction between where knowers were located socially (in terms of being locals or being experts) was less of a significant factor in their interactions than their ability to connect their knowledges with those of others. What was important was "whether participants were able to understand their knowledge as situated in the ground of their own experience, and able to link that knowledge to the ground of others' experience, building a landscape of knowledge that connects one ground to another" (Ashwood, Harden, Bell, & Bland, 2014, p. 428). This suggests that much can be gained in not only attending to the interactive spaces of participatory policy consultation, but also in understanding the ways in which knowledge moves between different forms and phases during this interaction.

It is evident from the above discussion that linking and integrating diverse forms of knowledge in policymaking is a complex task. Moving different forms of knowledge between the different contexts in which it is generated implies, too, that certain mechanisms must be identified through which this can be most effectively achieved. However, transfer of knowledge from one source or context to another is more than just a linear exchange. In addition, determining whether and how such transfer has been effected is complicated by a range of factors. These are explored next.

2.3.1.3 A note on terminology: Use, influence, transfer, movement

As was shown in an earlier section on policy consultation, one of the implicit principles and purposes of engaging with the public around policy is that their inputs will in some way be used or at least considered in relation to other factors influencing policy decisions. A key challenge for policymakers is how to balance and integrate these multiple sources of knowledge. While it is improbable that a linear or causal association might be drawn between consultation inputs and policy outputs, there is nonetheless a need to assess whether and how inputs at policy consultation events are or could be used, in order to avoid tokenistic public engagement. As with knowledge-translation approaches to optimising the uptake of research-based knowledge into policy, this is unlikely to be a simple process of

transfer. The degree to which public inputs influence policy might only be seen in more subtle ways further down the line, for example, in implementation buy-in and changed practice.

Even where consultation inputs do not have a direct impact in terms of changing policy, it seems reasonable to expect that there would be evidence of endorsement of draft or proposed policy interventions, through synergies between consultation inputs and policy outputs. Alternatively, there would be transparency in decision-making processes around why inputs were included or excluded. It is necessary, then, to clarify what is meant by knowledge transfer or use in this context, in order to address such questions as: Are these knowledge inputs used? How are they used or what are they used for? How do we know whether or not they have been used? There seems, however, to be little consensus on terminology concerning the use of consultation inputs, which is further complicated by difficulties with transferring tacit practical and experiential knowledge, in particular. Assuming the conditions for eliciting and capturing such knowledge are met, the issue considered in this section is how this knowledge might move through a consultation process, such that it is transferred in either inscribed (person-document transfer) or embodied (person-person transfer) form.

The concept of *use* points to ways in which public inputs to policy might be taken up and integrated with other forms of knowledge – in particular, evidence – within the complex policymaking process (Li et al., 2015). The uncertainty regarding how to incorporate other knowledge inputs into policy might to some extent be traced back to lack of clarity around how the concept of use is defined or understood. These terminology issues were discussed earlier in the consultative policymaking section (section 2.2.3.3). It was shown there that the term *use* has rarely been explicitly defined in studies examining the impact of public involvement in policymaking; when it is defined, it is usually in relation to what the inputs were used for, rather than to define what use itself was understood to mean, or how inputs were actually used (Li et al., 2015).

Li et al.'s (2015) study revealed a number of ways in which public knowledge was used in policy and policymaking to fill knowledge gaps, including "to open and change policy and political debates, to enhance the understanding of a policy problem, to choose between policy alternatives, and to address challenges of policy implementation" (Li et al., 2015, p. 17). Importantly, these researchers emphasise the need to understand *use* of knowledge inputs as a process rather than an outcome. This suggests that the purpose for which the public is consulted, and the function that their inputs may serve, are important factors in assessing public policy consultation and the use of knowledge in these processes. This might have positive implications – such as where public knowledge is used in instrumental or conceptual ways to solve policy problems or fill information gaps – as well as negative implications where, for example, public inputs are used to placate the public or legitimise dominant agendas.

The discussion above situates the concept of knowledge transfer in the broader process of policy consultation. In terms of the transfer of *knowledge* from one form to another (e.g. tacit to explicit), from person to person and from person to document, questions remain regarding how this might occur. This highlights again that knowledge exists in forms that might be transformed into others. In addition, although knowledge might be embedded or contained within people or documents, it is also dynamic and infused with the potential for movement – in words and documents and in people and actions (Freeman, 2009). This also suggests that it might be captured in different ways once it is explicit and 'in movement'. This confirms that knowledge forms can move and can be transformed through this movement (Sedlačko & Staroňová, 2015), which allows us to consider how to catalyse this process, particularly with respect to eliciting, capturing, and transferring tacit knowledge.

However, this discussion has also highlighted challenges in transferring and integrating multiple forms of knowledge, as well as in determining whether and how such knowledge is used in policy consultation. In addition to lack of clarity regarding terminology around knowledge *use* in policy, the multiplicity of ways in which knowledge itself has been conceptualised adds to this complexity. Freeman and Sturdy's (2015a) phenomenology of knowledge as embodied, enacted, and inscribed provides a useful framework for conceptualising not only different forms of knowledge, but also the ways in which knowledge moves and might be transferred in different forms through a policy consultation process. This framework is presented in the next section.

2.3.1.4 Knowledge in policy consultation: Embodied, enacted, inscribed

Conceptualisations of knowledge along the dichotomous tacit-explicit distinction discussed earlier have been expanded to consider the location of knowledge along individual/collective dimensions, as well as the forms in which knowledge is acquired and held. Including these elements allows for a more nuanced representation of how knowledge has been understood; this is depicted in Figure 2.3. Each of these conceptualisations of knowledge is described further below.

In Figure 2.3, knowledge is classified according to whether it is explicit or tacit and, respectively, abstract/theoretical or practical/experiential. It is further distinguished according to whether the explicit and tacit knowledge is held in individual or collective forms. The focus of the current study is on individual forms of knowledge and how these are transformed into knowledge that can be collectively used in policy development. Conceptualisations of knowledge at the explicit-individual (embrained), tacit-individual (embodied) and explicit-collective (inscribed) interfaces in Figure 2.3 are therefore

foregrounded in this discussion. Embedded knowledge and encultured knowledge are collective tacit forms of knowledge that are not explored in detail here[1].

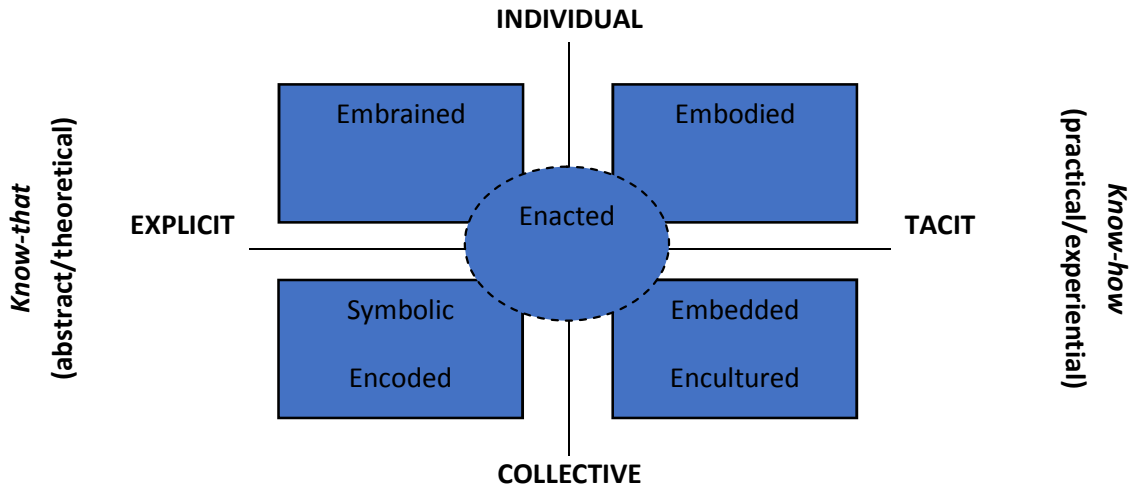


Figure 2.3: Conceptualisations of knowledge

It is important to note that, while distinguishing between different forms of knowledge provides a useful taxonomy for thinking about knowledge, in practice these distinctions are not as discrete. Not only are tacit and explicit knowledge "mutually constituted", it is also widely understood that knowledge creation is dynamic and interactive (Lam, 1998, p. 7). This implies that even the creation of new 'scientific' knowledge will necessarily involve the use and generation of tacit knowledge (Polanyi, 1962, 1966, in Lam, 1998). Nonetheless, a clear definition of terms is necessary for conceptual and analytical clarity.

Freeman and Sturdy (2015a) proposed a reconceptualisation of knowledge forms using the analogy of three phases of matter: solid, liquid, and gas. With the tacit/explicit classification as a starting point, they argue that knowledge also exists in three phases: embodied, enacted, and inscribed. Their conceptual schema builds on a number of theories regarding the locus of knowledge and how this

[1] Encultured knowledge (tacit-collective) is knowledge that is shared and made possible through language and social connectedness, through socialisation, and acculturation (Blacker, 1995; Collins, 1993). Embedded knowledge (tacit-collective) denotes the knowledge embedded in systemic routines, which represent relationships between different components of how a system or organisation functions, both architecturally and procedurally (Blacker, 1995; Lam, 1998).

influences form (Blackler, 1995; Collins, 1993; Lam, 1998). Synergies and divergences in each of these typologies are shown in Table 2.6.

Table 2.6: Theoretical development of conceptualisations of knowledge

Current study	**Freeman & Sturdy (2015a)**	**Lam (1998)**	**Blackler (1995)**	**Collins (1993)**
Embodied-Factual (abstract/evidence-based)	Embodied	Embrained	Embrained	Embrained
Embodied-Experiential (practical/experiential)		Embodied	Embodied	Embodied
Inscribed	Inscribed	Encoded	Encoded	Symbolic
(Not considered)	(Not considered)		Encultured	Encultured
(Not considered)	(Not considered)	Embedded	Embedded	(Not considered)
Enacted	Enacted	(Not considered)	(Not considered)	(Not considered)

Adapted from Maybin (2013, p. 43).

Freeman and Sturdy's (2015a) conceptual schema of knowledge has guided the analysis of the current study and is therefore elaborated on here. Links to concepts proposed in previous conceptualisations of knowledge are explained where relevant.

Embodied knowledge is a form of tacit-individual knowledge that represents how we understand and relate to the world through our bodies. Embodied knowledge represents *know-how*; it is tacit, practical, and "deeply embedded in bodily experience" (Freeman & Sturdy, 2015a, p. 9). Experiential knowledge is incorporated in this conceptualisation of embodied knowledge. However, Freeman and Sturdy contest the idea that this form of knowledge cannot be verbally articulated. They therefore collapse embrained knowledge into embodied knowledge, suggesting that embodied knowledge also includes knowledge that "sits in the mind" (Freeman & Sturdy, 2015a, p. 9). Embrained knowledge was defined by others as knowledge that is held in the brain (Collins, 1993), which includes abstract, theoretical, or higher level cognitive abilities that allow us to *know-that* (Blackler, 1995; Ryle, 1949). In Freeman and Sturdy's (2015a) classification, combining embrained knowledge and embodied knowledge collapses the distinction in Figure 2.3 between explicit-individual and tacit-individual knowledges. In this way, then, Freeman and Sturdy (2015a, p. 9) seek to synthesise *know-how* with *know-that* in embodied knowledge, arguing that, in practice, "the mobilisation or expression of verbal knowledge invariably involves an element of tacit knowledge … the embrained is also always embodied".

As shown in the first column of Table 2.6, the current study applies a slightly adapted form of Freeman and Sturdy's (2015a) conceptual schema, where embodied knowledge is understood to incorporate more tacit, experiential or practical knowledge, as well as more explicit, formalised, and abstract knowledge – what was previously referred to as embrained knowledge (Blackler, 1995; Collins, 1993; Lam, 1998). The embrained component of embodied knowledge, then, also includes scientific or factual knowledge, which is used interchangeably with evidence-based knowledge in this study, and is regulated by rules regarding validity, reliability, and generalisability. Importantly, this synthesis implies that embodied knowledge, regardless of whether it is more tacit or explicit, requires the presence of the human body to exist.

In contrast, *inscribed knowledge* is contained in material artefacts. In Freeman and Sturdy's (2015a) conceptual schema, inscribed knowledge is captured and encoded in words and symbols and is consistent with the symbolic and encoded knowledge forms conceived of in earlier frameworks (Blackler, 1995; Collins, 1993; Lam, 1998). Inscribed knowledge is a stable and easily transferable form of knowledge by virtue of its inscription in texts, diagrams, images, instruments, and tools; it is also "easily reproduced and highly mobile" (Freeman & Sturdy, 2015a, p. 10).

Enacted knowledge is an addition to the previous classifications in which Freeman and Sturdy (2015a) attempt to capture the action component of knowledge, that is, what we do with it. In one sense, enacted knowledge is embodied or inscribed knowledge in action; both of these forms of knowledge remain latent in people or in documents until they are enacted. Similarly, action lacks meaning unless it is informed by some kind of knowledge. However, Freeman and Sturdy (2015a) propose that when knowledge is enacted, it is also transformed in some way from its embodied or inscribed form. They suggest, therefore, that enacted knowledge is not just a representation of the other two knowledges, but rather "a distinct phase and form of knowledge in its own right" (Freeman & Sturdy, 2015a, p. 12), which may, in turn, result in the production of new embodied or inscribed knowledge. Like gas, enacted knowledge is transient, volatile, and open to interpretation: "fleeting, highly variable from one instance to the next and often unpredictable in form and expression" (Freeman & Sturdy, 2015a, p. 13). It is also, by its nature as an (inter)action, a collective activity.

Freeman and Sturdy's (2015a) conceptual schema is particularly useful for the purposes of this study in terms of the enacted and inscribed conceptualisations of knowledge, especially as they relate to policy consultation meetings (enactments of knowledge) and policy recommendations and documents (inscribed knowledge). Their conceptualisation of phases of knowledge transferring from one form to the other is another key component relevant for this study, as it is proposed that certain forms of knowledge (i.e. experiential/embodied knowledge) are harder to articulate and inscribe than others (i.e.

factual/embrained knowledge) and thus are more likely to be lost – or evaporate like gas – in their enactment. Freeman and Sturdy's conceptual schema was developed with a particular focus on how knowledge is used in policy. It is therefore also useful in the sense that it implies transformation between different knowledge forms, while also introducing a strong element of (inter)action into the conceptualisation of knowledge.

The specific intersection of embodied, enacted, and inscribed knowledge forms in policy consultation is considered in the sections below, with a particular focus on the transformation between these different knowledge forms. As the focus of the current study is on policy consultation in particular, these forms of knowledge have been conceptualised here in terms of how they might function during a specific policy consultation event: the embodied knowledge that individual participants bring to the process, the ways in which these embodied forms of knowledge are transformed into enacted knowledge during consultation discussions, and the ways in which this enacted knowledge might be captured as inscribed knowledge, which can be transferred beyond the consultation space.

2.3.2 Embodied knowledge in policy consultation

As mentioned above, Freeman and Sturdy (2015a) bring together *know-how* and *know-that* in their concept of embodied knowledge. Verbal, factual or propositional knowledge – previously conceptualised as embrained knowledge – is thus also seen as embodied knowledge. In the current study, then, both experiential and evidence-based knowledge, each conceived of as different kinds of expertise, are forms of embodied knowledge. While evidence-based knowledge might typically be thought of as that which exists in inscribed form, the form of evidence-based knowledge that is focused on in this study is that which is embodied in individuals. Evidence-based knowledge, then, is research-generated or factual knowledge that individuals embody, transfer, and draw on when engaging in 'evidence-based' discussions.

The advantage of embodied knowledge is that it is flexible, mobile and "capable of being rapidly updated, amended and corrected by new experiences or exposure to new information" (Freeman & Sturdy, 2015a, p. 10). However, given that it requires the human body in order for it to be accessed and used, it is as fragile and fallible as the human body itself (Freeman & Sturdy, 2015a). In policy consultation processes, then, embodied knowledge must be elicited and enacted in order to be shared. This, in turn, has the potential to result in the creation of new (enacted) knowledge, which must be captured in some way in order to move beyond the policy consultation space.

This conceptualisation of embodied knowledge foregrounds the importance of the individual in "the distribution, movement, and mobilisation of [this] knowledge" (Freeman & Sturdy, 2015a, p. 9). It also highlights the fact that individuals embody many of these different kinds of knowledge – evidence-based, experiential, practical – which may not always be compatible. The value and utility of evidence-based and experiential knowledge for policy, as well as their validity and relevance, must be carefully assessed and weighed up by individuals and their 'audiences'. Each form of knowledge has particular strengths and weaknesses and may be more useful in some contexts than in others and at certain stages in the policymaking process. Drawing on the proven effectiveness of health care interventions, for example, is important for formulating policies based on sound scientific knowledge/evidence, while the implications of implementing such interventions in particular contexts might be informed by experiential or situated knowledge. As has been argued throughout this chapter, the challenge of reconciling multiple and often conflicting kinds of knowledge is one of the challenges facing policymakers when developing and consulting on policies. It is a challenge that also faces individuals engaged in policy consultation discussions, as well as those facilitating and recording such processes.

The 'problem' of evidence-based knowledge and of experiential knowledge in policymaking has been explored in previous sections. These are briefly returned to here in order to explore the particular challenges that policymakers might face in eliciting, transferring, and using these kinds of embodied knowledge in policy consultation. If embodied or tacit knowledge is considered to be a legitimate input to policy, the focus shifts to how such knowledge might move through the policymaking process. Tacit experiential embodied knowledge is considered a valuable and legitimate source of information that could supplement explicit scientific or evidence-based knowledge in a number of contexts. The utility of such knowledge in adapting explicit formal knowledge for contextual relevance is of particular interest in this study. However, this type of knowledge is not easily elicited, captured, or transferred. As was discussed earlier, the integration of multiple forms of knowledge in policymaking is not a simple task.

The discussion thus far has focused on forms of knowledge as inert, embodied 'products' of knowing. An important line of argument followed in this thesis is that the production of knowledge is dynamic and interactive. The co-existence of multiple forms of knowledge, as well as the transformation of knowledge between forms, is captured in Nonaka's (1991, 1994, in Blackler, 1995, p. 1033) proposition that "knowledge is created out of dialogue between people's tacit and explicit knowledge". This introduces the notion that transfer of knowledge from one form to another, as well as from one source to another, is possible – from tacit to tacit, tacit to explicit, explicit to explicit, and explicit to tacit. Knowledge, then, moves in dynamic interaction between forms and sources – what Nonaka calls 'knowledge-creating' – with different forms of knowledge inherently related to others. This has led to Blackler (1995) and others suggesting that it may be more useful to talk about the process of knowing

than about knowledge per se. The idea that "knowing precedes knowledge, both logically and chronologically" (Nicolini et al., 2003, p. 3, in Sedlačko & Staroňová, 2015, p. 32) implies that knowledge is not static but active, and that it comes about through dynamic interaction.

Knowledge, then, is co-produced and socially validated. Lam (1998, p. 4) proposes that tacit knowledge is experience based and "can only be revealed through practice in a particular context and transmitted through networks of human relations", while Sedlačko and Staroňová (2015, p. 32) draw attention to the social or communal nature of knowledge: "While knowledge can be understood as a resource 'deposited' in individuals, knowing requires a community in which social practice is situated and only becomes visible in doing". Healey (2007) also takes this position, emphasising that our store of knowledge about the world is not static but is in constant evolution through practical engagements and our experience of living in the world; in addition, we have more formal modes of knowledge acquisition. Freeman and Sturdy's (2015a) conceptual schema is of value here, as it speaks to how the form of knowledge as embodied or inscribed might influence its transfer, as well as how embodied knowledge must be enacted in order for it be passed on to others. Their introduction of enacted knowledge, for example, through face-to-face consultations, provides clues to how knowledge moves and can be transferred and transformed from one form to another. The enacted knowledge concept captures this movement in a way that has utility for the current study in understanding, at a micro level, how knowledge moves – or does not move – in and through a policy consultation process.

Freeman and Sturdy's (2015a) conceptualisation of enacted knowledge is believed to encapsulate this (inter)active nature of knowledge, particularly as it is understood as representative of both embodied and inscribed knowledge, but different from these in form. This implies that knowledge changes form as it is enacted, and that new meanings and interpretations may be infused in this enacted form. The role of enacted knowledge in policy consultation is explored further in the next section.

2.3.3 Enacted knowledge in policy consultation

Enacted knowledge is knowledge in action. It is the form that embodied and inscribed knowledges are transformed into when they are enacted. Importantly, this enactment is a collective activity, such that "individuals may know things and may be able to draw on other knowledge inscribed in documents and other artefacts, but their enactment of that knowledge is channelled by the communities of knowers to which they belong" (Freeman & Sturdy, 2015a, p. 14). By virtue of its interactive nature, enacted knowledge is "fleeting, highly variable from one instance to the next and often unpredictable in form and expression" (Freeman & Sturdy, 2015a, p. 13). This also means that it is flexible and open to transformation through interpretation and judgement, which can be both an opportunity and a risk in

policy consultation spaces. Embodied and inscribed knowledge, then, are literally transformed once they become enacted knowledge. As Freeman and Sturdy (2015a, p. 13) suggest, this is why rules and laws are typically accompanied by guidelines on how to interpret these laws and by "commentaries on how to interpret the guidelines". This speaks to the importance of having detailed implementation plans to guide implementation of national policies at local levels.

The role of enacted knowledge in policy consultation becomes especially apparent in how it both creates and is created by particular kinds of interaction. Although enacted knowledge is flexible, volatile, and open to interpretation, it is also highly regulated by explicit and implicit social sanctions. Meetings and policy consultation forums, for example, are enacted spaces that are governed by certain (explicit) procedural rules and processes. Importantly, however, the spaces in which enacted knowledge is created are also "constantly monitored and regulated through the mutual surveillance and sanctioning of those involved at any given moment. Strong sanctions may be exerted against any actor who is judged to break the bounds of what is deemed normal or appropriate action" (Freeman & Sturdy, 2015a, p. 14). This links to earlier discussions regarding the implicit 'rules of the game' that may serve to exclude certain kinds of contributions to policy consultation discussions. It is another factor that contributes to the complexity of eliciting and reconciling multiple kinds of knowledge in policy consultation.

Evidence-based knowledge and experiential knowledge, as forms of embodied knowledge, can become enacted knowledge through interaction and engagement in policy discussions. The advantage of conceptualising enacted knowledge as a distinct form of knowledge is that it gives equal space to different kinds of knowledge once they are enacted. The disadvantage is that it makes identifying and reconciling conflicting – and 'invalid'– kinds of knowledge much more difficult to do. It implies that conscious attention needs to be paid to these enacted spaces in their design, facilitation, and management. This has been emphasised in earlier discussions regarding policy consultation as a form of knowledge management, and regarding the importance of designing participatory processes that allow for the optimisation of knowledges available in these spaces. Some of the challenges in transferring knowledge in policy consultation – and specifically in optimising the transformation of embodied knowledge into enacted knowledge – are briefly considered below.

With the increasing recognition of the importance of other forms of knowledge in policy came a greater appreciation of the multiple spaces for interaction between knowledge and policy (Jones et al., 2012). However, not only does the tacit and more embedded character of experiential or practice knowledge make it harder to access and transfer, Jones et al. (2012) argue that processes through which multiple forms of knowledge might be actively integrated into policy constitute a neglected area in the

knowledge-in-policy literature. While the evidence-based policymaking field is replete with studies and approaches to the transfer of evidence (i.e. scientific knowledge) into policy, knowledge transfer models in this area have seldom focused on transfer of other, more tacit, forms of knowledge. A theme in the policy consultation literature, on the other hand, has been on how to access and include various forms of knowledge from a wide range of sources or voices (cf. Jones et al., 2012). Few of these studies, however, have explicated at a micro level how such knowledge might be captured and transferred, and then integrated with other more explicit forms of knowledge in discussions at policy consultation meetings (with notable exceptions, such as Smith-Merry, 2012).

Given the objectives of public consultation outlined in earlier sections, it is important to understand how the inputs based on practical or experiential embodied knowledge might actually be used to influence policy, given the valuable information they may offer policymakers. As Smith-Merry's (2012) findings suggest, however, this type of knowledge is not easily captured or transferred during policy consultation processes, in part because it resists verbalisation and codification (Sedlačko & Staroňová, 2015). Prior to its transfer, then, there needs to be a way of both eliciting and capturing tacit knowledge in order for it to move or be moved.

Research in the organisational knowledge-management field regarding the transfer of tacit knowledge, in particular, could be useful to draw on here. In organisational knowledge management, there is a great deal of work exploring how knowledge is transferred within and between organisations, with particular emphasis on how tacit knowledge might be captured so that it is not lost to an organisation when people leave (see, for example: Abidi et al., 2005; Hansen, Nohira, & Tierney, 1999; Hussain & Raza, 2004; Nonaka & Takeuchi, 1995; Ranucci & Souder, 2015; Shulz & Jobe, 2001). There are obvious challenges in the transfer of tacit experiential knowledge, and much work has been dedicated to identifying strategies for effective codification of such knowledge.

Importantly, knowledge-management research on organisational knowledge transfer seems to operate from the premise that tacit knowledge, although implicit and difficult to access, can be elicited and transformed into forms that facilitate its transfer. Some have argued, however, that tacit knowledge is such that it cannot be recorded, and that knowledge can therefore only be shared through interaction between knowers (Al-Hawamdeh, 2002; Hildreth & Kimble, 2002). Kingston (2012a) counters this by asserting that if tacit knowledge is indeed unrecordable, then "it cannot be discussed directly, because if it could be discussed in words, then it can be recorded" (Kingston, 2012a, p. 2). Kingston also acknowledges that some of the contextual and rich value of tacit knowledge is likely to be lost in the capturing of it, but argues nonetheless that while "an inanimate repository may be incapable of adding to or refining an existing store of subjective knowledge … there is no reason why it should not record the

current contents of it" (Kingston, 2012a, p. 4). Adapting Milton's (2012, in Kingston, 2012a) techniques for capturing lessons learned from experience, Kingston proposes strategies for capturing and transferring tacit knowledge, which he categorises as 'connect' (person-to-person sharing) or 'collect' (distributing captured or recorded knowledge) strategies, using structured and unstructured techniques. He suggests that transfer of tacit knowledge is typically understood to be shared through connect techniques, which include conversations in communities of practice, as well as storytelling.

What is interesting to note from many of the studies in the knowledge-management field is an increasing recognition of the socially interactive nature of both knowledge and knowledge transfer (e.g. Bresnan, Edelman, Newell, Scarbrough, & Swan, 2003; Newell, 2003; Nonaka & Takeuchi, 1995). The importance of the human or social dimension of knowledge transfer was highlighted, for example, by Hansen et al.'s (1999) concepts of codification and personalisation strategies for knowledge transfer. In codification practices, knowledge is transferred from people to documents, whereby such knowledge is captured in a form that does not require the individual 'knower' to be further used. In contrast, personalisation strategies emphasise the transfer of knowledge through dialogue between individuals. Hansen et al. (1999) found that effective companies were those that pursued one strategy predominantly and used the second strategy to support the first, although they suggest that when drawing on tacit knowledge, personalisation strategies work best (e.g. the sharing of stories about how problems were solved). This has potential implications for how policy consultation processes are organised in order to facilitate the elicitation and transfer of tacit knowledge.

Various mechanisms that have been identified for transferring and optimising the use of embodied knowledge in policy have emphasised this interactive component. Knowledge brokering, for example, has been highlighted by Jones et al. (2012) as an active strategy for bridging and integrating multiple perspectives into policy. This was explored in some detail in the consultative policymaking section. At a more individual level, Restall, Cooper, and Kaufert (2011) identified a number of strategies that mental health care users employed to 'transfer' their experiential knowledge to policy. These strategies fell into two broad interactive approaches – direct or indirect communication – with each having different potential for influence. Direct communication with policymakers was impeded by a number of factors, and these pathways were thus found to be employed less frequently than indirect communication.

Indirect pathways typically involved user representatives or advocates who could translate or communicate the views of citizen-users to decision makers, along similar lines to knowledge brokering. In addition, as discussed in earlier sections, particular forms of more interactive participatory methods seem to provide greater opportunities for different forms of knowledge to mix. To avoid such exercises becoming merely tokenistic, however, participants must find a way of linking and sharing what they

know with one another in these spaces (Ashwood et al., 2014), while policymakers must equip themselves with skills to attend to and integrate multiple knowledge sources (Restall et al., 2011).

The social nature of knowledge and, in particular, its transformation and transfer through interaction, has been emphasised in this section. The meaning and form of knowledge may be (re)constructed through these social interactions, in part because tacit knowledge, once it is shared, exists in a more explicit form – in Freeman and Sturdy's (2015a) terms, in its enacted form – and in part because new meanings and knowledges are created through interaction and dialogue. This seems to be what Freeman and Sturdy (2015a) had in mind when they developed the concept of enacted knowledge, a form that exists in its own right and is substantively different from the embodied and inscribed knowledge that it may represent, precisely because it has been enacted.

This might be linked to the idea that such interaction, for example, through policy consultation discussions, can in itself enable learning, such that participants leave with transformed understandings and new embodied knowledge. Even if this enacted knowledge is not recorded or inscribed in written form, policy consultation may offer value in its own right, outside of whether it has been used in or influenced policy. This was evident in Smith-Merry's (2012) study of a mental health policy consultation process, where greater person-to-person (embodied – enacted – embodied) knowledge transfer occurred compared to person-to-document (embodied – enacted – inscribed) knowledge transfer.

Policy consultation itself, then, represents an enactment of knowledges (Freeman & Sturdy, 2015b; Smith-Merry, 2015). This requires a means of accessing and making explicit participants' embodied knowledges (Smith-Merry, 2012), as well as an epistemic pluralism in policymakers as they seek to integrate multiple forms of knowledge (Freeman, 2007; Healey, 2007). As previously mentioned, knowledge brokering has been identified as a useful mechanism in this regard. Finding pragmatic ways of capturing such enacted knowledge may also facilitate this process. Embodied knowledge is, after all, contingent on the human beings who embody it; if it is to travel outside of these bodies, it must be enacted and inscribed such that it can be available to different individuals in different contexts at different times (Freeman & Sturdy, 2015a). Once knowledge is enacted, it may become embodied once again within individuals, and in this way travel out of consultation spaces. However, this enacted knowledge must also be transferred into inscribed forms in order for it to move beyond policy consultation processes, and to be seen and used by policymakers tasked with integrating these inputs in policy decisions. The inscription and transfer of tacit experiential knowledge at this micro level of policy consultation is explored in the next section, which considers how such knowledge might be captured and moved through a particular consultation process.

2.3.4 Inscribed knowledge in policy consultation

Inscribed knowledge is knowledge captured in codified or symbolic form, in tangible forms such as documents. Perhaps in part because of the difficulties described above in eliciting and transferring embodied knowledges, the written form of knowledge has tended to persist as our dominant reference for formal knowledge (Collins, 1993). Freeman and Sturdy's (2015a) notion of inscribed knowledge contributes to understandings of the role of knowledge in policy by foregrounding the centrality to policymaking of inscribed knowledge in policy documents. In part, this is because of the inherent advantages of inscribed knowledge as "stable … easily reproduced and highly mobile. This means that it can be communicated or available to many different individuals separated in space and/or time" (Freeman & Sturdy, 2015a, p. 10). As "common points of reference" (Freeman & Sturdy, 2015a, p. 15), policy documents perform the coordinating work of policy; however, they also can therefore "serve to constrain and discipline our interactions with the world and with one another" (Freeman & Sturdy, 2015a, p. 11).

The coordinating function of inscribed knowledge is highlighted by Freeman and Sturdy (2015a) as one of the advantages it has over embodied knowledge. Whereas coordinated action takes place on a daily basis without reference to inscribed knowledge (documents), this happens at local sites, in face-to-face interactions between individuals. The stability and mobility of policy documents, in contrast, "makes coordination possible over a much larger area and involving far larger numbers of people" (Freeman & Sturdy, 2015a, p. 11). This highlights again, however, the importance of developing national policies that are applicable across diverse contexts, while including sufficient detail for clarity in the implementation of policies at local sites.

The transfer from embodied knowledge to inscribed knowledge is important for the purposes of policy consultation if such inputs are to be used in any way to inform policy. Policy consultation spaces offer opportunities for individuals with valuable experiential or practical knowledge to enact this knowledge through face-to-face meetings and discussions. The challenge, however, is how to transfer that embodied and enacted knowledge into inscribed knowledge, a form that may be amenable to further policy development. This section thus focuses on how tacit experiential knowledge might be transferred on a micro level, in processes that might be typical of policy consultation forums. As Freeman and Sturdy (2015a, p. 7) suggest, "if the role of knowledge in policy is to be understood in any depth, far more attention needs to be given to the material … forms that knowledge may take". There is thus great value for policymakers in "observing just what knowledge finds its way into inscriptions for policy purposes, and by attending to and following the movement of those inscriptions through the policy world" (Freeman & Sturdy, 2015a, p. 15).

There is a gap in the literature regarding the specific methods used in eliciting and capturing the results of collective decision-making in public participation (Morrison & Dearden, 2013; Oliver et al., 2008). Horlick-Jones et al. (2007) point out that much of the work on integrating knowledge from multiple sources in policy consultation has been focused on the way in which public engagement methods are structured as organisational processes, or on highlighting the legitimacy of such inputs. However, they argue that there is also a need for understanding, on a micro level, how information and knowledge are managed and integrated during these processes. They suggest that one factor that should be considered in evaluating public engagement in policymaking is "translation quality" (Horlick-Jones et al., 2007, p. 260), which includes attending to "processes of gathering, disputing and agreeing, framing and re-framing, and finally using different forms and sources of knowledge". The findings of their study revealed a lack of systematic methods for capturing and collecting the rich information generated through discussion and deliberation at policy consultation meetings. As a result, there was little evidence in terms of whether or how such discussions were used in the final decision-making process.

In a case study exploring how practitioners' experiential knowledge was used in mental health policy consultation, Smith-Merry (2012) also identified barriers to the transfer of embodied knowledge from the enacted discussion spaces to the inscribed policy documents. She argues that although the experiential nature of health professionals' knowledge is what holds value for policy, it is precisely this experiential nature that makes it difficult for this knowledge to have an impact on the resulting policy. The knowledge that practitioners brought to the consultation process in Smith-Merry's (2012) study was based not on their explicit formal knowledge, but in their experiences of implementing this knowledge, and their consequent knowledge of what did or did not work on the ground. This knowledge was then "traded in dialogue between the participants" in the policy consultation (Smith-Merry, 2012, p. 137).

Through these exchanges, and the individual and collective interactions with the proposed (inscribed) policy in relation to experience, new knowledge was created that spoke to ways in which the new policy might be implemented. However, Smith-Merry's (2012) findings showed that different forms of knowledge were not optimally utilised during the course of such processes, particularly with respect to finding their way into the final policy document. The responses from the consultation process were ultimately synthesised into a summary report, but the positive or negative implications of the policy in practice, as discussed by participant practitioners, were absent from this document.

Smith-Merry (2012, p. 140) proposes a number of possible reasons for this "gradual lessening of the use of practitioner knowledge the further it progressed through the chain of consultation events and texts". The complex and idiosyncratic knowledge held and transmitted by practitioners, for example, may make

it difficult to convert to an explicit form amenable to capture in policy, while the detailed nature of the experience-based anecdotes may have made it neither possible nor desirable to attempt to include this knowledge in summary reports. Indeed, the structured nature of policy consultations, and the implicit rules governing the format in which policy recommendations should be communicated, seemed to leave little room for the descriptive vignettes generated during consultation discussions. Ultimately, then, although much valuable experiential knowledge was generated and shared during consultation discussions, it was not possible to identify instances where this knowledge appeared in the policy document.

The transfer of tacit embodied knowledge to enacted or inscribed knowledge, however, involves making such knowledge explicit in order to for it to be captured; such processes invariably carry a number of risks. One of the key arguments against attempts to articulate or capture tacit knowledge is that some knowledge will inevitably be 'lost in translation'. Lam (1998, p. 8), for instance, argues that "codification inevitably involves a data sacrifice; some part of the knowledge will always stay behind in the knowing subject". There are also those who contend that the capture and transfer of tacit experiential or practical knowledge loses the rich contextual dimension of such knowledge. Constructionists are among those who would argue that knowledge that is partially captured – that is, outside of the context in which it exists – is not knowledge at all (Goodwin, 2009, in Kingston, 2012a).

While acknowledging these challenges, the current study adds support to those researchers advocating for finding ways to elicit, capture, and transfer embodied knowledge that has been gained through practice or experience (Horlick-Jones et al., 2007; Kingston 2012a, 2012b; Kothari, Bickford, Edwards, Dobbins, & Meyer, 2011), based on the great potential this may hold in relation to proposed policies. In particular, tacit knowledge might facilitate the adaptation of other more explicit (evidence-based) knowledge to be more contextually relevant and applicable. The challenge for policymakers is to balance the particular (contextual experiential knowledge) with the abstract (generalised inscribed knowledge) in policy development, in a way that allows for the abstract knowledge in policy to be applied locally in implementation. As Freeman and Sturdy (2015b, p. 217) argue:

> the problem of understanding the role of knowledge in policy may be reconceived as the problem of understanding how the local immediacy of practice is transformed into the generalising, standardising, abstracting function of government and policy knowledge, and then transformed back again into coordinated practice.

The focus of this review now turns to exploring the forms in which tacit embodied knowledge might be captured to facilitate their transfer.

While documents such as consultation reports might be a conventional form of inscribed knowledge resulting from policy consultations, the discussion above has pointed to some challenges in codifying and inscribing particular forms of knowledge inputs. These challenges may in part be mediated through the use of boundary objects, a concept that was linked in earlier discussions to knowledge brokering as a way of bridging different bodies of knowledge. Boundary objects, also referred to as knowledge artefacts, have value as a mechanism for the integration of knowledge (Trompette & Vinck, 2009), as well as for its codification and transfer (Abuhimed, Beheshti, Cole, AlGhamdi, & Lamoureux, 2013; Rooke, Rooke, Koskela, & Tzortzopoulos, 2009). As such, the utility of boundary objects for policy consultation is briefly elaborated on here.

In simple terms, policy consultation processes are spaces in which a number of perspectives come together so that proposals can be deliberated on and mutually agreed-upon recommendations formulated. Yeh (2013, pp. 3-5) suggests that "boundary tensions inevitably arise from the collision of different worldviews or ways of knowing" – tensions which might be resolved by the practical application of boundary objects. These are artefacts that are malleable enough to adapt to the needs of the knowledge communities employing them, but robust enough to maintain a common identity across sites (Star & Griesemer, 1989). Boundary objects or knowledge artefacts come in a number of forms, including documents, files, classification systems, pictures and diagrams, stories, mind maps, and props or objects (Abuhimed et al., 2013). They therefore encompass both tangible (pictures) and intangible (stories) forms. Such representational artefacts become boundary objects when they are used between groups for the purpose of integrating and co-constructing knowledge (Star, 2010). In policy consultation spaces, boundary objects can be "named, pointed to, and used by participants in identifying and repairing breakdowns in communication" (Morrison & Dearden, 2013, p. 181).

Boundary objects can remove barriers between different knowledge communities that have different languages, concerns, forms of interaction, and practices (Emad & Roth, 2009) and, because of their interpretive flexibility, they enable cooperation without requiring consensus (Star, 2010; Trompette & Vinck, 2009). They function as a shared reference point that is meaningful to different knowledge communities (Fominykh, Prasolova-Forland, Divitini, & Petersen, 2016), thereby enabling these communities to interact and develop "alternative, collective ways of knowing in policymaking processes" (Yeh, 2013, p. 1). They are thus a useful mechanism for the integration of knowledges between experts and non-experts, maintaining the integrity and character of the knowledges that contribute to them, and the autonomy of the social worlds that create them (Trompette & Vinck, 2009). This may be particularly useful in bringing together diverse mental health knowledges in policy consultation, mediating the risks of professionalising experiential knowledge, or de-professionalising expert knowledge in trying to find common ground (Morrison & Dearden, 2013). Boundary objects such

as concept maps have also recently been shown to have value in evidence-based policymaking, with concept mapping proving a useful mechanism for facilitating knowledge exchange between researchers and policymakers in developing country contexts (Langlois et al., 2016).

Boundary objects also represent mechanisms in which multiple knowledge inputs can be integrated and codified, and therefore transferred beyond the consultation space. In this way, boundary objects can be seen as "physical representations of knowledge" (Fominykh et al., 2016, p. 87) that are intended to be transferred for future use (Paavola & Hakkarainen, 2009). Boundary objects therefore expand on the range of available forms of inscribed knowledge that might be employed during policy consultation processes. As has been highlighted in previous discussions, experiential knowledge has value for policy in terms of how it might illuminate challenges and opportunities in the implementation of policy proposals under discussion. By its nature, this knowledge and, it could be argued, the enacted knowledge in policy consultation spaces, are likely to provide richer context and detail than is typical of policy documents. This, in part, is what makes these forms of knowledge difficult to capture. It also, however, points to the importance of finding ways of capturing this knowledge that preserves some of the valuable detail it has to offer. Some examples of boundary objects that may facilitate this are explored here.

Stories or narratives are one example of boundary objects that may have utility in policy consultation. In the organisational and knowledge-management fields, stories or anecdotes have been identified as a mechanism for the elicitation and transfer of tacit experiential knowledge (Classen, 2010; Denning 2004; Kalid, 2010; Labov & Waletzky, 1967; Perret, Borges, & Santoro, 2004; Wagner & Sternberg, 1986). In the policy consultation arena, narratives have the potential to capture experience in a way that makes them a "compelling vehicle for transporting perspective and opinion about health policy issues" (Mullan, 1999, p. 124). Not only do people convey knowledge through narratives, stories also facilitate the retrieval and assimilation of information (Hampton, 2004) and provide a way of making the knowledge needed for policy more accessible for policymakers (Shortall, 2013).

Similarly, Epstein et al. (2012) highlight the need for a way of drawing out the meaning of narrative contributions during policy consultation that both values the anecdotal experiences of lay participants and provides policymakers with information that can optimise policy outcomes. In particular, Epstein et al. (2012) show the value of anecdotes in illuminating the implications of various policy proposals. This is consistent with Emad and Roth's (2009) finding that employing boundary objects, at the point of policy formulation through consultation, can ultimately facilitate implementation.

In addition, the "flexibility of anecdotes at the boundary between science and its public can offer opportunities for participation and engagement" (Moore & Stilgoe, 2009, p. 654). Attending to narratives in public policy consultation, then, may facilitate the identification and reconciliation of diverse (and possibly marginalised) views and preferences (Hampton, 2004; Polletta & Lee, 2006). Stories or anecdotes therefore offer multiple possibilities for contributing to policy and policymaking processes. Not only do they offer a means (as a boundary object) for bridging expert and lay knowledges in deliberative spaces (Hampton, 2009; Moore & Stilgoe, 2009), they also provide a mechanism for making tacit embodied knowledge explicit in a way that may facilitate the movement of this knowledge through policy consultation spaces. This might be a particularly useful way of bridging expert and experiential knowledge in the mental health policy consultation space.

Morrison and Dearden (2013) expanded the use of stories as mechanisms for meaningful participation to using participants' stories to create emotion maps. The physical form and properties of the emotion maps influenced who was able to participate and how their participation was facilitated through the use of the maps. These maps then served as a collation of lay and expert participants' experiences that could be shared with people and groups outside of the participatory process. Importantly, Morrison and Dearden's (2013, pp. 183-184) study showed how such representational artefacts can provide:

> an alternative mechanism for facilitating language games that are accessible to broader audiences. In contrast to conversations and meetings in which professionals can dominate the interaction through their command of language and familiarity with the structure of meeting agendas and reports, the emotion map altered the normal turn-taking rules.

This has important implications for involving mental health care users in policy development. It links the use of boundary objects in policy consultation to the ways in which the processes in which these objects will be used are designed. It suggests, too, that the use of boundary objects alone is not sufficient to ensure meaningful participation. Attention must also be paid to the facilitation of interaction, as well as the creation and management of these shared knowledge artefacts (Clark et al., 2015; Paavola & Hakkarainen, 2009; Yeh, 2013). Innovative participatory processes, together with the use of boundary objects, have the potential not only for enabling meaningful participation, but also for optimising the integration and inscription of diverse knowledge inputs.

The availability of diverse forms of knowledge in policy consultation can be overwhelming in volume as well as in content. Even inscribed knowledge can be difficult to gather, process, and make use of in policy, and collecting more forms of knowledge increases problems related to volume. It is therefore important that processes that facilitate the enactment of knowledge, described above, be combined with processes for knowledge collection, storage, and synthesising in policy. This links to earlier

discussions on the importance of record keeping in policy consultation, and of adequate systems for ensuring systematic transfer of knowledge through such processes.

This section has highlighted the importance of understanding how different forms of knowledge function in policy and policy consultation. It has described some of the complexities associated with using more tacit, experiential kinds of knowledge in policymaking and, in particular, the challenges of integrating multiple forms of knowledge in policy decisions. The conceptualisation of knowledge as embodied, enacted, and inscribed has been presented as a useful way of understanding both where knowledge might be held, as well as its potential to transform into other forms. This, in turn, provides insight into the mechanisms though which participants' embodied knowledge might be elicited (enacted) and captured (inscribed) during policy consultation spaces, such that these knowledge inputs could be used to inform policy. This links directly into the current study, which explored how knowledge inputs at a mental health policy consultation event moved through various points of enactment and inscription, with a view to determining how the policy consultation informed policy.

2.4 Conclusion: Mental health policymaking as a knowledge problem

The literature review has considered the role of knowledge in policy and policymaking. The focus, in particular, has been on the transfer of knowledge in evidence-based and consultative policymaking. Knowledge transfer in policy development is a complex, iterative process, contingent on a wide range of factors that influence what knowledge inputs get taken up into policy decisions. Part of this concerns the perceived legitimacy of different forms of knowledge, with objective evidence-based knowledges typically being granted greater credibility than subjective experiential knowledges; this may happen for good reason, but has serious problems. Another factor in the uptake of knowledge in policy is how the particular form that knowledge takes affects the extent to which it can be elicited and captured. More tacit, embodied forms of knowledge pose greater challenges for policymakers in this regard.

Throughout the literature review, attempts were made to identify and unpack how policymaking represents a knowledge problem for policymakers, insofar as it requires them to balance a number of tensions thrown up by different sources and forms of knowledge. These tensions are especially apparent in the mental health context. In evidence-based policymaking in mental health, decisions about the best forms of evidence on which to base policy are by no means unambiguous. The dilemma for policymakers was presented as one in which they must reconcile abstract/objective with particular/subjective, global with local, and scientific with experiential forms of evidence. By virtue of its contingency on contextually

based understandings of health and illness, and its idiosyncratic embodied nature, mental health evidence is a particularly complex body of knowledge for policymakers to navigate.

The democratic imperative for public participation in government decision-making was the departure point for the consultative policymaking section. In policy consultation, policymakers must balance inclusivity and fairness in decision-making processes with technocratic considerations regarding the effectiveness of policy decisions. A number of process- and outcome-related elements contribute to the perceived effectiveness of policy consultation initiatives. Some of these were elaborated on in the consultative policymaking section. However, what emerged clearly was the importance of showing how consultation inputs related to policy decisions, as a way of demonstrating the authenticity of the consultation process. This, in turn, highlights the necessity of ensuring that policy consultation inputs are captured, and that systematic processes exist for providing feedback to participants regarding how their contributions were subsequently used.

With growing calls to include a greater diversity of stakeholders in mental health policy development, policymakers engaged in policy consultation are confronted with an increasingly complex task. The more embodied nature of many forms of mental health knowledge requires particular mechanisms for eliciting such knowledge, as well as particular means of capturing it in forms that are amenable to transfer and use outside of policy consultation spaces. Not only must multiple knowledge inputs be integrated during such processes, but there is also a need to move between the particularised forms of knowledge embodied in participants and the more abstract forms of knowledge inscribed in policy documents. Policy consultation processes offer potential as enacted spaces in which to find ways of balancing and moving between these different knowledge forms. In this sense, then, mental health policy consultation represents a microcosm of the broader knowledge problem that policymaking poses for policymakers. Viewing policy consultation through the lens of embodied, enacted, and inscribed knowledge may illuminate ways of responding to this problem.

Chapter 3: Methodology

In accordance with Babbie and Mouton (2001), the methodology describes the researcher's general approach to carrying out the research. In this chapter, I describe and justify the methodological decisions made and empirical processes undertaken in relation to this study. This includes an account of the paradigmatic position and research design, description of the selected case and units of analysis included in the data collection, and an explanation of the analytical framework and data analysis methods and procedures. The final section describes steps taken to enhance the quality of the study.

3.1 Study aim and research questions

The aim of this study was to explore how the mental health policy consultation process undertaken in South Africa in 2012 informed policy, by tracing the movement of different forms of knowledge through the consultation process. This was applied to a particular case of policy consultation in a particular point of time and, as such, in addressing this aim, the study sought to answer three research questions in relation to this specific case:

1. How were participants' embodied knowledges enacted and captured (inscribed) during the consultation process?
2. How did the consultation process enable or constrain the movement of knowledge from enacted to inscribed forms?
3. How did inscribed knowledge outputs from the consultation move through points of abstraction to inform policy?

These questions were developed in an iterative process of engagement and refinement as I moved between theory and data (Maxwell, 2013) to understand how the mental health policy consultation process had generated outputs that might inform policy. Consistent with case study research, the questions were framed as particular to this specific case, rather than in a manner that seeks to imply causal explanation and generalisation (Maxwell, 2013).

3.2 Study approach

A paradigm is an "epistemological stance" that guides how research questions are asked and answered according to assumptions about the nature and knowability of knowledge (Morgan, 2007, p. 52). It is, therefore, a philosophy of knowledge in which research methodologies are located. Researchers are

called upon to make explicit the philosophical assumptions underpinning their research, as these assumptions guide decisions about research design, questions and methods (Maxwell, 2013). Given the centrality of conceptualisations of knowledge in the current study, it seems especially prudent to provide substantive explanation of my paradigmatic choices that have guided this research. In addition, Maxwell (2013) argues that our paradigmatic assumptions are not entirely a matter of free choice. Researchers approach their research and the studies they conduct with particular a priori assumptions about reality and about the topics they explore. What is important is for researchers to be conscious of these choices, and to make this awareness explicit for their readers, in both epistemologically and personally reflexive ways (Willig, 2008).

This, in turn, highlights the importance of researchers describing their positionality in relation to their research. I reflect on how my positionality informed paradigmatic and methodological decisions in this chapter, and return to this at the end of this thesis. In the final section of this chapter, I describe the strategies employed to ensure a reflexive stance throughout this research process. One such strategy was adopting a first-person voice in certain parts of this thesis, including in the current chapter. I elaborate on my rationale for doing so in the study quality section (section 3.8).

This study is located within a pragmatist paradigm. Although "there is no unitary pragmatism" (DeForge & Shaw, 2012, p. 87), and the original thinkers all differed in terms of their conceptions of external or physical reality, "pragmatists' view of the measurable world (generally) relates…closely to an existential reality" (Dewey, 1925, p. 40, in Feilzer, 2009, p. 3). As a paradigmatic orientation in social science research, pragmatism draws on a number of elements of this philosophical tradition. Pragmatism rejects "the top-down privileging of ontological assumptions in the metaphysical paradigm as simply too narrow an approach to issues in the philosophy of knowledge" (Morgan, 2007, p. 68). Furthermore, "pragmatism not only replaces arguments about the nature of reality as the essential criterion for differentiating approaches to research, it also recognizes the value of those different approaches as research communities that guide choices about how to conduct inquiry" (Morgan, 2014, p. 1049). As such, Morgan (2007) argues for placing methodology at the centre of research approaches, thereby allowing for a more practical connection between epistemological beliefs and the actual design of research and its methods. Simply put, then, pragmatism sees truth as practical consequences (DeForge & Shaw, 2012).

Through its emphasis on an intersubjective approach, pragmatism provides a middle ground in the dualistic tension between objective quantitative and subjective qualitative methods (Morgan, 2007). In particular, it allows for the notion that there is both a "single, real world, and that all individuals have their own unique interpretations of that world" (Morgan, 2007, p. 72). This is consistent with Maxwell's

(2013) approach to qualitative research as bricolage. Although Maxwell asserts that critical realism is a valuable paradigmatic approach in this regard, there are many synergies between pragmatism and critical realism (DeForge & Shaw, 2012; Kivinen & Piiroinen, 2004) that allow for the same bridging across previously disparate quantitative and qualitative approaches; that is, these paradigms combine an ontological realism with an epistemological relativism or constructivism (Maxwell, 2013).

Importantly, pragmatism is concerned with an instrumental view of knowledge (Goldkuhl, 2012), which is synonymous with the way in which knowledge has been approached in this study. In addition, pragmatism's concern with the applicability of knowledge, in addition to its efficiency (Rescher, 2000, in Goldkuhl, 2012), was considered consistent with a central premise of the current study: that is, the value of evidence-based knowledge can be enhanced by contextual or experiential knowledge in terms of assessing the relevance of evidence-based policies in their real-world implementation. In addition, two fundamental aspects of the pragmatist paradigm – moving between objective and subjective positions, and between context-dependent and universal knowledges – were considered to be particularly relevant for the current study, as it seeks to find ways of integrating different forms of knowledge to resolve the tension between, for example, abstract and particular knowledges.

Together, then, a case study design from a pragmatic perspective resembles the bricolage that Maxwell (2013, p. 43) employs to challenge "the idea of paradigms as logically consistent systems of thought on which research practices are based". This echoes what Freeman (2007 in Freeman & Sturdy, 2015a, p. 6) refers to as the necessity for epistemological bricolage in policy work, with policymakers needing to operate "across and between different ways of knowing". The constant interplay between knowledge and action that is emphasised in a pragmatic paradigm (Goldkuhl, 2012) is also considered to be synergistic with the *embodied-enacted-inscribed* knowledge framework employed in this study.

In terms of the fit between research paradigm and research design, Maxwell (2013) allows for the possibility of combining different paradigms and traditions, as long as these elements are logically compatible with the design of the study. In some ways, this is what pragmatism and a case study research design have simultaneously allowed me to do. I will discuss case study research designs in more detail in the next section. However, I draw on relevant aspects of this design here to consider how a pragmatic paradigm aligns with case study research.

Although case study research has its origins in qualitative approaches, it has been used by researchers from diverse disciplines, with a range of philosophical underpinnings (Harrison, Birks, Franklin, & Mills, 2017). As such, case study research has been employed by those with positivist or realist orientations as much as by those with interpretivist or relativist positions (Harrison et al., 2017). As will be seen in

subsequent discussions, the case study methodology employed in this study follows closely the guidance offered by Yin (1994) on this subject. Harrison et al. (2017, p. 2) suggest that Yin's approach to case study research was informed by his background in the social sciences, which allowed him to apply "experimental logic to naturalistic inquiry and blend this with qualitative methods". As such, Yin's (1994) approach bridges the gap between quantitative and qualitative methods. Similarly, the pragmatic paradigm has been proposed as an approach that can resolve incompatibilities between realist and relativist philosophical orientations. As such, pragmatism has been identified as an approach that has relevance for case study research designs (Ihuah & Eaton, 2013).

From a pragmatic perspective, researchers play a central role in making decisions about what questions to ask and how to answer them (Morgan, 2007). The role of the researcher is thus central in both pragmatic approaches and case study research. In terms of the way that pragmatists define inquiry, research itself is a specific kind of experience: "inquiry is, like any form of experience, a continuous process that may involve many cycles between beliefs and actions before there is any sense of resolution" (Morgan, 2014, p. 1047). This, too, brings the importance of researcher reflexivity to the fore. In particular, pragmatism offers a "realist version of reflexivity" that was considered appropriate in how I approached the current study (Rosiek, 2013, p. 693). It also suggests a more narrative or experience-based approach to writing about our research and, as such, recognises the value of the first-person style of writing that is employed with regard to the methodological decisions and procedures undertaken in this study (Rosiek, 2013).

In addition, a paradigmatic approach emphasises reflection (Hall, 2013). This foregrounds the importance of explicating researcher positionality in the inquiry. As such, it is worth outlining here how my positionality influenced my decisions about both the paradigm and the research design adopted in this study. At the start of this research, I found myself positioned between two paradigmatic positions in a seemingly incompatible way. As a philosopher and psychologist, my orientation to and in the world was to emphasise the relativity of knowing and knowledge, and the way in which our interpretations and experiences construct our realities. As a researcher, however, at the more methodological level, I was more comfortable within a positivist approach, being uncomfortable with the unpredictability and 'messiness' of qualitative methods. Methodologically speaking, then, Yin's (1994) approach to case study design felt like the best fit and one that would allow me to bridge my quantitative research experiences to date, with the more qualitative methods employed in this study. However, I recognised that the paradigmatic orientation underpinning Merriam's (1991, 1998) case study approach was more aligned with my *philosophical* worldview.

My approach is consistent with Yazan's (2015) argument for the value of merging relevant empirical elements of Yin's case study design with more interpretivist or relativist understandings of how we come to know what we know. In outlining the synergies and divergences between the case study approaches adopted by Yin, Stake, and Merriam, Yazan (2015, p. 150) recommends that researchers should have "the opportunity to eclectically combine elements (e.g. different research techniques and strategies) from each approach that best serve and support their design". As such, I have attempted to approach this case study with "the pragmatic approach of Merriam, informed by the rigour of Yin and enriched by the creative interpretation described by Stake" (Brown, 2008, p. 9). In the next section, I describe in more detail the case study research design employed in this study.

3.3 Study design

This research involved questions about how knowledge moved through a contemporary policy consultation event in its real-life context, which required or allowed no intervention or control from me, as the researcher. These conditions were considered well suited to a case study design (Yin, 1994).
A case study methodology was selected to ensure methodological coherence between the research questions and research design. As Willig (2008, p. 21) suggests, "our research question should always precede our choice of methodology". It is my understanding that, while all relevant research designs and methodologies might be reviewed and considered in the initial phases of a study, the research question and objectives to a large extent determine what kind of design or more or less appropriate to answering the research questions. The choice to focus on the mental health policy consultation process and more specifically on a particular consultation event (summit) at a particular point in time almost at the outset necessitated a case study design, which allows for a focus on a particular unit of analysis – the "case" (Willig, 2008, p, 74).

The data associated with this particular case was considered too voluminous to explore more than one (consultation) process in an alternative (e.g. experimental) form of design. In addition, the retrospective nature of much of the data (with the exception of the interviews) precluded certain kinds of research designs (such as ethnographic methodologies), while the intention to apply the embodied-enacted-inscribed analytical framework to a policy consultation process excluded the possibility of choosing a grounded theory methodology. It is nonetheless acknowledged that qualitative research typically evolves in an iterative process as data is collected and analysed. The evolution of this study from its original starting point is outlined on pages 113-115 below. The original intention was to adopt Bacchi's (2009) *what's the problem represented to be* methodology to explore how the 'problem' of mental health was constructed through the uptake of evidence from the consultation process into policy. This

had to be rethought when the comparative analysis of the draft and final policy documents revealed very few changes following the consultation process. This necessitated rethinking the research question and objectives which, in turn, required consideration of alternative research designs and analytical approaches. The focus shifted to an exploration of the consultation process itself, for which a case study methodology was considered most appropriate.

The choice of a case study design, in turn, influenced decisions about the methods of inquiry – indeed, Yin (1994, p. 13) defines a case study as a "comprehensive research strategy". It was considered important in the current study to choose a research design that allowed me to "provide a chronological narrative of events relevant to the case, highlight specific events that are relevant to the case, and blend a description of events with the analysis of them" (Hitchcock & Hughes, 1995, p. 317, in Cohen, Manion, & Morrison, 2010, p. 253). Some of the distinguishing features of case studies include a narrow but detailed focus on a single case, and using multiple sources of both objective and subjective data to provide an in-depth understanding of the phenomenon (Babbie & Mouton, 2001; Denscombe, 1998; Dyer, 1995; Robson, 2002). This idiographic particularist focus also makes case studies amenable to qualitative research (Willig, 2008). These characteristics were considered important elements for the current study. Case studies have also been identified as valuable approaches in health policy research (Walt et al., 2008).

There are a number of different types of case studies and these design choices inform further decisions about approaches to data collection and analysis. The mental health consultation summits, while specific to the South African context over a particular period of time, were nonetheless considered to be an "exemplar of the more general phenomenon" of policy consultation (Willig, 2008, p. 77), making this an instrumental case study design (Creswell, 2014). However, the aim was not to provide a holistic account of a policy consultation process in its entirety, but rather to focus on embedded units within this case – in particular, on knowledge movement and utilisation through the consultation process. In embedded case studies, repeated observations are made across numerous (embedded) data points within the same case, based on propositions that are "related to but different from the propositions for the larger case" (Yin, 1994, p. 119). There are potential limitations associated with this approach, however, such as failing to move from the single embedded units to the larger case, and the inability of repeated observations of embedded units to "reflect all of a case study's concerns" (Yin, 1994, p. 121).

In order to provide a better understanding of, or new insights into, this phenomenon of knowledge use and transfer in policy consultation, a descriptive, rather than an explanatory, case study approach was selected (Willig, 2008). The case is therefore perceived to have "an existence that is independent of the researcher's view or interpretation of it" (Willig, 2008, p. 87), and the task of the researcher is to

provide as accurate and detailed an account of the case as possible, providing sufficient evidence in support of her interpretations (Willig, 2008). In pragmatic case study research, such as that conducted here, well-defined research questions guide the data collection and analysis, while the use of a single case allows for testing the "applicability of existing theories to real-world data" (Willig, 2008, p. 78).

The role of theory is particularly important here: pragmatic case studies "work with a set of propositions that identify key areas of interest which function as (tentative and flexible) hypotheses [which] are tested and revised during the course of the research" (Willig, 2008, p. 78). In case study design, theoretical propositions about knowledge can guide data collection and analysis (Yin, 1994). The use of such propositions is not considered incompatible with qualitative research (Maxwell, 2013; Miles & Huberman, 1994); in fact, they may be valuable in explaining what Miles and Huberman (1984, p. 132, in Maxwell, 2004, p. 3) call "local causality" – the actual events and processes that led to specific outcomes. In addition to reflecting key theoretical issues, these propositions can both help to answer the research questions and to draw boundaries around the case, informing the researcher where to look for relevant evidence (Yin, 1994). They also make it possible to move towards analytical – as opposed to statistical – generalisation (Yin, 1994), thereby countering one of the main criticisms of case study design, its limited generalisability. Additional measures to enhance study quality in case study research are discussed in section 3.8.

3.4 Context and case selection

3.4.1 Overall policy consultation process

According to Maxwell (2013), the notion of sampling in qualitative research is problematic, as it implies representativeness. A purposeful sampling strategy was more appropriate for a case study design in particular, as it allowed me to deliberately select the case and units of analysis to "provide information that [was] relevant to [my] research question and goals" (Maxwell, 2013, p. 97). The phenomenon of interest to me – the object of study – was policy consultation, and specifically the way in which knowledge is used and moved through a policy consultation process towards informing policy. As will be discussed below, the aim of this study was initially to conduct an in-depth analysis of the content of *South Africa's Mental Health Policy Framework and Strategic Plan 2013-2020*. In particular, I was interested in how the framing of mental health issues during consultation discussions had informed the changes that were made to this policy as a result of these discussions, and whether particular kinds of 'evidence' seemed to be privileged over others in the final policy document. I had planned to use

Bacchi's (2009) "*What's the problem represented to be?"* analytical framework to conduct a discursive analysis of the policy document, and of summit output documents in relation to this policy.

However, preliminary analysis revealed that few substantive changes had been made to the policy following the consultation, which shifted the focus of this study to the consultation process itself – specifically, the 2012 provincial and national mental health summits. As such, a particular slice of the policy consultation process that took place as part of the development of the mental health policy in South Africa was chosen as the concrete manifestation – the case – for this study. I believed that this case would help me better understand the object of the study (Hamel, 1993), being consistent with the instrumental case study design outlined above. This section briefly describes the broader context of the case before detailing and delimiting the case itself.

South Africa's first mental health policy was adopted in 2013. The development of the policy included an extensive policy consultation process during which mental health consultation summits were conducted early in 2012 in eight of the nine provinces: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, North West, and the Western Cape. This culminated in a national mental health summit in April 2012, which brought together representatives from research and academic institutions, non-governmental organisations, the World Health Organization (WHO), professional associations, mental health care user groups, mental health care professionals, and national and provincial government departments to provide input on the draft policy (Department of Health, 2013). Following the national mental health summit, a task team was constituted to finalise the policy, which included developing a strategic plan that identified priorities for implementation. The *Mental Health Policy Framework and Strategic Plan 2013*-2020 was promulgated in October 2013.

The drafting of the policy prior to the consultation summits in 2012 took place over a number of years, starting in 2006. The draft policy built on the 1997 *White Paper for the transformation of the health system in South Africa* and was based on extensive research findings that informed the content of the policy (Department of Health, 2013). This draft policy document was available for input at the provincial and national mental health consultation summits. These summits, driven by the national Department of Health (DoH), represented the official consultation process around this draft policy (Department of Health, 2013). More than 4000 stakeholders participated in these summits (Department of Health, 2013).

Time boundaries are important in defining the beginning of a case (Yin, 1994). In this case, the broader time period studied took the provincial consultation summits (starting in February 2012) as the start point and the promulgation of the final policy document in October 2013 as the end point. This was

considered to be the substantive component of consultation on this policy. It allowed for the inclusion of the draft policy document which was available during the consultation summits, as well as the final policy document that was adopted. However, the specific events that were investigated in detail are more narrowly delineated – from the end of the provincial consultation summits (with the requisite outputs of these summits) to the end of the national consultation summit in April 2012. An in-depth exploration of the two-day national consultation summit forms the most substantive component of this case. The components of this summit are briefly outlined here to contextualise the sources of data chosen for investigation.

The national consultation summit was held in Gauteng on 12 and 13 April, 2012. The programme included a number of formal speeches and presentations, as well as group discussions and feedback sessions. Ten topics were identified for discussion in ten breakaway group sessions, which participants self-selected into, and each group made recommendations that were fed back during a plenary session and in a closed-door meeting on Day 2 of the summit. Two documents were available for discussion during these group sessions: the draft mental health policy and a draft 'summit declaration' that, together with recommendations put forward at the summit, would form the official output of the national summit: The Ekurhuleni Summit Declaration. This was subsequently used in the finalisation of the policy document (Department of Health, 2013).

A visual map of the summit policy consultation process is presented in Figure 3.1. The map shows the chronology of the policy consultation and depicts the intersection between events, or processes, and their outputs. It is important to note that this map is based on information that could be gathered, either publicly or in the course of this study, about the policy consultation process. The complexity of the process – such as decisions about timing, programming, and inclusion of stakeholders – is not captured here, nor is the interaction of the policy consultation process with the broader development process. The following paragraphs provide a detailed narrative explaining the map.

The circular/oval shapes in the map represent events or processes that occurred during this consultation process. Rectangular shapes represent outputs from these processes. For the purposes of this study, the events or processes are seen as spaces for embodied and enacted knowledge. The output documents are seen as inscribed knowledge. In some cases, these outputs were moved or transferred, either into more summarised documents, or into other events. The solid arrow lines show this chronological movement. Colours are used to group together events and the outputs they generated, that occurred as part of the same process; for example, all the events that happened during the provincial summit consultations are coded purple, while those that occurred during the national summit are coded blue.

On either side of this consultation process are the draft and final mental health policies. The starting point was the drafting of this policy. Then, consultation summits were held in eight of the nine provinces. At these provincial summits, there were plenary presentations and group discussion sessions. The group recommendations were an output of these group discussions, which were subsequently summarised in some way in provincial summit reports. As will be discussed below, these reports varied both in form and in accessibility. It is also not clear how these provincial reports were transferred to the national consultation summit for further consideration there. However, there was a provincial feedback session at the national summit, where only three provinces fed back their recommendations. For provinces that did not provide feedback during the plenary session at the national summit, it is not clear whether or how any results of provincial-level consultations were fed back into the national process.

The national summit comprised a number of events. In addition to the provincial feedback session and plenary presentations, there were also breakaway group sessions, in which there were formal presentations and group discussions. Group recommendations were generated at these discussions, which were orally fed back at a plenary session. These recommendations were also taken into a closed-door meeting, where they were summarised in summit recommendations. There is no publicly accessible record of this closed-door meeting, where the group recommendations output was summarised in some way to provide the final summit declaration and recommendations output. This final summit declaration was read out at a plenary session at the national summit.

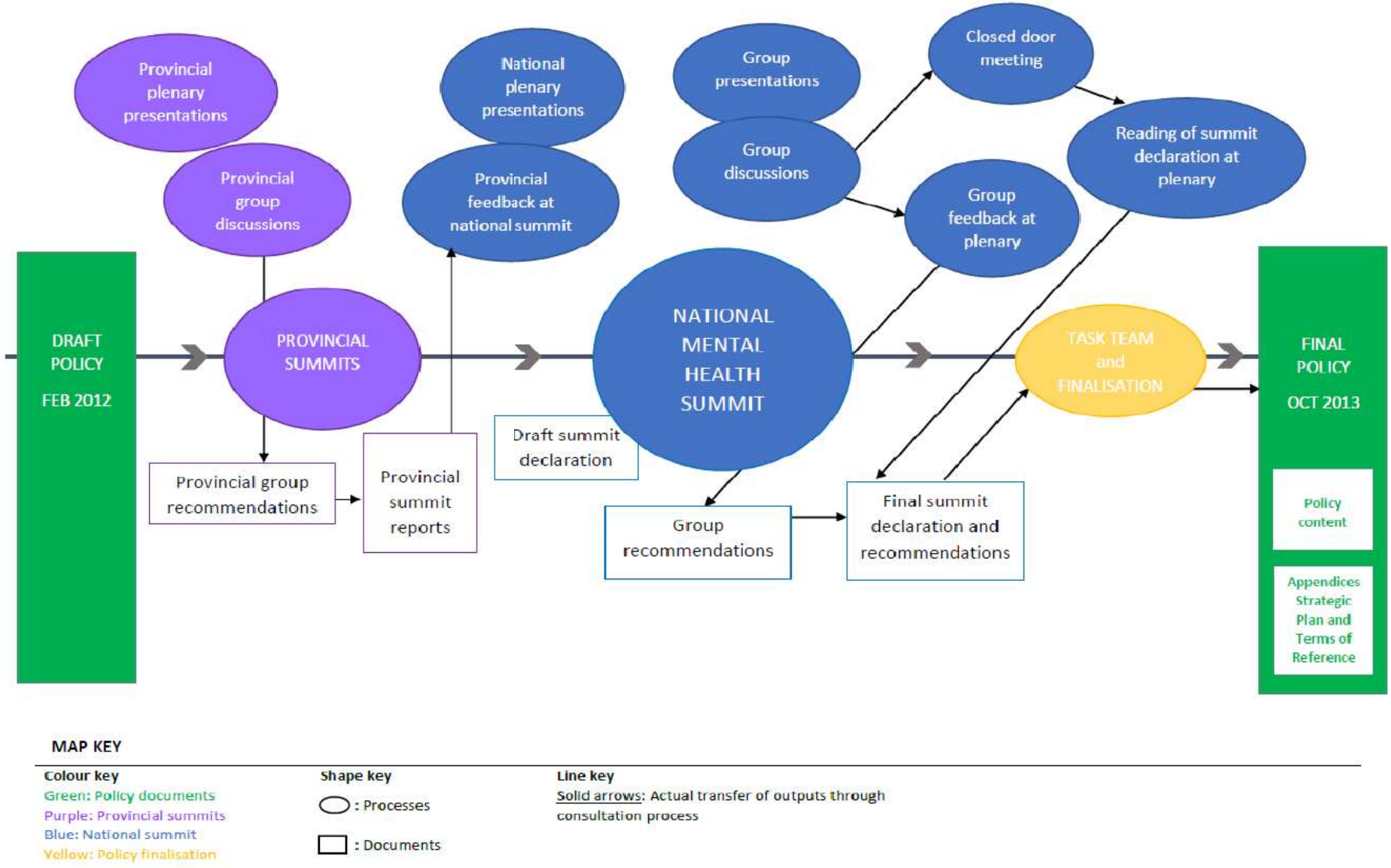


Figure 3.1: Case selection: Map of the mental health policy consultation process

Following the national summit, a task team was formed to finalise the policy and identify implementation priorities. It is assumed that this task team had access to (and used) at least the final summit declaration, and possibly also the group recommendations from the national summit and the provincial summit reports. However, with no record of this finalisation process, it is not possible to know if this was the case. The final policy that was adopted in October 2013 included two new appendices: a Strategic Plan (also referred to in thesis as the implementation plan) and a Terms of Reference document. Some of these outputs were included as data in this case study. The map also shows what data was 'missing' from this case; this includes information regarding whether and how provincial reports were used at the national summit or by the task team, as well as records of what happened at the summit closed door meeting or during the task team finalisation process.

This section has provided the context of the case study, as well as depicted the processes and outputs that comprised the consultation process. The specific data that were included from this process are described in section 3.5 below. However, because of the substantive focus on the national consultation summit event in this study, a more detailed description of the structure of this summit is briefly described here, before moving on to the data collection procedures.

3.4.2 National consultation summit process

The national mental health summit took place over 16 hours – nine hours on Day 1 and seven hours on Day 2 – and was structured around a number of components, as can be seen in Table 3.1. The programme included a number of protocol-driven and ceremonial aspects, such as the summit opening and delegate welcoming by departmental officials, keynote address by the Minister of Health, messages of support from key stakeholder groups, and entertainment. On Day 1, there was a round-table discussion on intersectoral issues in mental health, which included representatives from the High Court of South Africa, the Department of Education, Department of Social Development, the Ministry of Women, Children and Persons with Disabilities, and the Department of Correctional Services. This was followed by a number of plenary presentations which highlighted both the burden of mental disorders and the importance of mental health. Within this session, time was allocated for representatives from the nine provinces to report back on the recommendations from the provincial summits. As noted above, however, only three provinces (Gauteng, Eastern Cape, and Limpopo) gave feedback in this session. At the end of Day 1, the ten breakaway groups convened for a one-hour session. These groups would be discussing various aspects of mental health in relation to the draft policy, consistent with the themes discussed at the provincial mental health summits.

On the second day of the national summit, the ten breakaway groups met for three and a half hours to discuss the draft policy document and a draft declaration that would be the output of the summit. This was followed by a 40-minute plenary presentation on *Healing the nation*, after which the rapporteurs from each group presented their group recommendations back to the plenary. After the lunch break, the final summit declaration was read out to the plenary by a mental health care user, at which time summit participants officially adopted this summit resolution. Presumably, the relevant group recommendations had been added to the document at this point.

From comments made during the group discussion sessions, it seems as though group Chairs and rapporteurs went into a closed-door meeting with the organisers from the Department of Health, during which they may have presented their group recommendations so that these could be worked into the summit declaration prior to it being presented back to the plenary. The recommendations that were read out from the summit declaration remained unchanged in the final document that was included as an appendix to the mental health policy. However, one addition was made: "to implement with vigour the Health Sector Mini Drug Master Plan".

Just under half (44%) of the two-day summit was taken up by ceremonial and procedural aspects (e.g. lunch breaks, opening, and closing ceremonies). Twenty-two percent of the programme was dedicated to plenary presentations, not including the presentations given in each of the ten breakaway group sessions. A quarter of the summit (25%) was allocated for breakaway group discussion; some of this time was spent on group introductions and presentations. Less than a tenth of the programme (9%) was dedicated to feedback of recommendations – from provinces and from the ten breakaway groups – to the plenary. Just before the first group breakaway session, the organiser of the summit instructed participants to "take what has been said today and turn that into something concrete, something actionable" and to think about "how we can use the information we've got and translate that into something strategic, a plan that we can move forward with".

Table 3.1: National mental health summit programme

Time	Session type	Title
Day 1		
10:00 – 12:00	Opening ceremony	Opening remarks (Director General: Health)
		Welcome of delegates (Gauteng MEC for Health)
		Introductory remarks (Deputy Minister of Health)
		Keynote address (Minister of Health)
		Entertainment: Little Eden Residential Care Centre National Department of Health Choir
		Messages of support: South African Society of Psychiatrists South African Federation for Mental Health Psychology Society of South Africa Democratic Nurses Association of South Africa World Health Organization Local Office Mental health care user
12:00 – 13:00	Round table session	Intersectoral issues on mental health High Court judge Deputy Minister of Higher Education Department of Social Development Deputy Minister of Women, Children and Persons with Disabilities Department of Correctional Services
13:00 – 14:00	Lunch	
14:00 – 16:00	Plenary presentations	Presentation of resolutions from the provincial mental health summits
		The epidemiology of mental disorders in South Africa
		No health without mental health
		Situational analysis and findings on mental health services in South Africa
		Community concerns on substance abuse and the related health and socio-economic consequences
		Announcement of the formal breakaway sessions
16:00 – 16:15	Tea	
16:15 – 17:15	Breakaway sessions: Ten breakaway groups	
Day 2		
08:00 – 10:00	Breakaway sessions: Ten breakaway groups	
10:00 – 10:15	Tea	
10:15 – 11:30	Breakaway sessions: Ten breakaway groups	
11:30 – 12:10	Plenary	Healing the nation
12:10 – 13:00	Policy proposals from the ten breakaway groups (group rapporteurs)	
13:00 – 14:00	Lunch	
14:00 – 14:30	Reading and adoption of draft resolution (by mental health care user)	
14:30 – 15:00	Closing ceremony	Address by Deputy Minister of Health

Following the national mental health summit, the summit declaration was issued and published, which contained recommendations from the national summit (The Ekurhuleni Declaration on Mental Health, 2012). Eleven recommendations from the national mental health summit were included at the end of the summit declaration. In addition, the presenters in each group published papers based on their

presentations in November 2012 in the *African Journal of Psychiatry*. Following the consultation summits, a task team was formed to finalise the policy, which was officially promulgated in October 2013. The Department of Health (DoH) planned a provincial road show in 2014 to engage with each province around the policy and their role in developing provincial plans to implement the policy.

3.5 Data collection

A case study, according to Yin (1994), involves three essential data collection principles:
i) Using multiple, not just single, sources of evidence,
ii) Creating a case study database,
iii) Maintaining a chain of evidence.
Each of these is addressed in this section.

3.5.1 Data sources

The data for this case were selected from a number of sources relating to the policy consultation. These sources of data included documents, audio recordings, and interviews. Each of the data units represented an input or output of the provincial and national mental health summits, and were purposefully selected (Maxwell, 2013) to enable me to answer the research questions. Multiple sources of evidence were used in accordance with Yin's (1994) recommendation that case study research should include as many sources as possible. The sources included in this study were seen as complementary, in the sense that the strengths of one could balance the weaknesses of another. While documents are central to case studies, they should also be used to corroborate data from other sources (Yin, 1994). A preliminary document analysis of the draft and final mental health policy documents served as the point of departure for this study, and informed the decision to select the mental health policy consultation summits as the case for this study. Interviews were then used as a way into the case (consultation process), and documents, audio recordings and transcripts of summit processes were used to explore in greater detail issues thrown up by the interview data.

Interview data are valuable as a source of targeted insight into the case study, and allow for possible or perceived causal inferences to be identified (Yin, 1994). In both the case of documents and of interview data, however, inferences must be made cautiously, and throughout this analysis, I try to maintain an interrogative stance, exploring possible alternative explanations for what I was observing in the findings. Although the audio recordings represented something of a 'direct' window of participant observation on the summit group discussions, I was aware that they could not capture the explicit and implicit

interpersonal dynamics influencing these discussions, while limited audibility also restricted my access to what was said and consequent responses. Table 3.2 shows the data selected for this case study, as well as the relation of each of these to the policy consultation.

Table 3.2: Data sources selected from within case

Data source	Data	Relation to case context
Documents	Provincial summit reports (where available)	Outputs of the provincial consultation summits
	Draft pre-summit policy	Draft policy document under review at consultation summits
	National mental health summit programme	Programme of events at the national mental health summit
	Draft summit declaration	Draft summit declaration under review at national consultation summit
	Final policy document	Official mental health policy (including appendices) finalised post-summit and adopted October 2013
Audio recordings of national consultation summit	Transcripts of audio recording of provincial summit recommendations feedback at national summit	Feedback of provincial summit recommendations at the national summit by provincial representatives
	Transcripts of ten breakaway group presentations and discussions	Formal presentations and discussions that took place in each of the ten breakaway groups at the national summit
	Transcripts of group recommendations presented at plenary	Feedback of breakaway group recommendations at plenary of national summit by group rapporteurs
	Transcripts of reading out of final summit declaration	Adoption of finalised summit declaration, to be the formal output of the national summit
Interviews	Interview transcripts	Retrospective process evaluation of consultation process with seven key informant participants

3.5.2 Creating a case study database

A large amount of data relating to multiple sources and elements within the consultation process was collected. This necessitated careful record keeping in order to manage and work with the data. The collected data and various forms of its analysis were stored in an indexed computerised folder system within Windows documents library (see Table 3.3). The creation of such a case study database also contributes to the reliability of the study (Yin, 1994).

Table 3.3: Case study database

Index of data folders	Main folders of data	Sub-folders of data
Analysis plans and overviews		
Analysis tables		
Infographics		
Interviews		
Policy documents		
Mental health consultation summits	Department of Health correspondence	
	National mental health summit documents	
	National summit audio files and transcripts	Group 1: Prevention and promotion
		Group 2: Research, monitoring and evaluation
		Group 3: Mental health systems
		Group 4: Infrastructure and human resources
		Group 5: Mental health and other conditions
		Group 6: Mental Health Care Act
		Group 7: Child and adolescent mental health
		Group 8: Culture and mental health
		Group 9: Suicide prevention
		Group 10: Advocacy and user participation
	National summit plenary	Day 1
		Day 2
	Provincial summit reports	

Maintaining a chain of evidence can also assist in increasing reliability (Yin, 1994). After describing the preliminary analysis of the draft and final mental health policy documents, I provide detail regarding the data collection and management process for the interviews with key informants. I then describe how I collected the documents and audio recordings relating to the policy consultation summits, and describe how these were prepared for analysis.

3.5.3 Collecting the data: Maintaining a chain of evidence

Within qualitative research, data collection and analysis are iterative processes; the analysis often begins before the collection of data is complete. Initially, I had intended to document the changes that had been made to the mental health policy following the consultation, and to explore whether particular ways of framing mental health seemed to be prioritised over others in these changes. This required a comparative analysis of the draft and final policy documents. The study received ethical approval (see section 3.6 below) in January 2013. Early in 2013, the draft policy document that was in

circulation at the time of the provincial and national consultation summits early in 2012 was obtained from my (original) primary supervisor, who had been involved in the KwaZulu-Natal summit and the national summit. The final *Mental Health Policy Framework and Strategic Plan 2013-2020* (hereafter referred to as final policy) was also downloaded at this time from the national Department of Health website.

It is necessary to briefly mention here what emerged from a preliminary comparative analysis of the draft and final policy documents in order to explain methodological decisions that followed from this finding. A detailed discussion of these findings is presented in the findings chapter (section 4.2). The comparative analysis of these two policy documents revealed that very few substantive changes had been made to the mental health policy following the consultation. This analysis thus shifted the focus of the study from the content of the policy document, to the consultation process itself, as a means of understanding why this lack of change might have occurred. The preliminary comparative analysis of the policy documents, then, served as a point of departure into the case study of the consultation summits, and informed subsequent decisions regarding case selection and data to be included. The change in direction required me to consider ways of presenting the data and analysis that could include the background to this point of departure, as well as provide a logical structure to the subsequent analysis. I found it helpful to conceive of this research as proceeding through three levels of reflective knowledge construction (Kreber & Cranton, 2000; Mezirow, 1991):

1. Content reflection: describing WHAT happened,
2. Process reflection: exploring HOW it happened, and
3. Premise reflection: understanding WHY it happened.

The case description above, together with the preliminary comparative policy analysis presented as the first findings section (4.2) of Chapter 4, are seen as a content reflection on WHAT happened. This enabled me to move to the level of process reflection: using the analysis of the policy consultation process to explore HOW this may have happened. The analysis and subsequent sections of the findings chapter thus represent this level of knowledge construction. The interpretation of the findings presented in the discussion chapter (Chapter 5) allowed me to reflect on WHY this happened. This structure also made intuitive sense to me in that it mirrored the process of moving from a more concrete descriptive level of knowledge, to a more abstract conceptual level.

Preliminary data collection: Policy documents

As mentioned above, the final policy document (*Mental Health Policy Framework and Strategic Plan 2013-2020*) was downloaded from the Department of Health website at the start of this study in 2013. The draft policy document that had been available for review at the provincial and national mental

health summits in April 2012 was obtained from one of the participants of these summits (my original primary supervisor). The comparative analysis of these two documents served as the point of departure for this study, and informed decisions about subsequent data collection.

Data collection: Interviews

Between November and December 2013, semi-structured interviews were conducted with key informants who had been involved in the national mental health summit; this was done in order to develop converging lines of inquiry (Yin, 1994) regarding observations and findings that subsequently emerged from analysis of the consultation summit documents and transcripts (described below). Interviews are considered "essential sources of case study information … [as] well-informed respondents can provide important insights into a situation. They can also provide shortcuts to the prior history of the situation" (Yin, 1994, pp. 84-85). The interviews allowed for a retrospective process evaluation of the consultation process, and the national consultation summit in particular, and were conducted for the purpose of supplementing other findings around what happened and how it happened.

Using qualitative data such as interviews as a form of process evaluation can tell the story of the process by capturing and communicating the stories of the participants (Patton, 2003). This was also considered to be a good fit with a pragmatist approach, in that the purpose is to "gather information and generate findings that are *useful*" (Patton, 2003, p. 2). Although data collected through process-evaluation interviews, and the analysis thereof, are not very different from conventional qualitative interview research, the purpose for which these interviews are conducted differs if a process-evaluation lens is employed (Maxwell, 2012). This is because process-evaluation interview data is considered to be "evidence for real phenomena and processes", as opposed to constructions of these phenomena (Maxwell, 2012, p. 103). In this sense, then, the unit of analysis is not the individual per se, but the "events and processes around them: every unique programme participant uncovers a collection of micro events and processes, each of which can be explored in multiple ways to test theories" (Manzano, 2016, p. 350). This also requires that data collected through interviews – and the inferences they suggest – should be tested against additional data sources (Manzano, 2016), as was the case in this study. The interviews provided an additional source of evidence on various aspects of the consultation and allowed for triangulation of data towards increasing the validity of case study findings.

Interview participants

A generative, purposive sampling strategy was used to identify individuals who had played a substantive role in the national mental health summit. Purposive sampling – or what Maxwell (2013, p. 97) calls "purposeful sampling" – allows for flexible selection of participants on the basis of relevance to the

research question (Silverman & Marvasti, 2008). It is considered appropriate to case study design as it deliberately selects participants who are in a position to describe and elaborate on the events under investigation (Maxwell 2013; Yin, 1994). Snowball sampling was employed to identify each additional participant, with an emphasis on including perspectives from as many of the ten breakaway group sessions as possible in order to illuminate group process. An estimated sample size of between six and ten participants was anticipated.

Where possible, participants were identified who had participated in at least one provincial consultation summit as well as the national consultation summit – preferably from a cross-section of different provinces – in order to explore perspectives on the overall consultation process and follow-through of inputs and outputs. In many cases, participants had also been involved in some way in the development of the policy, historically or currently. It was also considered important to include the perspectives of representatives from the national DoH, in particular the organisers of the summit, who were closely involved in the drafting and finalising of the mental health policy document.

The national mental health summit programme was used to identify an initial list of potential participants. Contact was made telephonically or via e-mail in November 2013 to provide these individuals with information regarding the study and explore their willingness to participate. Those who agreed to participate were provided with additional details and sent information and consent sheets (Appendix 1) to review prior to the interview date. The information and consent sheets were discussed at the time of the interview; interviews proceeded only after participants had provided written documentation of consent. Further detail regarding participant autonomy and confidentiality is provided in the ethical considerations section (section 3.6) below.

A total of thirteen participants were invited to participate in the study; seven agreed to be interviewed. Three individuals declined to participate. No response was received from the remaining three individuals. A number of attempts were made to request participation of the conveners of the summit (DoH officials) but no responses were forthcoming. All but one of the participants who were interviewed were female. The participants were based in four of the nine provinces, and comprised researchers/academics, mental health care professionals, and mental health care user representatives/advocates. The lack of representation from the DoH, as well as from all provinces, are acknowledged as limitations.

Interviews took place in November and December 2013. All interviews were conducted in English, either telephonically or face to face. Each interview lasted between one and two hours and was audio recorded with the participant's permission, for later transcription. Interviews were transcribed using the

same literal transcription system as detailed for the summit proceedings above, and transcripts were uploaded into NVivo 10 for coding and analysis. All transcripts were de-identified, and participants were assigned pseudonyms for the purposes of analysis and reporting of findings. A list of interview participants is shown in Table 3.4 below. Descriptive details were kept intentionally broad to minimise the possibility of identification.

Table 3.4: Interview participants

Pseudonym	Gender	Location	Role
Bryanna	Female	Gauteng	Service-user/representative
Chantal	Female	Gauteng	Service-user/representative
Charles	Male	Western Cape	Academic/researcher
Ingrid	Female	KwaZulu-Natal	Academic/researcher
Sameera	Female	KwaZulu-Natal	Mental health care practitioner
Sarah	Female	Western Cape	Mental health care practitioner
Zama	Female	Eastern Cape	Mental health care practitioner

Questions included on the interview schedule (see Appendix 2) were around two major themes: the process of policy development and consultation, and the content of the policy itself. The open-ended interview questions were informed by a thorough reading of the literature regarding mental health policy and policy development in South Africa and globally, as well as by the study's research questions. As one of the original aims of this study had been to explore how mental health is problematised (Bacchi, 2009), and how this might influence how mental health interventions are targeted within policy, the interview schedule included questions regarding participants' perspectives on mental health challenges in the South African context, in addition to those about the policy consultation process. However, since the focus of the study subsequently shifted to the consultation process itself, interview responses regarding mental health issues in South Africa were not included in the final analysis.

Data collection: Consultation summit documents

As described earlier, the draft mental health policy that was discussed at the consultation summits and the final *Mental Health Policy Framework and Strategic Plan 2013-2020* were obtained and included in a preliminary analysis phase. In addition to these two documents, the final output from the national mental health summit – the Ekurhuleni Declaration on Mental Health April 2012 (hereafter referred to as the summit declaration) – had been published in the open access *African Journal of Psychiatry* in November 2012, and was accessed as data for this study.

In May 2013, requests were sent to the provincial (Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, North West Province, Northern Cape, and Western Cape) and national

departments of health for the records of the consultation summits. These letters were sent to the MECs of each of the respective departments of health via the postal service, as well as via email where such details could be obtained. The letters were sent via the Department of Psychiatry at the University of KwaZulu-Natal, and were signed by my primary supervisor. It was felt that this 'more official' request may facilitate responses.

A detailed discussion of this process of obtaining records regarding the consultation summits was subsequently written up and published in the *African Journal of Public Affairs* (Marais et al., 2017) and is included as Appendix 3. I made the decision to document this after our requests for summit reports elicited such varied and noteworthy responses from the different departments of health, which pointed to inconsistencies in both the recording and availability (and transparency) of information about the mental health policy consultation process in South Africa. This paper represents a case study within the larger case study of the use and movement of knowledge through a particular policy consultation process. It provides key insights into the broader process of information (knowledge) management forwards and backwards through the 2012 consultation process, and how this might obstruct the principles of public participation if not managed systematically. It also supplements the analysis of the links between provincial and national consultation processes.

In summary, four provinces that had held consultation summits sent their summit reports: Free State, KwaZulu-Natal, North West, and Western Cape. Another three provinces (Eastern Cape, Gauteng, and Limpopo) acknowledged receipt of the request, but never sent summit reports. No response was received from the remaining two provinces (Mpumalanga and Northern Cape). From discussions at the national summit, it seems as though the Northern Cape did not hold a provincial summit, which could explain their lack of response. As detailed in Appendix 3, the format of these reports varied substantially. As mentioned in the case description above, a half-hour session was allocated at the national summit for feedback from the provincial summits. Only three provinces presented feedback in this session: Gauteng, Limpopo, and Mpumalanga. As a result of the access provided by the national DoH to the audio recordings of the whole national summit (described below), I could document recommendations from these three provinces, despite not having access to their official reports. I thus could include provincial recommendations from seven of the nine provinces in the data set.

In response to our request for summit records and following some additional correspondence, the national DoH sent the national mental health summit programme and offered to send all documents and recordings of the two-day national summit. Arrangements were made for a flash drive to be sent to Pretoria in July 2013, onto which the DoH contact saved all these records from the national summit. This included PowerPoint presentations from most of the formal presentations given in both the plenary

sessions and the ten breakaway group sessions. These presentations had also been published as papers in the same issue of the *African Journal of Psychiatry* (November 2012) in which the summit declaration had been published. Each of the relevant articles was downloaded and saved.

However, the aim of this study was to trace how knowledge moved from group discussions to recommendations, through to the final policy document. As such, the PowerPoint presentations and the published versions of the presentations were considered less relevant and were not included in the final analysis. These are thus not listed in detail here. All of the documents discussed above were saved in the case study database, and uploaded into NVivo for analysis. The management of the audio recordings from the national summit is discussed in more detail below, as a number of critical data pieces were obtained from these recordings.

Data collection: Summit audio recordings

All of the proceedings from the national summit were audio recorded. The national DoH also transferred all the audio recordings from the entire two-day summit onto the flash drive sent to them for this purpose. These audio recordings were subsequently transcribed using simple transcription in order to prioritise content. This is consistent with literal transcription systems which provide "deliberately simple and quickly attainable transcription rules which considerably 'smoothen' speech and set the focus on content" (Kuckartz et al., 2008, p. 27, in Dresing, Pehl, & Schmieder, 2015, p. 27). Only selected transcripts were considered relevant for the purposes of this study and were included as data. As the focus of this study was on how knowledge contributions made by participants in consultation discussions regarding the draft mental health policy moved through the consultation process, the transcripts of the ceremonies and formal presentations made during the plenary sessions were not included in the analysis. The included and excluded transcripts are shown in Table 3.5 below.

Table 3.5: Transcripts from the national consultation summit that were included as data

Transcript	Included as data
Day 1	
Opening remarks (Director General: Health)	No
Welcome of delegates (Gauteng MEC for Health)	No
Introductory remarks (Deputy Minister of Health)	No
Keynote address (Minister of Health)	No
Entertainment	No
Messages of support	No
Round-table: Intersectoral issues on mental health	No
Feedback of resolutions from the provincial mental health summits	Yes
Plenary presentation: The epidemiology of mental disorders in South Africa	No
Plenary Presentation: No health without mental health	No
Plenary presentation: Situational analysis and findings on mental health services in South Africa	No
Plenary presentation: Community concerns on substance abuse and the related health and socio-economic consequences	No
Announcement of the formal breakaway sessions	Yes
Ten breakaway group sessions (1-2 hours)	Yes
Day 2	
Ten breakaway group sessions (3.5 hours)	Yes
Presentation: Healing the nation	No
Feedback of recommendations from breakaway groups	Yes
Reading and adopting of the summit resolution	No
Closing ceremony: Address by Deputy Minister of Health	No

Consistent with the aim of this study, to explore how knowledge inputs made by participants during a consultation process move through the process to inform policy, the primary focus of analysis from the proceedings of the national summit was on the transcripts from the breakaway group sessions. Each of the ten groups had two formal presentations, followed by discussions during which they were instructed to formulate recommendations to be presented back at the plenary session on Day 2 of the summit. No audio recordings were available for some of the group sessions on Day 1. This may have been because these sessions were not audio recorded, or because the recordings could not be retrieved by the national DoH to be sent upon request. The detail of the group transcripts that were included in the analysis is provided in Table 3.6.

Table 3.6: Transcripts of breakaway group sessions that were included as data

Breakaway group at national summit	Transcript from Day 1 audio	Transcript from Day 2 audio
Group 1: Mental health promotion and prevention of mental disorders	No (no audio available)	Yes
Group 2: Mental health research and innovation, and surveillance	Yes	Yes
Group 3: Mental health systems	Yes	Yes
Group 4: Mental health infrastructure and human resources	No (no audio available)	Yes
Group 5: Mental health and other conditions	No (no audio available)	Yes
Group 6: Mental Health Care Act of 2002 – lessons learned from implementation	No (no audio available)	Yes
Group 7: Child and adolescent mental health	Yes	Yes
Group 8: Culture, faith-based practices and indigenous mental health practices	Yes	Yes
Group 9: Suicide prevention	Yes	Yes
Group 10: Advocacy, social mobilisation, user and community participation	Yes	Yes

3.6 Ethical considerations

This study was approved by the Biomedical Research Ethics Committee (BREC) at the University of KwaZulu-Natal (ref: BE276/12) in January 2013, with subsequent annual renewals. As discussed above, the preliminary comparative analysis of the draft and final mental health policies conducted in 2013 revealed few substantive changes to the policy, which changed the aim and focus of the study. This was submitted as an amendment application to BREC in November 2013 and was subsequently approved. Data collection was completed at the end of 2013. Annual recertification applications to BREC in 2014, 2015 and 2016 documented smaller changes in the analytical focus of the study as data analysis progressed. An application for amendment of the study title was submitted to BREC in July 2017 and was approved.

Ethical considerations: Interviews

This study was considered to be of relatively low risk: no direct risks or potentially harmful consequences of participation in this study were anticipated, and no participants from vulnerable

groups were recruited. Recruitment of participants was done on an entirely voluntary basis and, during the informed consent process, participants were informed of their freedom to choose not to participate and their right to withdraw. While there were no direct benefits to participants as a result of their participation, there were also no direct costs, apart from their time. As such, no remuneration was offered for participation. I conducted all the interviews myself, over the telephone or face to face. All participants consented to the interview being audio recorded.

All reasonable steps have been taken to protect the confidentiality of participant responses. Participants were assigned pseudonyms, and transcripts were given identifying codes that could be linked to demographic data but not to the names of participants. These are stored together with the signed consent forms in a secured cabinet in my office. Electronic records are stored in a password-protected folder in the case study database. No identifying details are reported in this study, nor will be in any future publications. However, there is the possibility that participants could be identified by themselves or a third party on reading the thesis or subsequent publications, based on excerpt statements made by participants. Furthermore, due to the limited number of participants who could be interviewed for this research, they may be identified due to their role or involvement in policy decision-making. The risk to participants should this occur is considered to be minimal. Participants were informed of the possibility of future publications resulting from this work prior to the interview.

Ethical considerations: Summit documents and audio recordings

All of the audio recordings and related files from the national mental health summit were saved in a password-protected folder in my case study database, and the flash drive kept as back up. These files will be kept for five years following completion of the study and will thereafter be destroyed. The audio recordings were also transferred to a password-protected folder in the 'cloud' (Dropbox) to be accessed by the research assistant who was employed to transcribe all of these audio-recorded files. Although the research assistant was required to sign a confidentiality agreement, she was deliberately chosen due to her position outside of the mental health network in which I was positioned. She was therefore less likely to identify speakers at the summit. Her lack of familiarity with the mental health context was an advantage in this sense, as she could do a 'clean' transcription without implicitly imposing bias through unclear sentence completion or filling in gaps from poor audibility. This also meant, however, that certain mental health-related names, places, or concepts were mistyped. My own familiarity with the mental health context enabled me to pick this up on reading the transcripts, and go back to the audio recordings to correct these errors.

Upon engaging with the transcripts, I realised it was not possible to remain 'blinded' to the identities of many of the speakers, Chairs, or rapporteurs, not least because in most groups there were individual

introductions. I was thus aware of the need to remain mindful of my own potentially explicit and implicit biases in reading and interpreting the data, particularly as many of the individuals involved in the summit were well known and had made significant contributions at various levels of mental health in South Africa. I reflect more on my own position, and my reflexivity around this, in the study quality section below (section 3.8). Nonetheless, the research assistant assigned speaker numbers to each speaker during transcription, and after many re-readings of the transcripts and multiple layers of coding, I found that it was easy to 'forget' who was speaking and focus more on the message – the knowledge claim – being made.

Due to the nature of the analysis and findings, I did not consider there to be any risks to participants through breach of confidentiality or exposure. It is important to note here, though, that while participants were made aware during the group sessions that their sessions were being recorded (and notwithstanding debates about rights to access to information regarding matters of public record), they were not informed at the time that the recordings would subsequently be used for research purposes. It was thus particularly important that their anonymity be protected.

3.7 Data analysis

3.7.1 Analytical framework

The analytical framework used in this study was informed by Freeman and Sturdy's (2015a) knowledge schema of embodied, enacted, and inscribed knowledge. This is consistent with Yin's (1994) recommendation that the best analytical strategy in case study research relies on theoretical propositions. These concepts have been defined and discussed in detail in the literature review but will be briefly reiterated here.

For the purposes of this study, embodied knowledge includes both experiential and evidence-based (embrained) knowledges that individuals embody. Inscribed knowledge is a codified form of knowledge – in this study, primarily as words in documents. Enacted knowledge is knowledge-in-action, the observable enactment of other knowledge forms.

Using this lens to analyse the data allowed me to explore how knowledge moved through the consultation process in its different forms, thereby addressing the aim of this study. More specifically, it allowed me to focus on different forms of knowledge at various points in the process, as per each of the research questions. A common theme through this study is the tension in moving between the

particular and the abstract when developing policy in a mental health context. It was thus useful to approach the analysis along these lines – moving from the particular (embodied knowledge in policy) to the abstract (inscribed knowledge in policy). This is depicted in Figure 3.2.

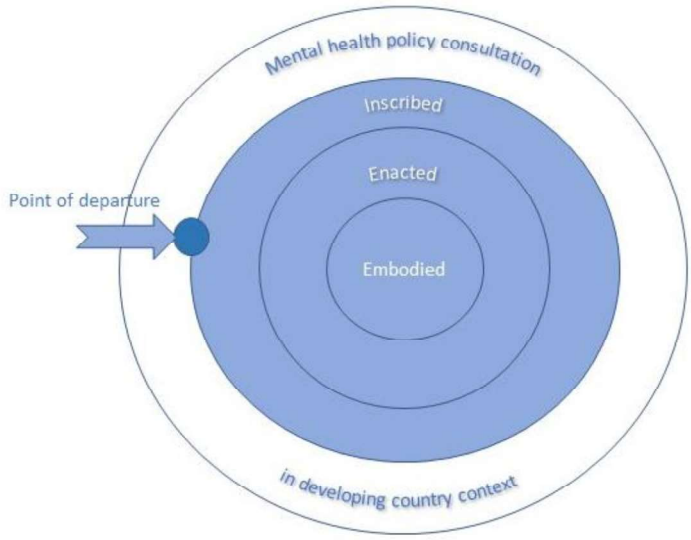


Figure 3.2: Analytical framework: Movement of embodied to enacted to inscribed knowledge

Also depicted in Figure 3.2 is the point of departure for this study: the preliminary document analysis of the draft and final mental health policy documents. This links to the analytical framework as it represents an analysis of knowledge inscribed in documents. However, the *embodied-enacted-inscribed* knowledge framework was not used as an analytical lens during this preliminary phase of analysis. The comparative analysis of these two documents is described in section 3.7.3.1 (*Point of departure*).

The analysis of the policy consultation process using the *embodied-enacted-inscribed* framework as an analytical lens was subsequently conducted and structured across five layers, moving from the individual to the abstract and back again. The detailed analysis conducted in each of these five layers is described in section 3.7.3 below. The analysis began with individual interviews with key informants regarding the policy consultation process. This provided a 'way in' to the consultation process from the perspective of those who participated in it, and is presented in section 3.7.3.2 (*From the inside out*). I then moved to the level of individual embodied knowledge, exploring how it was enacted and inscribed during the group discussions. This is described in section 3.7.3.3 (*Embodied knowledge enacted*). This component related to the first research question: How were participants' embodied knowledges enacted and captured during the consultation process?

At the next level, as described in section 3.7.3.4 (*Enacted knowledge inscribed*), I focused on the *process* through which enacted knowledge was moved to inscribed knowledge, thereby addressing the second research question: How did the consultation process enable or constrain the movement of knowledge

from enacted to inscribed forms? The third level considered how inscribed knowledge moved from more detailed to more abstracted form as it was transferred through the consultation process. This is described in section 3.7.3.5 (*Inscribed knowledge transferred*) and addressed the third research question: How did inscribed knowledge move through points of abstraction to inform policy? In the final component of the analysis, findings from the preceding analyses were triangulated to provide an overview of the whole consultation process from the outside in. This final section summarises how all three research questions were addressed in the analysis and is described in section 3.7.3.6 (*From the outside in*).

3.7.2 Analysis methods

As mentioned in section 3.4.1 above, the original aim of this study had been to employ Bacchi's (2009) *what's the problem represented to be* methodology to explore how the 'problem' of mental health was framed and constructed in policy documents (see pages 103-104). Consistent with this methodology, I intended to use a Foucauldian discourse analysis to explore issues of power and how the production of knowledge reinforced particular empowered and disempowered positions. Following the initial comparative analysis of the draft and final policy documents, which revealed very few changes to the policy as a result of the consultation process, the decision was made to focus instead on the real-life process of the mental health policy consultation in an effort to understand how knowledge was used and moved through this process. The shift to a case study methodology and the adoption of a pragmatic paradigm excluded certain analysis methods – such as discourse analysis – and called for a more a-theoretical, descriptive analytic approach. In addition, the data that was collected was considered too incomplete and fragmented (e.g. breakaway group discussions and gaps in provincial summit reports) as well as too voluminous to allow for a discursive analysis. Narrative analysis was also briefly considered, when I considered focusing on anecdotes as a form of experiential knowledge. However, insufficient (complete) anecdotes were identified to allow for this form of analysis.

Given the type and volume of data collected, as well as the particular objectives of this study – to identify embodied, enacted, and inscribed forms of knowledge and trace their movement through the consultation process – thematic analysis was considered the best fit for this study. A combination of thematic framework analysis and thematic content analysis were used to analyse the data. These methods were considered to be consistent with the descriptive, exploratory nature of the study. All of the analysis was conducted using NVivo. This allowed me to manage the extensive data set, while performing multiple layers of coding and analysis. It is also seen as a useful tool in conducting both thematic framework analysis and thematic content analysis (Leech & Onwuegbuzie, 2011).

Thematic analysis is a broadly defined method of qualitative data analysis, encompassing a diverse range of analysis techniques within a range of theoretical frameworks. Braun and Clarke (2006) suggest that the advantage of thematic analysis is that it is not tied to a theoretical framework, making it a flexible method of analysis that can provide a rich and detailed account of the data. However, this could also be seen as a drawback of the method, as it is not informed by a particular rationale that guides analysis choices and might be criticised as an "anything goes" approach to analysis (Braun & Clarke, 2006, p. 26). This approach thus requires the researcher to be reflexive and cognisant of his or her theoretical positions and values in relation to the data set (Braun & Clarke, 2006). In my case, for example, although I allowed some flexibility for the possibility of themes 'emerging' inductively from the data, much of my coding was deductive, highlighting my active role in the analysis, and requiring that I be explicit about my epistemic position and assumptions.

As the name suggests, thematic analysis is a method of qualitative data analysis that allows for the identification, analysis, and reporting of patterns (themes) across an entire data set (Braun & Clarke, 2006). It involves a recursive process of coding and analysis, moving back and forth across the entire data set. Themes are built upon initial codes and represent a higher level of patterned response or meaning within the data set (Braun & Clarke, 2006). The importance or significance of themes is considered not in relation to quantity, but in terms of their relative importance to the overall research question (Braun & Clarke, 2006). Both themes and codes can be revised as the analysis progresses, allowing the process to accommodate findings flexibly, and to allow emerging findings to refocus the analysis.

In the preliminary comparative analysis of the draft and final policy documents, content was coded thematically according to the extent to which changed content in the final document represented an addition, deletion or other change from the draft policy. This process is described in more detail in section 3.7.3.1 below.

In the embedded case study of the policy consultation process itself, the aim was to use thematic analysis to provide a detailed account of a particular aspect of the data set – knowledge forms and transfer through the policy consultation process – as opposed to a rich description of the entire data set. In keeping with a pragmatist paradigmatic approach, the focus of analysis was at the semantic level of the data, whereby "themes are identified within the explicit or surface meanings of the data, and the analyst is not looking for anything beyond what a participant has said or what has been written" (Braun & Clarke, 2006, p. 13). The final discussion provides a narrative, coherent, logical and interesting account of the story told by the data (Braun & Clarke, 2006).

In conducting the thematic analyses of various data sets in this study (including interviews, summit documents, and transcripts), I used the guidelines developed by Braun and Clarke (2006) as a guide through the process. This involved moving through a number of phases of engagement with the data, beginning with familiarising myself with the data. This process of familiarisation and making decisions about how to package and order the data was a particularly challenging one for me. My previous research projects had primarily involved quantitative data and analysis, or more 'simple' singular data sets, for example, of qualitative interviews. As I proceeded through this analysis process, I was constantly seeking to find order in dis-orderly data in an attempt to make sense of it. At various points, I made use of analytic techniques suggested by Miles and Huberman (1994) to package the data; this included creating data displays (such as mind maps and flowcharts) for examining the data; putting information in chronological order; tabulating the frequency of different events; and examining the complexity of such tabulations and their relationships by calculating second-order numbers such as means and variances. Within the breakaway group transcripts in particular, I struggled to make sense of what seemed very ad hoc and chaotic processes and discussions. I realised, subsequently, that this presented not as much an obstacle as an insight into the consultation process itself, and that my struggle to make sense of how knowledge had 'flowed' into recommendations was perhaps a mirror of what the Chairs and rapporteurs, at the micro level, and policymakers at the macro level, would have encountered in the face of multiple inputs.

The next phases in the thematic analysis involved generating an initial coding framework, identifying and refining themes within the data by sorting and categorising codes, and analysing the data within these themes in order to tell a story about the data in relation to the research questions. Much of the coding in this study was deductive, informed by theoretical propositions, and by a comparative focus. In other words, the initial thematic analysis was in most cases a way of categorising the data for further comparison. For this, framework analysis was used. Framework analysis is a form of thematic analysis that was employed to conduct the analysis of the interview data. Framework analysis provides a means of structuring data so that themes identified in the thematic analysis phase can be summarised and compared across individual data units – in this case, the interviews – to identify commonalities and differences and assist with interpretation (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

Like thematic analysis, framework analysis is not tied to a specific epistemological or theoretical approach; it has been identified as a flexible method for applied policy research, particularly for research with specific questions tied to a priori issues and a predetermined sample, where the primary objective is to understand what is happening in a particular setting (Marais & Petersen, 2015; Ritchie & Spencer, 1994; Srivastava & Thomson, 2009). Having identified themes across the data set using thematic analysis, the data is cross-tabulated according to specific pre-chosen comparators, in a step

Ritchie and Spencer (1994, p. 185) call "charting". This aids in constructing a picture of the analysed data as a whole, which in turn allows for identification and interpretation of commonalities and differences across the data units. The NVivo software allows for framework matrices to be constructed and the cross-tabulated themes to be linked back to the original data (e.g. verbatim interview quotes) for verification and further description.

Given the focus on tracing the movement of knowledge inputs through the consultation process, the next phase of comparative analysis across multiple data units required a more quantitative form of analysis. Thematic content analysis was therefore used for the analysis of the summit transcripts and documents. Thematic content analysis is "a technique for categorising data and determining the frequencies of these categories" (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005, p. 49). Maxwell (2013) suggests that qualitative analysis often makes implicit quantitative assumptions, and that 'counting' in qualitative analysis may be acceptable depending on the questions being investigated. Hannah and Lautsch (2011, p. 17) further suggest that counting in qualitative research may be warranted, provided that the goal of the research is not "to gain access to the perspectives of insiders … (or) to pursue unexpected findings during an inductive data collection process". It was not my intention to imply direct linear or causal links between what was said at the summit and what was inscribed in documents and policy. However, the volume of the data to be analysed and my objective to at least trace alignment of content meant that using a thematic content analysis method, supplemented with qualitative data (examples and interviews), allowed me to explore both thematic and numerical patterns in the data.

Thematic content analysis allowed me to analyse the data qualitatively, while simultaneously quantifying it, using a descriptive approach to the coding of the data as well as to the interpretation of quantitative counts of these codes (Vaismoradi, Turunen, & Bondas, 2013). I was aware, however, of the risks of this approach in making interpretations based on these quantifications outside of their context; as such, I continually sought to identify alternative explanations that may confirm or contradict my findings. Results of the thematic content analyses were formulated as frequencies in tabular form (Dixon-Woods et al., 2005; Hsieh & Shannon, 2005; White & Marsh, 2006).

3.7.3 Structuring the coding and analysis

As a first step in the analysis, every piece of data included in NVivo was coded deductively for major mental health issues ('themes') under the overarching code of *content*. This was to allow for consistency and comparison across documents and transcripts. It is important to note here that the ten breakaway group sessions were divided for discussion according to mental health issues. However, as would be

expected, a number of other issues inevitably came up within these group discussions. As such, it was necessary to code for different mental health themes within each of the group transcripts. Nonetheless, the ten breakaway group themes, together with the areas for action addressed in the mental health policy, were used to guide this thematic analysis to identify mental health issues. These codes are listed in Table 3.7 below. The definitions (coding rules) for each of these codes are included in the coding framework in Appendix 4. The breakaway group topics corresponding to each of the issue codes, where applicable, are also included in Table 3.7.

Table 3.7: Breakaway group topics corresponding to *issue* themes

Breakaway group topic	**Corresponding *issue* code**
Mental health promotion and prevention of mental disorders (Group 1)	Prevention and promotion
Mental health research and innovation, and surveillance (Group 2)	Research
	Monitoring and evaluation
Mental health systems (Group 3)	Mental health systems
Mental health infrastructure and human resources (Group 4)	Human resources
	Infrastructure
Mental health and other conditions (Group 5)	Mental health and other conditions
Mental Health Care Act of 2002 – lessons learned from implementation (Group 6)	Mental Health Care Act implementation
	Mental Health Review Boards
Child and adolescent mental health (Group 7)	Child and adolescent mental health
Culture, faith-based practices and indigenous mental health practices (Group 8)	Culture and mental health
Suicide prevention (Group 9)	Suicide prevention
Advocacy, social mobilisation, user and community participation (Group 10)	Advocacy and user participation
No specific breakaway group	Governance
	Intersectoral collaboration
	Funding
	Medicines, equipment, and protocols
	Quality assurance

3.7.3.1 Point of departure: Comparative analysis of policy documents

In the preliminary phase of analysis, the draft mental health policy document that was available for review at the consultation summits in 2012 was compared with the final *Mental Health Policy Framework and Strategic Plan 2013-2020* that was adopted in 2013. The content of the final policy was coded according to whether it represented: i) a change of wording from original text in the draft policy,

or ii) an addition to content in the draft policy. The draft policy was coded for content that had subsequently been deleted from the final policy document. Definitions for each of these codes are included in the coding framework in Appendix 4. As discussed above, this preliminary analysis represented a point of departure for the analysis of the mental health policy consultation process.

3.7.3.2 From the inside out: Interviews as process evaluation

As explained earlier, key informant interviews were conducted as a form of process evaluation of the consultation process. The interview schedule was thus structured in order to elicit information about the consultation process, as well as perspectives on the content of the mental health policy. Given the findings from the preliminary comparative analysis that the policy content had not changed substantively following the consultation process, interview questions focused in particular on participants' perspectives regarding the influence of the summit on the policy, and the way in which information regarding policy decisions was managed. The questions from this schedule were used deductively to develop the coding framework, categorised into process-related themes. Additional process-related themes were also identified from the literature on consultation process and outcome criteria. The thematic categories according to which the data were coded are shown in Table 3.8 below. Definitions for each of these themes are included in the coding framework in Appendix 4.

Table 3.8: Process-related themes from interview analysis

Main theme	**Sub-themes**
Knowledge about or involvement in broader policy development process	Pre-summit policy development
	Post-summit policy development
Information and consultation transparency about the policy consultation	Pre-summit consultation and information
	Post-summit consultation and information
Provincial follow-through	-
Impact of consultation summit	Signalled priority
	Influence on policy
Perspectives on final policy	General perspectives about the final policy
	Perspectives about the implementation of the policy
Opportunities for service user input	-

3.7.3.3 Embodied knowledge enacted: Transcripts of group discussions

For this analysis, I focused on the transcripts of the audio recordings from the ten breakaway group sessions at the national consultation summit (hereafter referred to as group transcripts). These ten transcripts had already been coded according to thematic categories for mental health issues. The focus in this analysis was on how different types of explicitly referenced knowledge claims – specifically, experiential and evidence-based knowledge claims – were enacted, responded to, and moved to

inscribed forms during the group analysis. This analysis thus proceeded along four dimensions, which are listed here and explained in more detail in the following paragraphs:

i) **Types of knowledge claims** made during group discussions: experiential or evidence-based, both of which, according to Freeman and Sturdy's (2015a) conceptual schema, are considered a form of embodied knowledge;

ii) Whether certain knowledge claims were more likely to be **responded to** during group discussions than others;

iii) What participants were drawing on particular knowledge claims to *do* – in other words, **how knowledge claims were being used or enacted** during group discussions; and

iv) Whether certain types of knowledge claims were more or less likely to be **'followed through' into inscribed form** (i.e. group recommendations).

The analytic process followed for each of these four components was broadly similar: group transcripts were coded either deductively or inductively according to the question being considered. They were then developed into composite codes that combined two or more coding categories (e.g. 'knowledge claim' + 'responded to'). These composite codes were analysed to determine frequencies (percentages) of particular types of knowledge claims within each area of interest and to allow for comparison across knowledge types, for example, the percentage of experiential knowledge claims that were responded to, **compared to** the percentage of evidence-based knowledge claims that were responded to.

Types of knowledge claims

At this stage, I was interested in whether certain types of knowledge claims were referred to in both the formal group presentations and the group discussions. It seemed likely that the formal presentations, by virtue of presenters being called on for their expertise, would show greater use of evidence-based knowledge than experiential knowledge. The group transcripts were thus first coded into two types of 'talk' categories: presentations and discussions.

The subsequent coding steps were as follows:

- Group transcripts were coded for types of knowledge: i) experiential, ii) evidence based, and iii) *Other*. Coding rules for each of these categories are detailed in the coding framework in Appendix 4.
- Composite codes were created for types of knowledge combined with types of talk (e.g. 'experiential knowledge' + 'presentations'). This allowed for a count of the three different knowledge types across the group presentations versus the group discussions.
- Composite codes were created for types of knowledge combined with types of talk, combined with mental health issue (e.g. 'experiential knowledge' + 'presentations' + 'human resources').

This allowed for analysis of frequencies of types of knowledge claims across different mental health issues, across different talk types.

- The *Other* category was coded inductively to identify types of talk that were being used in the discussions, that were neither explicit experiential nor evidence-based knowledge claims.

Responsiveness to knowledge claim types

Having identified the different types of knowledge claims, I was now interested in how these knowledge claims were 'responded to'. I decided to only focus here on the group *discussions*, as these were considered to be more interactive than the formal presentations within the groups. The subsequent coding steps were as follows:

- Within each group transcript, evidence-based and experiential knowledge claim codes were selected for (highlighted) in NVivo. This allowed for an analysis of these claim types within the *context* of the group discussions, in order to explore whether and how these claims were responded to by others in the group.
- These coded extracts were then also coded deductively for responsiveness in three categories: i) responded to, ii) not responded to, and iii) response inaudible. The coding rules for when extracts were determined to be responded to or not are outlined in the coding framework in Appendix 4.
- Within the 'responded to' code, extracts were then further coded according to whether they were 'responded to but not engaged with', versus 'responded to and further engaged with' (see coding framework in Appendix 4 for coding rules).

What knowledge claims were being used to do

Again only focusing on the group discussions, the experiential and evidence-based knowledge claim types were further coded for what participants were using these knowledge types to do within discussions. In this analysis, codes were developed inductively through reading and re-reading through the coded extracts, and identifying patterns in how knowledge claims were being used by participants across both knowledge types. The main themes identified were further categorised into sub-themes. These are listed in Table 3.9 below, with coding rules described in the coding framework in Appendix 4.

Table 3.9: Codes for what knowledge claims were being used to do

Main theme	Sub-theme
Illustrate current situation	Illustrate a challenge
	Illustrate a solution/best practice
Highlight implications of a proposal	Highlight benefits of, or motivate for, a proposal
	Highlight disadvantages of, or argue against, a proposal
Engage	Support a previous point made
	Counter a previous point made

Once all the experiential and evidence-based knowledge types had been coded according to the above themes, further steps were taken to allow for finer distinctions and counts to be made within these codes:

- Composite codes were created for knowledge claim type + knowledge use theme + knowledge use sub-theme in order to identify frequencies with which knowledge claims were being used to do certain things. Counts within themes, as well as within sub-themes, were done.
- As I was coding, it started to appear as though participants were illustrating current situations (main theme 1) in order to highlight the implications of a proposal (main theme 2). These themes were thus drawn into a composite code, along with the knowledge claim types, in order to explore frequencies of these composite uses. These composite codes are shown in Table 3.10 below. Note that there were no instances in which participants described a *solution* (current situation) in order to highlight *disadvantages of a proposal* (implications of proposal).

Table 3.10: Composite codes for what knowledge claims were being used to do

Main composite theme	Sub-composite theme
Illustrate current situation to directly highlight implications of a proposal	Describe challenges to highlight benefits
	Describe challenges to highlight disadvantages
	Describe solution to highlight benefits

Inscription of knowledge claim types in group recommendations

Finally, I was interested in whether particular knowledge claims types – evidence-based or experiential – were more or less likely to be attended to or captured, as evidenced by whether they were captured in the inscribed group recommendations. Here, the analysis was done within each of the ten group transcripts in order to allow for comparison with the specific group recommendations from each group. This was done as follows:

- Select for (highlight) experiential and evidence-based knowledge claim types within each group transcript. Compare the highlighted extracts with group recommendations and code for 'captured', 'partially captured', and 'not captured'. Coding rules for these codes are defined in the coding framework in Appendix 4.

- Create a composite code for ‘knowledge type’ + ‘captured’/‘not captured’. Do a count within each group according to frequency of experiential versus evidence-based knowledge claims captured.

A final note regarding the presentation of the findings from the above analysis. Analysis within each of the themes described above began at the level of identification of knowledge claim types and uses within each of the ten breakaway groups. Detailed comparisons between each group could be made at this level. From this fine-grained analysis, patterns were identified, which allowed for more general conclusions to be drawn regarding how evidence-based and experiential knowledge claims were being used and moved across all breakaway group sessions. Decisions about the level of detail to include in qualitative, case study research should be guided by how relevant it is to the most significant aspects of the design (Wolcott, 1994; Yin, 1994). As such, the findings from this analysis are presented in a form that has extrapolated results from the more detailed inter-group analyses; the latter are included as appendices.

3.7.3.4 Enacted knowledge inscribed: Transcripts of group discussions

Here, my focus moved to process, exploring how enacted knowledge became inscribed knowledge during the consultation process, specifically by focusing on group processes. This entailed an analysis of the format and structure of each of the ten breakaway group sessions at the national summit, to explore how the enactment of knowledge was facilitated in these spaces, and how this knowledge was ‘moved’ (was formulated and inscribed) into group recommendations.

The transcripts of the ten breakaway group discussions were used in this analysis. The aim was to provide an account of a number of process-related elements that might illuminate how knowledge inputs were elicited and moved into group recommendations during these discussions. These elements were compared across groups, and included the following:

- Access to audio from group sessions and audibility quality
- Overall format followed during group session
- Time spent on introductions
- Time spent on formal presentations
- Time spent on group discussions
- Direct engagement with available documents (draft policy and draft summit declaration)
- Chairing/facilitation style
- Extent of explicit management of microphone between participants during discussions
- Activity of rapporteur

- How the group formulated their recommendations
- Number of recommendations made.

The group transcripts were also coded for process- or procedure-related comments that were made by participants (including Chairs and rapporteurs). These were used to supplement observations made about process in the analysis above. In particular, group discussions were coded according to the following process-related themes: i) awareness of time constraints; ii) indications of microphone management; iii) general Chair or participant comments regarding process or procedure; iv) explicit engagement with draft documents (policy and summit declaration); and v) comments regarding capturing or recording of recommendations. These themes were chosen because they were considered to provide information about process because of explicit comments made regarding these process-related elements. Inferences regarding process could only be based on direct statements from participants relating to these issues. These themes were also considered to provide information regarding points of, or opportunities for, enactment (awareness of time constraints, microphone management, and general participant comments regarding process), as well as information about points of inscription (engagement with draft documents, and capturing or recording of recommendations) during the group sessions.

3.7.3.5 Inscribed knowledge transferred: Tracing content across documents

The knowledge inputs made at the consultation summits needed to be captured (inscribed) and transferred beyond the consultation space in order to have the potential to be considered in policy finalisation. Inscribed knowledge was thus a predominant knowledge form at this event. Knowledge moved from detailed (group discussions and recommendations) to more abstracted knowledge as it was transferred from one summit output document to the next. My interest was in tracing the follow-through of knowledge inputs from the level of embodied and enacted knowledge in the group discussions, to its inscription and abstraction in various output documents. This analysis of how knowledge was transferred from one point to the next through the consultation process was conducted in three phases. Phase 1 traced the points of inscription and abstraction of knowledge inputs through the provincial summit into the national summit. The next phase (Phase 2) focused on the national summit, looking specifically at the inscription and abstraction of knowledge from the group discussions sessions into subsequent outputs. In Phase 3, a similar process was followed to trace the transfer of inscribed knowledge in the final (national) summit declaration recommendations into policy outputs.

In many ways, the policy consultation process represented a process of summarising large amounts of information – contributed by hundreds of individuals in smaller group processes – into more succinct recommendations and reports. Such a process inevitably involves substantial reduction of detail into

more abstract pieces of information, which represent a generalised summary of that detail. The purpose of the three phases of analysis outlined above was to determine the extent to which knowledge inputs were either captured or 'inscribed out' at each point of transfer from one inscribed output to the next. Therefore, coding rules were developed for this thematic analysis that allowed me to distinguish between inputs that could be determined to be either reflected or not reflected through subsequent stages of the summarisation process. Generic descriptions of coding definitions for more detailed inputs that were considered to be comprehensively reflected, partially reflected, or not reflected in increasingly abstracted outputs are shown in Table 3.11.

Table 3.11: Codes for reflection of detailed inputs in abstracted outputs

Code	Coding rule/definition
Comprehensively reflected or aligned	Abstracted output reflects a comprehensive summary of detailed input
Partially reflected or aligned	Abstracted output partially reflects detailed input in broad, thematic ways, with some detail lost in summarisation
Not reflected or aligned	Abstracted output does not reflect the substantive content of the detailed input

These coding rules were applied to various detailed inputs and abstracted outputs in each of the three phases of analysis detailed below. Group discussions, for example, were considered to reflect detailed inputs in Phase 2, which were coded as being either comprehensively, partially, or not reflected in the more summarised, abstracted group recommendations, and so on through to Phase 3. It should be noted, however, that although these coding rules allowed me to trace knowledge inputs through subsequent levels of abstraction during the consultation process, the reflection of these inputs in the more summarised outputs does not imply a causal link. In other words, the reflection of detailed inputs in summit and policy outputs could be attributed to several factors, such as this being a prioritised issue in general, as opposed to being a direct result of inputs at the consultation summits.

Phase 1: Abstraction and transfer of inscribed knowledge through *provincial* to national consultation summits

Information from the interview analysis and a document analysis allowed me to construct a chronology of the consultation process in terms of the opportunities for enactment and inscription of knowledge at and between provincial and national summits. A map of the consultation process was presented in Figure 3.1 above. This information was then used to develop a descriptive account of how knowledge moved from one enactment point to another, and from one point or form of inscription to another. The following chronology was used in this phase of analysis, also shown in Figure 3.3:

Points of inscription and abstraction from provincial to national summit consultation:

- From provincial summit group discussions to provincial summit group recommendations,
- From provincial summit group recommendations to provincial summit reports,
- From provincial summit reports to provincial feedback at the national summit, and
- From provincial summit recommendations to national summit recommendations.

The data included and steps followed in this phase of the analysis are shown on the far left of Figure 3.3 below. Arrows between the blocks in this part of diagram indicate chronological steps in the analysis. The map of the policy consultation process (from Figure 3.1) is repeated as a reference point on the right-hand side of Figure 3.3 to illustrate the link between this phase of analysis and the relevant components of the policy consultation summits that pertain to this analysis. For ease of reference, the data and steps followed in the phase of analysis are colour-coded in accordance with the colour-coding of the policy consultation map – with purple indicating components from the provincial summits (as depicted on the map), and blue indicating components from the national summit.

As mentioned earlier, I had access to summit recommendations from seven of the eight provinces that had held provincial summits, either directly through provincial summit reports, or through the audio recordings of the oral feedback from provinces at the national summit. In this phase of the analysis, I was interested in whether the content of provincial summit recommendations was reflected in the national summit declaration recommendations. Given the inconsistencies in reporting from the provincial summits, it was not clear whether and how these reports had been available to the national task team during the finalisation of the policy, or whether they were assumed to have been integrated into the final recommendations from the national summit. This was considered important because South Africa's decentralised health system delegates authority for implementing national policy to provincial government. National policy should therefore be responsive to local context, and reflect priorities put forward by provincial stakeholders.

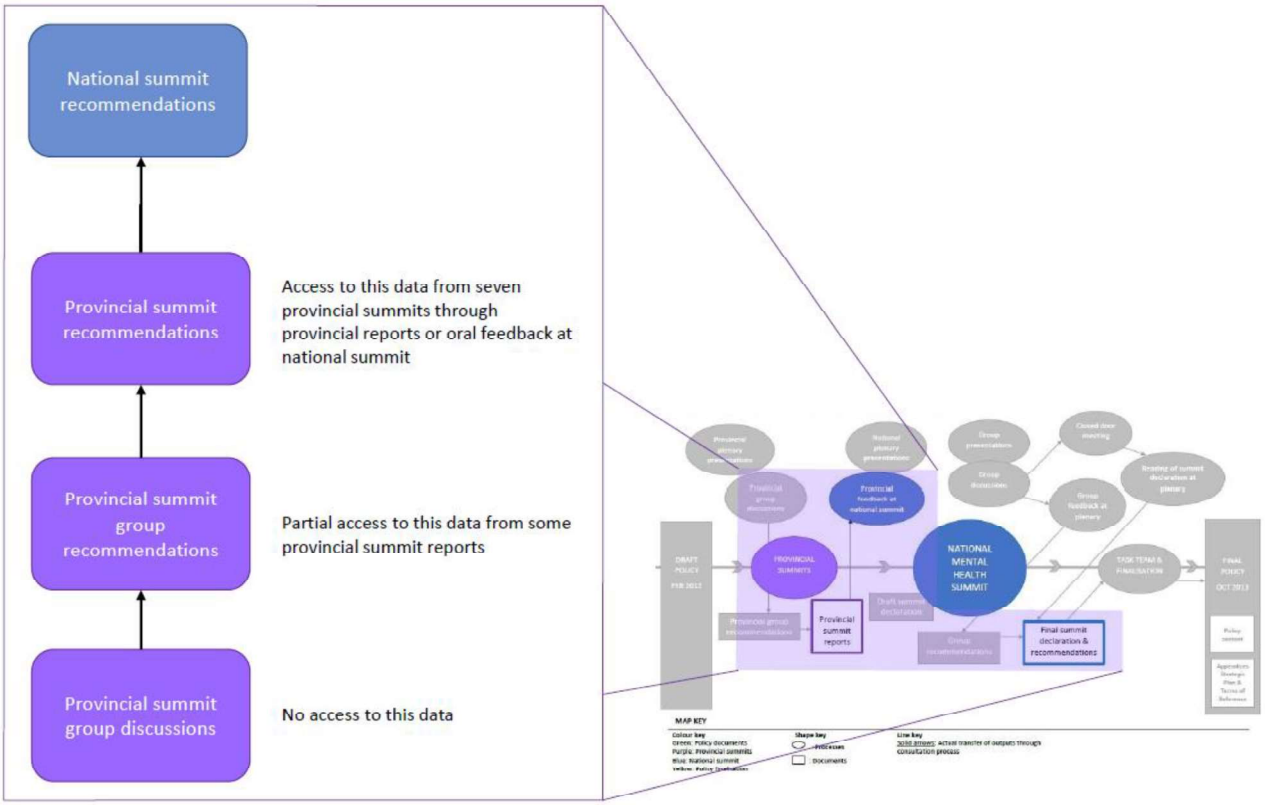


Figure 3.3: Analysis Phase 1: Abstraction and transfer of inscribed knowledge at the provincial summits

Phase 2: Abstraction and transfer of inscribed knowledge from national summit *group sessions*

In this phase, the focus of the analysis was on the movement and abstraction of inscribed knowledge through the national consultation summit specifically. As with the preceding analysis, I began at the level of the individual/particular, and proceeded outwards towards the more abstracted documents. The coding process through which this was achieved was described in detail at the start of this section. A visual illustration of the movement of inscribed knowledge through *all* points of inscription and abstraction at the national summit is shown in Figure 3.4.

Points of inscription and abstraction through the national summit consultation:

- From national summit group discussions to national summit group recommendations,
- From national summit group recommendations to national summit declaration recommendations, and
- From national summit declaration recommendations to final policy and policy appendices.

Steps followed and data included in this *overall* analysis of the national consultation summits are shown on the far left of Figure 3.4, with arrows here indicating the chronology of the analysis. As with Figure 3.3 above, the map of the policy consultation is included on the right-hand side of Figure 3.4 as a

reference point, to show the link between the overall analysis and the overall consultation process. Colour-coding indicates these links. Elements of the draft and final policies that were compared in this analysis, for example, are shown in green, to correspond with how they were depicted on the policy consultation process map.

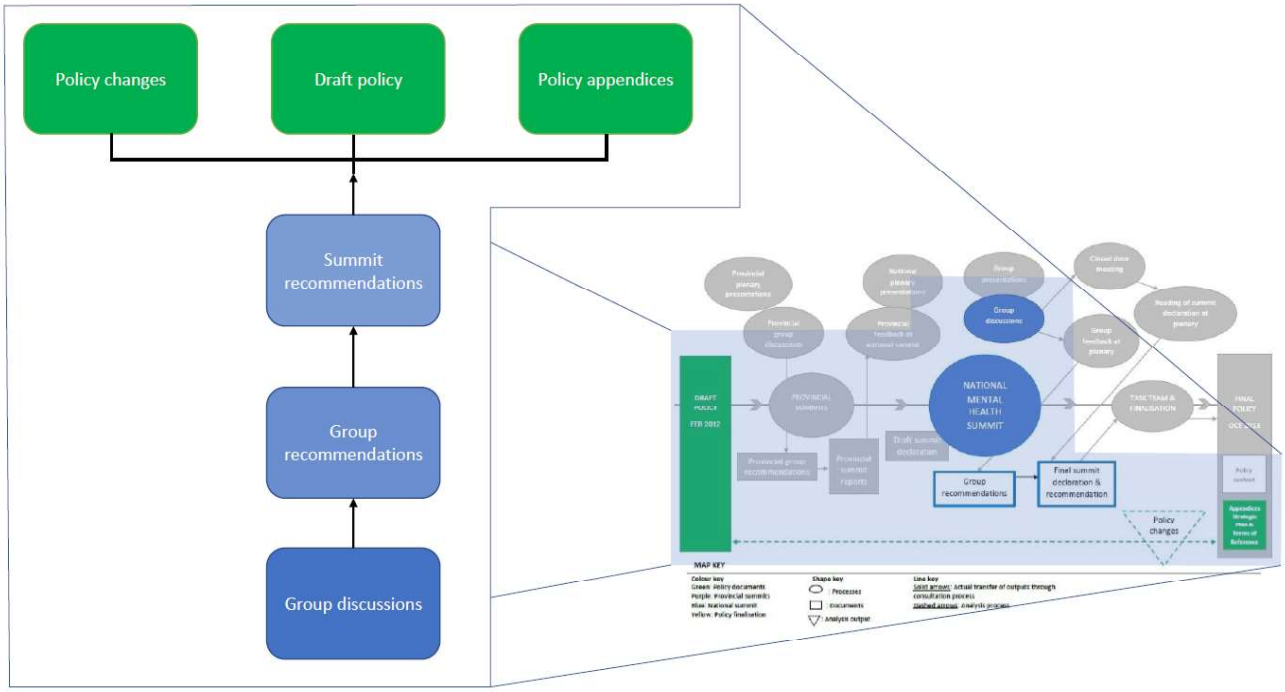


Figure 3.4: Overall abstraction and transfer of inscribed knowledge at the national consultation summit

In Phase 2 of the analysis specifically, the focus was on how knowledge inputs from the national summit group sessions moved through points of inscription and abstraction to summit and policy outputs. The steps involved in this analysis are shown in Figure 3.5, and described thereafter. As I was aware that there was not likely to be a linear link between knowledge inputs during group discussions and outputs in the form of recommendations or policy documents, I chose to code in this and the next phase for *alignment* or *reflection*, as opposed to *inscription*. For each of the analysis steps, the pre-coded mental health issues were added in as composites, in order to explore follow-through of particular issues (content). The coding rules for each of the coding steps are detailed in the coding framework in Appendix 4. In all cases, counts were done within each of these codes to determine frequencies.

In Figure 3.5, the steps followed and data included in Phase 2 of the analysis are shown on the far left-hand side. This shows that group discussions were compared with group recommendations, and that group recommendations were then compared with summit recommendations, and so on. For reference, the map of the consultation process is included on the right-hand side of Figure 3.5, to show links between Phase 2 of the analysis and the relevant components of the overall consultation process that correspond to this analysis. Colours are once again used to clearly indicate these links.

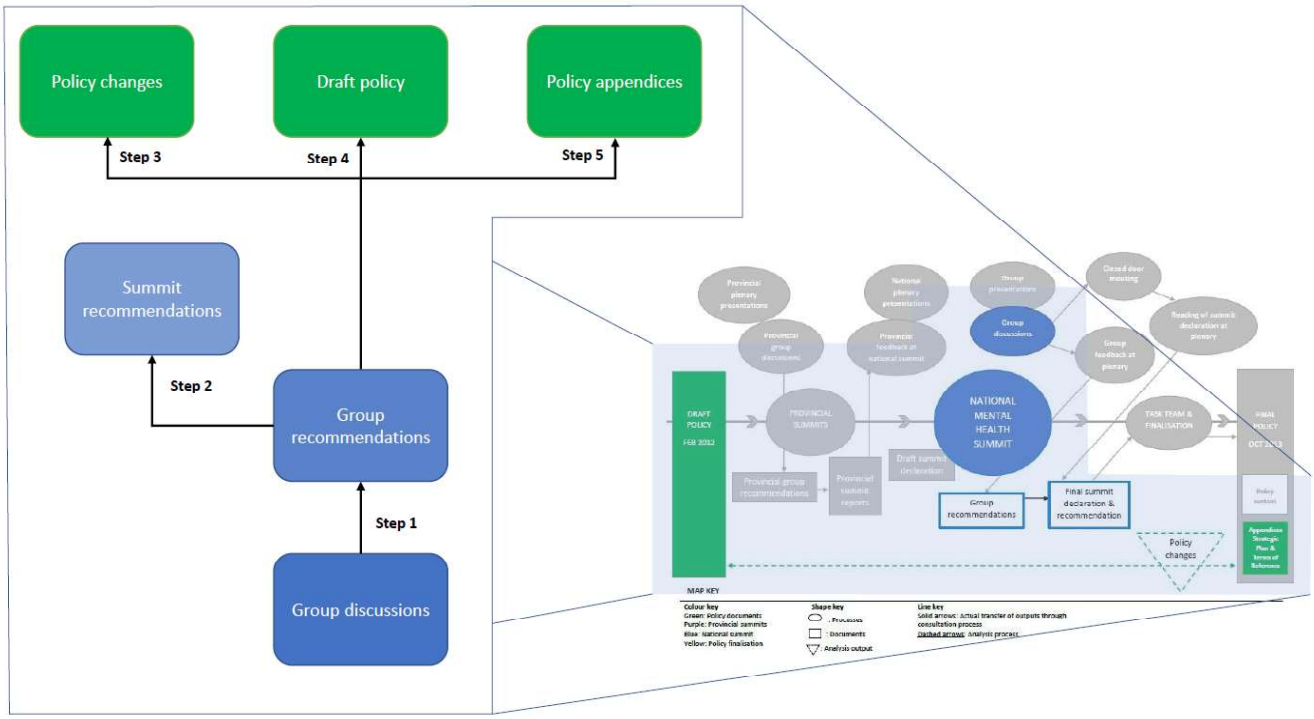


Figure 3.5: Analysis Phase 2: Abstraction and transfer of inscribed knowledge from *group* discussions and recommendations into summit and policy outputs

Step 1: Reflection of group discussions in group and summit recommendations. The first step in this analysis was comparing the content of the group discussions in each of the ten group transcripts with the group recommendations made by each group. This level of analysis was intended to be more descriptive, and so counts of followed-through content were not made. Given that policymakers were unlikely to have access to the content of the group discussions, I focused on the reflection of the group *recommendation*s in each of the subsequent outputs.

Step 2: Reflection of group recommendations in summit recommendations. The next step involved comparing the content of the group recommendations with the final summit declaration recommendations. Given that the group recommendations were taken to the closed-door meeting at the national summit in order to finalise the summit declaration, the recommendations included in this declaration were analysed to determine the extent to which they seemed to reflect the recommendations from the group sessions.

Step 3: Reflection of group recommendations in policy changes. A comparative analysis of the draft and final policy documents had produced an analysis output showing changes that were made to the policy following the consultation. The group recommendations were compared with these policy

changes across mental health issue themes, and coded as i) completely reflected, ii) partially reflected, and iii) not reflected.

It was possible that the group recommendations may not have been reflected in policy changes because they were already aligned with the content of the draft policy that was available for discussion at the national summit. A comparison of the group recommendations with this draft policy was thus conducted next.

Step 4: Reflection of group recommendations in draft policy document. Within each mental health issue theme, the group recommendations were compared with the draft policy content, and coded as i) completely reflected, ii) partially reflected, and iii) not reflected.

As described earlier in this chapter, there were only two substantive additions to the policy document following the consultation. These were in the form of appendices, relating to implementation activities: the Strategic Plan (implementation plan), and the Terms of Reference.

Step 5: Reflection of group recommendations in policy appendices. The group recommendations, categorised according to mental health issues, were compared with the two policy appendices (Strategic Plan and Terms of Reference), also categorised according to mental health issues, and coded as: i) completely reflected, ii) partially reflected, and iii) not reflected.

Phase 3: Abstraction and transfer of inscribed knowledge from national *summit recommendations* into policy outputs

The final recommendations included on the summit declaration (official output of the national summit) were considered to be a summarised reflection of the inputs and recommendations made at this summit. As this was the official output of the national summit and was publicly available as the summit report, it seemed likely that this output would have been available to the team tasked with finalising the policy. The analysis here was thus to explore the extent to which these summit recommendations were reflected in various policy outputs.

In each of these steps, the same coding procedures as outlined for the group recommendations in Phase 1 above were followed, and so will not be repeated here. The same coding rules applied for: i) completely reflected, ii) partially reflected, and iii) not reflected applied. Similarly, counts were done within each code to determine frequencies. The coding steps are depicted visually in Figure 3.6 and were as follows: **Step 1**: Reflection of summit recommendations in policy changes; **Step 2**: Reflection of

summit recommendations in draft policy; **Step 3:** Reflection of summit recommendations in policy appendices.

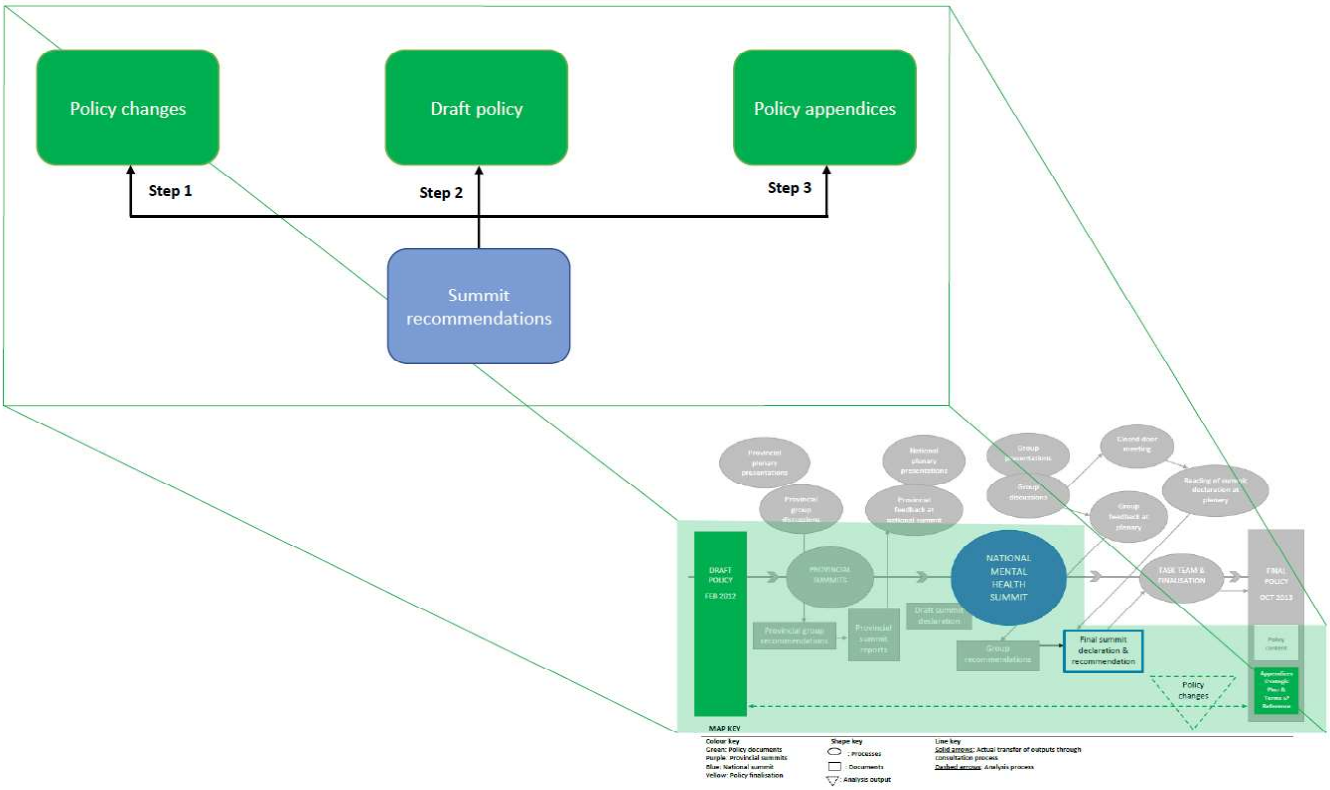


Figure 3.6: Analysis Phase 3: Abstraction and transfer of inscribed knowledge from summit recommendations into policy outputs

The three steps and data included in Phase 3 of the analysis are shown at the top of Figure 3.6 – the summit recommendations compared with various parts of the policy. The relevant components of the consultation summit process to which each of these components are linked at depicted through colour coding and linking with the magnified process map on the bottom left of Figure 3.6.

The findings of the analysis across each of the three phases described above have been presented in relevant sections in the findings chapter (Chapter 4). Following the coding process, comparative analyses were conducted across sets of inscribed data. The results were tabulated and interpreted according to breakaway group themes. At this level of detail, fine-grained observations could be made regarding follow-through of group inputs and of particular issues through summit and policy outputs. As analysis progressed, key findings emerged that related to how knowledge moved from one form to another – particularly, in this component of the analysis, between inscribed forms. In this way, my own analysis moved from a more detailed descriptive account to a more abstracted one. As such, more abstracted accounts of the findings in relation to the analyses above are presented in Chapter 4 (section 4.6), with detailed analyses included as appendices.

3.7.3.6 From the outside in: Triangulating findings

Being able to use data from multiple sources of evidence is one of the strengths of case study design (Yin, 1994). The process of comparing the findings from different sources of data in order to corroborate or validate conclusions is typically referred to as triangulation. Willig (2008) advises that "case study research should always involve a certain amount of triangulation (p. 80) … to arrive at a better understanding of what is really going on" (p. 86). Triangulation strategies include methodological triangulation (such as in mixed methods research), theoretical triangulation (using different theoretical perspectives on the same data set), and investigator triangulation (combining multiple researchers' perspectives on the same data) (Denzin, 1970). In the current study, data triangulation is used to assess convergence (or divergence) of findings from analysis of multiple data sources.

Triangulation processes in qualitative research are often not made explicit and may involve something of an intuitive approach (Farmer, Robinson, Elliott, & Eyles, 2006; Smaling, 1987, in Meijer, Verloop, & Beijard, 2002). More procedural approaches outline each comparative step in the process to ensure replicability (Farmer et al., 2006). Such procedures include following a thread, where a key theme or question is followed across different data components (Moran-Ellis et al., 2006). Other procedural approaches involve applying the convergence coding matrix developed by Farmer et al. (2006) as part of a triangulation protocol to triangulate findings from analysis of interview data with analysis of project reports. Following the example of Heslehurst et al. (2015), a combination of these two triangulation procedures was used in this study.

Each of the three research questions in this study focused on particular phenomena relating to the movement of knowledge through the policy consultation process. These three questions thus represented the threads that were followed across different data sets. In this case, findings from the interview analysis pertained to all three questions; findings from the summit document and transcript analyses that related to either Question 1, 2, or 3 were included in the convergence coding matrix shown in Table 3.12, for comparison with the interview findings.

Table 3.12: Triangulation of findings: Convergence coding matrix

	Interviews[(i)]	Group discussions[(ii)]	Group Process[(iii)]	Inscription and transfer[(iv)]	Convergence assessment
Question 1					
Question 2					
Question 3					

Data sources for each phase: i) interview transcripts; ii) group discussion transcripts; iii) summit programme, provincial summit reports, national summit declaration, group discussion transcripts; iv) group discussion transcripts, feedback of group recommendations at plenary session, national summit declaration, policy, and policy appendices

Triangulation of data proceeded by conducting convergence assessment for agreement or disagreement across the data sets, using the following coding categories:

- Convergence: Findings directly agree.
- Complementarity: Findings offer complementary information on the same issue.
- Dissonance: Findings appear to contradict one another.
- Silence: Themes arise from one component of the study but not others (Heslehurst et al., 2015, p. 7).

While each of the analyses described in sections 3.7.3.3, 3.7.3.4, and 3.7.3.5 directly address each of the three research questions, the interview analysis provides corroborating information to improve interpretation and understanding. These findings are thus drawn together in this final analysis section to re-view the consultation process from the outside-in, and to answer each of the three research questions. Explicit links to the concepts of embodied, enacted, and inscribed knowledge are made.

3.8 Study quality

In any research endeavour, the quality and the integrity of the study and the findings it produced must be established. Researchers need to be transparent and explicit about what they did to arrive at their findings, and about who they are – and how the latter might have impact on the former. In doing so, researchers provide readers with sufficient information to make their own judgments regarding the credibility and integrity of the research. However, there is little consensus concerning the criteria by which judgments of quality are made. Many have argued that quality criteria and strategies for assessing

rigour in quantitative research do not and should not be applied to qualitative research, which is fundamentally different both epistemologically and methodologically (Bryman, 2006; Lincoln & Guba, 1985; Maxwell, 2013). By its nature, qualitative research cannot be easily assessed for quality in the same ways as research based on statistical tests and analysis. It does not, cannot, and should not ensure certainty or universal truths (Willig, 2008). Nonetheless, while not aiming for certainty of rigour in qualitative research, we can aim for confidence concerning quality (Hammersley, 1992, in Cohen et al., 2010). Thus, what has been defined as rigour in quantitative research has been equated with trustworthiness in qualitative research (Babbie & Mouton, 2001; Lincoln & Guba, 1985).

The challenge, however, has been to identify criteria that might be employed to assess quality – or trustworthiness – in qualitative research, to the same level as quality in quantitative research. Some have proposed applying criteria (such as reliability and validity) adopted in quantitative research to qualitative research (Cohen et al., 2010). This seems to be what Yin (1994, p. 32) primarily does in proposing quality criteria for case study research, arguing that "because case studies are one form of empirical research, the … tests [to establish quality in empirical social research] are also relevant to case study research".

Others have proposed that even attempting to subject qualitative research to the same assessments of rigour is tantamount to eschewing what makes qualitative research distinct from quantitative research in the first place (Foreshaw, 2007, in Willig, 2008). The predominant approach, however, seems to be a middle ground between the two: adapting criteria employed in quantitative research (using parallel but amended terms) to qualitative research (Bryman, 2006; Frambach, van der Vleuten, & Durning, 2013; Sale, Lohfeld, & Brazil, 2002; Willig, 2008). While there is some variation in terminology, these criteria are generally defined as: credibility, dependability, transferability, and confirmability (Babbie & Mouton, 2001; Lincoln & Guba, 1985).

There are several features of the current study which influence how quality might be determined: it entailed qualitative research, in a case study design, and was located within a pragmatic paradigm. The study also focused on policy consultation, aiming to generate findings that might be relevant for how such processes might be organised to optimise the use of knowledge in policy. Each of these features has informed the strategies I employed to enhance the quality of this study, as well as to counter the limitations of qualitative case study research. The techniques for enhancing the credibility, dependability, transferability, and confirmability of the current study are drawn from those that converge across all of these dimensions; they have been applied in qualitative research (Frambach et al., 2013), case study research (De Weerd-Nederhof, 2001), research located within a pragmatic paradigm (Bryman, 2006), and health policy research (Gilson, 2012b; Gilson et al., 2011). These are outlined here.

In the discussion that follows, I have found it helpful to draw on Frambach et al.'s (2013) guideline regarding quality criteria for qualitative and quantitative research. They propose quality principles to which both quantitative and qualitative quality criteria relate. They then outline a number of techniques for enhancing each of the four quality criteria identified here. I supplement these with strategies proposed by several others in relation to qualitative and case study research.

3.8.1 Credibility

Credibility pertains to establishing the truth value of the evidence and has been proposed as the equivalent to internal validity in quantitative research (Frambach et al., 2013). It is defined as "the extent to which the study's findings are trustworthy and believable to others" (Frambach et al., 2013, p. 552).

Maxwell focuses on validity as a key criterion for assessing quality in qualitative research. Sidestepping the debates regarding the applicability of this criterion in qualitative research, he proposes that validity should do "what researchers want it to do, which is to give them some grounds for distinguishing accounts that are credible from those that are not" (Maxwell, 2013, p. 122). I would argue that this is a particularly important criterion from the perspective of a pragmatic paradigm, given its emphasis on testing out theory and data in an iterative abductive process, and its assertions that truth claims should always be warranted and always be tested. Pragmatism is a question-driven philosophy that is concerned with the utility of findings. Truth, in this paradigm, can be broadly defined as 'What works for whom in what circumstances?'. However, such 'truths' must be based on assertions that are both warranted and testable.

This relates to Yin's (1994, p. 35) assertion that a concern in terms of internal validity for case study research relates to the inferences a researcher must make that certain observations or events resulted from "some earlier occurrence, based on interview and documentary evidence collected as part of the case study". Yin argues that researchers must design studies that anticipate such questions as: "Is the inference correct? Have all rival explanations and possibilities been considered? Is the evidence convergent?" (1994, p. 35). While the a priori controls available to quantitative researchers for ensuring validity are not available to qualitative researchers (Maxwell, 2013), there are strategies that can "promote confidence that researchers have accurately recorded the phenomena under scrutiny" (Shenton, 2004, p. 64).

One of the key strategies for ensuring a study's credibility is triangulation. Triangulation can serve two purposes in this regard: to confirm (or disconfirm) findings by triangulating across multiple data sources, methods, theories, or investigators, and to ensure completeness of findings (Houghton, Shaw, & Murphy, 2013). Triangulating findings by using multiple sources of evidence is, in fact, one of the strengths of case study research (Yin, 1994), in addition to being a technique that can enhance study quality (Frambach et al., 2013; Sale & Brazil, 2004; Shenton, 2004). Data triangulation was a method employed in the current study in order to ensure as complete a picture as possible of the phenomenon being explored. An important aspect of this process was to search for divergences and contradictions across findings, in addition to convergence.

Related to constructing as complete a picture of the phenomenon as possible is developing a 'thick description' of the phenomenon, and examining the findings in relation to their congruence with those of past studies (Shenton, 2004). Adopting the *embodied-enacted-inscribed* knowledge framework as an analytical lens in this study required me to move back and forth between my observations in the data and "developing possible explanations for them through comparisons with the research literature, as well as to other data collected within the same study" (Maybin, 2013, p. 56). I believe that this is also consistent with the abductive reasoning that is a defining feature of studies informed by a pragmatic paradigm.

Prolonged engagement and familiarity with the study site has been recommended as a strategy for enhancing credibility (Frambach et al., 2013; Shenton, 2004). Williams (2011) suggests that "if it is apparent that the [researcher] was on the site long enough to see the range of things to be expected in such a site, the results produced will be more credible". This was a retrospective case study and, as such, it was not possible for me to spend time engaging with the study sites, that is, the consultation summits per se. However, over five years were spent engaging with data from these sites, which I believe allowed me to establish as close a familiarity with the process as possible. This is more consistent with what Williams (2011) defines as 'persistent observation', which allows researchers to conduct an in-depth exploration of the phenomena under study. In particular, my prolonged and continuous engagement with the transcripts of the group discussions from the national summit allowed me to develop multiple insights into the process, through repeated readings of the data at different levels. This, I have attempted to demonstrate through establishing a chain of evidence for the reader, as is recommended in case study research (Yin, 1994).

Another strategy for enhancing credibility of findings is member checking, that is, asking for feedback from study participants on the data or its interpretation (Frambach et al., 2013; Sale & Brazil, 2004; Yin, 1994). Although it might have been possible to verify the transcriptions of interview responses with

interviewees, the feasibility of performing member checks was partly limited by the number of years over which the study unfolded. In addition, the usefulness of member checking in ensuring study quality is a matter of some debate (Houghton et al., 2013) with some proposing that this may actually pose a threat to validity (Rolfe, 2006). Morse, Barrett, Mayan, Olson, and Spiers (2002, p. 7) argue, for example, that study results have typically been "synthesized, decontextualized, and abstracted from (and across) individual participants, so there is no reason for individuals to be able to recognise themselves or their particular experiences".

Of particular relevance to this study was the potential of member checks to force researchers to "restrain their results to a more descriptive level in order to address participants' individual concerns … and keep the level of analysis inappropriately close to the data" (Morse et al., 2002, p. 8). Given the aim of this study to explore policy consultation from a knowledge perspective, and the analysis of the data using the *embodied-enacted-inscribed* knowledge framework as a lens, member checking with study participants was not considered a feasible means of ensuring quality. However, I believe that sufficient care has been taken to employ other strategies for the purposes of improving the quality of this study for this not to have adversely affected the results.

3.8.2 Dependability

A second quality principle defined by Frambach et al. (2013) is consistency of both the process and the evidence produced. In quantitative studies, this relates to reliability; in qualitative studies, it is defined as dependability: "the extent to which the findings are consistent in relation to the contexts in which they were generated" (Frambach et al., 2013, p. 552). Shenton (2004, p. 71) posits that this criterion is somewhat problematic in qualitative research due to the "changing nature of the phenomena scrutinised by qualitative researchers". Nonetheless, researchers should endeavour to demonstrate that the findings are consistent with the raw data on which they were based, and therefore stable across the study context. Frambach et al. (2013) propose that iterative data collection and analysis, and saturation of data, are techniques that may enhance the dependability of findings.

The retrospective nature of the study, and its reliance primarily on document analysis as a method, limited the extent to which iterative data collection – in other words, continuous analysis of the data to inform further data collection – could be implemented. In addition, the bounded nature of this case study provided a finite set of documented data that was available for analysis, thereby limiting possibilities for saturation in data collection. However, the multiple levels at which the data was analysed allowed me to continuously return to and examine the data using insights that emerged from previous steps in the analysis. I was thus able to ensure saturation through iterative data analysis,

thereby increasing the dependability of the findings. Furthermore, efforts were made to be as explicit as possible about coding decisions made, including providing coding rules and how these were applied to the data. This, together with the use of verbatim extracts (Brocki & Wearden, 2006), was intended to enable readers to assess the logic and means by which interpretations were reached (Houghton et al., 2013).

Another aspect of establishing dependability of findings is through demonstrating consistency of the research *process*. Towards this end, Shenton (2004) argues for clearly describing the processes followed in the research in order for readers to establish consistency in process and therefore dependability of findings. Strategies for doing so in case study research, as identified by Yin (1994), include using a case study protocol, and developing a case study database. Both of these strategies have been carefully followed in this study and documented in this chapter. This is linked to leaving an audit trail, and being explicit about what was done at each step of the process – including the data that was included, and the analytical techniques employed – and providing a rationale for these methodological decisions (Houghton et al., 2013). I have attempted to describe in detail the decisions regarding the inclusion of the data in this study, as well as the process involved in applying the analytical framework at various levels of the analysis. I have also, as Shenton (2004, p. 72) suggests, endeavoured to document a theoretical audit trail, in the sense of tracking "the manner in which the concepts inherent in the research questions gave rise to the work to follow".

3.8.3 Transferability

Transferability is "the extent to which the findings can be transferred or applied in different settings" (Frambach et al., 2013, p. 552). It is linked to the applicability of evidence and is synonymous with the concept of external validity in quantitative research (Frambach et al., 2013). Some of the advantages of case study research, such as its strong contextual links and its flexibility as a method can, conversely, also be its downfall when assessing credibility and rigour. The limits on generalising case study findings beyond the contexts in which the research was conducted have been a major criticism of this kind of research (Willig, 2008; Yin, 1994). As Willig (2008, p. 159) suggests:

> case studies allow us to get to know a particular case very well, and to begin to understand why it came to be what it is. However, case studies are less good at providing a panoramic view of a phenomenon and to identify similarities and patterns across contexts.

Similar criticisms have been levelled against health policy research, with the context specificity of much of this research making generalising from its findings difficult (Gilson et al., 2011).

The most obvious way in which generalisability is limited in case study research is the small sample size, making it difficult to argue in any way that the findings can be said to be representative of similar cases. However, proponents of case study and health policy research, respectively, have argued that the goal in such studies is not (and should not be) statistical significance (Gilson, 2012a; Yin, 1994). Instead, what has been aimed for in this study is analytical transferability: the "development of general conclusions that, although derived from a limited number of particular experiences, provide theoretical insights that can be put forward for consideration, and testing, in other, similar situations" (Gilson et al., 2011, p. 3). I believe that the use of a conceptual knowledge schema as an analytical framework has required me to make connections continually between the findings and their implications for this theoretical approach to knowledge. This, in turn, has generated findings that, although specific to this case of policy consultation, might have relevance for how embodied, enacted, and inscribed knowledge are understood and, in particular, how such an understanding might enhance future policy consultation practices.

This has been achieved, in part, by establishing the theoretical audit trail mentioned earlier, that is intended to facilitate the reader's ability to consider the transferability of this study's findings to other contexts by making links between the findings and what is already known (Babbie & Mouton, 2001). Williams (2011) argues that transferability is a matter for the reader to determine, which requires the researcher to be as explicit and detailed as possible about the case and its context. Another strategy employed towards this end in this study, then, was providing a thick description (Frambach et al, 2013) of not just the phenomenon under study and of the boundaries of this case (Shenton, 2004), but also of every methodological step followed in reaching the study's findings, in addition to describing the findings in sufficient detail (Houghton et al., 2013). As such, I have provided as much detail as possible in describing the processes followed in choosing and delineating the study context, details of the consultation process, sampling and data gathering procedures, and coding and analysis of data (Sale & Brazil, 2004).

3.8.4 Confirmability

Confirmability speaks to the principle of neutrality of evidence, and is linked to the notion of objectivity in quantitative research (Frambach et al., 2013). In qualitative studies, confirmability can be defined as "the extent to which the findings are based on the study's participants and settings, instead of researchers' biases" (Frambach et al., 2013, p. 552). The subjective nature of qualitative research, given the instrumentality of the researcher as the primary research tool, has been a major criticism levelled against it. I would argue that the intersubjectivity within a pragmatic paradigm – whereby researchers move back and forth between objective and subjective – goes some way towards countering this risk.

Nonetheless, there are a number of strategies that should be implemented in order to guard against bias and thereby enhance confirmability of the findings.

This criterion is closely linked to dependability, and many of the same techniques can be employed to establish both. Some of these, such as creating an audit trail (Frambach et al., 2013; Sale & Brazil, 2004), have been discussed above. Williams (2011) suggests that "the confirmability audit can be conducted at the same time as the dependability audit, and the auditor asks if the data and interpretations made by the researcher are supported by material in the audit trail, and are internally coherent". At various points throughout the study, I have attempted to make explicit the "beliefs underpinning decisions made and methods adopted" (Shenton, 2004, p. 72). In Chapter 5, I also identify "weaknesses in the techniques actually employed" (Shenton, 2004, p. 72) when discussing the limitations of this study.

The interpretations of data, then, should represent more than "figments of the researcher's imagination" (Guba & Lincoln, 1989, p. 243, in Williams, 2011). Towards this end, then, it is important that researchers make explicit the potential for researcher bias or influence on the findings (Maxwell, 2013). How to use reflexivity in qualitative studies has been the subject of much debate and, while much has been written about being reflexive in qualitative research, there is less explicit guidance on ways of doing research reflexively (Belcher & Hirvela, 2005; Mauthner & Doucet, 2003) and on ways of presenting reflexivity in research writing (Patnaik, 2013). Some have equated reflexivity with acknowledging one's inevitable subjectivity during the research process, and making this explicit through first-person accounts (Berger, 2015); others have argued that "reflexivity goes beyond reflection or merely a process of introspection or self-awareness" (Patnaik, 2013, p. 101). As such, I draw on Willig's (2008) and Patnaik's (2013) distinctions between epistemological reflexivity and personal or introspective reflexivity to account for the reflexive strategies that I employed in this study.

Earlier in this chapter, I discussed ways in which my assumptions and perspectives regarding the nature of knowledge informed my decisions regarding the research paradigm and design adopted in this study. In doing so, I demonstrated my epistemological reflexivity in reflecting on my assumptions about the world and about knowledge, as well as on the "implications of such assumptions for the research and its findings" (Willig, 2008, p. 10). Throughout the course of this research process, I have also reflected on how my beliefs as a researcher, mental health practitioner, and mental health service user – in addition to my comfort and discomfort around particular epistemological practices – have influenced how I approached the data and my interpretations of it. Keeping this research journal was a way of making explicit my own attitudes and biases in order to "bracket" them and minimise their influence on the research process (Patnaik, 2013, p. 101). This, then, was a means of engaging in personal reflexivity, thinking not just about how my own values and experiences may have influenced the research, but also

"how the research may have affected and possibly changed [me], as a person and as a researcher" (Willig, 2008, p. 10). I document this in the epilogue at the end of this thesis, as reflections on the research process.

Another way in which I have explicated my positionality within this research is to employ a first-person writing style in certain parts of this dissertation. It was an approach that seemed an intuitive fit within a pragmatic paradigm, which emphasises (perhaps requires) the constant interplay between objective and subjective positions during the research process, and an interpretive epistemological stance (Morgan, 2007). Writing in the first person has become an accepted convention in interpretive or constructivist traditions (Piantanida & Garman, 2010). Furthermore, Patnaik (2013, p. 101) argues that "reflexivity acknowledges the role of the researcher as a participant in the process of knowledge construction and not merely an outsider-observer of a phenomenon". To me, this meant two things. First, it meant making my voice explicit in describing the methodological choices and decisions informing this study. As such, I have adopted a first-person style of writing in the current chapter.

Second, adopting a reflexive stance meant acknowledging my role in constructing the knowledge claims made in this study, particularly with respect to the contribution that this study makes to the fields of knowledge in which it is located. Kamler and Thomson (2014, p. 34) suggest that writing is a process of "negotiating textwork and identity work simultaneously. The challenge is to learn to speak/write with authority, standing back with 'hands on hips'". Earlier in this chapter, I described the three stages of reflective knowledge construction through which this study (and, by extension, I) moved: from understanding what happened, to how this happened, to why it happened (Kreber & Cranton, 2000; Mezirow, 1991). In the discussion chapter (Chapter 5), I reflect on what the findings of this study mean – the why – in relation to what is already known. It seemed important to make my own role in the construction of this new knowledge explicit during this discussion. I have therefore returned to a first-person writing style in that chapter.

In terms of the threat of reactivity – the influence of the researcher on the study participants and study setting (Maxwell, 2013) – to the confirmability of the findings, I did not consider this to be a significant issue given that this was primarily a retrospective document analysis. Nonetheless, I must acknowledge the potential for influence on the interview data that I gathered at the start of this study. Having found that the mental health policy did not change substantively following the consultation summits, I was aware that I went into these interviews with some of my own ideas about why this may have been the case. I was therefore conscious, in the analysis and reporting of these findings, to ensure that I looked for evidence that would disconfirm some of these hypotheses, in addition to confirming them. Another possible influence on the interview responses that must be made explicit here is the invisible presence

of potential readers of the study report. I was aware that some interviewees – particularly those who were more closely involved in the history and development of the mental health policy – were sensitive to portraying the consultation in a negative light, which was evident from what they seemed more comfortable saying off record, once the interview was officially terminated.

Williams (2011) also asserts that "reference to literature and findings by other authors that confirm the [researcher's] interpretations can strengthen confirmability." I would argue, along with Frambach et al. (2013), that identifying where findings diverge from or contradict previous research is also an important step in establishing the neutrality of the evidence. In Chapter 5 of this study, findings are discussed in relation to previous research, and efforts made to identify where this study has produced surprising or contradictory findings. In addition, Shenton (2004, p. 72) argues that triangulation of findings can be used to "reduce the effect of investigator bias". In this study, a triangulation protocol was followed that allowed for not just convergences, but also divergences and silences across multiple data sets to be identified. There are thus a number of strategies that have been employed throughout this study in an effort to enhance the trustworthiness of this study by enhancing its credibility, dependability, transferability, and confirmability. In the next chapter, the findings of the study are presented and discussed.

Chapter 4: Findings

4.1 Introduction

The aim of this study was to explore how different knowledge forms (embodied, enacted, and inscribed) moved through a consultation process to inform policy. Prior to focusing on the mental health consultation summit process, however, a preliminary comparative analysis of the draft and final policy documents had been conducted, to assess how the policy had changed following the consultation summits. As discussed in the previous chapter, this preliminary analysis had revealed that the content (body) of the mental health policy changed in only minor ways following the provincial and national consultation summits. This served as the point of departure for the case study of the consultation process itself. In the methodology chapter a detailed description was presented of *what* happened – i.e. of the mental health policy consultation process conducted in South Africa in 2012. This is extended in section 4.2 below, which details that what appears to have happened following the consultation process is that the content of the mental health policy did not change in any substantive way. Each of the findings sections that follow on from this point of departure employs the *embodied-enacted-inscribed* analytical framework to provide insight into *how* this happened, towards understanding why it happened.

The analytical framework used in this study was described in the previous chapter and is shown again here in Figure 4.1. This framework allowed for the tracing of embodied, enacted, and inscribed knowledge through the consultation summits, moving from the more particular embodied knowledge form within individuals to the more abstract inscribed knowledge form within policy outputs. Each of these elements comprises the focus of each of the three research questions: how *embodied* knowledge was enacted and inscribed; how group processes enabled or constrained the movement of *enacted* knowledge to inscribed knowledge; and how *inscribed* knowledge was transferred through points of increasing abstraction to inform policy. Individual interviews provided a means of gaining insight into these three issues, and supplemented the findings from the analysis of the document and summit transcripts. The point of departure for this study as depicted on the framework was the preliminary comparative analysis of the policy documents.

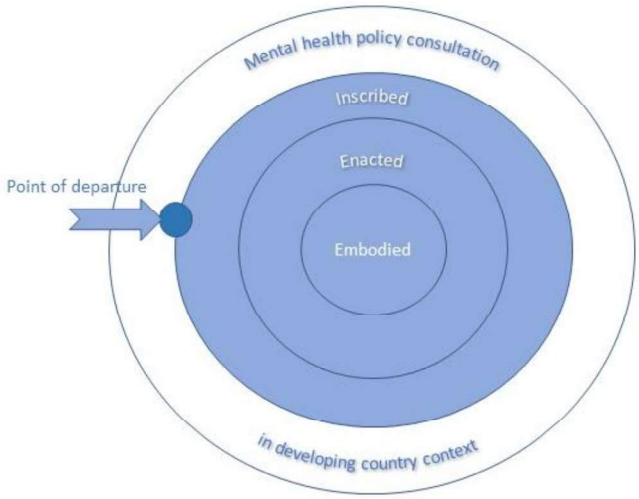


Figure 4.1: Analytical framework: Movement of knowledge from embodied to enacted to inscribed

There are six sections in this findings chapter. In section 4.2, findings are presented from the preliminary comparative analysis of the draft and final policy documents that served as the point of departure for this study. In section 4.3, findings from the interview analysis are presented, as a 'way in' to the consultation process. Section 4.4 focuses on the enactment and inscription of individual embodied knowledge within the summit group sessions. Findings from the analysis of the process through which enacted knowledge became inscribed knowledge are presented in section 4.5. In section 4.6, the focus is on the inscribed knowledge outputs and how these were transferred through increasing levels of abstraction (summarisation). The final part, section 4.7, draws all these findings together to provide a summary of the study's main findings as they relate to the research questions.

4.2 Point of departure: Changes to the policy following the consultation summits

The original aim of this study had been to focus primarily on the content of the mental health policy documents and in particular, to explore how ways in which mental health issues were framed at the consultation summits influenced whether or not this content subsequently appeared in the final policy document. A preliminary analysis phase at the start of this study thus involved a comparative analysis of the draft and final mental health policy documents. The draft mental health policy was circulated prior to the provincial and national mental health summits in April 2012. The final version of the policy was circulated in October 2013.

A comparison of the draft and final policy documents showed that 45 changes were made to the draft policy content in the period between April 2012 and October 2013. Two additional appendices were also added. During this preliminary phase of analysis, it was unclear whether these changes were a direct result of discussions and requests for changes at the provincial and national summits, or rather a result of the work done on the policy by the Technical Advisory Committee following the consultation summits. Many of the changes to the body of the policy document appeared to be editorial in nature and did not seem to have a substantive effect on the policy content. There were twelve minor changes to the original text, eight deletions, and 25 additions. As shown in Table 4.1, the majority of the changes (n=13) were made to the *Roles and Responsibilities* section, followed by the *Areas for Action* (n=11) and *Glossary of Terms* (n=10) sections. The detailed content of the changes can be found in Appendix 5.

The biggest change between the draft and final policy was the addition of the eight-point *Strategic Plan, 2013-2020* (hereafter referred to as the Strategic Plan, or implementation plan) to the final document. This plan outlined the strategic actions that needed to be implemented to effect the requirements of the mental health policy. It was added in the form of a tabular appendix to the final policy and seemed to operationalise the policy content into eight priorities for implementation, particularly focusing on the *Areas for Action* outlined in the body of the policy. The Strategic Plan was only added after the summits, following 18 months of further work by the Technical Advisory Committee and the Department of Health (DoH) to decide on the eight operational priorities. The plan provides a detailed outline of the key activities, outputs, target dates and responsible organisations for each of the eight prioritised implementation objectives.

The eight objectives were:

1. District-based mental health services and primary health care re-engineering
2. Institutional capacity building (national, provincial, district)
3. Surveillance, research and innovation
4. Infrastructure and capacity of facilities
5. Mental health technology, equipment and medicines
6. Intersectoral collaboration
7. Human resources for mental health
8. Advocacy, mental health promotion, and prevention of mental illness.

Table 4.1: Post-consultation changes between the draft and final policy documents

Section	Subsection	Changes	Additions	Deletions	Total
Glossary of terms		3	5	2	10
Introduction	Scope	-	1	-	1
Context	Context general	-	1	-	1
	Current service provision	-	3	-	3
	Policy and legislation mandates	-	1	-	1
Vision		1	-	-	1
Values and principles		1	-	1	2
Areas for action	Organisation of services	1	5	1	7
	Financing	-	1	-	1
	Intersectoral collaboration	-	1	-	1
	Advocacy	-	1	-	1
	Human rights	1	-	-	1
Roles and responsibilities	Minister of Health	1	1	1	3
	Director General	-	1	-	1
	Provincial departments of health	-	1	-	1
	District health services	-	1	1	2
	Designated psychiatric hospitals, care, and rehabilitation centres	2	1	1	4
	Non-governmental organisations	-	1	1	2
Intersectoral roles and responsibilities (Appendix)	Police services	1	-	-	1
Order of sections		1	-	-	1
Totals		12	25	8	45

A footnote to the Strategic Plan states that the objectives are "based on the National Mental Health Summit Ekurhuleni Declaration (April 2012) and the Mental Health Policy Framework and approved by the National Health Council" (Department of Health, 2013, p. 40). This implies that the prioritised objectives for implementation outlined in the eight-point plan were to some extent determined by the national mental health summit and the summit declaration that resulted from that summit.

A second substantive addition to the final policy was the appendix detailing *Terms of Reference for key structures* (hereafter referred to as Terms of Reference, or ToR). This provides detail regarding the functions falling under the mandate of the following key structures: i) district specialist mental health teams, ii) Ministerial Technical Advisory Committee on Mental Health, iii) Provincial Mental Health

Directorates, and iv) National Health Commission. It is possible that the discussions at the national mental health summit were also used to flesh out some of this detail. This is explored in later analysis.

Apart from the additions of the Strategic Plan and Terms of Reference, it appears that the nature of most of the changes made to the final version of the policy would not have had a significant effect on the nature or directives of the policy. Many of the changes seemed to be more editorial than conceptual, for example, the reordering of headings, or changing of phrases such as *mutual aid* to *self-help*. This suggests that the changes were as a result of editorial decisions made by the Technical Advisory Committee as they worked on the policy document following the summit and prior to its finalisation. Some of the additions to the *Glossary* section were definitions that were added where these definitions had been left blank in the draft version, such as for the terms *psychosocial rehabilitation, recovery model,* and *task shifting.*

The most substantive changes in terms of content in the body of the policy were two additional subsections that were added under *Areas for Action*: *Organisation of Services.* In the draft policy, the two subsections comprising *Organisation of Services* were i) community mental health services and ii) the district mental health system. The two additional sub-sections appearing in the final policy document were iii) psychiatric services in general hospitals and iv) specialised psychiatric hospitals. The activities outlined in each of these subsections refer to the required actions to be taken regarding psychiatric services in general hospitals and in specialised psychiatric hospitals. Given the push towards deinstitutionalisation and community-based care, it is notable that the most substantive content that was added regarding mental health services relates to services provided at tertiary (hospital) level. This is also indicated in the World Health Organization's (WHO) systems diagram added to the final policy, which shows where the focus of resources should be in the integration of mental health in primary health care.

A further addition made under *Areas for Action*: *Organisation of Services* also served to provide more context for the activities that follow, rather than changing the scope of those activities *per se*. The addition refers to the World Health Organization's (WHO) recommendations regarding the organisation of mental health services, such that mental health systems should include primary health care, community-based settings, general hospitals, and specialised psychiatric services. A diagram showing the WHO's pyramid for an optimal mix of services for mental health was added in to demonstrate this. Following this addition, the *Areas for Action* in *Organisation of Services* continue unchanged from the draft policy.

Two paragraph additions were also made to the *Introduction* and *Context* sections of the final policy. These additions referred mostly to comorbidities with mental disorders, and specifically to the responsibilities of the national DoH and other government departments regarding individuals with substance abuse issues and those with intellectual disabilities. In the *Context* section, South Africa's unique challenges with respect to the legacy of apartheid and the abuses of the system were also further elaborated on in the final policy. These additions to the background and context of the policy are not likely to have had a substantive effect on the operational elements of the policy regarding provision of mental health services in South Africa.

Finally, changes made to the *Roles and Responsibilities* sections also appear largely editorial in nature. Three bodies that were not mentioned in the draft policy are specifically referred to in the final policy document: Mental Health Review Boards, in the *Advocacy* section; the Ministry for Women, Children and Persons with Disability in the *Roles and Responsibilities* section; and the Mental Health Directorate, in the *Roles and Responsibilities* section.

Table 4.2: Sections of policy which did not change between draft and final versions

Unchanged sections	**Unchanged subsections**
Context	Epidemiology
	Determinants of mental health and illness
	Costs of mental illness
	Evidence for promotion, prevention, treatment, and rehabilitation
Mission	
Objectives	
Areas for action	Promotion and prevention
	Human rights
	Special populations
	Quality improvement
	Human resources and training
	Psychotropic medication
	Research and evaluation of policy and services
Roles and responsibilities	Other sectors
Intersectoral roles and responsibilities (Appendix)	Education
	Social Development
	Correctional Services
	Justice
	Housing
	Local Government
	Transport

It is worth noting those sections of the policy that were *not* amended between the draft policy document prior to the provincial and national summits, and the final policy document released in October 2013. As shown in Table 4.2, a number of sections remained unchanged.

In order to map this analysis of the changes between the draft and final policy documents onto later analysis of the summit transcripts, the changes were reorganised into the ten breakaway group themes from the provincial and national summits. The limitations of mapping content of the summit outputs directly onto policy outputs are addressed in the main analysis sections. The limits on what can be inferred from alignment or non-alignment are noted here, including the multiplicity of factors that may have contributed to what was (and was not) included in the final policy document. Not all of the categories or content of the changes from the policy corresponded directly to these breakaway group themes. It was therefore necessary to make interpretive decisions about the best fit, as well as to include additional themes where the content pertained to themes that were not explicitly included as a topic for discussion in the summit breakaway groups. In some cases, where there was more than one issue under discussion in a breakaway group, themes were split into two – for example, research, and monitoring and evaluation (surveillance). In eight cases, changes related to more than one theme and were recorded as such – hence the apparent increase in number of changes to the policy shown in Table 4.3.

In some cases, there was both a deletion and an addition – that is, a part of a sentence, a sentence or a section was deleted from draft policy, and an addition was made to the final policy. Themes corresponding to the deletion and addition would thus have been counted twice. Note, too, that some additional themes were included here even though they related neither to a specific summit breakaway group theme nor to *changes* between the draft and final policies. Later in this chapter, correspondence between recommendations made at the national summit and the content of the draft policy will be explored. In this analysis, additional themes were identified that related to both these recommendations and content contained in the draft policy. For consistency across these analyses, these additional themes are therefore also included in Table 4.3, identified by the blue text.

Table 4.3: Changes corresponding to the summit group commissions and other themes

Themes	Changes	Additions	Deletions	Total
Promotion and prevention	2	-	-	2
Monitoring and evaluation	-	1	-	1
Mental health systems	2	7	6	15
Human resources	-	2	-	2
Infrastructure	5	3	2	10
Research and innovation	-	-	-	0
Advocacy and user participation	2	2	-	4
Culture and mental health	-	-	-	0
Mental Health Care Act implementation	2	6	-	8
Mental Health Review Boards (MHC Act)	-	1	-	1
Suicide prevention	-	-	-	0
Medicines, equipment, and protocols	-	-	-	0
Governance	-	5	1	6
Intersectoral collaboration	-	1	-	1
Funding	-	1	-	1
Quality assurance	-	-	-	0
Child and adolescent mental health	-	-	-	0
Mental health and other conditions	-	2	-	2
Not applicable to a specific theme	2	-	-	2
Total	15	31	9	55

Roughly a third of the themes listed above were associated with no policy changes. From Table 4.3, it seems that the major focus of amendments (n=15) from the draft to the final policy document was on issues relating to strengthening mental health systems, specifically mental health service provision and integration of mental health into primary health care. A number of these changes related to additions or amendments to terms in the *Glossary* section. As mentioned above, the most substantive changes in terms of *Areas for Action* were the addition of two new sections under *Organisation of Services* that outlined mental health care and treatment to be provided in general and specialised psychiatric hospitals; this was coded under both infrastructure and Mental Health Care Act implementation. Much of the new content under psychiatric services in general hospitals seemed to be related to implementation of the regulations contained in the Mental Health Care Act. The new section on specialised psychiatric hospitals outlined specialist mental health services to be provided in these hospitals. This could be seen as contrary to the WHO service organisation pyramid, which shows that the quantity of services needed is highest at community and primary health care level.

Changes to policy following consultation summit: Conclusion

Of the 45 changes made to the mental health policy following the national summit, most appeared to be editorial in nature, and represented no significant changes in terms of the operational content of the policy. There were twelve changes to existing content, eight deletions, and 25 additions. The majority of the changes in terms of policy sections were made to the *Glossary*, *Areas for Action: Organisation of Services*, and *Roles and Responsibilities* sections. The majority of changes in terms of themes related to mental health systems. Four additions were considered to be substantive, particularly in terms of operational actions. Two subsections were added to *Areas for Action: Organisation of Services* that provided detail regarding the provision of mental health services in general hospitals, and provision of services in psychiatric hospitals.

Two appendices were added to the final policy, both of which represented actions to be taken in the implementation of the policy: the eight-point *Strategic Plan*, which outlined priorities for implementation, and the *Terms of Reference*, which outlined actions for key structures. Given that the breakaway groups at the summit seemed to focus on adding recommendations to the draft summit declaration, it is possible that the summit outputs were used, not to change the policy itself, but to inform the implementation priorities and actions included in the two additional appendices. A comparison between the policy changes identified in this section and the recommendations put forward at the national summit may shed light on the deletions, additions, and changes made to the final policy following the consultation summits. This was explored through further analysis forming the main focus of this study.

One of the initial conclusions that might be drawn from the results of this preliminary analysis is that the mental health consultation summits were simply a rubber-stamping exercise, as opposed to a genuine dialogue regarding the content of the mental health policy. Based on these findings, the focus of this study thus shifted to how the policy consultation process itself had unfolded. In particular, the aim was to trace the movement of knowledge inputs through this process, as a way of understanding whether and how these inputs might have been used to inform the policy. The key informant interviews thus became a way of gaining greater insight into the policy consultation process and how contributions were moved between and beyond the provincial and national consultation summits. While the analysis discussed above served as the point of departure for this study, the interviews provided a way into the consultation process. The findings of the interview analysis are discussed in the next section.

4.3 From the inside out: Reviewing the consultation process

The purpose of the key informant interviews was to provide insight into the ways in which the enactment and inscription of knowledge inputs to the consultation process were facilitated. As such, the findings presented here are seen as a way into the consultation summits from the 'inside out', from the perspective of individuals from within the breakaway group sessions. The findings were expected to identify issues relating to: i) the enactment and inscription of embodied knowledge in group sessions (research question 1); ii) the way in which group processes facilitated movement of enacted to inscribed knowledge (research question 2); and iii) the movement of inscribed knowledge through the consultation process to inform policy (research question 3). The issues identified in relation to the intersection of different knowledge forms with the consultation process were used to develop possibilities that could be explored further in the document and transcript analyses.

Interviews were analysed according to process-related elements. These process-related themes provided information regarding the overall policy consultation process, as well as participants' perceptions of how inputs to the consultation were used. Responses from interview participants regarding their knowledge about or involvement in the broader policy development process preceding and following the consultation summits were used to develop the detailed description of the case study context and the case itself; this has been included in the methodology chapter. In the final analysis, the information that the interviews yielded regarding the enactment and inscription of embodied knowledge within the different *group sessions* was limited to broader insights about the potential that there was for service-user representation at the summit. This is discussed below as it relates to the rationale for this study: the importance of attending to (eliciting and capturing) different forms of (embodied) knowledge during a consultation process. Interview findings are presented here using the convention of reporting findings under main themes and sub-themes, with verbatim quotes to illustrate these themes (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008; Sandelowski, 2000).

4.3.1 Follow-through from provincial to national summits

All of the interview participants had been involved in some way in one or more of the provincial mental health summits, in addition to the national consultation summit. They were asked about whether and how recommendations resulting from provincial summits had been transferred to the national summit. This spoke to the movement of inscribed knowledge through the consultation process, and how procedural factors enabled or prohibited this. These findings are presented in Table 4.4. The overall finding that emerged here was that the process of transferring provincial summit recommendations to

the national summit was not systematic; it was either not done, was inconsistent, or insufficiently visible to convey a clear link between inscribed outputs from provincial summits and the national summit inputs and outputs.

Table 4.4: Follow-through from provincial to national summits

Sub-themes	Participant responses
Transfer from provincial to national did not happen or was not systematic	And we felt that even though submissions were made at a provincial level, not all that information was taken through at the national summit (Bryanna). I think the main problem perhaps is the consultation that happened at provincial level, you know, perhaps not having sufficient voice at the, at the national level (Ingrid).
Lack of information about whether and how provincial recommendations transferred to national summit	I'm not sure of the process within the Department [of Health] that led to provincial level recommendations feeding into the national process … I don't think they were, although that may have happened through some other forum (Charles). So basically [we had] a list of recommendations from a provincial level … I don't know if it was ever sent to national because we were still collating it subsequently … So, I'm not quite sure what the process was (Sameera).
Space for feedback was provided at national summit	I can't remember! I think yes, we kind of, the resolutions from the different provinces was presented there (Chantal). There was somebody in charge, in the provincial office, of collating or summarising all of those views and there was a, there was a stage when, during the national summit, there was feedback from provinces. Some provinces were not as well represented, some provinces never managed to, um, hold their provincial summit, but those who did hold it were at least able to give some feedback (Zama).
Provincial feedback at national summit was not consistent or visible enough	I didn't see the feedback at the national summit. I mean, it might have been there … but I get a sense that it wasn't very visible (Ingrid). The provincial submissions were presented [at national] … but it didn't show continuity for me (Bryanna).
Provincial feedback at national summit was dependent on individual participants	There was no direct talking to between the provincial summit inputs … it wasn't a, kind of a, synchronised process. ... It would have just depended on if you had a representative from your province who was at one of the [group] commissions (Sameera). What was important at the national summit was to then make sure that if you were from a particular province, and you came with that, sort of, feedback from your province, when broke away into the different sessions, it would have been important to make sure that, in your session, you carry through what your provincial, um, input would have been (Zama).

4.3.2 Impact of national summit: Signalled priority of mental health

Two main themes emerged from questions regarding the purpose of the national consultation summit, and particularly the extent to which it informed the final policy. Some participants emphasised the significance of the consultation summits as a signal of the prioritisation of mental health by national government, and of the endorsement of the mental health policy process by the World Health Organization. This seemed to be considered an important end in and of itself, even where participants acknowledged that the policy document did not seem to have changed substantively following the consultation summits.

Table 4.5: Consultation summits signalled priority of mental health

Sub-themes	Participant responses
Signalled prioritisation of and commitment to mental health by national government/Minister of Health	There was a high level of political commitment, [and] the national Minister came, for the morning of the first day and then came back again, I think, in the afternoon of the second day (Charles). There seems to be a commitment from the national Minister of Health, because he was at the summit and he says he wants this implemented (Sameera). For the first time, the prioritisation was attached to the power of political will, in the national Minister [of Health]. And people said 'finally. We've got the Minister's ear'. So, if we can keep the minister's ear, we would love that. Because his word can make things shift (Sarah). The fact that the call came from national Department of Health says to us that, somewhere along the line, somebody realised there was a problem. We're hoping it was the national Minister of Health himself (Zama).
Signalled endorsement of policy and policy process by World Health Organization	The other thing that happened which was really good was that the Director of Mental Health and Substance Abuse at the WHO came to the South African national summit, which was a big thing, for a WHO person to come to a single country's policy process [and] showed the Minister that this is a really important area (Charles).
Raised profile of mental health	The purpose of the summits was, I think, a genuine, it was a genuine thing. The Minister did want to engage around this issue…I think the purpose of the summit was to raise the profile of mental health (Sarah).

4.3.3 Impact of national summit: Influence on policy

This theme provided insight into the movement of knowledge from enacted and inscribed forms at the consultation summit to the inscribed knowledge of policy. This process of movement between inscribed consultation recommendations and inscribed policy outputs has been referred to in the literature as *influence*, *use*, *uptake*, and *follow-through*. There were conflicting perspectives among participants regarding the extent to which inputs at the national summit were used to influence the mental health policy. Some participants highlighted key issues that had been flagged as recommendations at the national summit and that had subsequently been included in the final policy – in particular, the establishment of district mental health teams included in the eight-point Strategic Plan appendix added to the policy during the finalisation process. Others felt that the way in which the consultation had been conducted, as well as the availability of a draft summit resolution at the start of the summit, were indications that the process had been more of a rubber-stamping exercise than a genuine intention to engage in dialogue to review the policy. This seemed to be somewhat confirmed by observations that the policy document did not seem to change following the consultation summits, although it was also noted that the draft policy (already) reflected the issues being raised at the summit.

Table 4.6: Impact of national summit: Influence on policy

Sub-themes	Participant responses
The summit was not a genuine consultation, so did not influence the policy	Through this process, we've realised that consultation doesn't always mean involvement and dialogue. Consultation really is government telling you what is their plan and then implementing that plan (Bryanna). Everyone has a different understanding of what a summit should be. For the NPO sector, we felt, it should have been a dialogue. You know, looking at unpacking all the problems and then being able to in a workshop set up, come up with strategic ways forward. But that didn't happen. You know, the summit was more, um, it was cast in stone. There was discussion, there was a lot of objection and a lot of issues were raised from the floor. But even that, couldn't always be tabled (Bryanna). And what concerned me is that when we got to the summit in the morning, we were already handed a sheet … basically it was the resolution of the summit. It was already printed out. This was before the summit started. So now I was really taken aback. I said now listen, if the resolution has been drawn up, then what's the point? Because my idea was that we all come in there and we deliberate issues and then you draft your resolutions and you go forward. Then I realised that this was just a kind of, rubber-stamping to say that they had done consultation. You kind of, you know, did something and then you realise you have to go back and make sure it's supposed to have been the process so you kind of, in hindsight go through it so that you can tick the boxes (Sameera).

Table 4.6 continued: Impact of national summit: Influence on policy

Sub-themes	Participant responses
The summit did not seem to result in any changes to the policy	No, I think it was, it did serve a purpose. What came out in the, both the provincial and the national summit, that reflects in the, in the draft policy that I saw. But ja. I don't know how much was changed from the draft to the, the final one (Chantal). They were fairly minor, the overall framework and the structure was pretty much the same, was pretty much intact, and, you know there [hadn't] been a lot of changes to that document as far as we could work out … I need to actually go back and check the extent to which the summit recommendations actually found their way into the final policy. So there's the policy document, there's the summit document, and then there's the action plan. And both the summit and the policy document fed into the action plan. But the extent to which the summit document got integrated into the policy document, I don't know. I think the substance of the summit recommendations were not that different from the policy document (Charles). Then the real policy came out and it was the same policy. The policy doesn't seem to have been amended in any way, so I can only make that comment, I can't say whether it was or wasn't (Sarah).
The way the summit was run gave participants the chance to give input and the policy did change in some key ways	So, it gave everyone the opportunity to workshop issues and then there's sort of the key issues that came out of those workshops were then summarised and put into this declaration. Then it was summarised in the backroom and then fed back … I don't think there was time [to do it another way]. And that was fine. I mean, I think in the end the product's really good (Ingrid). There were one or two very important issues that were clearly highlighted following the summit. And one of them relates to the establishment of district mental health teams. Such a concept was not even considered, let alone included in the last draft, but following the summit, that was one of the very important changes that I picked up in the latest draft (Zama). So, one of the recommendations we made was that in all training, of different health professionals, not just mental health professionals, it's crucial to actually focus on language, and to make sure that when, from first year, whatever the discipline the person is training in, if it's going to be health services, they should actually learn the most predominant African language spoken there … I think that was mentioned [in the policy document] (Zama).

4.3.4 Information regarding finalisation of policy following national summit

Participants were asked about the access that they had to information about the policy finalisation process following the consultation, including whether further consultation had occurred during this time. This was expected to provide insight both to the *process* of follow-through, as well as the way in which summit inputs were subsequently used (to inform policy), depending on feedback that participants received about this.

Interestingly, even participants who had been part of the summit organising committee, or of the task team established to finalise the policy, were either not clear about the process of finalisation and how summit inputs had been used towards this, or had only heard about the official adoption of the policy 'accidentally'. Some participants felt that the identification of the eight implementation priorities included in the Strategic Plan should have involved further consultation, and that due process had not been followed in this regard; thus, the priorities reflected more of a service-provider than a service-user perspective.

Table 4.7: Information/consultation regarding finalisation of policy document

Sub-themes	Participant responses
Lack of information regarding finalisation of policy	We waited because that policy was supposed to have been launched in the media, on 10 October. That didn't materialise. Eventually we got wind that the policy was already circulated to the provincial coordinators. And it is the provincial coordinator in Cape Town where I got hold of that policy, the official policy. Even as a technical advisory committee member, I hadn't got that policy first. And that was very disturbing for me (Bryanna). It's a bit confusing it, with the launch. Because they would've launched it in the Free State, né? About … 3 weeks ago I think? Or a month? Then a few days before, it's cancelled. So that's where I lost of track of what's happening with this thing … Is this final one available on the internet, do you know? Please send it. Cos' the other day I was actually trying to find it online and there was nothing (Chantal). Ok, the final document doesn't look bad. It is fairly comprehensive. But it just would be nice if there's a documented process. You know, generally they say that, first you invite submissions on this thing, there's some kind of a formal procedure, and then you have a first draft of things, people comment, then you send it in, then you get a revision, then you get a second draft, etc. etc. So, I'm not sure, maybe that process was, maybe I'm not one of the people that was consulted. So, it may well be there. But I don't think that that process has been made transparent (Sameera).

Table 4.7 continued: Information/consultation regarding finalisation of policy document

Sub-themes	Participant responses
Lack of consultation on implementation plan/final policy	But I think even that last part of developing the policy itself, I wasn't so much really involved in, that final thing. And maybe that should've also been, stretched to there. You know, the involvement of all the parties in the final development of the policy itself (Chantal). And then this year sometime we got a thing, draft mental health [implementation] plan. I don't know how that was arrived at. So, I'm just saying there was no, like, back and forth giving inputs etc. We got the draft plan and then subsequently I think it's now been passed so that's implemented and that's your national policy. And that's the sum total of our involvement with the national one (Sameera). I think it's nice for each province to know this, these are the people that constitute the committee [task team], these are their areas of expertise, etc. What principles guided them in terms of constituting the national task team. And you should have frames of reference, etc. For me, I would think that's the way one should go about it in terms of policy development. Then communicating exactly who's on that. So, you know, listen, that these are the experts in this respective fields. Because we know that certain people will have certain kind of, inclinations as far as certain things go. So, I think it's part of transparency when you know that these are the people that constituted that task team (Sameera). Then that committee was put together, and from that process, eight areas were flagged and now accepted for implementation. And, it's eight good things that were selected. However, there may have been one or two other things that people would have liked to have seen in there. Again, that eight-point plan was never consulted. You know, the people in that committee will highlight what is important to them. The strongest voices in a committee will hold sway. So, it's not a bad document; the priorities are some priorities. But, it's the priorities of that committee. It wasn't consulted (Sarah).

4.3.5 Perspectives on the final policy: Implementation issues

Regardless of participants' (positive or negative) perceptions of the policy consultation process, their perspectives on the final policy document were unanimously positive. This suggests that the process of policy development does not necessarily need to be viewed positively for the policy itself to be accepted as such. Some participants highlighted ways in which the policy differed in important ways from previous mental health guidelines. There was also, however, a general sense that the policy lacked service-user input, and may have been stronger – as well as differed in focus – had there been greater service-user involvement. The service-user involvement component is explored further in the next subsection.

The major theme that emerged in relation to participants' perspectives on both the consultation process and the final policy document involved concerns around the implementation of the policy. There was a sense that it was a good policy, but that the success of the document would only be revealed through effective implementation. Interestingly, participants frequently referred to the disconnect between national policy development and the implementation of this policy at provincial level, with some linking this back to the absence of a systematic process of follow-through of provincial summit inputs to the national (summit) level. This highlights the tension between moving from particular contexts of provincial needs and resources to the abstract level of policy, and back again in the implementation.

Table 4.8: Perspectives on the final policy: Implementation issues

Sub-themes	Participant responses
Implementation and monitoring	I think, yes, a lot of the policy's quite impressive. The policy can be implemented. For me it's, after the policy, that's where we are right now and I think that's, that's the biggest issue for me… The problem is, the strategy for implementation. Policy has been written. But we've got to get it very clear who will monitor that implementation of that policy. You can't just email the policy and expect implementation. There's a lot of strategy and, and guidance that needs to go with it (Bryanna). You know, it's a nice policy all in all…I just hope with the policy, that there will be monitoring and implementation. That there would be a system in place to actually look at that. Cos it doesn't help if you develop a policy just for the sake of having a policy and it's not implemented and monitored effectively (Chantal). It's nice, everything looks nice on paper, but how are you going to effect that. And I think that's the acid test of that policy. So, it's nice to see that such a document has arrived, but it's not worth more than the paper it's written on unless it's implemented, it's changing things on the ground. So, I'm not being pessimistic. Just cautious (Sameera).
Implementation at provincial level	[There will be] provincial roadshows, where we meet with provincial health directors, and set out the requirements of the mental health action plan, what is expected from the provinces and really engage with them about how to do this. And I think a lot will depend on who comes to those meetings, you know, does the head of health for the province come, or do they deputise it to somebody else (Charles). It's a great policy and plan, but there does seem to be this gap between what's happening at national and what's happening at provincial. And I think the whole idea of having provincial summits leading to a national summit was great to try and bridge that gap. But I really am concerned about going forward now; how do you get your provinces to actually embrace it and dedicate resources to now being able to implement this plan beyond just these specialist teams (Ingrid). The implementation plan, is now going come to the provinces for implementation, I believe there's going to be a roadshow to introduce it. I'm not sure if national government has a plan to identify certain key things that will be funded in an extraordinary way over and above the usual allocations to province, but provinces will really have, you know, free rein, to implement those eight to ten things in the way that they see fit. Whereas if one had consulted that document with the provinces, and come to consensus around what the key issues are and what the time frames are, then you kind of can hold the provinces to what they said they would do (Sarah).

Table 4.8 continued: Perspectives on the final policy: Implementation issues

Sub-themes	Participant responses
More detail required for implementation	But it's the how. You know, we've been saying all of this from 1994; this is what we should be doing. We need to integrate into primary health care. We need to do task shifting. I mean we've been doing it, you know. But what we need to do is actually identify the roles and functions of all the different health care personnel in the health care system in relation to mental health … So, you know, in terms of the structure for a mental health care plan at a district level, that's what the plan doesn't have, is who will do, what to actually implement. Now, maybe it's not supposed to be at a national level. But again, it's like, you know, we must do this and we must do that, but, how to do it at district level needs to be made clearer for the districts, I think (Ingrid). They've drafted this national mental plan. I mean, they've issued this plan but what is the implementation plan? So, it's one thing to have a document, but now what does it mean for the man [sic] on the ground? Apart from guiding us in terms of what needs to be done, it needs to tell us how it's going to get done (Sameera). In the policy, they state just one sentence which says each district must have a district mental health team. But because of how things work especially in the Eastern Cape province, if you do not sit and define what you mean by district mental health team, you may have a scenario where a psychiatrist gets employed for a district and that's your team. So, I think it would be nice to actually have a very specific statement that says, for a district mental health team, you need a minimum of, and then list, you know, what you need (Zama).

4.3.6 Opportunities for service-user involvement and input

A number of questions were asked in relation to opportunities for service-user input to the consultation summits, including representativeness of participants, support available for service-user participation (including in terms of preparation), and the ways in which service users were included in the overall summit programme. This was of interest because of the focus of this study on how embodied knowledge inputs were elicited and captured during micro (group) consultation processes, with the idea that service users' contributions would be more likely to be in the form of experiential embodied knowledge.

There appears to have been limited service-user representation at the provincial and national summits, which interview participants attributed to a number of factors. One was a lack of the necessary (government) support that would have enabled service-user participation, which was reinforced by the view that it was left to service-user advocates to take proactive initiatives to involve themselves. This service-user support needed to be in the form of both more tangible support such as funding and accommodation, and capacity-building support such as sufficient preparation time and assistance.

Negative or misinformed perceptions may also have contributed to this, particularly around the perceived inability of service users to advocate for themselves. Perhaps because of this, the limited service-user involvement at the consultation summits was perceived by interview respondents to have been tokenistic, lacking a genuine intention to incorporate service-user voices into the policy. The policy, as a result, was seen to be dominated by a service-provider voice, at the expense of issues that may have been emphasised had more service users had the opportunity to participate in the policy consultation and its subsequent development.

Table 4.9: Opportunities for service-user involvement and input

Sub-themes	**Participant responses**
Limited service-user representation at summits	I think what it lacked was service-user involvement. For us, that was the biggest void … And the policy would have been very proactive and very human rights orientated if service users were given the chance (Bryanna). I had some issue with them because they put a limitation on the amount of mental health care users attending. Cos' I felt they should have had more. They should make space because ultimately, it's about, us, we with mental illness … Maybe also someone from a rural area, because I can't really speak of their experiences, you know, from different aspects (Chantal).
Service-user involvement dependent on initiative of service users/service-user organisations themselves	But through our involvement, because I knew of the summits happening in the different provinces, it was easier to inform … our service users in the province to say there will be a call, here's the, you know, the schedule. So, some of our NGOs had to actually contact the department and say I want to be invited to the summit … If we know it's happening, we take the initiative and we get involved (Bryanna). I got us on the mailing list of the Ministry. So that is the only way I know that there's this policy up for review. But that's now me, what about other service users, you know? They don't know about what there is (Chantal).
More support required from government for service-user participation	They didn't want to pay for the support staff, for service users. And that's lack of understanding, what does a mental health care user require to be able to participate. So, if you're flying a service user out from Cape Town, they need support staff. And we had to get into arguments with the Department, to say well, you haven't made provision for, service-user support and it was like, why do they need support? So it's a lack of understanding even from the Department side (Bryanna). With all these things, it's always very short notice, doesn't give you enough time to really prepare for it. That's always a problem. Especially when you have to review policies… they would tell you, the deadline is in two days, but then the document is this thick [shows with hand] so, you know, you need to go through all that. And, let's say, I had to present it [to] mental health care users. Means I now quickly need to consult with other mental health care users because I need to get their view as well. So, it makes it a bit difficult (Chantal). It would have been nice to have had a stronger mental health service-user input, but I think that reflects that nature of how service-user organisations are configured at the moment. They're not a strong advocacy lobby group; I think we should be doing more to try and support them to take on that role (Charles).

Table 4.9 continued: Opportunities for service-user involvement and input

Sub-themes	Participant responses
Service users not involved because of negative perceptions	I think even globally, people still think, you know, people with mental illness can't speak for themselves. And, even come up with resolutions themselves, you know? (Chantal). And I think the biggest barrier is the still prevalent view that if you have a mental illness, somehow you can't engage around these issues. You know, which is not true. People can and do engage. It's just that the available avenues for their engagement was not that accessible to them. Either because nobody is inviting them, or in my case, they were invited, but we didn't support their participation (Sarah).
Involvement of service users that did occur was tokenistic	And although they invited service users, a declaration was written up, without service-user involvement. And what happened in the end, a document was given to them, and said, read it. It wasn't even discussed with them. It was, here's a declaration, you go and read it. And I think that is a slap in the face (Bryanna). The people that came and gave a talk, to open it, they gave key-note presentations, in the plenary, it was Dr So-and-so from the University of XYZ, it was Professor So-and-so from the Organisation of ABC, and so it went on and then it came to the last person, and there it was just Joe Bloggs, service user. There was no organisation affiliation, he was a different animal to all the rest. So, all he needed to do there was come and stand there, doing what, representing, what was he doing? It's nice to have a service user come and tell you a story, but nobody else was telling their stories! Now he comes with his story and they say, wow, wasn't that quaint. It's not appropriate. So, there's a lot of work to be done (Sarah).
Policy not as representative of a service-user focus as it could have been	Service-user involvement was for us the biggest absence, the biggest void. Knowing that we had service users, even on the technical task team, it would have been … I think it's important to know that, you know, service users were part of that. And we've got brilliant voices in the country around service-user advocacy. And the policy would have been very proactive and very human rights orientated if service users were given the chance (Bryanna). In terms of gaps in the policy, I think it would have been nice to have had a stronger mental health service-user input (Charles). If you look at it, it's mainly about the service-provider voice. And powerful voice, always sticks out. Now service-provider voices are hugely strong. They legitimate voices. They have decades of 'this is how we do things' behind them. We're used to putting up district teams and working like this, and having HR, you know, and, knocking out the budget, and, that's the easy part … What hasn't been addressed is our philosophy of mental health care. You know, mental health care, is primarily been psychiatric … So, this policy gives us an opportunity to flip that on the head, and say, psychiatry is a strand of what needs to be delivered for people's recovery. And that's why I'm emphasising that recovery is a barrier to policy implementation, because it's a completely different thing from what we're used to (Sarah).

4.3.7 From the inside out: Conclusions

The key informant interviews highlighted several positive aspects about the mental health consultation summits. These included a signal as to the importance of mental health to national government, as well as the inclusion of certain key issues that had been put forward as recommendations as implementation priorities on the Strategic Plan. Some tentative propositions can be drawn from this. The first is that policy consultation may be valuable as an end in itself, if it raises the profile of the issue (in this case, mental health) and demonstrates the commitment of government to prioritising this. The second is that the summit recommendations, while not appearing to change the content of the policy document, may have been used to inform the identification of implementation priorities on the eight-point Strategic Plan appendix added following the summit. Furthermore, although participants identified a number of problems in terms of the process followed during and after the consultation summits, their consensus that the policy is a good one suggests that the absence of a fully inclusive and transparent process does not necessarily affect perceptions about the final product.

In terms of the extent to which inscribed knowledge moved through the consultation process to inform policy, the lack of information and consultation during finalisation of the policy subsequent to the summits makes it difficult to determine exactly how consultation inputs were used. Interview findings confirmed what had been suggested by the comparative analysis of the draft and final policy documents conducted in the preliminary phase of this study – that there were few substantive changes to the policy following the consultation. This suggests that, at the level of inscribed knowledge at least, there was not much follow-through of inscribed knowledge from the summits to the final policy. However, as one participant intimated, many of the issues raised at the national summit may have already been reflected in the draft policy. However, a number of process-related elements identified in these findings suggest that, at worst, the consultation may have been a rubber-stamping exercise – such that inputs would not have been used to further adapt the policy – or, at best, the consultation process was not structured in a systematic way that could have optimised the transfer of inscribed knowledge through the process to be utilised in finalisation of the policy.

Interview findings also suggested a number of insights into how the consultation process enabled or constrained movement of knowledge. At the one extreme identified above, the sense that some or all of the consultation outputs were predetermined would have acted as a significant constraint on the opportunities for enacted and inscribed knowledge to move through the process. In other ways, however, it seems that the movement of knowledge – particularly from provincial through to national summits – was somewhat ad hoc. This meant that opportunities may have been limited in terms of moving embodied knowledge through enacted knowledge to inscribed knowledge, in order to use this

knowledge towards informing policy. The findings from this analysis seem to highlight quite strongly the tension between moving from the specific contextual knowledge (e.g. individual level or provincial level) to the more abstract inscribed knowledge of policy, with subsequent implications for policy implementation. This was confirmed by interview participants raising concerns about the lack of detail contained in the policy and the potential difficulties of this in effectively implementing the policy across different provincial contexts.

These findings point to the influence at the level of the individual on the consultation process and outcomes – through, for example, individual knowledge contributions, initiative required of individuals to ensure participation and representation at the consultation, and the endorsement of the process by certain key individuals. The findings also highlight the importance of ensuring inclusion of a wide range of perspectives in the consultation process. In this case, there seems to have been inadequate service-user representation at the national summit. The lack of opportunities for service-user involvement provides some insight into how the broader organisation of the process may have affected how participants' embodied knowledge could be enacted and inscribed during the summit. In particular, the findings suggest barriers to service-user participation in terms of preparation and support for enabling participation. They also indicate that what representation there was may have been somewhat tokenistic, with the implication that even where service users' embodied knowledges were enacted, the possibility that these would be captured and transferred as inscribed knowledge may have been limited. The ways in which summit participants' embodied knowledges were enacted and inscribed during breakaway group discussions are explored in the next section.

As mentioned at the start of this section, these interview findings were used to identify key threads or propositions in relation to the research questions that might be explored further in the analysis of summit documents and transcripts. It is worth briefly summarising here what these findings seem to suggest at this point about each of the three research questions:

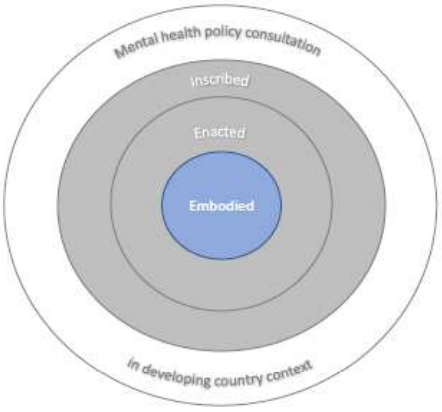
1. *How were participants' embodied knowledges enacted and captured (inscribed) during the consultation process?* Although interview findings provided limited insight into what was happening during group discussions at the summit, they reiterate the importance of attending to the influence at the level of the individual during such processes. They also suggest that the nature of embodied knowledges that were enacted during these small group sessions may not reflect the experiences of mental health care service users, and that the policy itself lacks a strong service-user perspective.

2. *How did the consultation process enable or constrain the movement of knowledge from enacted to inscribed forms?* While there were several positive aspects of the consultation summits, these findings suggest that the process did limit opportunities for the movement of knowledge from embodied to inscribed forms in particular ways.

3. *How did inscribed knowledge outputs from the consultation move through points of abstraction to inform policy?* These findings indicate that the inscribed knowledge from the consultation summits may not have been used in any significant way to change the final policy. This suggests that the in-depth analysis of summit documents and transcripts may not reveal a great deal of follow-through of content. There are also indications, however, that summit inputs may have been used to inform the identification of implementation priorities, such that greater alignment might be revealed between summit recommendations and the eight-point Strategic Plan.

The next section links the individual to the group level by exploring how individuals' embodied knowledges were moved from enacted to inscribed knowledge during group discussions, and from particular or idiosyncratic knowledges to more abstracted forms of knowledge.

4.4 Embodied knowledge enacted



This section presents the findings from the analysis of whether particular forms of embodied knowledge (specifically, experiential and evidence-based knowledge) were more readily attended to during their enactment, as well as whether they were transferred to inscribed forms. This analysis was thus focused at the individual level within group sessions at the consultation summit. An understanding of what was happening at this level with the elicitation and transfer of knowledge might provide insight into why knowledge inputs at the consultation summit did not appear to result in substantive amendments to the final policy.

The focus of this analysis was thus to identify the types of knowledge that policy consultation participants explicitly drew on during the breakaway group discussions at the national mental health summit, and how these knowledge types were used and responded to in their enactment. A secondary

aim was to assess whether the type of knowledge claim made by participants seemed to influence uptake (inscription) into group recommendations. A number of factors could of course have affected the follow-through of particular knowledge claims into group recommendations, including pre-determined agendas or dominant voices or individuals in a position to influence uptake. It is also possible that a particular issue was put forward in several forms – that is, drawing on both evidence-based and experiential knowledge claims – and it is thus not possible to tease out more particularly what influenced its uptake into recommendations. It is therefore neither feasible nor advisable to draw a linear or causal link from type of knowledge claim to recommendation uptake. Nonetheless, an analysis of the kinds of knowledge claims that seemed to be more – or particularly *less* – reflected in recommendations than others might yield useful information about what knowledges are more or less amenable than others to transfer and capturing in policy consultation processes.

Of particular interest was whether participants seemed to draw primarily on evidence-based knowledge or on experiential knowledge to back up their statements or proposals. As will be shown below, there is some indication that participants were made aware – either explicitly or implicitly – that proposals should be linked to evidence and to clearly identified, measurable indicators in order to be seriously considered. In addition, the group discussions were framed by presentations from individuals identified as experts on the topic under discussion. It was therefore expected that, on the whole, there would be more reference to evidence-based knowledge claims than to experiential knowledge claims. Although this turned out to be partially the case, there was far less reference than anticipated to either evidence-based knowledge or experiential knowledge.

As described in the methodology chapter (Chapter 3, section 3.7.3.3), detailed analyses were conducted across each of the themes discussed here. These showed inter-group differences and similarities with respect to how explicit knowledge claims were used and moved through group sessions. This was a necessary step in the analysis in order to subsequently collapse group results to identify patterns in terms of the use of evidence-based and experiential knowledge claims across all groups. The more detailed analyses are included as Appendix 6. In this section, the findings that emerged from these analyses that are most relevant to the aim of this study are presented.

The findings in this section are presented in three subsections. The first provides an analysis of the *types* of knowledge claims made through the presentations and discussions in the ten breakaway group sessions at the national summit, specifically identifying the occurrence of claims making reference to evidence-based or experiential knowledge. The second subsection considers the enactment of these knowledge claims, with the analysis focusing on what these knowledge types were being drawn on to *do*, and the extent to which particular types were – or were not – responded to within the discussions.

The third subsection assesses the extent to which these types of knowledge seemed to be reflected – that is, inscribed – in the recommendations put forward by groups at the plenary session.

4.4.1 Types of knowledge claims

Presentations and discussions within each of the ten groups were coded according to whether speakers made reference to experiential knowledge or evidence-based knowledge. Where neither of these types of knowledges was explicitly drawn on, content was coded as O*ther*. The coding framework used in this analysis is detailed in the methodology chapter (Chapter 3). Detailed analysis, on which the findings presented here are based, is included in Appendix 6.

Within both the experiential knowledge and evidence-based knowledge categories, second-level analysis was conducted. Content was further categorised according to whether these claims were made within the formal presentations or during the discussions. As mentioned above, it was expected that there would be more frequent reference to evidence-based knowledge in the formal presentations and, as a result, that this might to some extent have framed the content of the discussions. Two limitations are worth noting again at this point: firstly, not all of the within-group presentations were available on audio, and secondly, there was variable quality in the audio recordings, restricting quite substantially what could be heard and transcribed in some groups.

A total of 130 evidence-based knowledge claims and 95 experiential knowledge claims were identified. However, in most of the talk (both presentations and discussions), no reference to either of these knowledge types was found; this content was thus coded as *Other.* Examples of each of these types of *Other* talk are included in Appendix 7. For the purposes of this analysis, inaudible talk was also coded as *Other*, so that total calculations could correlate. Talk within this *Other* category varied considerably and included the following:

- Introductions and greetings.
- Instructions and logistical information.
- Within presentations – theoretical background and descriptions or explanations with no explicit reference to evidence or experience.
- Comments on presentations and presenter responses to questions or comments.
- Suggestions for changes to words, phrases, or content on one of the documents being reviewed.
- Requests for clarification/provision of clarification of terminology and concepts.
- Reframing or summarising previous points made, primarily by the Chairs.

- Attempts (also mostly by Chairs) at refocusing discussions and/or requests for more feasible proposals.
- Adding to, reiterating, or countering statements made by others.
- Providing information, descriptions, or explanations phrased in the abstract, without specific reference to evidence-based knowledge or experiential knowledge.
- Generic observations or opinions, proposals, or appeals. These were mostly used in reference to *what was currently happening* and/or to *what needed to happen*, without explicit reference to either evidence-based or experiential knowledge from within a specific (personal) instance.
- Formulating and prioritising recommendations.
- Feedback to the group from the rapporteur/s.

Most of the experiential knowledge claims referred to practical or professional 'on-the-ground' experience, and most was referenced in the collective (e.g. in *our* experience …; what *we* have found ...). Claims framed around experiential knowledge were used in a number of ways in the group discussions, including: i) to call attention to problems – whether in terms of current practice or in terms of users' experiences – not currently addressed in the policy or encountered in the implementation of policy proposals; ii) to share lessons learned in implementing certain policy proposals; iii) to back up claims about problems or what was not working, usually as a way of calling for particular solutions; iv) to provide detail about what was working, as a way of proposing that this be adopted as a solution; and v) to make claims for particular solutions over others. The purposes for which experiential knowledge was drawn on are explored in more detail in subsection 4.4.2.

As mentioned above, there are indications that participants seemed to be aware – either implicitly or through explicit guidance – that it was important to frame recommendations in concrete (evidence-based) terms, preferably linked to targets and measurable outcomes. This was either evident throughout group discussions, implicitly guided by Chairs or rapporteurs (such as in Group 3, for example, where the Chair consistently requested group members to link recommendations to explicit indicators or targets) or in statements made by participants drawing their group's attention to the need for tangible recommendations based on evidence. One participant in the child and adolescent mental health group, for example, proposed that they link their recommendations to neuroscience research as a way of increasing the likelihood of them receiving attention. In addition, in at least one instance, one of the summit organisers from the DoH attended part of a group discussion and raised the issue of what was likely to be attended to when prioritising recommendations. This extract is included in Box 4.1.

Box 4.1: Explicit guidance from summit organiser regarding framing of recommendations

"… I mean, the biggest need for all of us is really to focus on what is evidence, and what can make a difference, and I think all these other anecdotal stories are going to come but really, you can't put a bigger solution for them, because they're not really substantial to make an impact. I think the second big issue really, you have to take the 80/20, you've really got to find where you can create the most difference with minimal resources – so the 20 percent of resources that can make the change. I think the other part, of course, is really … it's not going to be solved by one particular approach. It is going to be a combination of approaches, and they're done in a manner that they work together and they're coherent, and they create one compact aspect so the notion that a case management would be better than a sort of a broader support by community health worker, that's not going to work.

And so, all these solutions must be seen as contributions to a combination of solutions that will make a difference. I think the last part is that there are a number of very important initiatives that are happening in government, so whatever proposals, one needs to find how they fit within this. I think the ((*inaudible*)) is around re-engineering of primary health care with so-called, you know, stream at community level - it's an important policy where you could make a huge difference. I am actually very interested in the idea of the different levels of really assessing the quality of the counsellors and their level of readiness, and really identifying those outstanding points, that point you were making over there. I think those are the things that we need to figure out.

...

Let me just be very controversial on this. The point about it - and this is really what I'm raising to all of us here, is that the point about it, when the recommendations come, they will be assessed amongst other recommendations. They will be assessed on the possibilities of whether they are feasible; they will be assessed in terms of the costs and the benefits that they provide. They will be assessed at the level of evidence they provide. They will be assessed, in a sense, [on] how they contribute and align and harmonise with other - at the end of all that, then you have to make a call and see what [the] resources are.

So, it's very important for people making recommendations; they actually consider those because that's the [iterative] process I'm going to be going through, to be honest, when I get your recommendations. That's a process I'm going to go through, to see to what extent these recommendations are going to make a difference. So, I think it's very important for us to be very focused, pick the things that we think can make a difference, you can scale them up, they can make a difference, and so I think it is absolutely very important. Thank you."

Evidence-based knowledge was largely referenced within formal presentations to highlight where problems were and what solutions had been shown to be effective. In many cases, presenters referred to their own research work, although there were also references to other national and international research evidence, and to international best practice (e.g. guidance from WHO) in order to support claims. Some of this made reference to 'data' without making explicit reference to the source of this data. In the group discussions, evidence-based knowledge claims were used in several ways: i) to elaborate on or explain points made; ii) to counter or refute others' proposals; iii) to caution around the feasibility of proposed interventions by referring to or critiquing available evidence; iv) to justify or back

up own or others' claims – referring to evidence to highlight gaps; v) to demonstrate the significance of problems to be addressed; or vi) to demonstrate effectiveness of proposed interventions.

In order to contextualise the knowledge claims made during each group discussion, it is useful to note whether and how the formal presentations seemed to frame or influence the discussions. Further analysis was thus conducted to distinguish between when experiential and evidence-based knowledge claims were made during the formal presentations versus during the group discussions. It seemed likely that the presentations might reflect a more formalised form of evidence-based or scientific knowledge. However, it is worth noting that the presenters mostly joined in the discussions and, in some cases, were quite vocal and/or were deferred to by group participants, which may have placed a more evidence-based slant (where presenters were more likely to draw on such knowledge) on discussions than in other groups. In addition, in some groups there was an almost equal split between these two forms of 'expertise' – experiential knowledge and evidence-based knowledge – in the formal presentations; in other groups, *both* presentations were strongly experiential. It is also possible that presenters relied on their expert status to give authority to their experiential knowledge claims. Attention will be drawn to where these instances occurred and may have influenced the findings in the discussions below.

Table 4.10 shows examples of the two main types of knowledge claims identified within the group discussions: evidence-based knowledge and experiential knowledge. The coding definitions for each of these claim types can be found in the coding framework in Appendix 4.

Table 4.10: Examples of knowledge claim types

Knowledge claim type	Examples
Evidence-based knowledge claims	The second point related to that is the discussion about task shifting because we all within our different professional categories have historically performed certain roles. But a lot of the discussion in World Health Organization and in mental health literature in recent years has been around the issue of task shifting. So, for example, in the UK, there's a specific programme to train nurses in specific aspects of cognitive behavioural therapy for depression and other common conditions. Or in India, there are programmes to train community health workers in interpersonal group therapy for depression. And I think that question of task shifting and what is done at what level is quite critical. (Speaker 9, Group 4) I was reading this book called *The silent cure* by [Helen Epstein], not sure if folks have read it, but it's really an account – she's a medical anthropologist and epidemiologist that has done a lot of work on the continent. And she calls attention to the fact that the average number of sexual partners among people in Africa is really no different from the average number of sexual partners in North America and Europe. It's the same ballpark figure. So, it's not clear that it's the number of sexual partners that's the issue, but what she does call attention to is the different kinds of sexual networks that operate on this continent compared to other continents. (Speaker 3, Group 5) And also what we don't know is, we don't know what happens in the rural areas. Because if you look - if you'll allow me just to mention this book of mine, which is suicidal behaviour in South Africa, which gives quite a lot of data, but, if you look at the studies that I quote in here, most of them are based on hospital and mortuary statistics. We don't really know what happens in the smaller towns and villages where there is a big problem. (Speaker 3, Group 9)
Experiential knowledge claims	I just want to share … in correctional services, because of the nature of the thing, of the correctional environment we tried to 'verticalise'. You know what happened? HIV services, mental health services died. Because this nurse says, I'm only doing chronic disease, I won't do mental health, I won't do HIV and if that nurse is not there for a month, it means, patients won't get their treatment. I think for three to four years, we trying to reverse that but the nurses say, you said we must do this only and we won't do the others. (Speaker 26, Group 1) I still miss the days when our psychiatric community sisters had cars. And they could drive to the patient's home, and they would come to Chris Hani Baragwanath hospital with their files and they would tell us exactly what's going on and they'd say "You know what? So-and-so didn't come for an appointment. I'm just going to pop down and see what's going on at the house". What's happened to that? Talk about community care. Let me understand what's happened to the community psychiatric nurse in her car, who lived and understood and knew the community that she serviced. And would liaise with us and say "Hey, watch out for so-and-so because we haven't seen them for a while. Don't know what the hell's going on. Be on the lookout". What's happened to that? Where've they gone? I don't know. It's very sad. Funding? Yes. Funding. Organisation. Administrative efficiency. (Speaker 1, Group 3) What I've done this morning is bring you – I would like to just pass them round – some copies of what has been in the paper recently. I'll tell you what my concern is. I'm on the board of an NGO, and the health department has suddenly, for no reason, stopped paying them. They have done that to a lot of NGO's, this particular one that I'm passing around is the [name of NGO]. Now, [NGO name] went to the paper… Now, these are the people that are not being paid. And I think this is just so horrendous and so important that I think it should take precedence very much because when it gets to the situation that we have to rectify this situation through going to the media, I think it is chronic. (Speaker 32, Group 10)

The percentages of talk drawing on experiential, evidence-based, and *Other* knowledge claims in the breakaway group presentations and discussions are shown in Figure 4.2 below. The talk that did not draw explicitly on either evidence-based or experiential knowledge claims (i.e. *Other*) comprised the bulk (62%) of group presentations and discussions across all ten groups. Evidence-based knowledge claims (22%) were made slightly more frequently than experiential knowledge claims (16%).

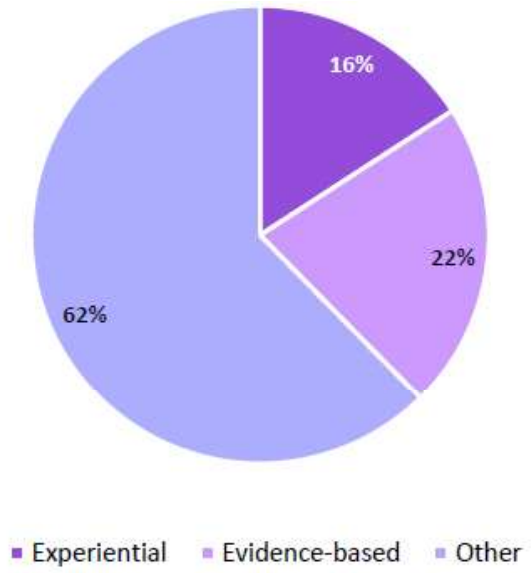


Figure 4.2: Percentage of types of knowledge claims in breakaway groups

More detailed analysis of how experiential and evidence-based knowledge claims were used in each breakaway group at the national summit is presented next. For ease of reference in the presentation of these findings, the titles of the breakaway group topics have been abbreviated, as shown in Table 4.11.

Table 4.11: Abbreviation of breakaway group titles

Title of breakaway group at national summit	Abbreviated title used in analysis
Group 1: Mental health promotion and prevention of mental disorders	Prevention & promotion
Group 2: Mental health research and innovation, and surveillance	Research & surveillance
Group 3: Mental health systems	Mental health systems
Group 4: Mental health infrastructure and human resources	Human resources & infrastructure
Group 5: Mental health and other conditions	Mental health & other conditions
Group 6: Mental Health Care Act of 2002 – lessons learned from implementation	Mental Health Care Act
Group 7: Child and adolescent mental health	Child & adolescent mental health
Group 8: Culture, faith-based practices and indigenous mental health practices	Culture & mental health
Group 9: Suicide prevention	Suicide prevention
Group 10: Advocacy, social mobilisation, user and community participation	Advocacy & user participation

Figure 4.3 shows a more detailed breakdown of the use of evidence-based and experiential knowledge claims in the ten breakaway groups, showing the percentage of explicit knowledge claims made in each group compared to talk coded as *Other.* Within the explicit knowledge claim bars, the proportion of experiential versus evidence-based knowledge claims is depicted. Participants in Group 8 (culture & mental health) seemed to make less reference to explicit evidence-based and experiential knowledge claims than other groups. It should be noted, however, that this is the only group for which there was no audio of either of the two formal presentations, which limits the interpretation of findings for this group.

The greatest proportion of knowledge claims were made in Group 6 (Mental Health Care Act), with an almost equal split between experiential and evidence-based knowledge. There were no references to experiential knowledge claims in Group 2 (research & surveillance), and Group 4 (human resources & infrastructure). In general, more evidence-based knowledge claims than experiential knowledge claims were made across all groups. A more detailed analysis of the breakdown across groups can be found in Appendix 6.

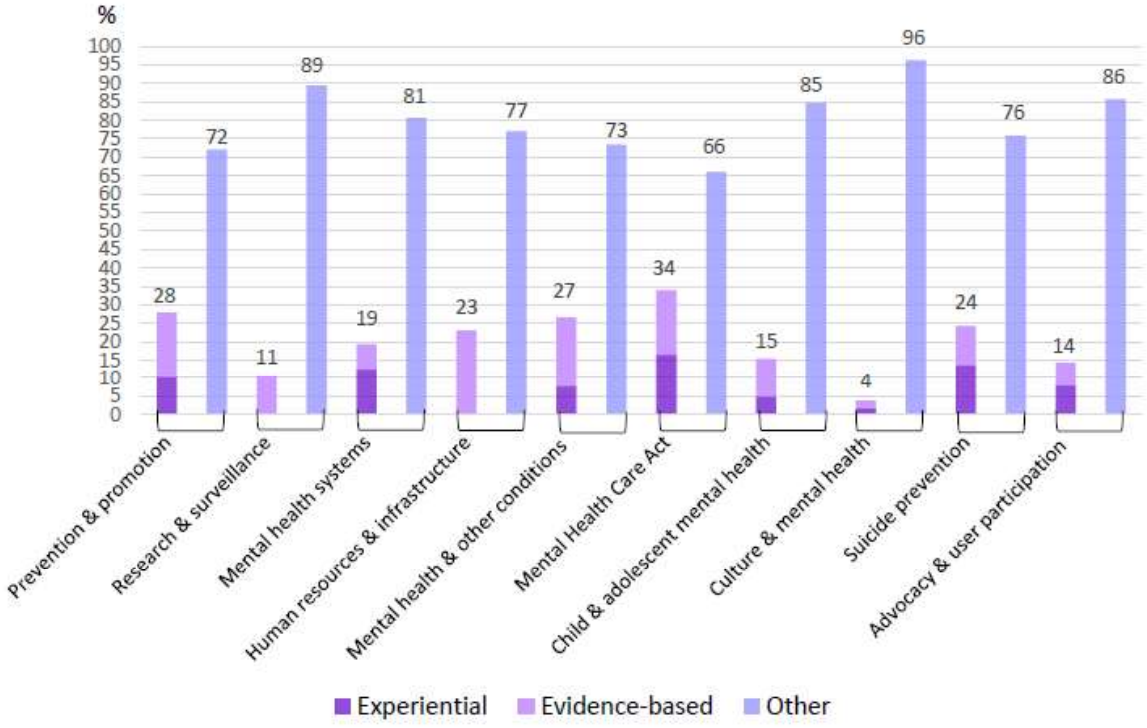
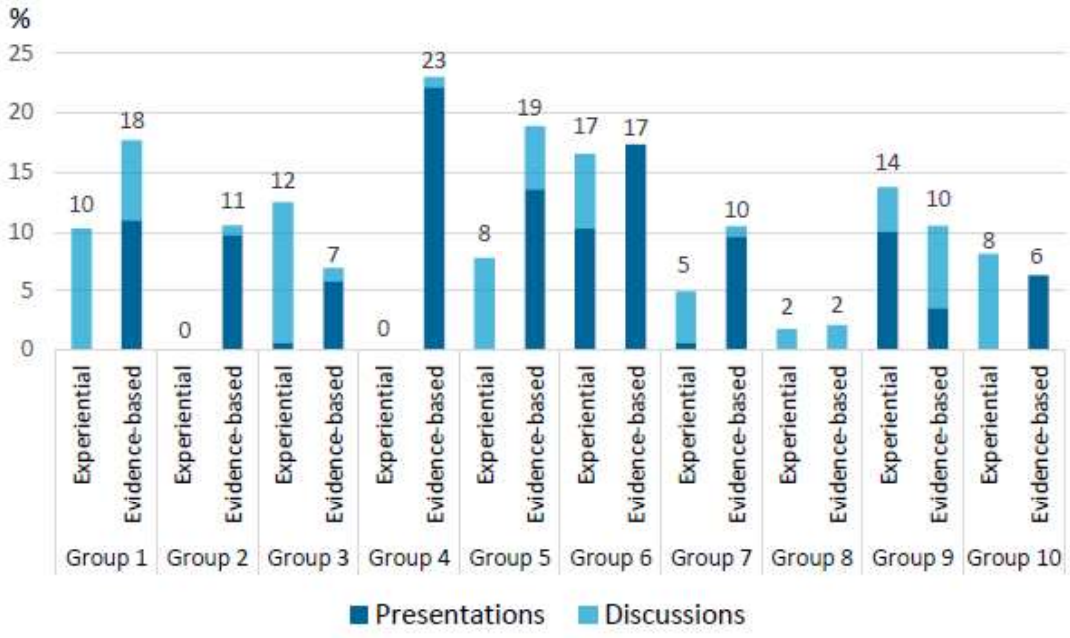


Figure 4.3: Types of knowledge claims used across breakaway group themes

Within the explicit knowledge claim theme, second-level analysis was conducted to determine whether more evidence-based or experiential knowledge claims were made during formal group presentations or during group discussions. Given the emphasis on ensuring that policies are evidence based, it seemed likely that the more formal presentations would emphasise evidence to highlight gaps and challenges with respect to mental health, as well as best practices and effective interventions. By virtue of the contribution of more participants' voices during the group discussions, there was likely to be a mix of more experiential knowledge claims, together with evidence-based claims.

Of the total 95 experiential knowledge claims made, 59 (62%) were made during the discussions, and 36 (38%) were made during the presentations. Of the 130 evidence-based knowledge claims, 32 (25%) were made during the discussions, and 98 (75%) were made during the presentations. A more detailed breakdown of the use of experiential and evidence-based knowledge claims in the presentations and discussions in each breakaway group is shown in Figure 4.4. As mentioned and shown above, *Other* was the predominant form of talk in all groups, relative to the explicit use of knowledge claims. Talk coded as *Other* was left out of Figure 4.4 to allow for more nuanced comparison of how evidence-based and experiential knowledge was used in the breakaway groups.



Group key: 1. Prevention & promotion; 2. Research & surveillance; 3. Mental health systems; 4. Human resources & infrastructure; 5. Mental health & other conditions; 6. Mental Health Care Act; 7. Child & adolescent mental health; 8. Culture & mental health; 9. Suicide prevention; 10. Advocacy & user participation

Figure 4.4: Types of knowledge claims in breakaway group presentations and discussions

As seen in Figure 4.4, more evidence-based knowledge claims were made during the presentations and more experiential knowledge claims were made during the discussions across all but one of the seven groups in which both types of knowledge claims were made and for which access to audio for the presentations was available. This pattern was reversed in Group 9 (suicide prevention). This may be because one of the presentations in this group focused explicitly on the experience of setting up a suicide prevention helpline. More detailed analysis of the breakdown across groups is included in Appendix 6.

It appears, then, that evidence-based knowledge was drawn on with slightly more frequency than experiential knowledge during breakaway groups at the national summit. However, as the findings above have shown, much of this evidence-based knowledge was contained in the formal presentations. What is more notable from this analysis is that very few explicit knowledge claims – whether evidence-based or experiential – were made in all the group presentations and discussions. Most of the talk could be classified as *Other.* The implications of these findings will be further explored in Chapter 5.

In the next subsection, the way in which these knowledge claims were used (enacted) by participants during discussions will be explored.

4.4.2 Enactment of knowledge claims

4.4.2.1 Functions of knowledge claims: What were they being used to do?

The aim of the analysis presented in this subsection was to explore, firstly, what experiential knowledge claims and evidence-based knowledge claims appeared to be drawn on to do during group discussions. Given that the breakaway group discussions represented the enactment of knowledge, it was useful to consider *how* such knowledge was being enacted. A secondary level of analysis explored whether there appeared to be an association between particular types of knowledge claims (i.e. experiential and evidence-based) and the function they seemed to serve. The analysis here focused only on experiential and evidence-based knowledge claims made during the group discussions, as the formal presentations could be argued to be governed by pre-existing conventions regarding structure and content. There were thus 59 experiential knowledge claims and 32 evidence-based knowledge claims available for this analysis.

Three main functions were identified for which both experiential and evidence-based knowledge claims seemed to be employed. These were to illustrate a current ('on the ground') situation, to highlight the implications of or motivate for a particular proposal, and to engage with previous points made. Each of these functions could be further differentiated. Where knowledge claims were made to illustrate a current situation, this was either in relation to a particular challenge encountered, or in relation to a solution or best practice being utilised. Where implications of a proposal were highlighted, knowledge claims were either drawn on to highlight the benefits of such proposals, or to highlight the disadvantages. Finally, where participants drew on knowledge claims to engage with others' points, this was either in support of a previous point, or to counter it.

Examples of each of these knowledge claim functions are presented in Table 4.12. It is worth noting here that the coding done within this 'uses of knowledge' theme was done inductively. The themes described above were identified as a result of patterns noted during this coding. It is notable, then, that explicit knowledge claims were being employed predominantly to highlight whether and how policy proposals would work 'on the ground'. This suggests that the value of such inputs during policy consultation events could be to identify gaps and opportunities for policy implementation. The converse of this is the finding that so few explicit knowledge claims were employed in general, given the value they could hold to support or counter policy proposals with respect to implementation implications. This consultation-implementation link will be explored further in Chapter 5.

Table 4.12: Examples of functions of knowledge claims

Theme	Sub-themes	Knowledge claim type and examples
Illustrate current situation	Challenge	**Evidence-based**
		In fact, in another study, which I haven't spoken about here, we are conducting interviews with patients who meet the diagnostic criteria for major depressive disorder, and we are trying to elicit from them, in the local expressed language – Xhosa in this case – the manifestations of depression from their own perspective … And what we are finding is that a lot of people are talking about the somatic dimension of depression. People are reporting pain and idioms of distress, such as "My heart is sore", "My mind is not right", those kinds of idiomatic expressions of distress. And finding the language to be able to express that is part of the challenge that we are trying to engage with. (Speaker 3, Group 5)
		Experiential
		Then my other concern is, as a community member of the mental health review board, we're supposed to take this information and all that to the community, be a resource in the community. But then many a times we find that that the patient says, the user says, that "The medication I'm getting is not treating me well; there's a lot of side effects. And if I go to work, I've got this mask face, and immediately people recognise that and, you know, that's where the whole stigma and discrimination starts all over again". So, many a time, the psychologists, the doctors, doesn't wanna listen to us, the user, or even, you know, as a board member that try and adjust the medication so that this person can function as normally as possible in the community. Those other are the nitty gritty's that I thought that would be discussed here. (Speaker 34, Group 10)
	Solution/best practice	**Evidence-based**
		And then fourthly I wanted to mention the WHO norms for mental health, which includes norms for human resources. I don't know if people are familiar with them but in fact the lead author on that was (name) … who spoke yesterday. And that model, which is available online, follows a fairly similar process to the one that (presenter) has outlined and from that one's able to look at looking at staff norms based not just on a needs-based or epidemiological approach, but on a demand-based approach, which I agree is really the way to go. (Speaker 9, Group 4)
		Experiential
		If I may share some of what we're finding, is working on the ground as an NGO … We are trying to roll out psycho-social services for children in a children's home with a zero budget and only one qualified psychologist. And we're having quite a lot of success in terms of task shifting. We are using volunteers from all over. A lot of pupilships; large companies are sending us volunteers so that we can then deploy them playing soccer with the children, helping them with homework … We're trying to see how we can, with zero money – or as little as possible – bring the services to the kids who really need them, and we're finding that using volunteers and interns is a wonderful pathway. (Speaker 11, Group 7)

Table 4.12 continued: Examples of functions of knowledge claims

Theme	Sub-themes	Knowledge claim type and examples
Highlight implications of a proposal	Highlight benefits of, or motivate for, a proposal	**Evidence-based**
		Can I also say, and that the evidence shows, that we know like the one you need a bit more than one counselling on site. Yes, have it on site, initially, but I mean what the international evidence shows that the most effective programmes, and here we're talking about mental health promotion for maternal depression and promoting psycho-social stimulation which can have long term impact, twenty years later ((inaudible)) is through home visitation programmes. Because you know we can't be guaranteed that mother who's got maternal depression's going to come back to the facility. (Speaker 1, Group 1)
		Experiential
		I started reading *On recovery* about a year ago, and personally, I can say that there's been a fundamental change in my own levels of job satisfaction and enjoyment. The reward when you start seeing the positive, and helping people to see that and bring it out is just immense … The point about the recovery movement is that we create a force that actually allows us to get the job done – not only get the job done, but improve society as well. (Speaker 3, Group 10)
	Highlight disadvantages of, or argue against, a proposal	**Evidence-based**
		Please, can I just say, I think that it's a bit of a problem that we can put wonderful things here, but what is actually possible and feasible within our resources of today? So, I would endorse that we need to promote strong families or whatever, but, if we're looking at programmatic interventions to strengthen families, both (name) and I have been involved in a random controlled trial of a family strengthening programme, and it's quite resource intensive. You know, so you need warm bodies to actually facilitate those programmes … So, the issue is, do we use our limited resources for everybody? That's really nice, but in a resource-constrained situation, which we have, do we try and rather target those particularly in need of a strengthening programme? (Speaker 1, Group 1)
		Experiential
		I'd like to say something coming from the ground. I'd like to comment on the issue of dedicated person at each facility. Being a person who is working on the ground, I have observed that really if you have a dedicated person in a clinic who is doing mental health, you tend to have a relationship with your patients. The patients, when they come they know who to contact and whenever they start to develop either side effects or whatsoever, they are very open. And when they change or when introduction of integration started, whereby any professional has started could render mental health services, we realised that it led to default rate, because patients were not having relationships with a particular nurse and some of the nurses were not even having passion in mental health. (Speaker 28, Group 3)

Table 4.12 continued: Examples of functions of knowledge claims

Theme	Sub-themes	Knowledge claim type and examples
Engage	Support previous point	**Evidence-based**
		I agree with (name). I think under-reporting is a big problem in this country, mainly because of the distribution of people. Rural versus urban. The second point that I just want to support (name), is that the study that I just completed in the Durban, the three Durban mortuaries, showed me conclusive evidence that the reporting leaves a lot to be desired in the mortuaries. (Speaker 4, Group 9)
		Experiential
		I'm from a district hospital in Kwazulu-Natal, and this slide here pleases me so much. This is exactly what is happening on the ground, in our district. Only one thing I'd like to add to the clinic, the need for a professional mental health person and a facility for the clinic to communicate with and give the necessary intellectual input, pharmacological input, care input where necessary, is absolutely essential. So from that clinic's picture there, I'd like to have an arrow to the district hospital. In our district hospital, we're very lucky; we've established a psychiatric unit, so we're able to care for members of the community that require the expertise of a psychiatric unit and give feedback and support to people at the clinics. (Speaker 18, Group 3)
	Counter previous point	**Evidence-based**
		I want to slightly disagree with (name). I think we need to be more vocal. We need to be advocates for the mental health sector and I think the national Minister for Health is very serious about the concern. Being the third highest burden of disease, we need to plough in a hell of a lot more when it comes to funding. So, I want to suggest that we call for ring-fencing, with clear indicators as to what it is we want to achieve by when. You know, there's already a massive gap in the finding stream. We heard yesterday about the study that was done in Kwazulu-Natal - psychiatric services received over a five-year period about 3.5 percent increase, whereas general health received 10, between 10.5 and 12 percent increases. Already we see that disparity. If we want to reduce the impact of this burden, reduce the economic burden, then we've gotta plough more money into ensuring that we lower the burden. (Speaker 46, Group 3)
		Experiential
		What I would like to say is that I do understand what my colleague is saying, that they would like to expedite the matter and things, but in terms of the act if you look at it, the reason we actually give two weeks from the date of when you receive the appeal … is to allow the applicant to request legal representation from the legal aid if they so wish. And another valid point is also that, as the review board, we have to issue summons for the psychiatrists and health care practitioners to make themselves available to come and give evidence in the hearing. (Speaker 23, Group 6)

The enacted uses of knowledge claims in the breakaway group sessions are shown in Figure 4.5. This figure shows that that both experiential and evidence-based knowledge claims were explicitly drawn on to illustrate the current situation in relation to a particular issue (far left of Figure 4.5), more frequently than to perform any of the other functions identified. Of the instances identified where knowledge claims were used to illustrate a current situation, the majority of these were experiential knowledge claims, either illustrating a challenge or a solution/best practice. Similarly, where knowledge claims were used to highlight the implications of a particular proposal (centre of Figure 4.5), the majority of these were also experiential knowledge claims, either to highlight the benefits of or motivate for a proposal, or to highlight the disadvantages or argue against a proposal. Given the consultation-implementation link noted above, it is not surprising that participants drew on their 'on-the-ground' experiences (more than on evidence, in this case) to argue for particular policy proposals.

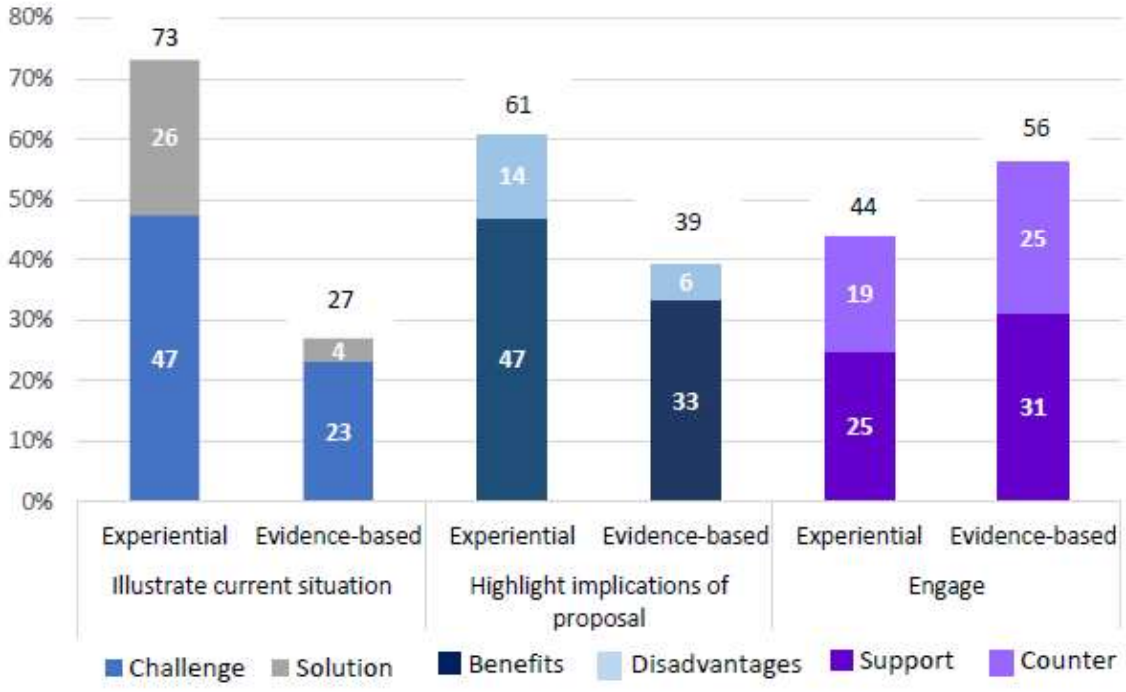


Figure 4.5: Enacted uses of knowledge claims in breakaway group sessions

Conversely, evidence-based knowledge claims seemed to be used more frequently than experiential knowledge claims to engage with previous points made, either to support or to counter these points (far right of Figure 4.5). This lends partial support to the notion that evidence-based knowledge might be seen as a more valid and robust form of knowledge than experiential knowledge. Thus, in trying to substantiate arguments when engaging in debate with other group members, participants may be more likely to back up their arguments with evidence-based claims than with experiential claims. However, the difference between use of evidence-based knowledge claims and of experiential knowledge claims when engaging with others was too small to make stronger conclusions in this regard.

4.4.2.2 Responses to knowledge claims: Were they responded to?

The enactment of knowledge in consultation spaces draws attention to the interactive nature of knowledge creation. In addition to the functions that evidence-based and experiential knowledge appeared to serve during these group discussions, then, the extent to which such contributions were responded to was also of interest. While evidence-based knowledge might carry a certain authority or legitimacy, experiential knowledge might be more likely to elicit direct responses during group discussions due to their more interpersonal characteristics (for example, evoking empathy in their listeners). The references to experiential knowledge and evidence-based knowledge during the discussions were therefore coded according to whether these received a direct response. Where they were responded to, this was further differentiated between cases where the contribution was acknowledged, but not engaged with, and cases where the contribution was taken up and there was engagement.

There are a few issues worth noting before discussing these findings. The extent to which knowledge claim contributions were responded to or not seemed to be quite strongly dependent on the person who was Chairing or facilitating the discussions. In most cases where there were responses, these were primarily made by the group Chair or facilitator, as opposed to other group participants. Some Chairs were consistently responsive (summarising, reframing, and checking for understanding), while others consistently did not respond to or acknowledge contributions, and some even shut down discussions if the contribution deviated from what they deemed to be on the table for consideration (see section 4.5.2 for more detailed analysis of group processes). The degree to which particular knowledge claims were (or were not) responded to in such cases may not have been related to the form in which the contribution was made. Where there was direct engagement, it was usually in the second half of group discussions, where there was focused formulation of specific group recommendations.

Overall, the group discussions were typically quite disjointed and hard to follow, unless there was a skilled Chair or facilitator guiding the discussion. Some responses (or lack thereof) were inaudible. There was also limited time in which to follow through in depth about any particular point or proposal. It is possible that a more structured way of eliciting preferences and opinions in the context of both available evidence and draft policy might be more constructive way of optimising this kind of process. Note that where there were responses, the evaluative nature of such responses – that is, whether they were positive or negative, in support of or countering – was not analysed. Examples of the types of responses to knowledge claims, where these were made, are shown in Table 4.13.

Table 4.13: Examples of responses to knowledge claims

Response type	Examples of responses
Responded to but not engaged with	**Evidence-based**
	Thank you for that. (Speaker 2, Group 5) And this is the place to do it. Question there, okay this will be the last question and then we can save the others for later. (Speaker 2, Group 5)
	Experiential
	Okay, so we've got that one solved. We're packing it away now. There's two other issues I want you to address before you can go to tea in two minutes' time. (Speaker 1, Group 3)
Responded to and engaged with	**Evidence-based**
	That's a good point you're making. I mean, with all that you've said there, you've made the point that why so few are children involved in sports at school. I will give you lots of reasons. Schools don't have facilities, schools have attitudinal issues, all sorts of issues. (Speaker 9, Group 1)
	Experiential
	Okay. What you saying there is very important. You are saying people with skills in psychiatry and understanding are not involved in the infrastructure planning. Okay, that's vital, and that should happen. That expertise should come there. (Speaker 3, Group 6)

Figure 4.6 illustrates the breakdown of responsiveness to evidence-based and experiential knowledge claims during breakaway group discussions. These findings are discussed further below.

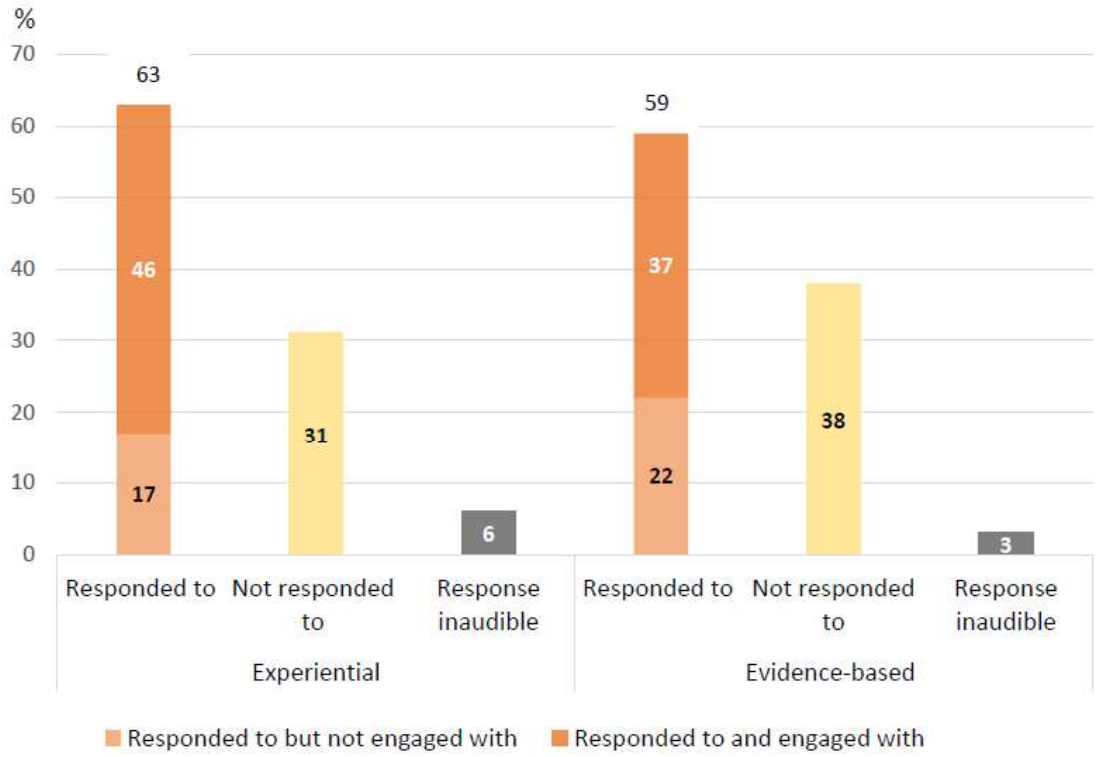


Figure 4.6: Responsiveness to experiential and evidence-based knowledge claims

As shown in Figure 4.6, both experiential and evidence-based knowledge claims were more frequently responded to than not. There did not seem to be a substantial difference, however, between experiential and evidence-based knowledge claims: both seemed equally likely to elicit some form of response or acknowledgement. This pattern is similar when looking at the extent to which different knowledge claims seemed to result in engagement. Where both types of knowledge claims elicited direct responses, the response was more frequently to engage with the points being made than merely to acknowledge an input (and move onto other points or participants). While those knowledge claims that were responded to were more likely to be engaged with more substantively than merely acknowledged, neither experiential nor evidence-based knowledge claims seemed more likely than the other to result in such engagement.

The lack of substantive differences between likelihood of responsiveness in relation to evidence-based and experiential knowledge claims seems to suggest that contributions to consultation discussions that drew on either of these two knowledge types were equally likely to receive attention. The question that is explored in the next subsection is whether this pattern continued in the extent to which different knowledge claims appeared to be captured or followed through into group recommendations.

4.4.3 Inscription of knowledge claims

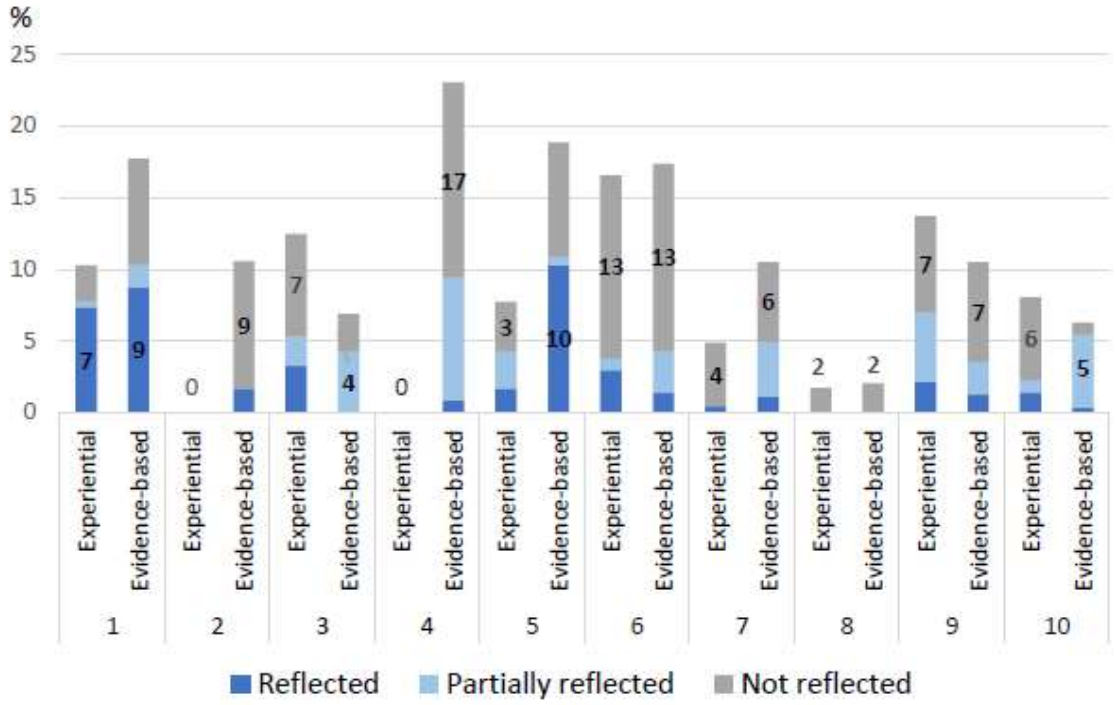
Various knowledge claims were coded as reflected or inscribed in group recommendations if the group recommendation was considered to closely reflect the underlying proposal contained in the particular knowledge claim. Partially reflected knowledge claims were coded as such where the group recommendation made reference to the general idea contained in the knowledge claim, but did not directly recommend what the speaker seemed to be proposing within that claim. Where there was no direct link to the knowledge claim in any of the recommendations put forward by the group, these knowledge claims were coded as not reflected. Coding definitions can be found in Appendix 4.

As mentioned earlier, it is important to bear in mind throughout the findings presented in this section that particular proposals may have been put forward by multiple speakers, in multiple forms, whether as various types of knowledge claims or as other forms of talk. Where particular knowledge claims are shown to be reflected in group recommendations, then, it is not possible to draw a direct link, as this may also be attributed to a number of other factors. Where particular knowledge claims are clearly shown *not* to be reflected in group recommendations, stronger conclusions might be drawn, although, again, the extent to which this can be attributed to the framing of the proposals as opposed to other influencing factors is limited.

In Figure 4.7, the percentage of experiential and evidence-based knowledge claims that were reflected, partially reflected, and not reflected in group recommendations is illustrated. There are roughly equal proportions of reflected, partially reflected, and not reflected claims across the two knowledge types, and in both cases, these knowledge claims were predominantly not reflected in group recommendations (66% and 61%, respectively). This suggests, firstly, that linking policy proposals to explicit knowledge claims did not seem to be associated with these inputs being take up into recommendations (although, as will be explored later, there are several possible reasons for this). Secondly, neither experiential knowledge claims nor evidence-based knowledge claims seemed more likely to be reflected in group recommendations than the other.

Figure 4.7: Percentage of knowledge claims reflected in group recommendations

Figure 4.8 shows a more detailed breakdown of the proportion of evidence-based knowledge claims and experiential knowledge claims that were or were not reflected in group recommendations across the ten breakaway groups. The numbers included on each bar reflect the theme (reflected, partially reflected, or not reflected) that was *in the majority* for the experiential and evidence-based knowledge claims in each group. For example, within Group 1, the largest proportion of both experiential (7%) and evidence-based (9%) knowledge claims were found to be reflected in group recommendations, as opposed to partially reflected or not reflected. In only Group 1 (prevention and promotion) and Group 5 (mental health & other conditions) were a greater proportion of knowledge claims found to be reflected in group recommendations than partially or not reflected. In Group 1, this was the case for both experiential and evidence-based knowledge claims. More detailed analysis of inter-group differences is included in Appendix 6.

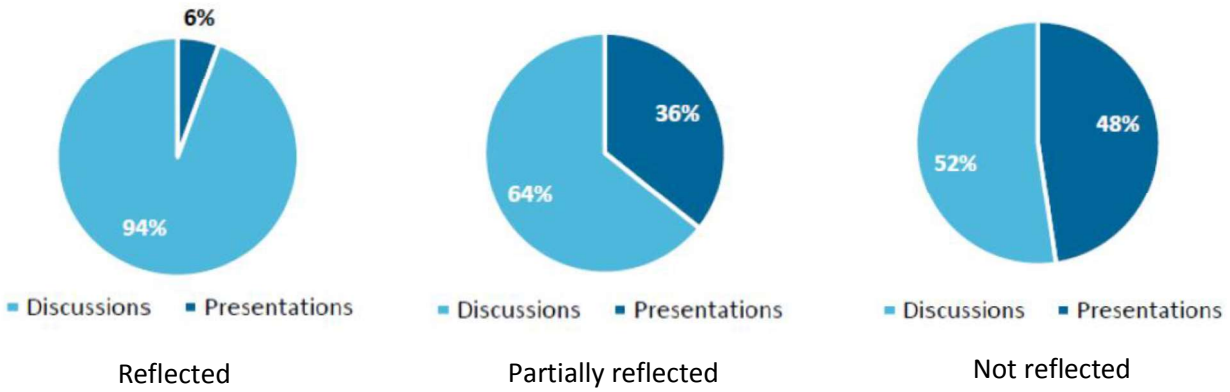


Group key: 1. Prevention & promotion; 2. Research & surveillance; 3. Mental health systems; 4. Human resources & infrastructure; 5. Mental health & other conditions; 6. Mental Health Care Act; 7. Child & adolescent mental health; 8. Culture & mental health; 9. Suicide prevention; 10. Advocacy & user participation

Figure 4.8: Reflection of knowledge claims across breakaway group themes

The next level of analysis focused on finer distinctions in terms of whether evidence-based and experiential knowledge claims seemed more likely to be reflected if they were made during group presentations versus during group discussions. Figures 4.9 and 4.10 show, respectively, the percentages of experiential and evidence-based knowledge claims made in the group presentations and the group discussions that were considered to be reflected, partially reflected, or not reflected in the respective group's recommendations. A more detailed analysis of inter-group differences in this regard can be found in Appendix 6.

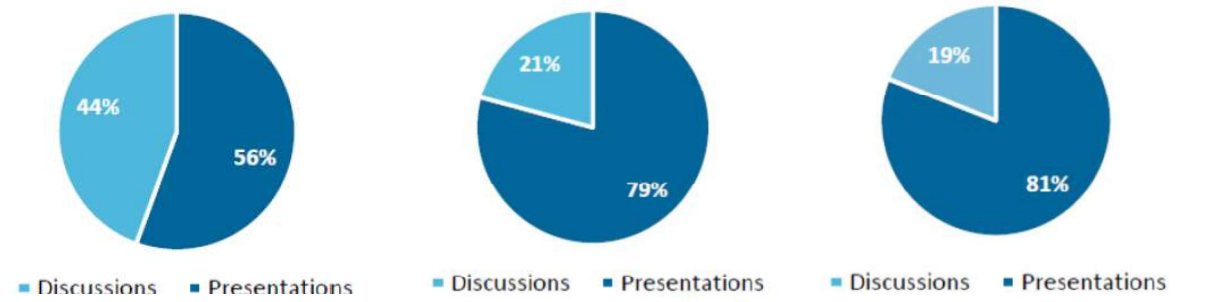
A note about the coding here: each category of explicit knowledge claims (experiential and evidence-based) was first coded according to whether these were determined to be reflected in some way in the group recommendations. Then, within the 'knowledge claim + reflected' composite code, a third level of coding was conducted to determine whether the reflected, partially reflected, and not reflected claims occurred more during the presentations or during the discussions. On the far left of Figure 4.9, for example, experiential knowledge claims that were coded as reflected in group recommendations occurred more frequently during group discussions (94%) than during group presentations (6%).



Reflected | Partially reflected | Not reflected

Figure 4.9: Percentage of experiential knowledge claims in group presentations and discussions reflected in group recommendations

While the legitimacy of experiential knowledge as a sound basis for informing policy decisions might be questioned, if this knowledge was drawn on by a perceived 'expert' (i.e. presenter), it may be more likely to be attended to and therefore reflected. As can be seen in Figure 4.9, however, this did not turn out to be the case. The majority of experiential knowledge claims that were found to be reflected in group recommendations occurred during group discussions. As will be seen in later analyses, most of the breakaway groups began formulating their recommendations in the second half of the group sessions. It was thus during the group *discussions* that these recommendations were captured. This may explain, at least in part, why the captured (reflected) experiential knowledge claims were found to be made more predominantly during discussions, as opposed to presentations.



Reflected | Partially reflected | Not reflected

Figure 4.10: Percentage of evidence-based knowledge claims in group presentations and discussions reflected in group recommendations

Figure 4.10 shows the proportions of reflected, partially reflected, and not reflected evidence-based knowledge claims that occurred during group presentations versus group discussions. The distinction between evidence-based knowledge claims reflected in the group presentations versus the group

discussions was made for a number of reasons. First, evidence-based knowledge claims made during formal presentations might be more likely to be reflected in group recommendations due to the expert status of both the format of the presentation as well as the presenter. In other words, those presenting this content were invited to do so on the basis of their expert knowledge and, by this very fact, their proposals may have been seen as more credible and legitimate than those put forward by other group participants. Second, most of the presentations were available to group members as PowerPoint slides and handouts (in some cases), which were sometimes explicitly drawn on or referenced during the discussions. Thus, the content of these presentations – and the evidence-based knowledge claims within them – might be more readily reflected in group recommendations.

As Figure 4.10 shows, those evidence-based knowledge claims that were found to be reflected in group recommendations occurred in group presentations (56%) and group discussions (44%) with almost equal frequency. The majority (79%) of evidence-based knowledge claims that were found to be only partially reflected in group recommendations occurred during the presentations. Interestingly, of the evidence-based knowledge claims that were adjudged as not reflected in group recommendations, the majority (81%) of these occurred during group presentations. The fact that groups formulated their recommendations in the later part of the group sessions, as mentioned above, may go some way toward accounting for this. However, because presenters were in most cases also participants in the group discussions, it is also possible that their (evidence-based) contributions during the formulation of recommendations could have held greater weight by virtue of their expert status. This may explain why roughly half of evidence-based knowledge claims that were reflected in recommendations occurred during group discussions. More detailed analysis would be needed in order to draw stronger conclusions about the reflection (or not) of discussion-based, evidence-based knowledge claims in group recommendations, as this may simply be a result of formal presenters' inputs.

In Figure 4.11, this analysis is presented slightly differently, to show more clearly the distinctions between the group presentations and group discussions categories, in terms the proportion of knowledge claims occurring in each of these categories that were determined to be reflected, partially reflected, or not reflected in group recommendations. Consistent with findings presented above, this figure also clearly shows, again, that explicit knowledge claims made during group breakaway sessions were predominantly not likely to be reflected in group recommendations. The main findings emerging from this analysis are summarised in the next subsection.

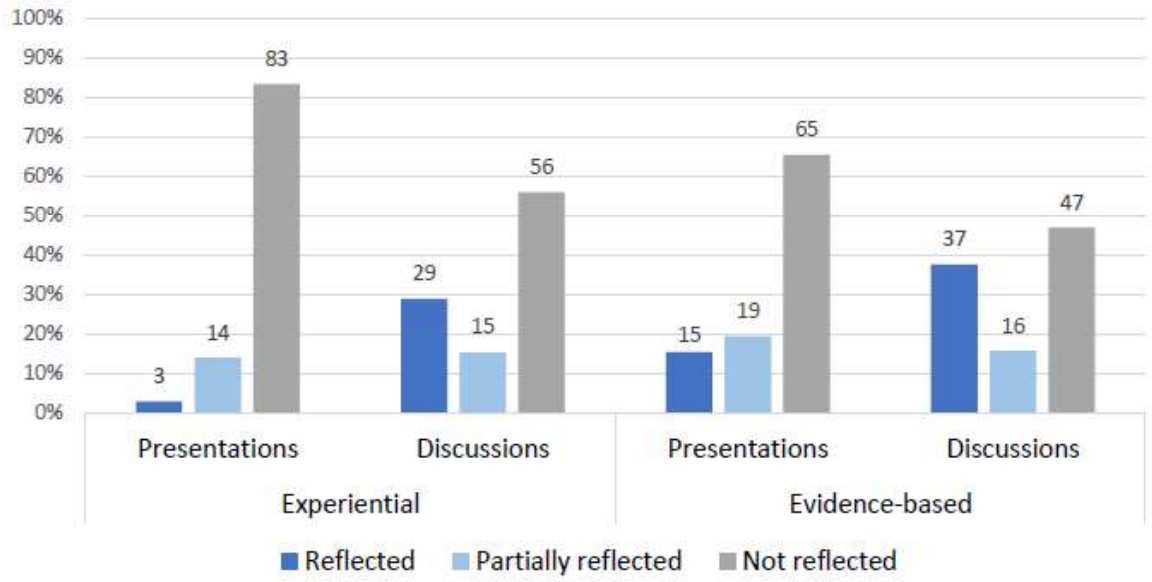


Figure 4.11: Knowledge claims in group presentations and discussions reflected in recommendations

4.4.4 Embodied knowledge enacted: Conclusions

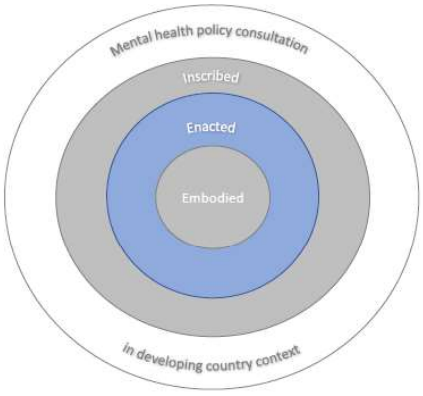
The findings of this section suggest that the majority of talk during the ten breakaway group sessions at the national mental health summit did not draw explicitly on either evidence-based knowledge or experiential knowledge. While more evidence-based knowledge claims than experiential knowledge claims were made, most of the presentations and discussions in all groups were categorised as *Other,* which covered a wide variety of talk in which no explicit reference to either evidence or experience was made. Most of the references to evidence-based knowledge occurred during formal presentations within the groups, while experiential knowledge claims were utilised more frequently during group discussions.

In terms of how knowledge was enacted, participants drew explicitly on both evidence-based knowledge and experiential knowledge to illustrate a current situation (challenge or best practice), highlight the (positive or negative) implications of a proposal, or engage with previous points made. Evidence-based knowledge claims were more often used to engage with previous points – whether to support or counter these – while experiential knowledge claims were consistently more frequently used to illustrate current situations or highlight implications of proposals. Notably, there were no evident differences between the frequency with which either experiential or evidence-based knowledge claims were responded to or engaged with during group discussions. In terms of follow-through, neither evidence-based nor experiential knowledge claims appeared to be more likely to be reflected in group recommendations across all groups, with the exception of the groups focusing on promotion and prevention, and on mental health and other conditions.

In summary, there was much less explicit reference to any type of knowledge claim to back up statements or proposals than might be expected during policy consultation discussions, particularly given the evidence-based focus of the policymaking process. While it did seem to be the case that more evidence-based knowledge claims were made, this did not seem to have had an effect on rendering these claims any more likely than experiential knowledge claims to be reflected in recommendations. The low percentage of evidence-based knowledge claims reflected in group recommendations is a surprising finding, given what is known about the perceived credibility or legitimacy of this type of knowledge compared to other knowledges. In contrast, based on previous research, it was expected that experiential knowledge might be less amenable to capturing and follow-through. This appeared to be confirmed by these findings.

Given the relatively low proportion of explicitly referenced knowledge claims found here, as well as the corresponding low percentages of these claims that seemed to be reflected in group recommendations, the focus of the analysis now shifts to an exploration of group process. The format and process followed by each of the ten breakaway groups are described and compared, toward understanding how enacted knowledge in these spaces might have been enabled or constrained. In particular, the focus is on identifying how each of these groups managed the process of moving the enacted knowledge of the discussions to the inscribed knowledge of the group recommendations. This could provide some insight regarding the capture (inscription) and transfer of knowledge in and beyond consultation discussions.

4.5 Enacted knowledge inscribed



This section presents findings from the analysis of the process that was followed in each group breakaway session at the national summit. As such, the focus here is on the enactment of knowledge, and in particular how group processes may have enabled or constrained the transfer of knowledge from enacted to inscribed forms. This may give some indication of how knowledge inputs were elicited and managed during group discussions. A number of process-related elements are considered, including the time spent on presentations and discussions within groups, the engagement of groups with the draft policy and summit documents, and the way in which Chairs managed the enacted space, including how each group reached their inscribed outputs (group recommendations).

A descriptive overview of the programme and structure of the two-day national summit was presented in the methodology chapter. In this section, the overall format of the ten breakaway group sessions is reviewed in greater detail to provide context for the process-related analysis that follows. Particular consideration is given in this first subsection to the timing of different components of the summit, to identify the opportunities that participants had to engage in discussions around the draft policy during the summit. The process analysis is presented in two subsections: i) opportunities for enactment, in which issues relating to time availability and facilitation are discussed; and ii) points of engagement between enactment and inscription, in which engagement of participants with draft documents and the formulation of group discussions into (inscribed) recommendations are considered.

4.5.1 Overview of breakaway group sessions at national summit

Participants at the national summit divided themselves into ten breakaway groups, each of which would be discussing a specific component of mental health, as follows (abbreviated titles used in the analysis and presentation of findings are included in parentheses after each group title):
Group 1: Mental health promotion and prevention of mental disorders (prevention & promotion)
Group 2: Mental health research and innovation, and surveillance (research & surveillance)
Group 3: Mental health systems (mental health systems)
Group 4: Mental health infrastructure and human resources (human resources & infrastructure)
Group 5: Mental health and other conditions (mental health & other conditions)
Group 6: Mental Health Care Act of 2002: Lessons learned from implementation (Mental Health Care Act)
Group 7: Child and adolescent mental health (child & adolescent mental health)
Group 8: Culture, faith-based practices, and indigenous mental health practices (culture & mental health)
Group 9: Suicide prevention (suicide prevention)
Group 10: Advocacy, social mobilisation, user, and community participation (advocacy & user participation).

All the breakaway group sessions included some or all of the following elements: participant introductions, two formal presentations, comments or questions about these presentations, review of the draft policy document, consideration of the draft summit declaration, and formulation of group recommendations. Each group had a Chair who facilitated the session and a rapporteur who captured discussions and reported group recommendations back to the plenary session. The degree of engagement with the two draft documents – the mental health policy and the summit declaration –

differed across groups, as did the process each group followed to reach their recommendations, which were then presented back at the plenary session. The groups all convened briefly at the end of Day 1, and met again the following morning to continue discussions.

Audio recordings of the whole national summit, including of the ten breakaway group sessions, were received from the national DoH, and subsequently transcribed. Table 4.14 presents an overview of the format of these group sessions. Audibility of four of the ten group sessions was poor (Groups 2, 7, 8, and 9), while no audio was available for four of the group sessions convened on Day 1 (Groups 1, 4, 5, and 6). Due to the inconsistent availability of and quality of the audio from the ten breakaway group sessions, it is not possible to provide a complete overview of the way in which each group spent the time dedicated to these sessions. It seems as though group members in the majority of the groups spent some time introducing themselves.

The time taken up by presentations varied greatly across the group sessions. The presentation time was calculated based on the total time allocated to group sessions and ranged from 25 minutes for both presentations (e.g. Group 3: Mental health systems), to over one hour for one presentation (e.g. Group 4: Human resources & infrastructure). No audio recordings were available for the presentations in Group 8 (culture and mental health); the presentation time was calculated based on the total time allocated to group sessions. In general, groups spent over an hour in discussions, with three groups devoting the majority of the time allocated to group sessions to discussions: Group 2 (research & surveillance), Group 3 (mental health systems), and Group 10 (advocacy and user participation).

Chairing styles differed across groups, ranging from Chairs playing an active role in facilitating discussions and formulating recommendations, to Chairs who seemed to engage mostly in microphone management between participants, with little direct engagement with participant contributions. In some cases, rapporteurs were silent participants during the group discussions, while other rapporteurs were active in assisting the Chair in moving the group towards recommendations. Only two of the groups (Group 1: Prevention & promotion, and Group 8: Culture and mental health) engaged directly with the draft policy document, while four groups (Group 3: Mental health systems; Group 7: Child & adolescent mental health; Group 8: Culture & mental health; and Group 9: Suicide prevention) engaged directly with the draft summit declaration during discussions.

Fifty minutes were allocated on the summit programme for the ten groups to present their recommendations back to the plenary (five minutes per group). It seems that this session ran 15 minutes over time. There was substantial variation in the number of recommendations presented by each group, ranging from four (Group 6: Mental Health Care Act) to 27 (Group 4: Human resources &

infrastructure). Although the two groups with the greatest number of recommendations (Group 4 and Group 10) spent the majority of the time allocated for group feedback on the programme presenting these recommendations (19% and 17% respectively), the number of group recommendations did not always correlate with plenary feedback time. Group 7 (child & adolescent mental health), for example, spent just over five minutes presenting their 17 recommendations, while Group 5 (mental health & other conditions) spent just over nine minutes presenting 16 recommendations. The way in which feedback was given at the plenary seems to have been largely dependent on the person presenting (i.e. the group rapporteur).

Table 4.14: Overview of format of group breakaway sessions at national summit

Group[*]	1	2	3	4	5	6	7	8	9	10
Introduction and time	Yes 5 min 30 sec	Yes 15 mins	No	Unknown	Yes 6 mins	Unknown	Yes 34 mins	Yes 35 mins	No	Yes 8 mins
Presentation time	42 mins	35 mins	25 mins	1hr 5 mins +	55 mins	1 hr 25 mins	1 hr	54 mins	1 hr 10 mins	33 mins
Discussion time	1 hr 30 mins	2 hr 10 mins	2 hr 5 mins	1 hr 30 mins	1 hr 55 mins	1 hr 22 mins	1 hr 35 mins	1 hr 55 mins	1 hr 58 mins	2 hr 33 mins
Recommend-ation report back time	6m22s (9%)	6m4s (9%)	4m36s (7%)	12m38s (19%)	9m36s (14%)	1m54s (3%)	5m16s (8%)	4m50s (7%)	4m51s (7%)	11m10s (17%)
# of recommend-ations	12	9	5	27	16	4 (or 15)	17	9	5	21
Access to audio	Day 1: No Day 2: Yes	Day 1: Yes Day 2: Yes	Day 1: Yes Day 2: Yes	Day 1: No Day 2: Yes	Day 1: No Day 2: Yes	Day 1: No Day 2: Yes	Day 1: Yes Day 2: Yes	Day 1: Yes Day 2: Yes	Day 1: Yes Day 2: Yes	Day 1: Yes Day 2: Yes
Audibility[#]	Good	Poor (30% inaudible)	Good	Good	Good but audio cuts out at points	Good	Fair (7% inaudible)	Poor (15% inaudible)	Good	Good
Direct engagement with draft documents	Policy: Yes Declaration: Intro reference only	Policy: Intro reference only Declaration: Intro reference only	Policy: Yes Declaration: Yes	Policy: No Declaration: No	Policy: No Declaration: No	Policy: No Declaration: Intro reference only	Policy: No Declaration: Intro reference only	Policy: Yes Declaration: Yes	Policy: No Declaration: Yes	Policy: Intro reference only Declaration: No
Chair style	Active throughout	Inactive: microphone management Active towards end	Active throughout	Inactive: microphone management Active towards end	Silent Active towards end	Active throughout	Inactive: microphone management	Active throughout	Silent Active towards end	Active throughout

[*] Corresponding breakaway group topics: 1. Prevention & promotion. 2. Research & surveillance. 3. Mental health systems. 4. Human resources & infrastructure. 5. Mental health & other conditions. 6. Mental Health Care Act. 7. Child & adolescent mental health. 8. Culture & mental health. 9. Suicide prevention. 10. Advocacy & user participation.

[#] Audibility key: Good <5% inaudible content. Fair = 5-10%inaudible content. Poor >10% inaudible content.

4.5.2 Opportunities for enactment

Two key process-related elements were identified in the literature as having an important role in the effectiveness – perceived and actual – of consultation processes. These elements were considered to be factors that might enable or constrain opportunities for enactment of embodied knowledge during the group discussions; these were found to be common factors across all groups. The findings of the analysis of the group breakaway sessions around time availability and facilitation are discussed below.

4.5.2.1 Time availability in breakaway group sessions

The different ways in which time was managed during breakaway group sessions are presented in Table 4.15. Group discussions were coded for comments made during group sessions, which indicated an awareness of timing and time limitations. This is shown as a proportion of the total group talk in column 2 of Table 4.15. The breakaway groups are listed in the table from the group that had the greatest proportion of time awareness comments (Group 8: 6.59%) to the group with the smallest proportion (Group 1: 0.12%). Qualitative examples of references to time in each group are included in the third column. The proportions of time spent on introductions and instructions, on presentations, and on discussions during the group sessions are shown in the fourth, fifth, and sixth columns respectively.

There were clear indications that the Chairs of the group sessions were aware of the time constraints on the group discussions, with frequent references to timing of various components of the sessions, and to availability of time – particularly with respect to formulating recommendations, which is discussed in more detail later in this section. While this speaks somewhat to the logistics of managing large group processes such as the consultation summits, it is also evident that opportunities for engaged discussions were limited by these time constraints.

Despite the commonalities noted above, there was a fair degree of variation across groups in terms of how aware of time Chairs (and to a lesser extent participants) were during discussions. Group 8 (culture and mental health) had the highest proportion of talk demonstrating awareness of time availability in relation to the total group talk. Interestingly, this was also a group that spent less time on discussions (57%) than many other groups, in proportion to time spent on introductions (17%) and formal presentations (26%).

Table 4.15: Time availability in breakaway groups

Group*	Indications of awareness of time availability and limitations		Proportion of time spent on components of group sessions		
	Awareness of time %	Comment examples of awareness of time	Intros	Presentations	Discussions
8	6.59%	The two papers presented are good but justice was not done to them. Time that they were presented could not afford us to comment and to critique where possible. (Speaker 6)	17%	26%	57%
6	2%	Are there any points now that if you don't make this point, the sky is gonna fall on our heads? Because otherwise we can go on and we'll miss out on the plenary. (Speaker 3)	0	51%	49%
10	1.86%	We've got very limited time, okay ... We have to finish this. We *have* to go for a meeting at half past, so if we can just move on. (Speaker 28)	4%	17%	79%
7	1.68%	Guys, we're going to have time problems. So I'm going to suggest if you have two points, make them briefly, so that you can give other people a fair chance. (Speaker 1)	18%	32%	50%
4	1.1%	Sorry, we really need to follow our plan. We've had our ten minutes. (Speaker 2)	0	42%	58%
5	0.93%	I'm concerned about the time, and that we need to get through other recommendations as well. (Speaker 2)	3%	32%	65%
3	0.67%	Okay, we have to stop because we won't finish … But I do think we need to break now and everybody go … and drink five minutes of tea and come back as soon as possible. (Speaker 1)	0	17%	83%
9	0.62%	We've got five minutes by the way … Now I'm in big trouble because I'm late [to closed door meeting]. (Speaker 1)	0	37%	63%
2	0.6%	We only have 15 minutes left. Is this relevant? Is this a relevant issue? (Speaker 3)	8%	20%	72%
1	0.12%	Any other points? Everybody else is having tea, I'm just trying to let you know … Last point now and then we need to stop. (Speaker 9)	4%	31%	65%

* Corresponding breakaway group topics: 1. Prevention & promotion. 2. Research & surveillance. 3. Mental health systems. 4. Infrastructure & human resources. 5. Mental health & other conditions. 6. Mental Health Care Act. 7. Child & adolescent mental health. 8. Culture & mental health. 9. Suicide prevention. 10. Advocacy & user participation

The groups that dedicated the most amount of time to group discussions, proportional to overall session time, were Group 3 (mental health care systems: 83%), Group 10 (advocacy & user participation: 79%), and Group 2 (research & surveillance: 72%). There was no consistent relationship, however, between actual time spent on discussions and Chairs' or participants' explicitly referenced awareness of time availability. It should also be noted that the amount of time spent on introductions for Groups 4 and 6 was unknown, due to unavailability of audio for these group sessions on Day 1 and no reference being made by Chairs on Day 2, regarding what had been done during this first group session.

4.5.2.2 Facilitation of breakaway group sessions

Findings regarding facilitation of group sessions are presented in Table 4.16. All of the breakaway groups followed a form of microphone management to structure group discussions. This entailed having the Chair, or co-facilitator/assistant, directing a microphone to participants who indicated that they wanted to speak. Any explicit references to the management of the microphone, including passing it between participants or Chair directions regarding who could speak next, were coded as 'microphone management'. The proportion of references to microphone management made during group sessions, in relation to the total group talk, is shown in the second column of Table 4.16. The groups are listed vertically in the table from largest proportion of microphone management references (Group 6: 2.31%), to smallest proportion (Group 5: 0.04%). Examples of these microphone management references are included in column 3.

General procedural comments made by the Chair in relation to group discussions are included in the fourth column of Table 4.16. In this theme, Chairs frequently demonstrated a certain Chairing style or influence over group process which, in turn, was generally consistent with the microphone management that most groups followed. What emerged within this theme was the influence that Chairs (and/or rapporteurs) had over the process, and in enabling or constraining opportunities for enactment and interaction. A description of how active the Chair was in terms of facilitation is provided in the last column of Table 4.16. This refers specifically to how active the Chair was in engaging directly with inputs from participants, through summarising, clarifying, and reframing these inputs.

The large group meeting format of the group sessions was evident throughout all the breakaway sessions, with frequent references to the turn-taking that was enabled or constrained by the movement of the microphone around the room. There seemed to be a greater amount of

microphone management, as indicated in explicit reference to such in the talk, in Group 6 (Mental Health Care Act: 2.31%) than in other groups, while Group 5 (mental health & other conditions: 0.04%) demonstrated the least. Interestingly, there did not seem to be a consistent association between the extent of explicit reference to microphone management during group discussions, and how active Chairs were in engaging with participant inputs. In other words, where much reference was made to the direction of discussion via microphone turn-taking, this did not seem to indicate limited willingness or ability of Chairs to engage actively with inputs made during these discussions.

There seemed to be three general styles of facilitation by Chairs, in terms of the extent to which they engaged with group inputs during discussions. These were: i) active engagement (clarifying, reframing, summarising); ii) predominantly microphone management throughout, with little direct engagement with inputs; and iii) silence or microphone management until the second half of the session when recommendations needed to be formulated. There could be argued to be advantages and disadvantages to each of these facilitation styles. Active engagement with inputs helped to structure the discussions and to increase the likelihood that what was captured represented participants' inputs to the degree that Chairs had interpreted them. The active inputs of Chairs over this process, however, also meant that Chairs could have had a significant influence over what got attended to and captured. On the other hand, where Chairs were mostly silent, there may have been greater fluidity in discussions and possibility for more natural conversational turn-taking between participants. However, there was also a more ad hoc or stochastic quality to the discussions that may, in turn, have resulted in somewhat arbitrary capturing of inputs and recommendations.

Table 4.16: Facilitation of breakaway groups

Group*	Microphone management references		General procedural comments by Chair	Chair engagement with inputs
	%	Examples of microphone mgt. comments	Examples of general procedural comments	Description
6	2.31%	Sorry, just before I go to you, can I go to the gentleman with the blue shirt? Because your hand's been up. (Speaker 1)	It's very important that if you make a comment that you use the microphone, otherwise your comments might not be recorded and I think it's important that we have an accurate recording of the proceedings here. (Speaker 1)	Active engagement (clarifying, reframing, summarising)
10	1.13%	So, I'm gonna go … firstly, I saw that hand first. And then I saw a hand over there as well… (Speaker 28)	Are there any other burning issues before we divide up into groups? Oh, we've got a very burning person here. And another burning person there – is it very burning? (Speaker 28)	Active engagement (clarifying, reframing, summarising)
7	0.89%	I'm going to jump to my two senior colleagues here because I know they talk a lot and they have a lot to offer, so let me move on to this side. (Speaker 1)	Now, if you have other specific thing, without making long speeches, just say it so the rapporteur can capture it. (Speaker 1)	Mostly managing microphone
3	0.86%	There's a hand at the back. (Speaker 1) I even stood up. (Speaker 22) Sorry, and I still ignore you … Do you want to come pick up the mic? (Speaker 1)	I don't want us to get into comments. Remember we were not even supposed to have a debate or a speaker tonight so we need to finish. (Speaker 1)	Active engagement (clarifying, reframing, summarising)
1	0.79%	Nobody wants the mic? (Speaker 9) Simone wants to talk; Simone wants the power again. (Speaker 1) The power of the mic. (Speaker 9)	Okay, so really need to try and keep people's focus on one issue. (Speaker 1)	Active engagement (clarifying, reframing, summarising)
4	0.28%	So, we have one here, here, and then I know you were next … I have an extra mic for those who wants to speak. (Speaker 2)	Just to reassure you, I'm going to give a very brief summary to (Name of organiser). This presentation still takes place in plenary. But I just want to make sure that the very brief summary I give to them now meets what we have discussed (Speaker 2)	Mostly managing microphone until end of session; active in formulating recommendations
2	0.13%	Just pass the microphones around … Do you want to repeat that for the mic? (Speaker 1)	I'm getting worried. Can you assume your responsibilities, Chair? You know, others are not going to be given the opportunity to interact in this commission. (Speaker 76)	Mostly managing microphone until end of session; active in formulating recommendations
9	0.12%	Now, we need to apparently record things here, so I'm going to have to move around a little bit. (Speaker 1)	I'm going to run quickly to my meeting with (Name of organiser). If you two would like to quickly just put your heads together, so that (Name of rapporteur) has the correct thing to feed back over there (Speaker 1)	Silent until second session; active in formulating recommendations
8	0.06%	Right, I see a hand at the back. (Speaker 1)	I just want to make a plea, let's not make speeches. If you are given a chance to comment, if you make a speech, it gets boring. There are people who have been designated to give speeches. (Speaker 1)	Active engagement (clarifying, reframing, summarising)
5	0.04%	Sorry, there's someone who wants to speak over there. (Speaker 2)	I think we need to maybe focus less on the difficulties and more about where do we think it's reasonable to get, and how are we going to get there. (Speaker 2)	Silent until second session; active in formulating recommendations

* Corresponding breakaway group topics: 1. Prevention & promotion. 2. Research & surveillance. 3. Mental health systems. 4. Infrastructure & human resources. 5. Mental health & other conditions. 6. Mental Health Care Act. 7. Child & adolescent mental health. 8. Culture & mental health. 9. Suicide prevention. 10. Advocacy & user participation

4.5.3 Points of engagement between enactment and inscription

A number of common patterns emerged across groups in the analysis regarding how groups were directed, firstly, to engage with the inscribed knowledge contained in the draft policy and summit declaration, and secondly, to formulate and capture their recommendations in inscribed form. Thematic analysis was conducted on the group transcripts according to these themes: i) references to direct engagement with the draft policy and summit documents; ii) general references to processes through which recommendations were formulated; and iii) the role that rapporteurs played in capturing recommendations, including the form that this capturing took. These were considered to represent points of engagement between enacted knowledge and inscribed knowledge, whereby one form was transformed into another. They were also an indication of individual-level influence – specifically, that of the Chairs and rapporteurs – over what got captured in inscribed form, to be transferred beyond the groups' enacted spaces.

In most cases, group recommendations were captured in writing of some form by rapporteurs who were assigned to each group. The ways in which each rapporteur captured these, however, whether paraphrased, in summarised form, or in more reframed or interpreted forms, was not possible to determine from the discussions. Nonetheless, a common trend across all groups was the recording of group recommendations in written form, whether handwritten on notepaper or flipcharts, typed onto a computer (e.g. as Microsoft Word files) during or after discussions, or written as points on PowerPoint slides, also during or after discussions, usually in electronic form. Explicit references to the *process* through which group discussions, proposals, and recommendations were captured provided more insight into the opportunities for inscription during these group sessions. Of interest, then, were the ways in which participants were afforded opportunities to engage directly with inscribed knowledge during discussions, as well as the specific ways in which group inputs were captured or recorded (where such information was evident in the discussions).

4.5.3.1 Engagement with draft documents during breakaway group sessions

Table 4.17 presents findings regarding the extent to which breakaway groups engaged with the draft documents that were available for review at the national summit, specifically, the draft mental health policy and the draft summit declaration. Group discussions were coded for explicit references to reading or engaging with either of these two documents. The total proportion of comments relating to engagement with the documents, in relation to total group talk, is presented in the

second column of Table 4.17. The groups are listed in descending order, from groups with the highest proportion of document engagement comments (Group 8: 18.05%) to those with the smallest (Groups 4 and 5: 0%). The specific proportion of the total document-engagement talk referring to the draft policy is shown in column 3, followed by a brief description of the extent of engagement that each group seemed to have with this document. Similarly, the specific proportion of total document-engagement talk referring to the draft summit declaration is shown in column 4, followed by a brief description of the engagement style followed in each group.

The group that engaged most directly with both the draft policy and draft summit declaration, in almost equal proportion, was Group 8 (culture & mental health: 18.05%). This was followed by Group 9 (suicide prevention), which spent 7.15% of total talk time referencing direct engagement with draft documents. This group spent all of this time engaging with the draft summit declaration, however, with no time spent engaging with the draft policy. In general, groups seemed to engage more with the summit declaration than with the draft policy document. However, in only three of the groups (Groups 8, 9, and 3) did this engagement extend beyond the Chair merely referencing the need to engage with these documents during their instructions to groups. As will be seen in later analysis comparing group discussions with group and summit recommendations, and with policy changes (see section 4.6.2), in almost all cases where groups made specific proposals for changing phrasing or detailed content of the policy or summit declarations, these changes were not subsequently made.

Table 4.17: Engagement with draft documents in breakaway groups

Group*		**Engagement with policy**		**Engagement with summit declaration**	
	% of total document engagement talk	**Policy refs (% of total)**	**Description of extent of engagement with draft policy**	**Summit decl. refs (% of total)**	**Description of extent of engagement with draft summit declaration**
8	18.05%	40%	Direct detailed engagement with during discussions	60%	Direct detailed engagement with during discussions
9	7.13%	0%	No reference to or direct engagement with during discussions	100%	Direct detailed engagement with during discussions
3	6.03%	58%	Direct engagement	42%	Direct engagement with
1	4.86%	42%	Direct detailed engagement; framed presentation and discussion around this	58%	Referred to briefly at end
2	2.22%	17%	Referred to in instructions only	83%	Referred to in instructions only
10	1.29%	100%	Referred to in instructions only	0%	No reference to or direct engagement during discussions
7	0.35%	0%	No reference to or direct engagement with during discussions	100%	Referred to in instructions only
6	0.34%	0%	No reference to or direct engagement with during discussions	100%	Referred to in instructions only
4	0%	0%	Instructions unknown; no direct engagement during discussions	0%	Instructions unknown; no direct engagement during discussions
5	0%	0%	Instructions unknown; no direct engagement during discussions	0%	Instructions unknown; no direct engagement during discussions

* Corresponding breakaway group topics: 1. Prevention & promotion. 2. Research & surveillance. 3. Mental health systems. 4. Infrastructure & human resources. 5. Mental health & other conditions. 6. Mental Health Care Act. 7. Child & adolescent mental health. 8. Culture & mental health. 9. Suicide prevention. 10. Advocacy & user participation

4.5.3.2 Formulation of recommendations in breakaway group sessions

Group discussions were coded for talk referring to the need to formulate recommendations for reporting back in various forums (e.g. plenary session, closed door meeting with organisers). These findings are shown in Table 4.18. Two aspects of the group talk relating to recommendations were coded: i) an awareness of needing to formulate recommendations, including of needing to phrase proposals in particular ways in order to facilitate this, and ii) references to the process through which recommendations would be or were being formulated during group discussions. The total proportion of group talk that referred to formulation of recommendations generally is presented in column 2 of Table 4.18. Groups are listed in the table from the group with the highest proportion of explicit recommendation references (Group 8: 4.62%) to the group with the smallest proportion (Group 1: 0.08%).

The proportion of the total recommendation-related talk relating to *awareness* of needing to ensure that recommendations were formulated is presented in the third column of Table 4.18, while the proportion of total recommendation-related talk that referred to *processes* for formulating these recommendations is shown in the fifth column. Qualitative examples of references showing awareness of the need to formulate recommendations are included in column 4. In the final column of Table 4.18, a brief description is provided about the process through which each group seemed to formulate their recommendations.

Table 4.18: Formulation of recommendations in breakaway groups

Group*	**Total refs to formulating recommendations**	**Awareness of need to formulate recommendations**		**Process through which recommendations would be or were being formulated**	
	Total refs to formulating recommendations	Awareness of need to formulate	Comments demonstrating awareness of need to formulate recommendations	Process for formulating refs (% of total)	Description of process of getting to recommendations
8	4.62%	56%	Obviously, we will not have a shopping list that would be a hundred demands. We will need to come up with a very limited number of issues. (Speaker 1)	44%	Direct engagement with wording of draft documents and suggested changes, which formed basis for recommendations
3	3.16%	19%	I first want a solution. Nobody's going to talk unless they talk about what's the target. Alright? (Speaker 1)	81%	Participants put forward recommendations on paper; Chair took majority and directed discussion on formulating recommendations
10	3.12%	25%	Just to remind you and those that joined us later, tomorrow's very outcomes based for us to give input into this policy. How are we going to make advocacy a reality? (Speaker 1)	75%	Broke into four small groups to discuss recommendations proposed by Chair; small group discussions not audio recorded
7	2.93%	50%	I understand that this session, what we need to do is to try to add to the points that you've made with some specific targets that the Department of Health can adopt. (Speaker 9)	50%	Formulated during second half of session by rapporteur, with input from participants
9	2.07%	18%	(Name of organiser) just said to us yesterday that please, when we come with those proposals, they must be reasonable, they must be achievable; it mustn't be completely bizarre. (Speaker 1)	82%	Formulated during second half of session by Chair, with inputs from one or two participants
6	1.65%	35%	I think that what would be very important for the summit would be to be able to move away from the summit with some key proposals that came from this group in terms of achievable and realistic objectives that could be implemented. (Speaker 3)	65%	Formulation of recommendations began at start of discussions and continued throughout

Table 4.18 continued: Formulation of recommendations in breakaway groups

Group*	Total refs to formulating recommendations	Awareness of need to formulate recommendations		Process through which recommendations would be or were being formulated	
	Total refs to formulating recommendations	Awareness of need to formulate	Comments demonstrating awareness of need to formulate recommendations	Process for formulating refs (% of total)	Description of process of getting to recommendations
5	1.25%	63%	Going forward the rest of this time, we actually need to come up with targets in terms of what we want to achieve in terms of mental health management of chronic diseases. (Speaker 2)	37%	Chair proposed five major recommendation categories; directed discussion to formulate specific recommendations around these
4	1.18%	34%	Please ask yourself, are your comments taking us forward into resolution to possible ideas? (Speaker 2)	66%	Pieces of paper collected ad hoc
2	0.81%	100%	Just keeping in mind that we have to have something concrete to feedback at the plenary … declarations rather than a wish list because I think it just won't happen. (Speaker 3)	0%	Formulation of recommendations at end
1	0.08%	100%	So we should definitely add something to that. Can you formulate something then? (Speaker 1)	0%	No explicit formulation of recommendations

* Corresponding breakaway group topics: 1. Prevention & promotion. 2. Research & surveillance. 3. Mental health systems. 4. Infrastructure & human resources. 5. Mental health & other conditions. 6. Mental Health Care Act. 7. Child & adolescent mental health. 8. Culture & mental health. 9. Suicide prevention. 10. Advocacy & user participation

Although all groups made some explicit reference to the need to formulate recommendations, and the process for doing so, there was again a fair amount of variation across groups in terms of the extent to which such references were made. Group 8 (culture & mental health: 4.62%) was again the group with the highest proportion of references to recommendation formulation in relation to total group talk, with an almost equal balance within this between references showing awareness of needing to formulate recommendations (56%) or reference to the process through which this should be achieved (44%).

As had been the case with the smallest proportion of explicit references to time availability discussed earlier, Group 1 also demonstrated the smallest proportion of explicit references to needing to formulate recommendations, or processes for doing so. This is worth noting in terms of the influence it may have had on enabling both opportunities for enactment and for inscription. Group 1's process was notable in the sense that there were fewer 'process-related' references than in any other group. This resulted in the discussions having a quality of fluidity and more 'natural' conversation, with greater interaction between participants. However, as a result of the absence of explicit cues regarding process, it was not possible to determine the process that was followed – whether systematic or ad hoc – for formulating or capturing recommendations, or for checking these recommendations with group members prior to reporting them back at the plenary session.

Perhaps unsurprisingly, the two groups that deviated somewhat from the microphone management format when it came to formulating their recommendations, engaged in the highest proportion of references to process for formulating recommendations compared to other groups (Group 3: 81%; Group 10: 75%). The Chair of Group 3 (mental health systems) asked group participants to write their two priorities for recommendations on pieces of paper, which were collected and counted; those priority issues with the most amount of 'votes' were carried forward and discussed as the group's recommendations. Group 10 (advocacy & user participation) broke up into four smaller groups (for which there were no audio recordings) to discuss major categories of recommendations, and then reconvened as a larger group to report back on these. These more 'unusual' processes for formulating recommendations could explain the higher proportions of explicit references to such processes in these two groups.

4.5.3.3 Inscription of recommendations in breakaway group sessions

The way in which recommendations were actually captured (inscribed) during the breakaway groups is summarised in Table 4.19. A brief description of the role of the group rapporteurs is included in the second column. This documents the extent to which rapporteurs could be heard explicitly engaging with participants and their inputs during group discussions, as well as how active they appeared to be during the formulation of group recommendations. In the third column of Table 4.19, the form or format that the inscription of the recommendations took is described, as far as this could be determined from the group discussions. The fourth and fifth columns indicate, respectively, the number of recommendations made by each group, and the proportion that these comprised of the total recommendations made by all groups. The groups are listed in top-down order from the group with the largest number of recommendations (Group 4: n = 27), to the groups with the smallest number of recommendations (Groups 3 and 9: n=5).

In only two breakaway groups (Group 6: Mental Health Care Act, and Group 10: Advocacy & user participation) were the group rapporteurs active (vocally) during group discussions, playing a role in clarifying inputs and in a sense acting as co-facilitators with the Chairs. In some groups, rapporteurs remained mostly silent during group discussions, but became vocal and active during formulation of recommendations (Groups 4, 7, and 8), while in other groups, rapporteurs were completely silent (Groups 1, 3, and 5), such that their role in capturing or checking back in with group members about recommendations could not be established. In these latter groups, it seems that the Chairs took on a more active role in capturing discussions and recommendations.

As has been noted previously, the number of recommendations put forward by each group varied substantially, from 27 (Group 4: Infrastructure & human resources), to 5 (Group 3: Mental health systems, and Group 9: Suicide prevention). Interestingly, there does not seem to be any particular correspondence between the number of recommendations and the form or format in which these recommendations were captured during group sessions. In some cases, rapporteurs gave oral retrospective report backs on the notes and recommendations that they had captured; in other groups, recommendations were captured in real-time as they were being formulated. In these latter groups, projecting what was being captured onto a screen for all group members to see and read seemed to be an effective way of increasing opportunities for more participants to engage directly in formulating recommendations. In a sense, then, these projections of inscriptions served as something of a boundary object, which facilitated co-production of knowledge. This will be elaborated on further in the discussion chapter.

Table 4.19: Inscription of recommendations in breakaway groups

Group*	Role of rapporteur	Format of inscription	Number of group recommend.	% of total number
4	Feedback on notes made at various points in process; active in formulation of recommendations	Captured onto PowerPoint slides before and during formulation; shown on screen during formulation of recommendations	27	20%
10	Active during discussions; individual rapporteurs from small groups reported back	Oral report back of presentations and comments on these; oral report back of recommendations from small groups by small group rapporteurs	21	15%
7	Silent during discussion; active during formulation of recommendations	Oral report back by rapporteur	17	13%
5	Silent	Unknown; no report back	16	12%
6	Active during discussion, clarifying, and capturing	Captured and projected onto screen during discussion and formulation of recommendations	15 (only 4 in plenary)	11%
1	Silent; no checking back in	Unknown; no report back	12	9%
2	Unknown	Captured onto PowerPoint slides; shown on screen during formulation	9	7%
8	Active during engagement with documents and formulation of recommendations	Oral report back by rapporteur	9	7%
3	Silent	Written down by Chair/ rapporteur during formulation	5	4%
9	Silent until oral report back of notes made during discussions	Oral report back on discussions by rapporteur; captured by Chair on board at front of room during formulation of recommendations while rapporteur typed	5	4%

* Corresponding breakaway group topics: 1. Prevention & promotion. 2. Research & surveillance. 3. Mental health systems. 4. Infrastructure & human resources. 5. Mental health & other conditions. 6. Mental Health Care Act. 7. Child & adolescent mental health. 8. Culture & mental health. 9. Suicide prevention. 10. Advocacy & user participation

The next section will consider the extent to which the inscribed recommendations that were put forward by the groups at the plenary session reflected the inputs made during group discussions.

4.5.4 Enacted knowledge inscribed: Conclusions

Each of the ten breakaway groups at the national mental health summit put forward a number of recommendations at the plenary session and, apparently, in a closed-door meeting with the summit organisers. The processes through which the groups arrived at their recommendations varied significantly and were somewhat determined by the way in which group Chairs structured and facilitated the group sessions. The availability and quality of audio recordings of these group sessions also varied, with four of the groups having recordings of very poor audibility, making inputs and process difficult to follow.

Some groups spent the majority of their group sessions on the formal presentations and discussions around these; others chose to allocate less time to presentations and more to group discussions and formulation of recommendations. Groups spent a minimum of one hour and 22 minutes and a maximum of two hours and 33 minutes on group discussions. The degree of direct engagement with the draft policy document and with the draft summit declaration also differed between groups. Only one group engaged directly with both documents throughout the group discussions; the document most engaged with (by four of the ten groups) was the draft summit declaration.

Each group had a Chair and a rapporteur and was structured as a large meeting: discussions rotated between participants by way of a microphone, such that participants took turns in raising points or making comments on previous points. This kind of format may have been appropriate in managing a large amount of input from a large number of people, but it did have implications for how enabling the consultation space was of interaction and co-creation of new knowledge. In many cases, the discussions were therefore somewhat stilted, with 'microphone movement' gaps between statements and little continuous follow-on from one point made to another. There was also the sense that participants had to limit their inputs due to time pressures, and the mandate for the groups to come up with a number of concrete recommendations meant that much of the talk was focused more on formulating recommendations than on engaging with the policy document or with one another. This might have impacted on opportunities for embodied knowledge to engage with inscribed knowledge and be transformed into enacted knowledge, as well as on the content of enacted knowledge generated in these group discussions.

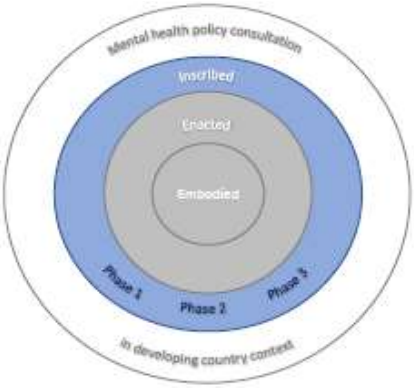
Chairing style varied across the groups, ranging from active facilitation and consistent summarisation or reframing, to inactive microphone management. One group chose to break up into smaller groups

to formulate recommendations around identified themes; another group engaged in an anonymous vote to identify priorities for recommendations. Rapporteurs appeared to be predominantly silent, with most reporting back what they had captured towards the end of the group sessions. Much of what was captured during group discussions and formulated as recommendations was dependent on the Chair and/or the rapporteur. Groups also differed regarding the extent to which group participants had the opportunity to confirm or co-formulate group recommendations. The number of recommendations put forward by the groups at the plenary session varied from four to 22.

The particular format followed in the breakaway group sessions was may have been driven, in part, by pragmatic considerations, and in part by conventionality. From this analysis, there are some indications that this format may have constrained the movement of embodied to enacted knowledge, in particular, with much of the focus being on moving enacted knowledge into inscribed knowledge. While this may have resulted in an effective outcome in terms of producing a number of recommendations, there is likely to have been less opportunity for knowledge exchange between participants, or for the co-creation of new embodied knowledge in the enacted space. In terms of the legitimacy of the process, therefore, there seems to have been an implicit focus on *effectiveness* at the expense of *inclusivity* (participation).

There are limits, however, in terms of assessing whether these group processes related to observed changes in the subsequent outputs, such as the summit declaration recommendations and the final policy. Even where a process was deemed to have been effective, this may not have resulted in uptake of recommendations into policy which, as previously discussed, would have been determined by a number of factors beyond the consultation group sessions. Nonetheless, what this analysis does provide is some insight regarding how enacted knowledge was transformed into inscribed knowledge during the group discussions. Once this inscribed knowledge left the group space, it was then subject to a range of other processes and influences determining whether it ended up being used or reflected in policy. The focus of the analysis now turns to the inscribed knowledge form in which knowledge left the enacted group spaces, and to how inscribed knowledge subsequently moved through summit outputs.

4.6 Inscribed knowledge transferred



The previous analyses have considered how embodied knowledge was enacted at the consultation summit, and how group processes may have enabled or constrained this enactment and the transfer of knowledge from enacted to inscribed forms. While embodied knowledge is contained within individuals and enacted knowledge is visible only fleetingly during interaction, inscribed knowledge is the form that can be transferred most easily beyond the individual and enacted spaces. Inscribed knowledge, regardless of how well it captures enacted knowledge, is also the only record of this knowledge to which policymakers, who may not have been present during discussions, have access. Inscribed knowledge is thus an important form of knowledge at policy consultation processes.

This section presents findings from the analysis of how inscribed knowledge moved, through points of increasing summarisation or abstraction during the consultation process, to summit and policy outputs. It is important to note that no direct causal links can be made between recommendations put forward at the consultation and corresponding changes to policy outputs identified during this analysis. A change to policy content may have been the result of several factors, including decisions made by the technical task team during finalisation of the policy. The fact that these changes may have been aligned with recommendations made during the consultation summit could reflect the importance of the issue, for example, as opposed to being a direct result of particular consultation recommendations. Stronger conclusions can be drawn where policy changes do *not* reflect recommendations put forward at the summit, because this implies that additional information that was proposed during the consultation process did not get followed through or taken up following the summit. The discussion chapter will explore possible reasons for why this may have been the case.

A common trend that emerges in the following analysis is that much valuable detail is lost as knowledge moves through each point of abstraction. Although somewhat inevitable in policy development, this highlights the tension between formulating a policy document that is general enough to apply across multiple contexts, while attending to participants' contextually located embodied knowledge during consultation.

This section includes findings from three phases of analysis, each presented in separate subsections. Phase 1 (subsection 4.6.1) traced inscribed knowledge from the provincial to the national summits. The second phase (subsection 4.6.2) focused on the transfer of inscribed knowledge from group discussions to summit and policy outputs. The third and final phase (subsection 4.6.3) traced the transfer of inscribed knowledge in the summit declaration recommendations into policy outputs.

As described in the methodology chapter (Chapter 3, section 3.7.3.5), detailed analyses were conducted across these three phases, identifying and describing follow-through and summarisation of inputs across each breakaway group and relevant topic. This was a necessary step in the analysis in terms of identifying how detailed inputs were summarised or abstracted at each point of inscription and transfer. The fine-grained analyses for each phase discussed in this section are in Appendices 8 and 9; these are referenced at relevant points in the subsections below. In this section, the findings that emerged from these analyses and that are most pertinent to the aim of the study, are presented.

4.6.1 Phase 1: Transfer of inscribed knowledge from provincial to national summits

This subsection focuses on the points of inscription of inputs from the provincial consultation summits to the national consultation summit. In particular, the analysis was concerned with the potential for follow-through of inscribed knowledge inputs from these consultation events (where such information was available), identifying points where these inputs would, by necessity, have been summarised and inscribed into recommendations. Figure 4.12 below shows the points of abstraction and transfer of inscribed knowledge at and beyond the provincial summits. In this phase, the recommendations from the provincial summits were also compared with the final declaration recommendations from the national summit, in order to assess the extent to which these national recommendations reflected the recommendations made at local levels. The steps followed in this phase of the analysis are shown as blocks on the far-left of Figure 4.12, with arrows indicating the chronology of these steps. The concentric analytical framework diagram is included at the bottom left of Figure 4.12, as a reference point showing the link between Phase 1 of the analysis and the overall analytical framework.

The process through which provincial summit records were obtained was described in the methodology chapter. It is worth drawing attention again here to the inconsistencies in the

availability of this information in terms of the access that different provinces provided, as well as the form that these records took. The data collection process, then, already suggested that processes for capturing and transferring inputs from provincial summits through to national level were not systematic. It also demonstrated a lack of transparency and feedback regarding the policy consultation process. These issues are documented in detail in the published paper that is linked to this study (Marais et al., 2017), included as Appendix 3.

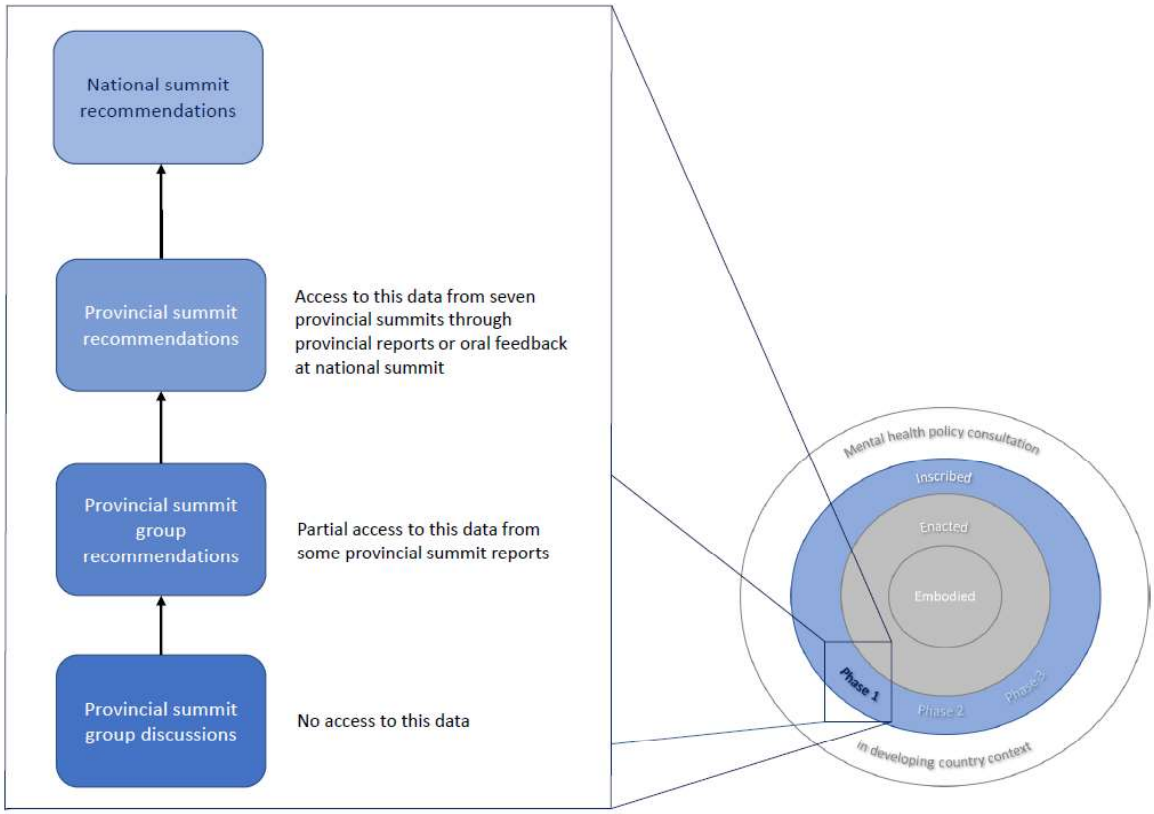


Figure 4.12: Abstraction and transfer of inscribed knowledge at the provincial summits

4.6.1.1 First point of inscription: Provincial summits to provincial reports

The draft mental health policy document was available for review and input at the provincial mental health summits. The format of the provincial summits seems to have been similar to the national summit in terms of the major themes that were on the programme for consideration and the breakaway group sessions. There was variation across provinces, however, with respect to the number and topics of the breakaway group sessions. There would presumably have been report backs from the breakaway groups to the provincial plenaries which, as at the national summit, would be a summary of the group discussions, formulated as recommendations. It was not possible to determine this conclusively due to the aforementioned inconsistences in availability of records from

these summits. Deliberations at these provincial summits were thus summarised in some way to allow for the inscribed reports to be generated – once from group discussions to group recommendations, and then again to compile the provincial summit report. However, some provinces also captured the more detailed group recommendations in their summit reports, either as appendices or within the narrative body of the report.

4.6.1.2 Second point of inscription: Provincial reports to national summit

One province – the Northern Cape – did not hold a provincial summit. Out of the eight (of nine) provinces that held mental health consultation summits, only three gave feedback at the national summit. It was thus difficult to determine whether or how the information and recommendations from the provincial health summits were followed through into the national summit and recommendations, due to a lack of consistent information from these provincial summits. However, with recommendations available in some form from all but one of the provincial summits, it was possible to conduct a comparative documentary analysis of these provincial recommendations with the final national summit declaration recommendations. This was done to determine alignment between the recommendations put forward by each of the provinces with those put forward at the national summit. Ultimately, all of these recommendations would have needed to be consolidated and prioritised for consideration during finalisation of the mental health policy. It was thus of interest to identify whether and how issues prioritised at the provincial summits aligned with those prioritised in the final summit declaration – the official output of the national consultation summit.

As discussed above, the form and availability of the provincial summit reports varied substantially. It was therefore not possible to determine whether or how these reports were used in finalising the draft policy, or in identifying priorities for the implementation plan, although it might be fair to assume that the reports were sent to the national DoH following the provincial summits. The three provinces (Gauteng, Limpopo, and Mpumalanga) that gave oral feedback at the national summit session did not send summit reports upon our request, so it was not possible to determine whether the oral feedback was a comprehensive or summarised version of what was contained in those reports. However, with the oral feedback from these three provinces and the provincial summit reports we received from another four provinces (Free State, KwaZulu-Natal, North West, and KwaZulu-Natal), it was possible to extract recommendations from seven of the eight provincial summits that were held prior to the national summit. The recommendations from the provincial summits are presented in Appendix 10.

Recommendations from each provincial summit were compared with the corresponding national summit declaration recommendations for consideration of the alignment of provincial summit resolutions with national summit resolutions. In order to conduct this comparison, the resolutions from provincial reports were re-categorised to fall under each of the ten themes of the breakaway group sessions at the national summit, which were also used to code the recommendations on the national summit declaration. The topic "human resources and infrastructure" was split into two themes in order to differentiate recommendations made regarding each of these issues.

Table 4.20 depicts the alignment of provincial summit recommendations with national summit declaration recommendations. Each column shows the alignment of recommendations per province. Reading across each row shows the relative alignment of provincial recommendations with national recommendations for each topic. The provincial summit recommendations were coded according to how they were reflected in the national summit declaration recommendations as: i) mostly reflected; ii) broadly or partially reflected; or iii) not reflected. In cases where no recommendations were made by a province regarding a particular theme, this was coded as such (no recommendations). For ease of reference, these categories are colour coded in Table 4.20: dark blue for mostly reflected, light blue for broadly or partially reflected, and grey for not reflected.

It should be noted that while the provincial recommendations were generally quite detailed, the summit declaration recommendations were fairly broadly phrased. As such, it was not difficult to identify broad or partial alignment according to the correspondence in topics, but in most cases, the detail of the provincial recommendations was not captured in the national summit recommendations. In general, provincial summit recommendations tended to be more focused on more specific on-the-ground details than national summit declaration recommendations. At this level 'transfer' from one inscribed knowledge output to the next, there was a degree of summarisation in which some of the detail from provincial recommendations was abstracted out in the national summit recommendations. Notwithstanding the inconsistencies in whether provincial summit outputs were incorporated into national summit outputs, the national-level recommendations represented a substantially abstracted version of the recommendations that had been put forward by provinces. The implications of this disconnect for policy implementation are considered in the discussion chapter.

Table 4.20: Alignment of provincial summit recommendations with national summit declaration recommendations

	Free State	Gauteng*	KwaZulu-Natal	Limpopo*	Mpumalanga*	North West	Western Cape
Prevention & promotion	No recommendations	Broadly or partially reflected	No recommendations	No recommendations	Broadly or partially reflected	No recommendations	Broadly or partially reflected
Research & surveillance	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected
Mental health systems	Broadly or partially reflected	Mostly reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected
Human resources	Broadly or partially reflected	Broadly or partially reflected	Mostly reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	No recommendations
Infrastructure	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Mostly reflected	Broadly or partially reflected	Mostly reflected
Mental health & other conditions	No recommendations	No recommendations	No recommendations	No recommendations	Mostly reflected	No recommendations	No recommendations
Mental Health Care Act	Broadly or partially reflected	Broadly or partially reflected	Mostly reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected
Child & adolescent	Not reflected	Not reflected	Not reflected	Not reflected	Not reflected	Not reflected	Not reflected
Culture & mental health	No recommendations	No recommendations	No recommendations	Broadly or partially reflected	Broadly or partially reflected	Broadly or partially reflected	No recommendations
Suicide prevention	No recommendations	No recommendations	No recommendations	Not reflected	Broadly or partially reflected	No recommendations	No recommendations
Advocacy & user participation	Not reflected	Broadly or partially reflected	Broadly or partially reflected	Not reflected	No recommendations	Not reflected	Broadly or partially reflected

Key

Mostly reflected | Broadly or partially reflected | Not reflected

* Oral feedback given at national summit

As seen in Table 4.20, most of the recommendations that were put forward from provincial summits were broadly or partially reflected in the national summit declaration recommendations. Two notable exceptions were recommendations relating to child and adolescent mental health, and advocacy and user participation. No recommendations regarding child and adolescent mental health were included in the national summit declaration, so any provincial recommendations made in this regard were not reflected – and all provinces made recommendations relating to this issue. The recommendations made by the Free State, Limpopo and North West provinces relating to advocacy and user participation were also considered not to have been captured in the broad summit declaration recommendations. Only two of the seven provinces put forward specific recommendations regarding suicide prevention: Limpopo's recommendations were not reflected in the national declaration recommendations, while Mpumalanga's were broadly or partially reflected.

In some cases, there were no provincial recommendations relating to themes for which recommendations were put forward in the national summit declaration. Perhaps most notable were the lack of recommendations put forward by the majority of provinces regarding prevention and promotion, culture and mental health, and suicide prevention. These themes were nonetheless reflected in recommendations made in the national summit declaration. On the other hand, the provincial recommendations that may have related to mental health and other conditions were generally incorporated into other themes or topics, thus accounting for the apparent lack of provincial recommendations regarding this theme in Table 4.20.

In only a handful of cases were provincial recommendations considered to be *mostly* reflected in the national summit declaration recommendations: for Gauteng's mental health system recommendations; KwaZulu-Natal's recommendations on human resources and the Mental Health Care Act; Mpumalanga's recommendations relating to infrastructure, and mental health and other conditions; and the Western Cape's recommendations regarding infrastructure. There did not seem to be any particular patterns with regard to provinces that presented oral feedback at the national summit (Gauteng, Limpopo, and Mpumalanga) and the reflection of provincial recommendations in the national summit declaration recommendations.

Three further points are worth noting here. The first is that all provinces in some way endorsed or advocated for the integration of mental health into primary health care. This was consistent with the emphasis on integration at the national summit. However, only one province (KwaZulu-Natal) recommended that this be achieved through the establishment of district specialist mental health teams. Not only was this one of the eleven recommendations that were included on the national summit declaration, as will be seen later, it was also explicitly identified as an implementation priority

on the eight-point Strategic Plan (implementation plan) added to the policy after the summit. There are indications that the establishment of the district teams is one of the major stumbling blocks in implementing the policy at provincial level (Burgess, 2016). Conversely, child and adolescent mental health was flagged as a priority in all of the provincial summit reports. However, this issue was not included as a recommendation on the national summit declaration, nor was it mentioned in subsequent implementation priorities and activities outlined in the policy.

4.6.1.3 Third point of inscription: National summit group discussions to group recommendations

At the national mental health summit, participants in the breakaway group sessions were asked to deliberate on ten pertinent issues relating to mental health in breakaway group sessions. Each of these groups formulated recommendations that were presented to the whole summit audience at the plenary. It was arguably necessary that the level of detail contained in group discussions would need to be abstracted into inscribed recommendations that would be appropriate as policy proposals. Analysis of the reflection of group discussions in the group recommendations is presented in subsection 4.6.2.1 below.

4.6.1.4 Fourth point of inscription: National group recommendations to summit declaration

The recommendations from the ten breakaway groups were presented back to the plenary and, it seems, in a closed-door meeting with the summit organisers from the national DoH. From these group recommendations, recommendations were added to the summit declaration, which was the official output from the national mental health summit. Of the 125 recommendations made by the ten breakaway groups at the national summit plenary, eleven recommendations were included on the summit declaration. There was thus substantial summarisation from the group recommendations to the summit declaration recommendations. Analysis of the reflection of the group recommendations in the final summit (declaration) recommendations is presented in subsection 4.6.2.1 below.

4.6.1.5 Fifth point of inscription: Summit declaration to final policy and implementation plan

Following the national mental health summit, a task team was convened to finalise the mental health policy based on inputs from the consultation process. The task team comprised individuals who had been part of the organising committee for the national summit. According to the policy document, this task team worked on “further selection of key activities … from the long list of priorities that the summit adopted” (Department of Health, 2013, p. 4). It seems likely, then, that the task team considered not only the summit declaration but the group recommendations as well in their deliberations around

finalising the policy and drafting the implementation plan. A footnote on the eight-point implementation plan states that it was informed by inputs from the national mental health summit.

In summary, eight provincial consultation summits were held prior to the national consultation summit in April 2012. Knowledge inputs at each of these summits moved from detailed group discussions to group recommendations, which likely reflected a summarised version of these participant inputs in inscribed form. These group recommendations were subsequently summarised and captured in provincial summit reports. The process of transferring these reports from provincial summits to either the national summit or the national DoH for consideration in policy development is not clear; it certainly seems to have been not systematic. Only three provinces presented oral feedback at the national consultation summit. It is evident from this analysis that, although the provincial recommendations were mostly represented by *theme* in the national summit declaration recommendations, much of the detail of the provincial recommendations was lost – or abstracted out – in the more broadly phrased national recommendations.

At the national consultation summit, a similar process of summarisation of knowledge inputs occurred as recommendations were transferred from group level to final summit reporting (declaration) level. The detailed group recommendations were substantially reduced and summarised in the national summit recommendations. At each point of inscription, then, as knowledge inputs were moved through the consultation process, a significant amount of detail seems to have been lost in the abstraction of detailed recommendations into more broadly summarised recommendations. In addition, at each point of inscription, the only information available was that which had been inscribed at previous points, rather than the more detailed inputs or inscriptions on which these summarised forms were based. This has implications for the manner in which inscribed knowledge is captured, including decisions about what gets captured at each point. The extent to which the inscribed knowledge at each subsequent level of abstraction captured the proposals put forward by individuals and groups at the national summit is explored further in the subsections below.

4.6.2 Phase 2: Transfer of inscribed knowledge from national summit group sessions

Phase 2 of the analysis focused on the transfer of inscribed knowledge from the group discussions to the group recommendations, and from the group recommendations to summit and policy outputs. This analysis was conducted in five steps, as shown in Figure 4.13. The main findings are presented here; detailed analyses of how particular issues from particular groups moved through inscription points have been included as appendices and are referenced at relevant points in the subsections below.

The five steps in Phase 2 of the analysis are shown as blocks on the left-hand side of Figure 4.13. Arrows between these blocks depict the chronology of the analysis. The concentric analytical framework diagram is included at the bottom right of Figure 4.13 as a reference point, showing the link between Phase 2 of the analysis and the overall analytical framework.

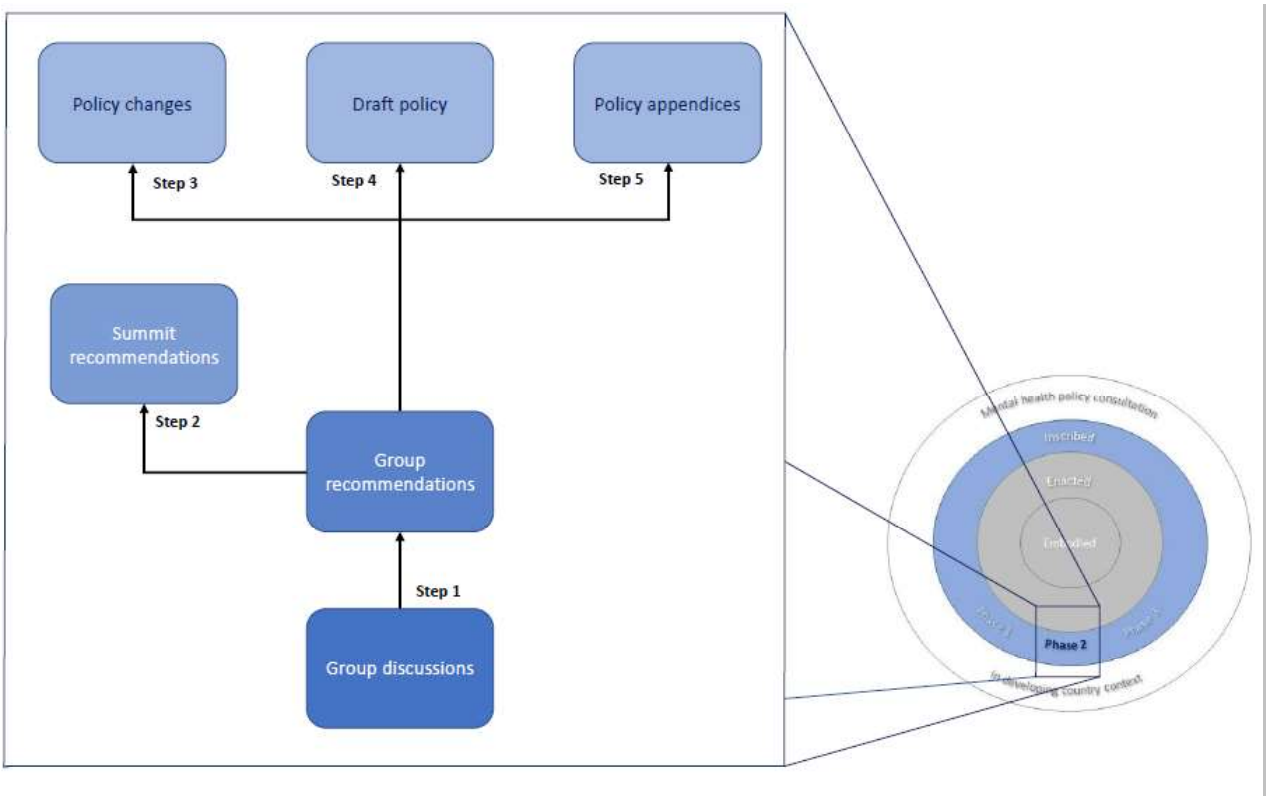


Figure 4.13: Abstraction and transfer of inscribed knowledge from national summit group sessions

4.6.2.1 Reflection of group discussions in group and summit recommendations

This subsection presents the results of a comparative analysis of follow-through of group discussion content to group recommendations, and from group recommendations to final summit recommendations, to establish if and how knowledge inputs moved from group discussions to group

and summit recommendations. As such, the findings presented in this subsection comprise both steps 1 and step 2 as shown in Figure 4.13.

It is important to note the following about coding in these two steps: the comparative analysis was conducted *within* group topics. In other words, the recommendations from each separate group were compared with the discussions from within the corresponding group. Similarly, the recommendations from each separate group (i.e. rather than across mental health content *themes*) were compared with the summit recommendations. This was to allow for an analysis of how knowledge moved into inscribed forms from within each breakaway group session specifically. In the subsequent steps of analysis, as will be explained below, the discussions from the separate breakaway groups were collapsed and comparisons then done across mental health content *themes* to enable tracing of this content across documents. The detailed recommendations put forward by each group at the national summit are included in Appendix 11.

A note about the summit declaration recommendations: a draft of this document was available at the start of the national summit, with a number of broadly stated recommendations included. These are referred to subsequently as *pre*-summit recommendations, where relevant. From the ways in which this draft document was discussed in the group sessions, the summit declaration seems to have been drafted up to the point of "*And consequently to* …", prior to the summit, and groups were asked to fill in their recommendations in this final section. The only parts of the summit declaration that therefore seemed to actually come directly out of the summit discussions are those that are phrased in the future tense; the rest appears to have already been written prior to the summit, up to and including the "*Hereby commit to* …" section.

Eleven recommendations were added to the declaration following the national summit. These could thus be more plausibly linked to inputs made at the national summit, and are referred to as *post*-summit recommendations. Given that each of these eleven post-summit recommendations correspond to a breakaway group topic for almost all the breakaway groups at the national summit, it seems as though one broad recommendation was included for each breakaway group, with the exception of child and adolescent mental health, and advocacy and user participation.

The analysis of follow-through from group discussions to group recommendations and from group recommendations to summit declaration recommendations is shown in summarised form in Table 4.21. The reflection of group discussions in group recommendations, and of group recommendations in summit declaration recommendations, was coded as: i) comprehensively reflected; ii) partially reflected; and iii) not reflected at all. Coding definitions can be found in the coding framework in Appendix 4. A

descriptive analysis of the alignment of group discussions with group recommendations, and of group recommendations with summit recommendations, is included as Appendix 12.

In general, the group recommendations presented at the plenary largely seemed to at least partially reflect group discussions, with the exception of recommendations on the Mental Health Care Act. As mentioned earlier, only four of the stated 15 recommendations from this group were reported back at the summit plenary. In most cases, these group recommendations were a partial reflection of the group discussions, in the sense that (inevitably) some of the detail of the discussions was not captured in the recommendations.

Table 4.21: Reflection of group discussions in group recommendations and group recommendations in summit recommendations

	Group	**Group recommendations reflect group discussions**	**Summit recommendations reflect group recommendations**
1	Prevention & promotion	Comprehensively	Partially
2	Research & surveillance	Partially	Partially
3	Mental health systems	Partially	Comprehensively
4	Human resources	Comprehensively	Partially
	Infrastructure	Comprehensively	Partially
5	Mental health & other conditions	Comprehensively	Partially
6	Mental Health Care Act	Not at all	Partially
7	Child & adolescent mental health	Partially	Not at all
8	Culture & mental health	Partially	Partially
9	Suicide prevention	Partially	Partially
10	Advocacy & user participation	Partially	Not at all

A total of 125 recommendations were put forward by the ten breakaway groups at the national summit. From this, eleven recommendations were added to the final summit declaration that was read out at the plenary session at the end of the summit. No information was available regarding the criteria used for prioritising group recommendations or decisions made about which of these recommendations to include in or as summit recommendations. Generally, the eleven summit recommendations seemed to partially but broadly reflect the group recommendations. Again, much of the detail of the group recommendations was lost at this point. The summit declaration recommendations roughly reflected the *themes* of eight of the ten breakaway groups, suggesting that the prioritisation of these issues for discussion at the national summit was mirrored by their prioritisation in the final summit declaration. Child and adolescent mental health was not specifically referenced in the final summit recommendations, nor was advocacy and user participation.

Viewed in light of the findings from the previous section on group processes, these findings have some implications about the way in which enacted knowledge was transferred to inscribed knowledge at the consultation summit. There was much variation in group process across the groups, in terms of the amount of time they dedicated to presentations versus discussions, the number of recommendations put forward, and the ways in which they reached these recommendations. Many of the groups seemed to follow a somewhat ad hoc process in formulating their recommendations, and yet the analysis presented here shows that most of the groups' recommendations largely reflected their discussions, which suggests that this may also have been somewhat ad hoc, or fortuitous. The fact that all of the groups followed a 'one microphone-one speaker' format seems to have limited the number of 'voices' that could be involved during the formulation of recommendations, which frequently entailed a back-and-forth between a handful of people. Opportunities to speak would have been somewhat dependent on the manner in which the Chair facilitated the session; similarly, what got captured during these discussions would have depended on the person doing the capturing (rapporteur). This highlights the importance of individual-level influences on these processes.

The summarisation of the 125 group recommendations into eleven summit declaration recommendations implies that across all groups, regardless of process followed or number of recommendations made, only one broad recommendation was likely to be 'selected' per group for inclusion in the final summit recommendations. As mentioned above, no information was available regarding the basis on which these decisions were made. Which of the group recommendations per group got prioritised was likely the result of a range of factors, not least of which would have been the influence of the people attending the closed-door meeting where the summit declaration recommendations were finalised.

It may also be that the summit recommendations mostly reflected group recommendations, albeit on an abstracted level, because most of the groups engaged in some way with the summit declaration document when drafting their recommendations. There was much less direct engagement, however, with the draft policy. It is therefore possible that the changes made to the policy following the summit may not be related to the recommendations made by the groups (which related primarily to the summit declaration). This possibility is explored in the next subsection.

4.6.2.2 Reflection of group recommendations in policy changes

The findings from the preliminary comparative analysis of the draft and final policies presented in section 4.2 indicated that few substantive changes were made to the policy document that was finalised by the task team following the consultation summits. However, it is possible that the recommendations

put forward at the national summit may have informed those changes that *were* made to the policy. In this subsection, breakaway group recommendations are thus compared with these policy changes.

During the breakaway group discussions at the national summit, some of the groups engaged directly with the draft policy document. In some cases, these discussions focused specifically on terms or phrases used in the policy, suggesting additions or changes. This level of detailed engagement and feedback was not captured in the group recommendations presented at the plenary session which, arguably out of necessity, represented a prioritised and summarised list of suggestions made during the group discussions. It is unlikely that the technical task team appointed to finalise the policy following the summit would have had access to records of group discussions (the audio recordings of the summit, for example), unless individual members of this task team participated in particular breakaway groups. These in-group recommendations would thus not likely have resulted in micro-level changes to the policy. Nevertheless, the group recommendations that did form part of the plenary feedback were greater in number and in detail than the recommendations that were ultimately included in the summit declaration.

For the purposes of this and other analyses going forward, the recommendations made by the groups at the national summit were re-categorised according to the themes to which they most corresponded, as opposed to the topic of the specific breakaway group in which they were made. The codes for these themes were presented and described in section 3.7.3 of Chapter 3. They are shown again here in Table 4.22. This allowed for a more accurate comparison of group recommendations made at the summit and the changes made to the policy after the summit. In some cases, group recommendations pertained to more than one theme and were counted in both. Thus, the total number of recommendations increased from the actual 125 to the thematically categorised 136. The detailed analysis of the reflection of group recommendations in policy changes is presented in Appendix 8 (section 8.1).

Table 4.22: Categorisation of themes for analysis

Theme	
Prevention and promotion	Child and adolescent mental health
Research	Culture and mental health
Monitoring and evaluation	Suicide prevention
Mental health systems	Advocacy and user participation
Human resources	Governance
Infrastructure	Intersectoral collaboration
Mental health and other conditions	Funding
Mental Health Care Act implementation	Medicines, equipment, and protocols
Mental Health Review Boards	Quality assurance

Due to the more detailed, specific nature of both the group recommendations and the policy changes identified, it was possible that correspondence between these group recommendations and changes between the draft and final policies would be identified. However, it is important to note that where policy changes seemed to reflect group or summit recommendations, this demonstrated possible alignment between issues, as opposed to causality. In other words, a direct, causal link between group or summit recommendations was not assumed. Stronger conclusions could be drawn in instances where these recommendations did not appear to be reflected. Consequently, the discussion going forward will focus predominantly on those issues that did *not* seem to be reflected in policy outputs.

This analysis showed that the majority (84%) of group recommendations put forward at the national summit did not seem to be reflected in the changes that were made to the policy during its finalisation, as shown in grey in Figure 4.14. Where policy changes and group recommendations did seem to correspond, this was largely in terms of a broad association with the same *issue*, rather than direct and specific correspondence between the content of the recommendation and the content of the policy change. These were coded as partially reflected (11%). Direct alignment (4%) could only be identified for recommendations regarding funding, infrastructure, and monitoring and evaluation, and policy changes relating to these themes. There was only one instance in which a policy change directly *contradicted* the summit group recommendations, as shown in red in Figure 4.14. This was where the group recommendation was that no new psychiatric hospitals should be built; however, the provision in the draft policy stipulating no new hospitals was deleted from the final policy. No other policy changes seemed to be contrary to what was proposed by the groups at the national summit.

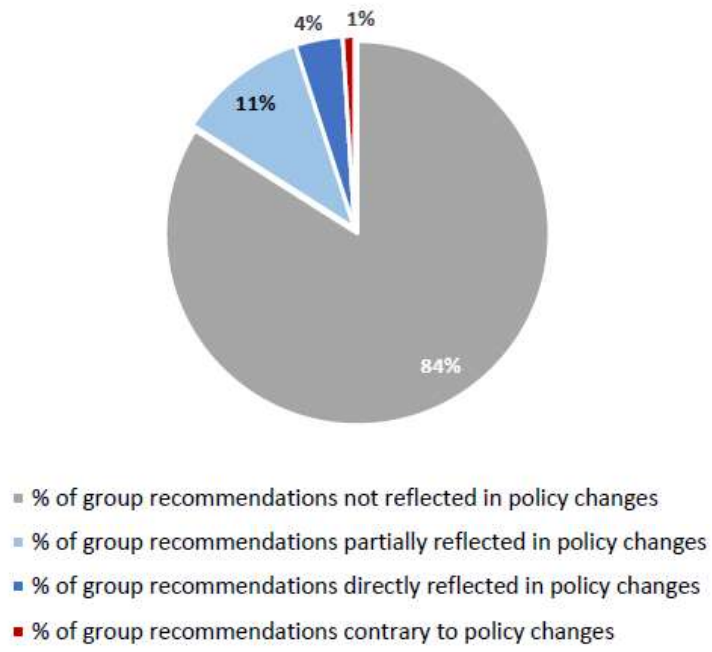


Figure 4.14: Percentage of group recommendations reflected in policy changes

Although it could be the case that the group recommendations were simply aligned with *existing* policy content, the lack of correspondence between the changes between the recommendations put forward at the summit and the changes that were made to the draft policy following the summit and the recommendations put forward at the summit is interesting. If, as will be explored in the next subsection, the group recommendations were not aligned with the draft policy itself, this suggests that inputs made at the consultation summits differed from or built on policy content in some way but were nonetheless not used to inform the policy – at least not in any direct way. However, as previously mentioned, many of the groups at the national summit did not engage directly with the draft policy document. It is perhaps thus not surprising that there appeared to be little alignment between the group recommendations and the changes that were made to the policy following the summit. It is also possible that the recommendations proposed by the summit groups were aligned with existing (draft) policy content. This is explored next in subsection 4.6.2.3.

4.6.2.3 Reflection of group recommendations in draft policy

From previous analyses, it seems that the mental health policy did not change substantively following the national consultation summit, nor did the group recommendations made at the summit seem to correspond with the changes that *were* made to the final policy during the finalisation period after the summit. However, it is possible that the outputs from the policy consultation – particularly those from the national summit – may have simply already aligned so closely with the draft policy content that the recommendations comprised no significant deviations from or additions to the policy document that was available for review at the consultation summits.

This subsection thus presents findings from the analysis of the reflection of group recommendations in the content of the draft policy. The pre-consultation version of the policy was chosen for this analysis as it was the document that was available to participants at the national summit. It is worth noting again here that a fairly large amount of leeway was allowed for in the coding for alignment between group recommendations and policy content. Where group recommendations were coded as reflected, this was typically because of alignment between the main issues referred to in both the policy content and the recommendations; a degree of detail contained in the group recommendations was nonetheless 'lost' in the policy content. The detailed analysis of the reflection of group recommendations in the draft policy is presented in Appendix 8 (section 8.2).

As shown in Figure 4.15, just over a third (37%) of the group recommendations put forward at the national summit seemed to be reflected in the draft policy. The themes for which the majority of the

recommendations were broadly reflected in policy content were: governance; prevention and promotion; intersectoral collaboration; mental health systems; medicines, equipment and protocols; and quality assurance. Limited conclusions can be drawn about the apparent alignment of group recommendations with the draft policy content, particularly given the limited engagement with the draft policy by many of the groups at the summit. The alignment may simply reflect consistency across the major issues in or approaches to mental health. It does suggest, however, that the policy in some way already addressed around a third of the proposals put forward at the national summit.

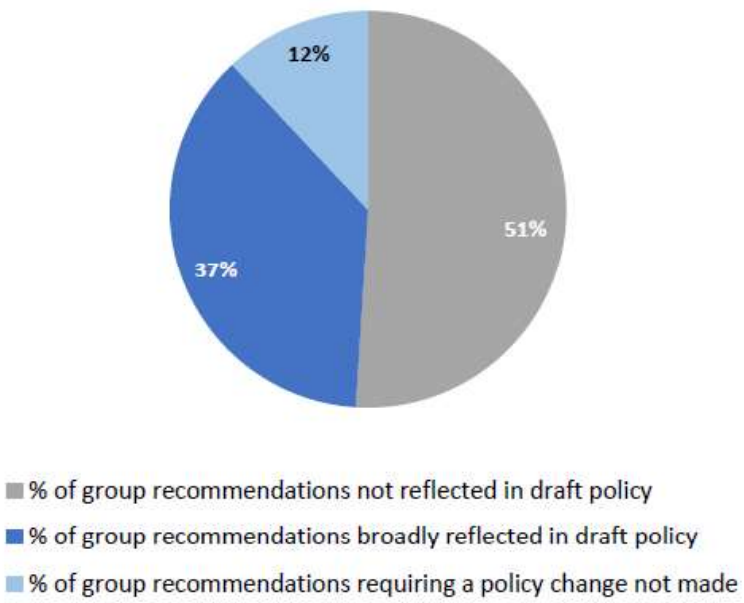


Figure 4.15: Percentage of group recommendations reflected in draft policy

A minority of group recommendations (12%) were partially reflected in the draft policy, in the sense that they aligned with a broad theme or issue already addressed in the policy document, but required an expansion or more detailed addition to this content – changes which were not subsequently made. More than half (51%) of the recommendations proposed by the breakaway groups were not reflected in the content of the draft policy. This was the case for the majority of the recommendations made regarding suicide prevention, Mental Health Review Boards, Mental Health Care Act implementation, culture and mental health, child and adolescent mental health, research, and advocacy and user participation. Figure 4.16 shows the percentage of recommendations per issue that did not seem to be reflected in draft policy content. See Appendix 8 for detailed analysis.

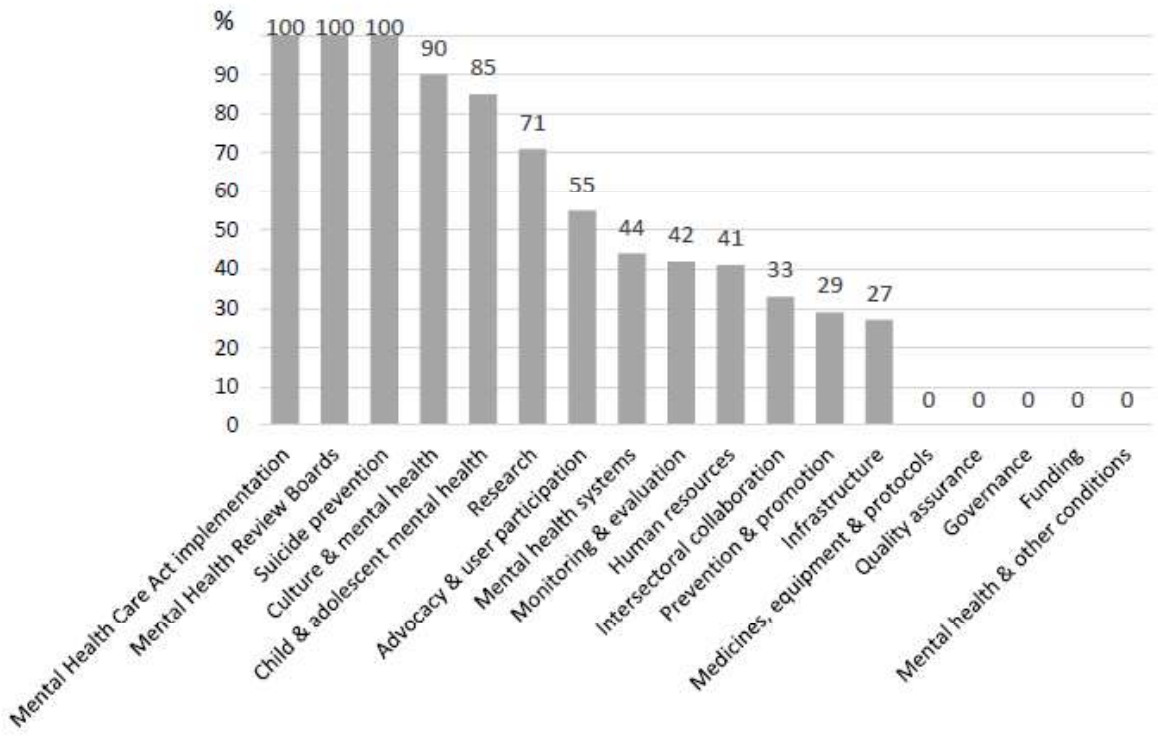


Figure 4.16: Percentage of group recommendations not reflected in draft policy content

There were thus a substantial proportion of recommendations made by breakaway groups at the national summit that were reflected in neither the draft policy nor the changes made to the policy following the summit. One possible conclusion that can be drawn from this is that the policy was already a *fait accompli* prior to the summit. Another is that the summit endorsed the content of the policy and recommended no substantive changes, although the recommendations added to the summit declaration at the end of the summit did not give this immediate impression. However, there were two major additions to the policy during its finalisation following the summit – the Strategic Plan, outlining implementation priorities, and the Terms of Reference for key structures. In the next two subsections, the reflection of group recommendations in these two policy appendices is explored.

4.6.2.4 Reflection of group recommendations in Strategic Plan

The substantive new additions to the final policy, post-summit, were the eight-point Strategic Plan (hereafter also referred to as the implementation plan) and the Terms of Reference (outlining detailed activities assigned to various structures), both in the appendices of the policy. It is possible that the summit outputs were drawn on when developing these two new documents. Certainly, the more detailed nature of the group recommendations may have made them more amenable to being captured in more operational terms – that is, in these implementation priorities and actions. In addition, a footnote in the final mental health policy document indicates that the implementation plan was

informed by the national mental health summit, as well as by the policy. From the group discussions at the consultation summit, it also appeared that the summit organisers from the DoH might have asked groups to identify priorities for implementation. Findings from the comparative analysis of the group recommendations with the eight-point implementation plan are presented in this section. The more detailed analysis is included in Appendix 8 (section 8.3).

The Strategic Plan that was included in the final policy document identified eight priorities for implementation. A number of key activities were associated with each of these implementation priorities. Under the *Infrastructure and capacity of facilities* implementation priority, for example, is the key activity, "Revitalise dilapidated mental health facilitates in all provinces", while under the *Mental health, technology, equipment, and medicines* implementation priority is the key activity, "Make all psychotropic medicines, as provided on the essential drug list, available at all levels of care". These key activities reflected the operationalisation of the implementation plan in particular actions. The implementation priorities, together with the corresponding number of key activities (KAs), are as follows:

1. District-based mental health services and primary health care re-engineering (two KAs).
2. Institutional capacity building (national, provincial, district) (three KAs).
3. Surveillance, research, and innovation (three KAs).
4. Infrastructure and capacity of facilities (five KAs).
5. Mental health technology, equipment, and medicines (two KAs).
6. Intersectoral collaboration (one KA).
7. Human resources for mental health (three KAs).
8. Advocacy, mental health, and promotion of mental illness (one KA).

A number of these implementation priorities reflect the themes that were included on the consultation summit programme for the breakaway group sessions. It is possible, then, that the priorities for implementation were already somewhat predetermined as priorities, given their inclusion as issues for group deliberations at the consultation summit. It may also be the case that the group and summit recommendations were aligned with implementation priorities and actions because these are commonly accepted as the pressing issues in mental health context in South Africa. The purpose of this analysis was therefore not to determine causality in terms of attempting to identify a direct link between recommendations and implementation priorities. Several considerations would have factored into the identification of implementation priorities and activities, including the content of the policy itself, feasibility issues, and current health system context and constraints.

However, given that the implementation plan was one of the only two substantive changes made to the policy following the summits, and that this is explicitly stated as having been informed by the summit, it is useful to look at alignment of summit recommendations with this document. Of particular interest were issues that were raised as priorities (recommendations) by the summit groups but that were subsequently omitted from implementation priorities and activities, as this is an example of where the consultation explicitly *did not* inform policy changes.

Several issues for which groups had proposed recommendations at the national summit were not reflected in any of the eight priorities identified for implementation on the Strategic Plan. These are shown in Figure 4.17, with the numbers of recommendations associated with each of these issues depicted on the vertical axis (see Appendix 8 for detailed analysis). If the numbers of recommendations put forward around particular issues at the national summit are taken as an indication of where emphasis was placed, the key issues coming out of the summit included human resources, advocacy and user participation, prevention and promotion, child and adolescent mental health, infrastructure, and culture and mental health. These were issues for which ten or more recommendations had been put forward across different groups at the summit. All but two of these issues – child and adolescent mental health, and culture and mental health – were reflected in the eight priorities identified for implementation on the Strategic Plan appendix.

The apparent 'neglect' of child and adolescent mental health, on both the summit declaration and the implementation plan, may be partly explained by the fact that separate policy guidelines on child and adolescent mental health had already been developed (Child and Adolescent Mental Health Policy Guidelines, 2003). However, these guidelines do not represent official policy directives. This was thus a missed opportunity for additional guidance on child and adolescent mental health to be included in the mental health policy, and particularly for it to be prioritised in implementation.

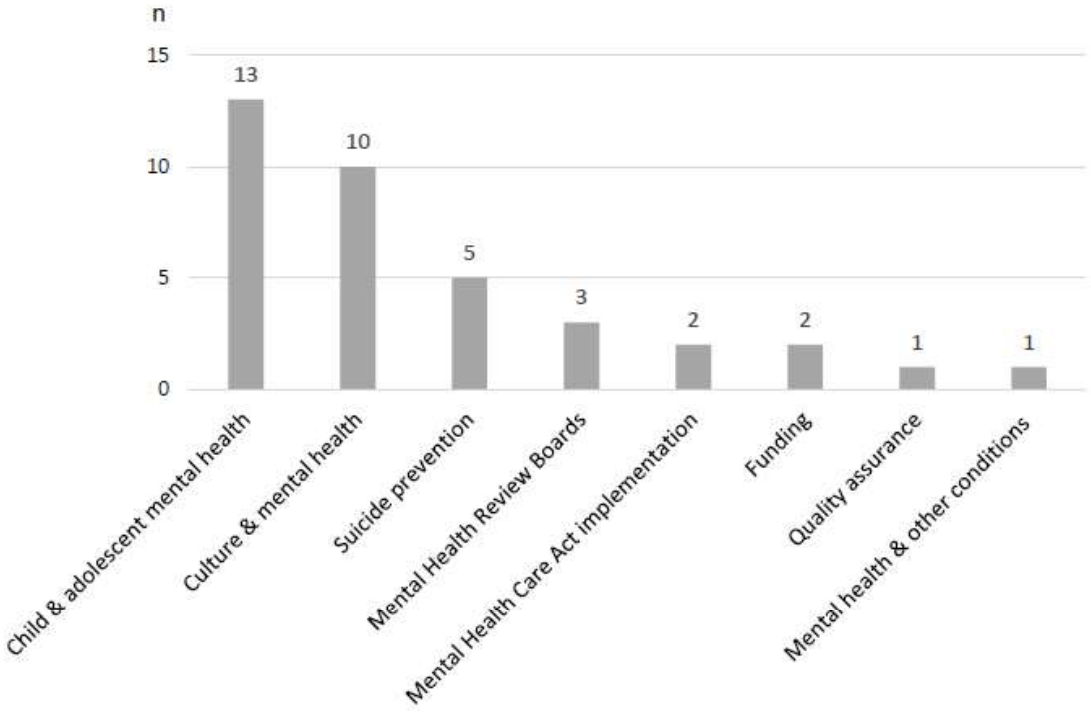


Figure 4.17: Issues not reflected in implementation priorities

Conversely, there were three issues which did not seem to generate a lot of recommendations (five or fewer) at the summit but were nonetheless included among the eight implementation priorities. These were governance, intersectoral collaboration, and medicines, protocols and equipment. Notably, these issues had also not been identified as topics for discussion in the ten breakaway groups at the summit. This suggests that decisions to include them as priorities for implementation were unrelated to the consultation.

It was possible to identify instances in which group recommendations were not reflected in the eight priorities identified for implementation on the Strategic Plan, but were nonetheless reflected in the more detailed key activities associated with one or more of these implementation priorities. However, as shown in Figure 4.18, the majority (70%) of group recommendations were not reflected in these more detailed key activities.

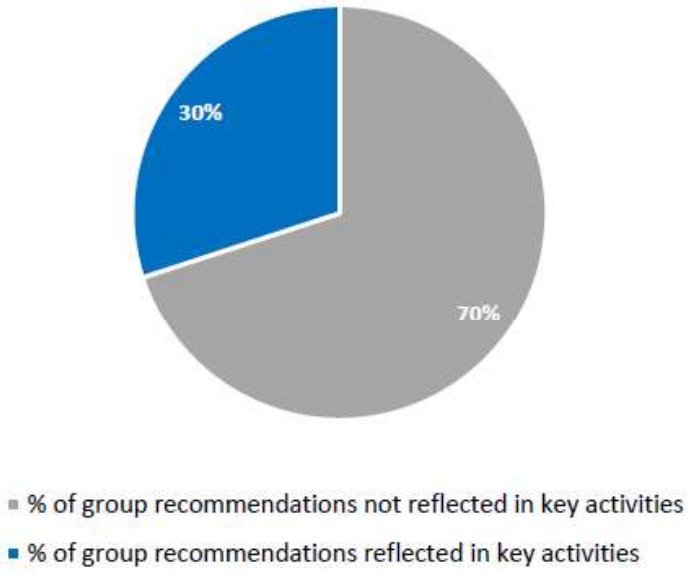


Figure 4.18: Percentage of group recommendations reflected in key activities on implementation plan

Less than a third of the group recommendations from the national summit were determined to be reflected in some way in the *key activities* associated with the implementation priorities on the Strategic Plan. There were several instances of issues that had not necessarily been identified as one of the eight implementation priorities, but which were nonetheless reflected in the key activities listed for particular priorities. An example of this was culture and mental health, which was not identified as an implementation priority per se, but which was considered to be reflected in the key activity relating to proficiency training in indigenous languages for mental health care practitioners, under the human resources implementation priority. The percentages of group recommendations, by theme, that were not reflected in key activities on the implementation plan are shown in Figure 4.19.

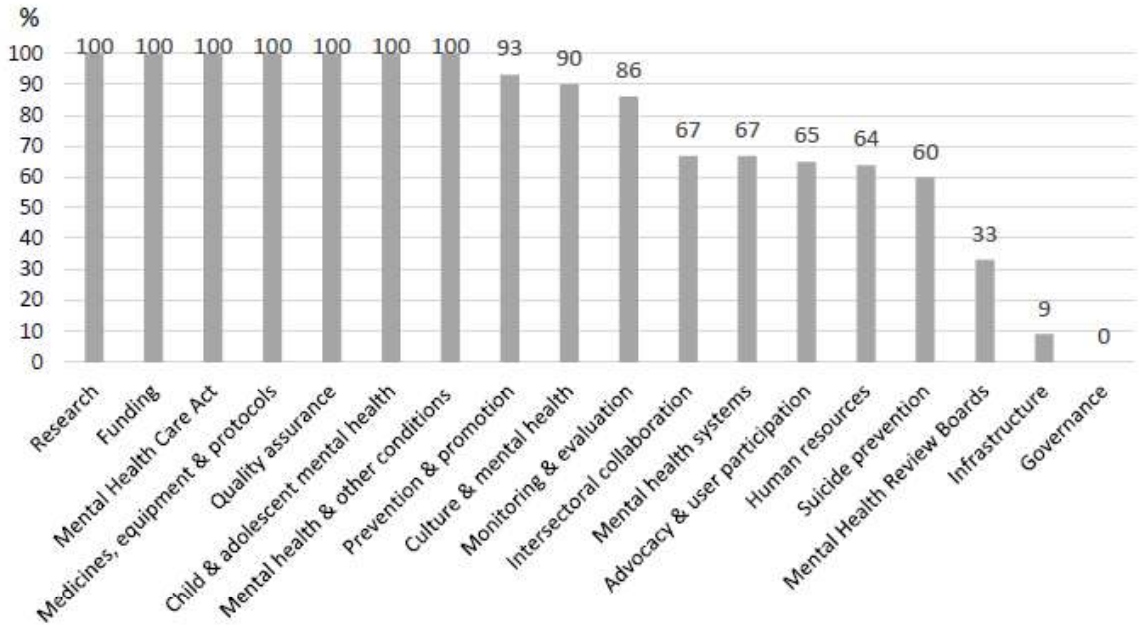


Figure 4.19: Percentage of group recommendations *not* reflected in implementation plan key activities

The majority of group recommendations proposed at the national summit were therefore not reflected in the implementation priorities and key activities detailed on the Strategic Plan. The final level of analysis, then, explored whether these recommendations may have been reflected in the other addition to the policy following the summit: the Terms of Reference document. These findings are presented in the subsection below.

4.6.2.5 Reflection of group recommendations in Terms of Reference

The Terms of Reference (ToR) for key structures was added as an appendix to the mental health policy during the period between the national summit and the promulgation of the final policy. Together with the eight-point Strategic Plan, this was the only substantive addition to the policy following the consultation summits. It was considered relevant for analysis to determine whether this new content might reflect recommendations put forward at the consultation summit. Due to the more detailed nature of the actions outlined in the ToR, it was possible that it would reflect the more detailed summit group recommendations. This subsection presents these findings. The detailed comparative analysis of group recommendations with the ToR actions is included in Appendix 8 (section 8.4).

It has already been shown that the policy document did not change substantively following the national summit (section 4.2). As previously discussed, this may be because the summit and group recommendations were aligned with the existing policy content. However, it was also noted that the groups at the summit seem to have been instructed to produce priorities for implementation. It may be,

then, that the outputs from the consultation summit would have informed either the implementation plan priorities and key activities, or the ToR actions, or both. Once again, it is not possible to determine causality, that is, an issue raised at the summit being directly taken up in the implementation actions, as other factors that may have influenced this decision. The recommendations that were *not* reflected in either the implementation plan or ToR allow for more definite inferences to be made that the specific recommendations had no influence.

There were four key structures to which actions were delegated in the ToR appendix. These key structures are listed here, with the number of actions outlined for each structure included in parentheses, were:

1. District specialist mental health team (11).
2. Ministerial Technical Advisory Committee in Mental Health (6).
3. Provincial Mental Health Directorates (9).
4. National Health Commission (1).

An example of an action associated with the district specialist mental health team is to "establish routine ongoing training and supervision for primary health care staff". Actions associated with the provincial Mental Health Directorates included "monitor functioning of the provincial (Mental Health) Review Boards" and "ensure representation of mental health specialists on appropriate budget allocation committees".

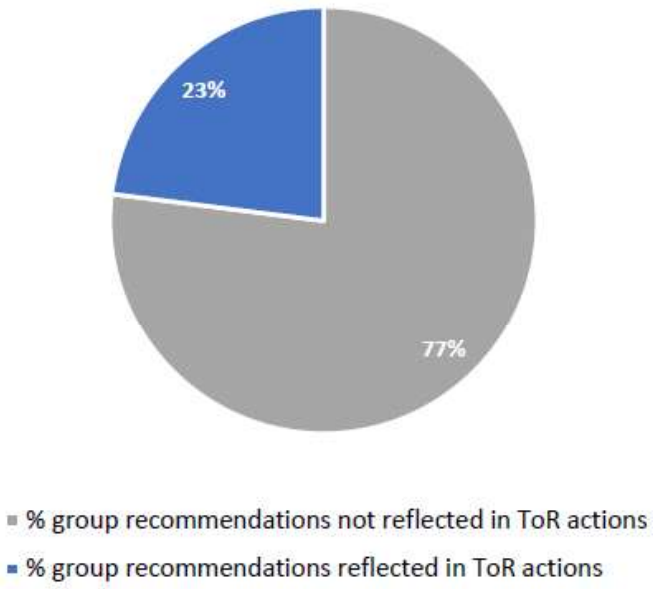


Figure 4.20: Percentage of group recommendations reflected in Terms of Reference actions

Of the 136 group recommendations proposed at the national summit, less than a quarter (23%) of these were reflected in the ToR actions (see Figure 4.20). As shown in Figure 4.21, the majority of group

recommendations across all themes were not reflected in the ToR, with the exception of recommendations relating to quality assurance and Mental Health Review Boards. This was a surprising finding, given that the more detailed nature of the group recommendations may have made them more amenable for inclusion or alignment with more detailed actions relating to implementation.

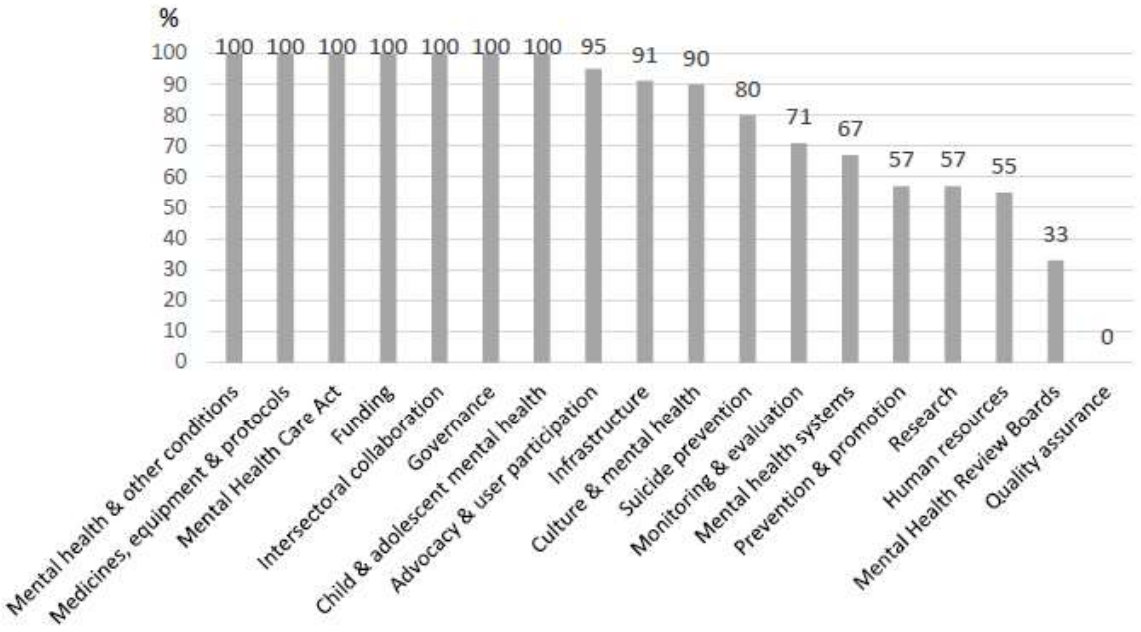


Figure 4.21: Percentage of group recommendations *not* reflected in Terms of Reference actions

In a second level of analysis, the reflection of group recommendations in either one of the two implementation-related appendices added to the policy was explored. More than half of these recommendations were found not to be reflected in any way in either the implementation plan or the ToR. Those themes for which none of the group recommendations was captured in either appendix were Mental Health Care Act implementation, medicines, equipment and protocols, funding, and child and adolescent mental health. This is shown in Figure 4.22.

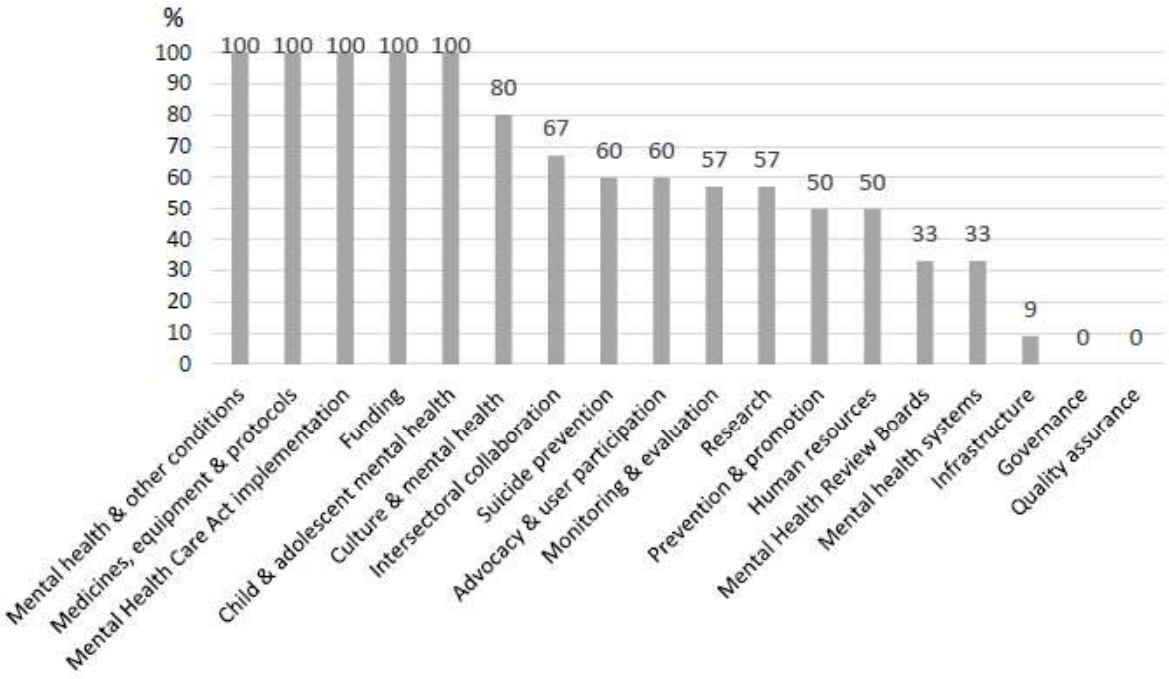


Figure 4.22: Percentage of group recommendations not reflected in *either* new appendix

The finding that less than half of the group recommendations were reflected in these additions could be interpreted in several ways. Firstly, the summit declaration was the official output of the national summit. This was ultimately included in the final policy document. It seems likely that the task team appointed to finalise the policy after the consultation summits would have had access to – and referred to – this summit declaration during this process. It is not clear, however, whether this task team would have had access to the more detailed group recommendations reviewed in this section. Thus, there may have been no potential for uptake of any of this content into the amendments made to the policy during the finalisation process.

Another way of interpreting these findings is to propose that just under half of the group recommendations being reflected in the two substantive additions to the policy following the summit represents a significant number, considering that this is only one element that would have been reviewed when finalising the policy. Given that the content of the policy itself did not change significantly following the summit, nor did the changes seem to be related to the summit recommendations (particularly the group recommendations), it is notable that a number of these recommendations did seem to be reflected in the appendices that outlined more detail for the implementation of the policy.

This subsection has presented analysis of group recommendations made at the national summit with various inputs (group discussions) and outputs (summit declaration recommendations and policy

content and amendments). As noted above, the summit declaration was considered to be the official report of the national summit. In the next subsection, these summit declaration recommendations will be compared with policy outputs to determine the extent to which these outputs reflect the official contributions (i.e. the summit declaration recommendations) from the consultation.

4.6.3 Phase 3: Transfer of inscribed knowledge from summit recommendations

A draft summit declaration was available for review at the national mental health summit. The draft 'pre-summit' text highlighted the context and challenges faced by South Africa in relation to mental health, and the importance of integrating mental health into primary health care. It also included a number of broad actions or pre-summit recommendations that should be followed in implementing an approach to mental health care in this context. These pre-summit declaration recommendations roughly corresponded to a number of the topics identified for discussion by the group commissions at the national summit. At the end of the summit, eleven recommendations were added to the end of the summit declaration. These eleven recommendations were thus presumed to be a reflection of the inputs and group recommendations made at the consultation summit.

As mentioned earlier, the summit declaration was the official output of the national summit and was publicly available as the summit report. It therefore seems likely that this output would have been available to the team tasked with finalising the policy. The purpose of the analysis in this subsection was thus to explore the extent to which these summit declaration recommendations were reflected in various policy outputs, as shown in Figure 4.23. The findings from this final analysis phase are presented in the subsections that follow. Detailed analyses on which the findings of each subsection are based have been included in Appendix 9.

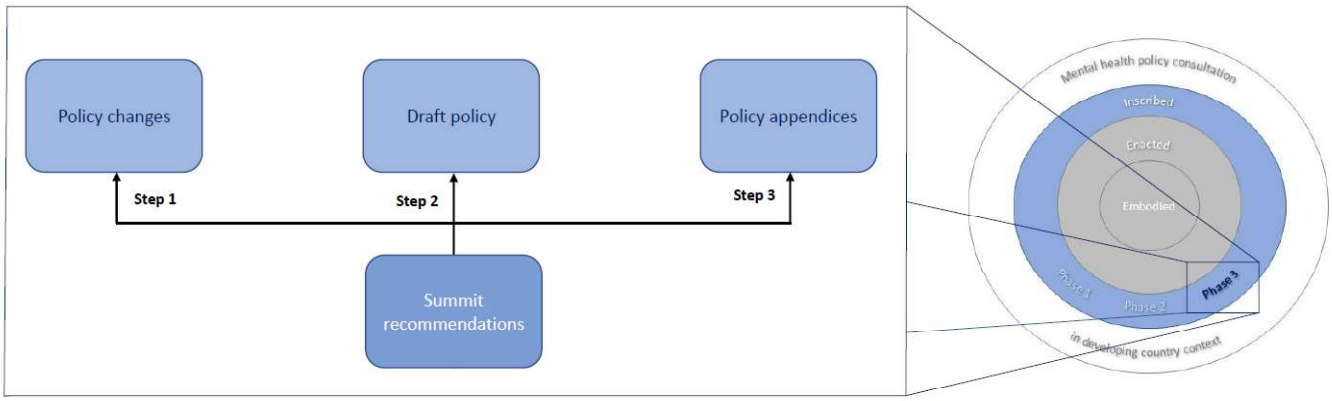


Figure 4.23: Abstraction and transfer of inscribed knowledge from summit recommendations

As with previous figures, the steps followed and data included in Phase 3 of the analysis are shown as blocks on the left-hand side of Figure 4.23, with arrows between blocks depicting chronology of these steps. The concentric analytical framework is included for reference at the bottom right of Figure 4.23, to indicate the link between Phase 3 of the analysis and the overall analytical framework.

4.6.3.1 Reflection of summit recommendations in policy changes

As noted above, a number of pre-summit recommendations were already included in the draft summit declaration at the start of the summit. As such, these were not considered to be a reflection of the discussions or recommendations emanating from the summit itself. In addition, few of the summit breakaway groups engaged directly with the draft declaration and, more specifically, with the content of the pre-summit recommendations relating to their topic. The majority of the summit groups focused instead on formulating recommendations to be added to the end of the summit declaration, without direct engagement with existing texts. Thus, in the analysis going forward, only those eleven recommendations that were added to the summit declaration at the end of the summit were included for comparison with policy content and amendments. One of these post-summit recommendations pertained to more than one theme identified in the analysis, and thus these were counted as such, bringing the total number of recommendations coded by *theme* to twelve.

It is important to note that the summit declaration recommendations were – probably intentionally – phrased in somewhat generic and broad terms, while the changes made between the draft and final policy following the summit were very specific and detailed in relation to a particular point or issue. A broadly defined summit recommendation could thus be said to be reflected in a policy change by virtue of it broadly pertaining to the same issue, as opposed to containing the detail of the change. No recommendation from the summit declaration was specific enough to allow the argument that it was definitely and specifically related to a particular change on the level of minor changes and amendments, which formed the majority of changes made to the policy. A plausible indirect link could only be made if or where a more substantive policy change reflected a broad recommendation regarding this change, although attributing causality is not possible. At best, the analysis could show where policy changes were focused in relation to summit declaration recommendations in terms of themes or issues.

By virtue of their specific nature, policy changes were recorded as broadly aligned with group recommendations when they were considered to represent the operationalisation of a summit recommendation. Even where the policy change was a minor amendment to a term or phrase, as was the case for the majority of policy changes, if this was nonetheless consistent with the broad notion

captured in the pre- or post-summit declaration recommendations, the policy change was recorded as being aligned with summit recommendations. The possibility of a more direct or detailed link was also allowed for in the analysis; this was coded as such if the policy change seemed to more directly reflect a detailed application of one or more pre- or post-summit declaration recommendations. An example would be where the summit declaration recommended that a specialist mental health team be established in each district, and a change or addition was made to the policy which directly related to the district specialist mental health team. Coding definitions for detailed reflection, broad reflection and no reflection of summit recommendations in policy changes are included in Appendix 4. Detailed analysis of the reflection of summit recommendations in policy changes is presented in Appendix 9 (section 9.1).

There was little direct, detailed reflection of the summit declaration recommendations in the changes made to the policy following the national summit. None of the summit recommendations was reflected in detail in the policy changes. Just over half (58%) of the post-summit recommendations around seven issues were *broadly* reflected in corresponding policy changes, as shown in Figure 4.24. However, where there appeared to be alignment between policy changes and summit recommendations, this was very broadly applied and the comparison somewhat arbitrary, as the summit recommendations were in many instances so broad that they could be said to correspond to any number of minor detailed changes. Similarly, the findings around how little direct alignment there was between summit recommendations and policy changes has only limited interpretation, given this crude comparison.

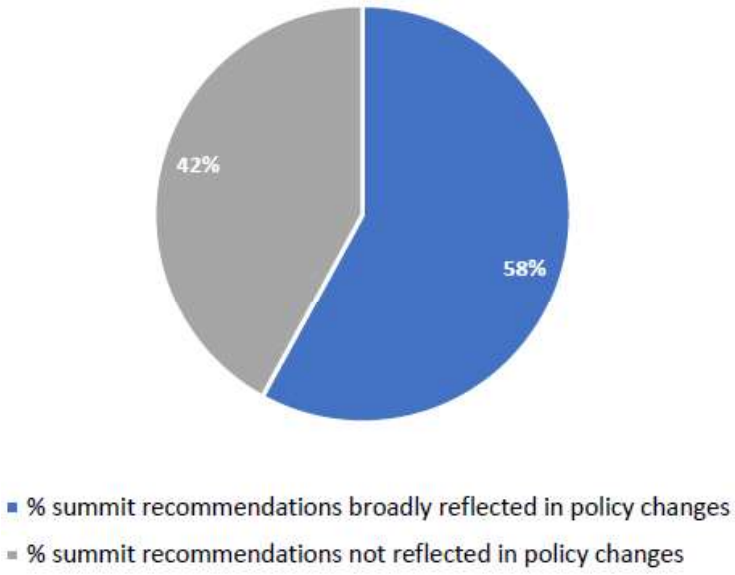


Figure 4.24: Percentage of summit recommendations reflected in policy changes

Summit declaration recommendations relating to five issues were not reflected in any changes made to policy following the summit. As shown in Figure 4.25, these were: human resources, culture and mental health, suicide prevention, quality assurance, and medicines, equipment and protocols. There were several issues for which recommendations were not included in the summit declaration. No comparison could thus be made with policy changes relating to these issues.

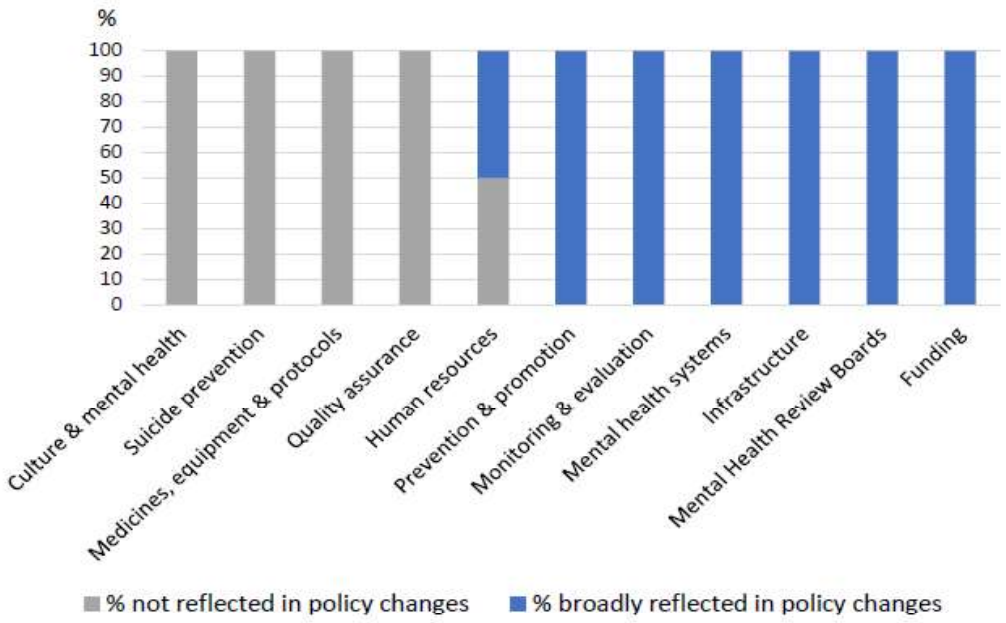


Figure 4.25: Percentage of summit recommendations reflected in policy changes by topic

It is not possible to conclude from this that the summit declaration – or outputs – did not have any influence on the changes made. It would, however, have been notable if there *were* any apparent direct links, or if policy changes seemed to be in direct opposition to summit recommendations. It is of course also possible that the summit recommendations did not seem to result in any direct changes because they were all already aligned with existing policy content. This possibility will be explored in subsection 4.6.3.2.

4.6.3.2 Reflection of summit recommendations in draft policy

It is possible that a substantive change might have been made to the policy had any of the recommendations coming out of the summit strongly reflected a deviation from the draft policy available for discussion at the summit. Explicit instructions given to the ten breakaway groups were to review the relevant section/s pertaining to their theme, and to identify some key recommendations to be added to the summit declaration. As shown in the subsections above, the changes that were made to the policy following the summit did not seem to represent a deviation from any of the broad

recommendations that were included on the summit declaration, but they also did not seem to correspond with much of the detail of the group recommendations that were made at the summit. This may have been because the group and summit recommendations were aligned with the content of the draft policy, so that no substantive changes were required following the summit. In this subsection, the summit group recommendations' alignment with or deviation from the draft policy will be explored. Detailed analysis of the reflection of summit recommendations in draft policy is included in Appendix 9 (section 9.2).

The majority (75%) of the post-summit declaration recommendations seemed to be broadly aligned with existing policy content (Figure 4.26), which represented operational detail that corresponded to the broad recommendations included on the declaration. It would seem, then, that the particular consultation around the draft policy that was undertaken at the national summit may have served to endorse, rather than amend, existing draft policy content. However, it should be noted that the participants themselves did not phrase their contributions in these terms – in other words, as aligning with existing policy content and therefore not necessary to take forward as a recommendation. As previously argued, this alignment cannot be interpreted as a linear or causal association. More definitive conclusions might be drawn where a recommendation called for a change or addition to the existing approaches outlined in the policy, but where this change did not seem to have been effected. This was the case, for example, with recommendations relating to suicide prevention, quality assurance, and Mental Health Review Boards. It should be noted, however, that these changes were generally in line with existing policy content, requiring *additions* or *expansions* rather than changes that were contrary to or required a change in direction of draft content.

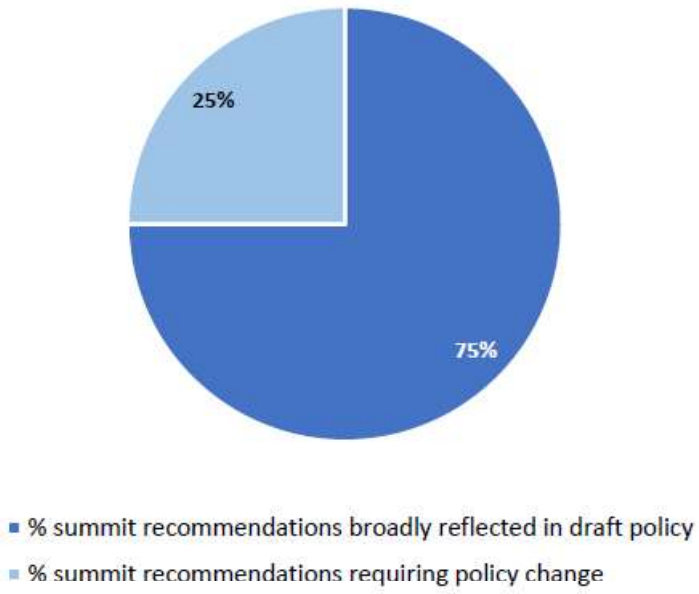


Figure 4.26: Percentage of summit recommendations reflected in draft policy

It is possible that the summit outputs required no substantive changes to the draft policy because the breakaway groups generally did not engage directly with the policy, but focused rather on putting forward recommendations for actions to be implemented. It is also possible that there seemed to be alignment largely because the summit declaration recommendations were so broadly phrased that they would have been aligned with most detailed content that related to the same issue, although this is still an indication that there were no substantive deviations in terms of policy directives. There were, however, the two substantive additions to the policy following the summit of the eight-point Strategic Plan and the Terms of Reference. The possibility that the summit declaration recommendations were reflected in the content of these two appendices is explored in the subsections below.

4.6.3.3 Reflection of summit recommendations in Strategic Plan

As detailed in the analysis of group recommendations (section 4.6.2.4), the eight-point Strategic Plan (also referred to as the implementation plan) was one of the two new substantive additions to the mental health policy following the consultation summits. The purpose of the comparative analysis conducted here was thus to determine whether post-summit declaration recommendations were reflected in the implementation priorities and their corresponding key activities on the eight-point implementation plan. The recommendations added to the summit declaration at the end of the summit were broadly phrased and represented a summarised version of the group recommendations made at the summit. It was thus only possible in this analysis to identify broad correspondence between the summit declaration and the implementation plan priorities, which themselves were very broadly phrased. Similarly, the comparison of each summit recommendation with the more detailed key activity was done to determine whether the former was broadly reflected in the latter. Detailed analysis of the reflection of summit recommendations in the implementation plan is presented in Appendix 9 (section 9.3).

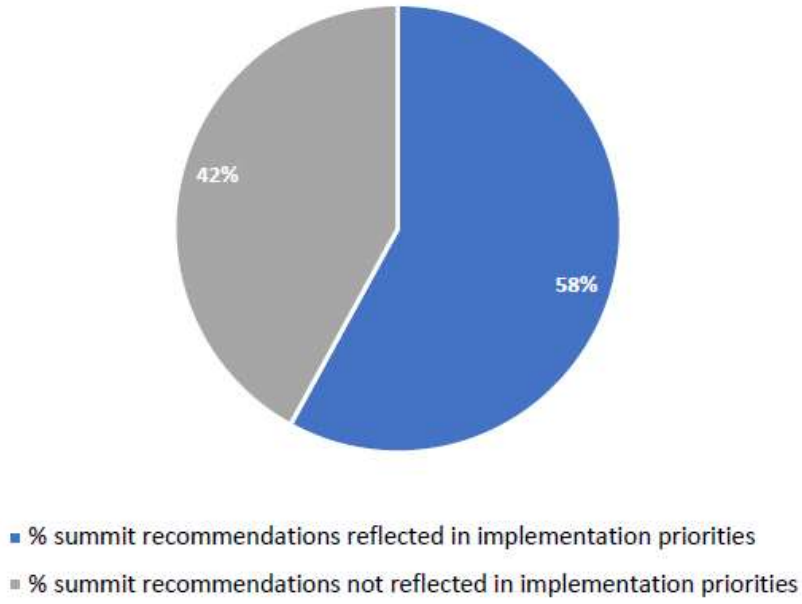


Figure 4.27: Percentage of summit recommendations reflected in implementation priorities

The majority (58%) of post-summit declaration recommendations were reflected in some way (whether in the implementation priorities or the key activities associated with these) on the implementation plan (Figure 4.27). Priorities chosen for implementation corresponded to half of the summit declaration recommendations. Only three summit recommendations were not reflected in either implementation priorities or key activities on the implementation plan: culture and mental health, funding, and quality assurance. There was thus some consistency in terms of issue priorities across summit and policy outputs. However, four issues were identified as priorities for implementation on the Strategic Plan (research, advocacy and user participation, governance, and intersectoral collaboration) that had not been put forward as recommendations on the summit declaration. This suggests that these priorities were not chosen on the basis of consultation inputs.

The reflection of summit themes and recommendations in the implementation priorities and activities, and the omission of others, may be explained partly by the fact that some issues lent themselves to being captured more easily in operational (implementation) terms (e.g. mental health systems, and human resources and infrastructure), while others did not (e.g. culture and mental health, and the recovery approach). This does not, however, explain the omission of funding and quality assurance, or of child and adolescent mental health, from both the summit declaration recommendations and the implementation priorities and key activities. Given that only eight issues were chosen as priorities for inclusion on the implementation plan, the second more detailed appendix added to the policy could have allowed for greater inclusion of summit recommendations. The comparison of summit recommendations and this Terms of Reference appendix is presented next.

4.6.3.4 Reflection of summit recommendations in Terms of Reference

The other substantive addition to the policy following the consultation summit was the Terms of Reference (ToR), which included a number of detailed actions to be undertaken by certain key structures (such as the district mental health teams). A comparative analysis was therefore conducted to identify areas where these ToR implementation-related actions reflected the recommendations included on the final summit declaration. The first part of this analysis considered which of the summit declaration recommendations were reflected in the ToR actions. The second part reviewed which summit declaration recommendations were reflected in one or both of the two new additions to the final policy following the summit (i.e., the implementation plan key activities and the ToR actions) and which were not reflected in either. The detailed analysis on which the findings presented here are based has been included in Appendix 9 (section 9.4).

As shown in Figure 4.28, the majority (83%) of summit declaration recommendations were reflected in ToR actions. Only two of the summit recommendations did not correspond to content in the ToR in some way. These related to infrastructure, and to medicines, equipment and protocols. Notably, both of these issues were covered somewhat extensively in the Strategic Plan, as discussed earlier. For those issues that had not been included as recommendations on the summit declaration, no comparison with ToR actions could be conducted.

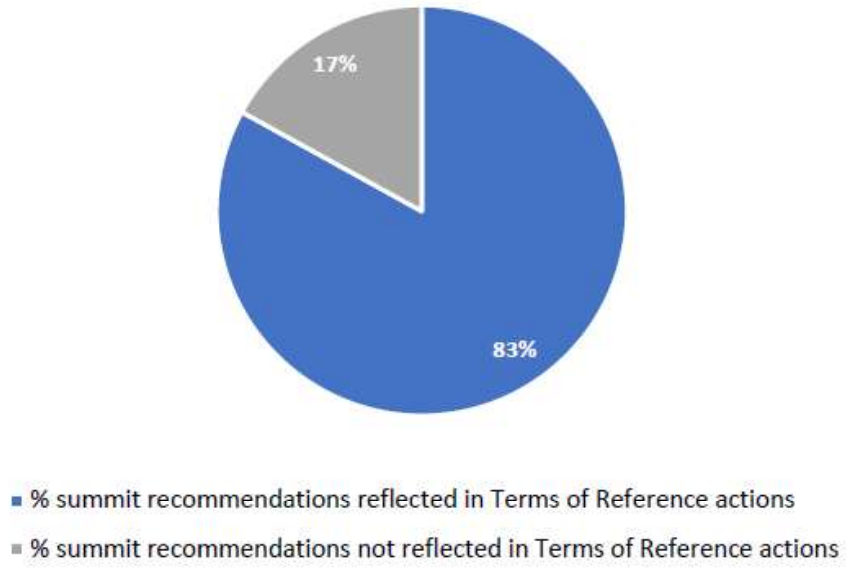


Figure 4.28: Percentage of summit recommendations reflected in Terms of Reference actions

The second level of analysis showed that all of the summit declaration recommendations were reflected in at least one of the two new appendices added to the mental health policy following the national summit (i.e. either in the eight-point Strategic Plan, or in the ToR). This suggests, in turn, that the summit recommendations may have been used to inform implementation priorities and actions, as opposed to changes to the body of the policy itself. This analysis has also highlighted, however, the difficulty of moving from more abstract or broadly phrased recommendations of the kind included on the summit declaration to the more detailed actions and activities required in implementation plans. This was mirrored in the previous subsection, which showed that much of the detail of the breakaway group recommendations was lost in the summarisation to summit declaration recommendations.

4.6.3.5 Reflection of issues across summit and policy outputs

In this final subsection, a brief analysis of the prioritisation of issues from the consultation through to the policy is presented, drawing together all of the findings from the analyses in the subsections above. This was done to get an impression of whether and how specific issues seemed to get prioritised across the mental health consultation summit and policy framework. In this analysis, an issue was coded as 'reflected' simply by virtue of its appearance in content relating to that issue, as opposed to reflecting the actual content of group or summit recommendation made in relation to this issue. Detailed analysis on which these findings are based is included in Appendix 9 (section 9.5).

A number of breakaway group topics did not get taken up in the recommendations added to the summit declaration at the end of the summit, despite several group recommendations being made in relation to these themes. This was particularly the case for advocacy and user participation, research, and child and adolescent mental health. This analysis showed that the biggest omission from post-summit outputs and implementation actions was child and adolescent mental health. Although included as a breakaway group theme at the national summit, and although this group made a number of recommendations, these were not captured in any way in the pre- and post-summit declaration recommendations, or as an implementation priority or key activity. This issue is addressed within the policy as content within other sections, as opposed to in its own separate section. The only other reference to this topic in the documents included in this analysis was as one action on the ToR appendix.

Conversely, governance and intersectoral collaboration, although not included as breakaway group topics at the summit, or identified as post-summit recommendations, each featured as one of the eight priorities identified for implementation, as well as in key implementation activities. There were five issues that were consistently reflected as a priority on the implementation plan, and in the implementation key activities, across all the summit group sessions the pre-summit declaration text, and

the post-summit declaration recommendations. These were prevention and promotion, monitoring and evaluation, human resources, mental health systems, and infrastructure. With the exception of those themes already discussed above, the remaining issues were all addressed in some way in one or the other pre- or post-summit recommendations, policy outputs, and appendices.

This subsection has presented a brief overview of issue prioritisation across summit inputs, and summit and policy outputs, regardless of correspondence of actual content across these documents. This followed an analysis of the reflection of inscribed knowledge inputs across all of these documents, using breakaway group recommendations and summit declaration recommendations as the consultation outputs with which to compare policy and implementation-related appendices. In the final subsection below, the main conclusions from these analyses are presented.

4.6.4 Inscribed knowledge transferred: Conclusions

In this subsection, the findings from the comparative analysis of the group recommendations, and of the summit declaration recommendations, with various policy outputs are drawn together, and conclusions are made based on the main findings emerging from the analyses above.

There was a great deal of extensive input and discussion at the national consultation summit, which generated a number of recommendations regarding key areas in mental health service provision. There were ten breakaway group sessions at the summit, which each discussed a key issue/s relating to mental health. Each of these groups put forward a number of recommendations which, for the purposes of this analysis, were re-categorised according to relevant themes. These group recommendations were then refined and summarised at the national summit, and eleven recommendations were added to the draft summit declaration that became the official output of the summit.

The mental health policy did not seem to change substantively following the national consultation summit. At first glance, then, it would appear that the consultation was not used to inform the policy in any substantial way. The analysis in this section has shown that the changes that were made to the final policy did not correspond to the majority of recommendations put forward by the breakaway groups at the national summit. To some extent, this could be because – as was shown in the analysis – some of these recommendations, as well as some of the summit declaration recommendations, were already reflected in the draft policy, which thus required no significant modifications. However, the group participants making the inputs that led to these recommendations did not talk as if this was the case; in other words, as though they were merely endorsing existing policy content. Furthermore, the findings showing reflection of group recommendations in the draft policy are based on analysis that required a

high degree of abstraction of these recommendations to consider them reflected in either the draft policy or summit declaration recommendations.

Nonetheless, the findings presented in this section suggest that where the summit declaration and group recommendations represented changes to existing policy content, these were primarily extensions of, rather than in opposition to, existing content. It might be concluded, then, that the consultation summit largely endorsed the mental health policy. In addition, most of the summit breakaway groups did not engage directly with the draft policy document, focusing instead on formulating recommendations to be added to the draft summit declaration. This lends support to the view that the policy seems to have been largely taken as a given and to be endorsed at the national summit. From the instructions given to some of the groups by policymakers who joined them, the purpose of the group discussions was oriented towards identifying priorities for action or implementation. This may explain why few substantive changes were made to the body of the policy document following the summit, as well as why few of the group and summit declaration recommendations were reflected in the changes that were made.

A note of caution here: the participants at the national summit seemed to be predominantly academics and service providers, with some non-governmental organisation representation. The approach adopted in the policy, and possibly endorsed at the summit, is aligned with global approaches and trends in mental health service provision – specifically, that of the World Health Organization. This is particularly evident in the attendance at the summit of a key representative of the WHO, which was also seen as this organisation's endorsement of South Africa's mental health policy. While on the one hand it would appear positive that the consultation summit seemed to endorse the policy, on the other hand, it may reflect the adoption of dominant narratives around mental health, at the expense of other possibilities and approaches. It is possible that if there was greater representation of service users at the summit, and, by extension, non-governmental and service user-led organisations, recommendations regarding the policy may have required greater shifts in focus. It is notable, for example, that those recommendations around advocacy and user participation that were either already captured or taken up in some way related more to strategies around elimination of stigma and discrimination and, to a lesser extent, user participation in service and policy planning. Almost none of the recommendations relating to the adoption of a recovery approach in mental health service provision was reflected.

Another possibility that was considered in the analysis presented here was that the consultation outputs may have been used to inform priorities for implementation, which seems feasible given that the substantive additions to the policy following the summit were the two appendices that related specifically to implementation activities: the eight-point Strategic Plan, and the Terms of Reference for

key structures. A comparison of the post-summit recommendations and the two implementation-related appendices added to the policy after the summit showed that all of the summit declaration recommendations were reflected in some way within these additions. It was noted, however, that these summit declaration recommendations were broadly stated and, as such, tended to be reflected in these more detailed activities by virtue of pertaining to similar issues as opposed to relating to the same content. The reflection of the 136 recommendations put forward by summit groups, on the other hand, was somewhat different, with over half of these not appearing in either the implementation plan or the ToR. Despite the fact these group recommendations were more detailed, the greater detail contained in the implementation-related appendices added to the policy did not seem to reflect this detail.

The next section presents an overview of this study's main findings. In particular, findings from the summit transcript and document analysis in relation to each of the three research questions are triangulated with findings from the key informant interviews, towards addressing these questions.

4.7 From the outside in: Re-viewing knowledge in the consultation process

Each of the preceding three sections presented findings in relation to each of the three research questions. Interviews that were conducted as a form of process evaluation provided a way into this analysis and contained components that related to all three questions. These interviews seemed to confirm findings from the preliminary comparative analysis of the draft and final policy documents showing that the policy had not changed substantively following the consultation summits. They also highlighted a number of possible threads to pursue in the subsequent analysis of the summit transcripts and policy documents in terms of if and how knowledge inputs had moved through the consultation process. The analytical framework provided a useful way of structuring the analyses, moving from the particular level of the individual (embodied knowledge) through enacted spaces to the more abstract level of policy documents (inscribed knowledge). This is included again here for reference in Figure 4.29.

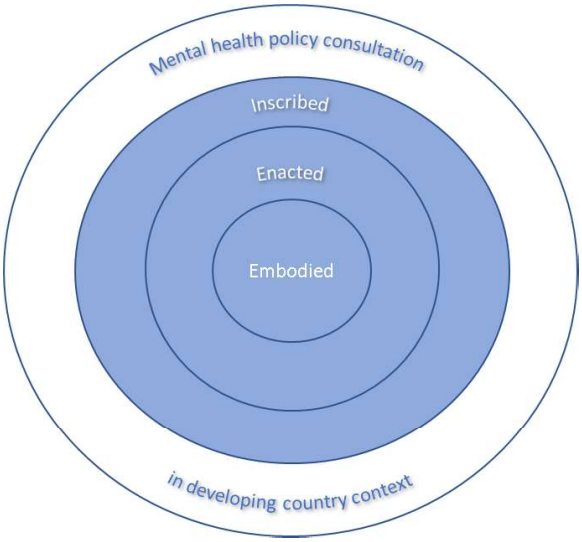


Figure 4.29: Analytical framework: Movement of knowledge from embodied to enacted to inscribed

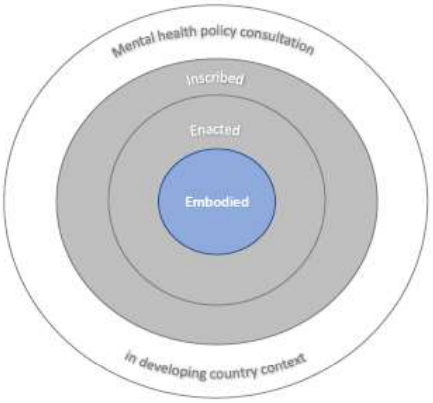
In this final findings section, individual perspectives from the interviews are integrated and triangulated with findings from the analysis of summit transcripts and policy documents. The triangulation procedure was described in the methodology chapter (Chapter 3, section 3.7.3.6). A convergence coding matrix was constructed for each research question, and the integrated findings assessed for: i) convergence (findings directly agree); ii) complementarity (complementary information on the same issue); iii) dissonance (findings contradict each other); and iv) silence (issues arising from one component but not others) (Heslehurst et al., 2015). This convergence coding matrix is included in Appendix 13.

It is important to note that the key informant interviews were conducted at the start of this study. As is frequently the case in qualitative studies, the research questions and analytical framework evolved as the research progressed. There were thus components of the summit transcript and policy document analysis that had not been pursued as lines of inquiry in the interviews. It was therefore not possible to do a direct comparison across all findings and, where silences around issues were noted, this was in many cases the result of the absence of interview questions relating to such issues rather than highlighting analysable differences across themes.

The following subsections present a factual synthesis of findings, summarising the main findings in relation to each research question. Explicit links are also drawn to the interplay between embodied, enacted, and inscribed knowledge within the findings. These conceptual links will be further developed in the discussion chapter (Chapter 5).

4.7.1 Embodied knowledge enacted

How were participants' embodied knowledges enacted and captured (inscribed) during the consultation process?



The focus of this analysis was on how different types of knowledge were responded to and captured during the group discussions at the national consultation summit. In particular, two forms of embodied knowledge – experiential and evidence-based knowledge – were identified and traced through the discussions into the inscribed outputs (group recommendations). Although the interviews had not focused directly on the breakaway group sessions, the findings provided some insight regarding the representativeness of the summit, as well as the influence of particular individuals on various aspects of the consultation, which provided interesting supplementary data to make sense of the findings from the summit transcript analysis.

Embodied knowledge is knowledge within individuals. In Freeman and Sturdy's (2015a) schema, embodied knowledge incorporates both experiential/practice and factual/theoretical ('embrained') knowledge. This knowledge must be enacted in some way to be seen by or transferred to others and, once it is, it becomes enacted knowledge. Enacted knowledge, in turn, may result in the production of new embodied or inscribed knowledge. In a sense, then, the national consultation summit represented a microcosm of the interplay between these three knowledge forms at various levels. Participants engaged with one another and with documents (inscribed knowledge) to produce new forms of knowledge, as well as new knowledge content.

The content of the group discussions that was available for analysis represented the knowledge inputs of individuals in interaction. These findings showed that, while individuals would have been drawing on embodied knowledge to make verbal statements, this knowledge was not explicitly referenced in their verbal inputs at the summits. Thus, in reviewing the draft policy and formulating recommendations, breakaway group participants mostly provided information in the form of observations, proposals, and explanations without linking these to knowledge claims. Such claims may have been elicited by asking participants, *how do you know that?*

The talk that did contain explicit knowledge claims was analysed to identify where this knowledge was experiential (making explicit reference to on-the-ground experience or practice) or evidence based

(making explicit reference to research or evidence). So, while most of the talk during the group discussions drew neither on evidence-based knowledge nor on experiential knowledge, there were more references to evidence-based knowledge during formal presentations than during group discussions. However, within the discussions, there were no clear differences between the frequency with which either experiential or evidence-based knowledge received responses or experienced engagement. In addition, neither evidence-based nor experiential knowledge appeared more likely to be reflected (inscribed) in group recommendations across all groups.

These were surprising findings. During policy consultation discussions, participants might be motivated to strengthen proposals or counter-proposals by drawing explicitly on knowledge claims, for example, from experience or from 'evidence'. Evidence-based or experiential knowledge might be more likely to be engaged with, attended to, or captured for different reasons – evidence-based knowledge because of its apparent credibility, for example, and experiential knowledge because of its emotive appeal. In the context of policy consultation discussions where service providers and service users are present, the discussions may be characterised by references to experiences of what works and what does not, from each of these perspectives. This certainly seemed to be supported by these findings, which showed that participants drew on experiential or evidence-based knowledge to illustrate a current situation (challenge or best practice) or to highlight the (positive or negative) implications of a proposal.

Possible reasons for the relative absence of such knowledge claims will be explored further in the discussion chapter (Chapter 5). However, the interview findings provide some potential insights. These findings indicated that there seems to have been inadequate service-user representation at the summit. In South Africa, the capacity of mental health care service users to engage in policy and service planning is limited, and, as interview respondents suggested, service-user-led advocacy organisations are in a 'fledgling state'. The technical and legal complexity of policy documents, as one interview respondent commented, requires extra support to enable service-user participation. In combination with the largely 'academic' way that the summit programme and process were structured, this suggests that the consultation space may not have been enabling of knowledge inputs that deviated from the more formal or academic styles. There was thus some complementarity here between interview findings and findings from the summit transcript analysis. However, the absence of explicit references to both experiential and evidence-based knowledge contradicts this somewhat. Possible explanations and implications of this will be discussed further in Chapter 5.

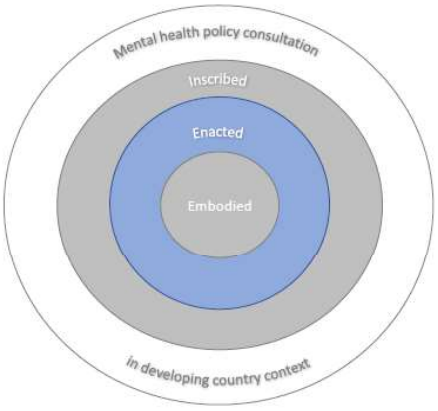
In addition, interview findings also suggested that what service-user representation there was may have been somewhat tokenistic. This implies that, even where service users' embodied knowledges were enacted, they were frequently not captured or transferred as inscribed knowledge, which supports the

summit transcript analysis findings. However, the equal likelihood of experiential and evidence-based knowledge being captured – or not being captured – suggests that other factors may have been at play. These will be further explored later.

Interestingly, the interview findings also pointed to the importance of individual-level influences on and during the policy consultation process – such as the initiative required of individuals to ensure participation, or the strength of certain perspectives in the policy document due to the strength of these voices in the finalisation process (technical task team). There is a slight disconnect here, between these findings and those from the summit transcript analysis discussed above, as the explicit voices of individuals (through explicit knowledge claims) did not come out strongly in the analysis. This has implications both for how individual participants engage with policy consultation processes, as well as for how such processes are structured and facilitated to allow for input from a wider variety of perspectives. The focus now shifts to a consideration of process-related elements.

4.7.2 Enacted knowledge inscribed

How did the consultation process enable or constrain the movement of knowledge from enacted to inscribed forms?



The focus of analysis here moved to a descriptive exploration of group processes at the national consultation summit, to explore how enacted knowledge in these spaces might have moved into inscribed knowledge. Interview participants were asked to comment on the overall consultation process, as well as on aspects relating to how knowledge inputs were transferred between and through the summits. As the interviews did not explicitly focus on the small group discussion sessions, there was not much data to triangulate with findings from the summit transcript analysis. The interviews did, however, highlight some inconsistencies with regard to the process of transferring knowledge inputs through the summits, and with how these inputs were intended to be (and ultimately were) used, which has implications for the interpretation of the analysis of group processes.

The national summit took place over two days. A large part of the programme was dedicated to formal plenary sessions, which included keynote addresses, formal presentations, and procedural and ceremonial formalities. Within the three-hour breakaway group sessions, there were further formal

presentations, and then group discussions and formulation of recommendations. Proportionately, then, there was little time for direct engagement and discussion around the draft policy. There were, however, ten of these breakaway group sessions, with each considering a different aspect of mental health relating to the policy. Although there was variable engagement with the two documents available for review (the draft policy and a draft summit declaration), the engagement of embodied with inscribed knowledge in these enacted spaces allowed for new knowledge to be created. This new knowledge would have left the enacted space as embodied knowledge within individual participants, and/or as inscribed knowledge within documents.

All of the breakaway groups were structured, for the most part, as a form of 'microphone management', with a Chair who facilitated the discussions through providing participants with the opportunity to speak by passing a microphone around the room. This created a somewhat stilted discussion, with direct interaction mostly occurring between the Chair and a particular participant, and with pauses between 'getting time with the mic' frequently resulting in a disconnect between points raised. Given what was mentioned above regarding the creation of new embodied knowledge during enactment, the limitations that a microphone management format placed on the discussions, and the limited time available, may also have limited the valuable exchange of knowledge (as well as the creation of new knowledge) that could have taken place between individuals. In this sense, the value that the policy consultation process could have had in and of itself may not have been optimised. The strong focus within group discussions on generating *inscribed* knowledge (recommendations) likely contributed to this, with individual participants getting limited opportunity and time to speak because of the need to 'get to the recommendations', which, in turn, placed limits on what they could say. This may, in part, help to explain the earlier findings that participants did not make explicit knowledge claims to support their proposals, rather using the time to make proposals in which such claims were assumed to be implicit.

Group processes also differed in relation to how groups formulated their recommendations – how enacted knowledge was captured as inscribed knowledge. There were inconsistences regarding processes through which recommendations were formulated, including a lack of clarity on how decisions were made regarding what inputs to prioritise as recommendations. There were differences across groups in terms of who was responsible for capturing (inscribed) enacted inputs and the form that this inscription took. In addition, the process varied in terms of the extent to which participants were given opportunities to engage with draft recommendations – either in enacted (oral report back) or inscribed (projected onto screen) forms – prior to these being finalised.

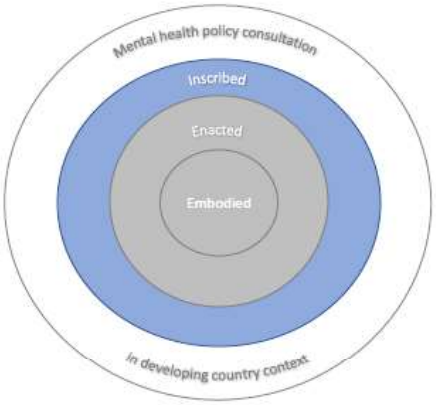
Furthermore, what got captured (inscribed) from the group discussions was largely dependent on the Chair and rapporteur, which picks up on the influence of individuals on process and outcome highlighted

in interview findings above. In addition, representativeness of stakeholders' perspectives at consultation events extends beyond their attendance, to whether opportunities to give input are taken up. For example, one interviewee observed that linking provincial summit feedback to national summit inputs was somewhat dependent on provincial representatives ensuring their participation in various breakaway group discussions. In one sense, then, the expression and selection of inputs during group discussions was somewhat arbitrary, depending on whether someone got the microphone or not. Certainly, the formulation of recommendations in most groups seemed to involve a discussion among a handful of individuals. This speaks to the importance of designing participatory processes that ensure that all voices have the chance to be heard. This is elaborated on further in the discussion chapter (Chapter 5).

Interview findings conveyed the sense that some or all of the consultation outputs were predetermined, which would have acted as a significant constraint on the opportunities for enacted and inscribed knowledge to move through the process. This, together with indications that the purpose of the summit may not have been explicitly focused on changing the policy itself, suggests that the way in which groups were run, and how they reached their recommendations, may have been somewhat inconsequential in terms of policy change. It also suggests that the follow-through of knowledge from group discussions into summit and policy outputs may have been influenced, at least in part, by this predetermination. The movement of knowledge inputs through inscribed outputs is discussed in the next subsection.

4.7.3 Inscribed knowledge transferred

How did inscribed knowledge outputs from the consultation move through points of abstraction to inform policy?



Inscribed knowledge was a central focus in this study, in part because it is considered a tangible, movable output of policy consultation events. The purpose of tracing knowledge inputs through the consultation process and between inscribed documents was not to establish a linear, causal link between summit inputs and summit and policy outputs. However, inscribed, documented knowledge is a critical element in a policy consultation process as it is knowledge that can be moved beyond embodied and enacted knowledge spaces to be seen and 'used' in policy. As such, tracing the transfer of inscribed knowledge from one document to the next through

the consultation, and ultimately to policy, could reveal what might have got lost – or 'abstracted out' – at each of these points of inscription. Tentative conclusions can be drawn, in turn, regarding the follow-through of knowledge inputs into policy, or at least their alignment with it.

4.7.3.1 Abstraction of inscribed knowledge inputs

Findings from the interview analysis seemed to highlight quite clearly the tension between moving from particular (detailed) or localised knowledge (such as that at individual or provincial level), to the more abstract inscribed knowledge of policy, with subsequent implications for policy implementation. Summit transcript and policy document analysis, at least at the level of inscribed knowledge transfer between documented outputs, seemed to mirror this tension.

Firstly, provincial summit inputs went through a number of points of inscription and summarisation to produce provincial summit recommendations. Comparison of these recommendations with national summit recommendations suggested broad alignment. However, the more detailed and localised recommendations from provincial summits were inevitably not reflected in the broadly focused national summit recommendations. In addition, the lack of consistency highlighted by interviews regarding whether and how provincial recommendations were used in or beyond the national summit suggests that alignment may have been more arbitrary or ad hoc than systematic.

Secondly, at each point of inscribed knowledge transfer during the national summit, there was a degree of abstraction, in which knowledge inputs were summarised to be included in the next 'level' of output. Although in most cases group recommendations broadly represented the content of group discussions, the enacted knowledge inputs during the group discussions were substantially abstracted and summarised in these recommendations. Similarly, summit declaration recommendations partially and broadly reflected group recommendations in summarised form, but much of the detail of the group recommendations was lost in moving from the 125 group recommendations to the eleven summit declaration recommendations.

Finally, analysis of summit and policy documents indicated greater alignment of the detail of group and summit recommendations with the detail contained in the two new additions to the policy following the national summit – the eight-point Strategic Plan and the Terms of Reference – than with the policy itself. This could indicate that the level of detail contained in knowledge inputs at policy consultation events may make such inputs more amenable for uptake into implementation-related plans (i.e. the operationalisation of the policy document). Interview findings complemented these findings in two ways. On the one hand, interview respondents suggested that there needed to be clearer, more detailed

directives in terms of how the policy should be implemented, thereby confirming what was shown in the analysis regarding alignment of (detailed) summit inputs with implementation-related outputs. On the other hand, the need for *more* detail suggested by interview participants could be linked to the loss of a significant amount of detail from summit inputs in the inscription and abstraction process.

This could also be linked to the lack of clear information or further consultation regarding the identification of priorities for implementation which was highlighted by the interview findings. Further consultation, particularly at provincial level, may have influenced not only the content of the implementation plan, but also the necessary buy-in or commitment to implementation of the policy. However, upon finalisation of policy, it is expected that provinces will develop their own provincial implementation plans, which is likely where such detail could be included. Nonetheless, the disconnect between provincial summit inputs and the national summit might similarly create a disconnect between nationally identified implementation priorities and the implementation priorities of provinces. These patterns regarding the abstraction and summarisation of inscribed knowledge were considered an interesting stand-alone finding, particularly in light of concerns raised by interview participants around the challenge of implementing the policy without sufficient detail on how to go about doing so. They may also provide some explanation for why there did not appear to be significant follow-through of summit inputs to policy outputs. This is discussed further below.

4.7.3.2 Follow-through of inscribed knowledge inputs

In terms of the influence of the consultation summit on the final policy, there was a lack of clear information regarding how the inputs and outputs of the consultation summits were used during the policy finalisation process. The absence of audio recordings or records from the closed-door meeting at the national summit, at which group recommendations were summarised into summit declaration recommendations, limits what can be known or concluded regarding the follow-through from group inputs to summit outputs. It was therefore only possible to make tentative inferences regarding observed alignment of inscribed knowledge in summit documents with inscribed knowledge in the policy document (e.g. reflection of summit inputs in the eight-point implementation plan). Interview findings were particularly valuable in corroborating or disconfirming these inferences. Stronger conclusions might be drawn about what got lost than about content that was consistent across these documents, as many other factors are likely to have influenced what got 'taken up' into policy from the consultation summits, and from elsewhere.

The clearest indication that the consultation summits did not influence or inform policy is revealed in the findings that the policy content did not change substantively following the consultation summit, and

that the group and summit declaration recommendations did not seem to be reflected in the changes that *were* made to the final policy. This may, in part, be because few of the breakaway groups engaged directly with the draft policy document during the summit. However, there was also strong convergence with interview findings regarding the lack of policy change following the consultation. In addition to the lack of transparency and consistency regarding whether and how summit inputs were used during finalisation of the policy, interviewees also gave some indication that consultation outputs may have been somewhat predetermined. They suggested, too, that the consultation summits may have been more of a rubber-stamping exercise than a genuine dialogue. This supports findings from the comparative document analysis showing few changes between draft and final policies which, in turn, suggests that the purpose of the summit may not genuinely have been to make substantive amendments to the policy document.

However, analysis also indicated that the eleven summit declaration recommendations were broadly aligned with the content of the draft policy, while the group recommendations requiring policy change built on the existing (draft) policy content, rather than opposing it, or requiring modifications that would change the nature or direction of the overall policy approach. There were some indications in the interview findings that many of the issues raised during summit discussions were already reflected in the draft policy document. Nonetheless, the fact that more than half of the group recommendations were *not* reflected in this draft policy suggests that, consistent with the abstraction theme discussed above, much valuable information that may have contributed to the policy was not followed through from the consultation summits. This may be partially explained by the reflection of recommendations in the implementation-related appendices which were added to the policy during its finalisation. This alignment is discussed further below.

This study also revealed inconsistencies in format and availability of provincial reports, as well as the link between provincial feedback and the national summit. It was therefore not clear how provincial recommendations, based on localised knowledge, would follow through into policy, and, similarly, how the policy would be translated or filtered through these local concerns in its implementation. These findings converged with interview findings regarding the disconnect between provincial and national levels and the subsequent potential impact on policy implementation. Furthermore, the fact that only one province recommended the establishment of district mental health teams – a clear priority at national level as reflected in its inclusion on the eight-point implementation plan – suggests a disconnect between national and provincial priorities which, in turn, may create challenges at the level of implementation. This is also evident in the notable absence of child and adolescent mental health in national-level recommendations and priorities, despite this being a clear priority across all provincial summit reports.

The majority of the summit declaration recommendations seemed to be broadly reflected in one or both of the implementation-related appendices (eight-point Strategic Plan, and Terms of Reference) added to the policy during the finalisation process. However, the broadly phrased summit declarations allowed for a great deal of leeway in determining alignment, such that alignment may have been more a reflection of alignment of *topic* than alignment of content. Certainly, there was less reflection of the more detailed group recommendations in these implementation-related documents – fewer than half of the group recommendations were reflected in them. This could be interpreted in at least two ways. On the one hand, it suggests that a substantial amount of knowledge inputs at the summits was 'lost' to policy. On the other hand, the reflection of nearly half of the detailed recommendations made at the summit in the policy and implementation-related appendices could be interpreted as a significant uptake in the context of policy development, particularly given the degrees of abstraction that were evident as inscribed knowledge was transferred through the consultation summit and into policy outputs.

It might be argued that not all issues raised during the consultation process could or should be prioritised for implementation. This is neither feasible nor possibly even advisable. There were indications in the interview findings that certain issues that had been flagged as important during summit group discussions – notably, the establishment of district mental health teams, and African language proficiency requirement in training of mental health care practitioners – had in fact been included in the implementation plan, where they had not previously appeared in the policy. In addition, there were various indications during the summit (such as in instructions given) that one of the purposes of the consultation may have been to inform implementation priorities. Nonetheless, the fact that few groups at the summit engaged directly with the policy when making their recommendations suggests that there may be a disconnect between recommended actions for implementation and policy content. A more systematic process may be needed to ensure that these are aligned.

4.7.4 From the outside in: Conclusions

The aim of this study was to explore how the mental health policy consultation process undertaken in South Africa in 2012 informed policy, by tracing the movement of different forms of knowledge through the provincial and national consultation summits. Ultimately, no clear conclusions can be drawn regarding whether, and how, knowledge inputs at the summits were followed through into the final policy document. There are a number of indications in the findings as to why this may have been the case – for example, the substantial abstraction and summarisation of knowledge as it moved through points of inscription, or the limitations that process-related elements may have placed on the

enactment and inscription of embodied knowledge. It is also possible that summits may have served either as a rubber-stamping exercise, or an endorsement of the draft policy, or perhaps as a means of identifying priorities for implementation.

Findings suggest that the consultation process was not structured in a sufficiently systematic way that could have optimised the movement of knowledge from embodied to enacted to inscribed forms. The findings of this study also seem to indicate quite clearly the tension between moving from individual or local (more detailed or contextualised) knowledge to the more abstract, generalised knowledge of policy, such that this enables the enactment of this policy at local levels during implementation. It highlights the dilemma for policymakers in including sufficient detail to facilitate implementation, while broadly responding to mental health care needs within national health system frameworks and feasibility constraints. The pragmatic and conceptual implications of these findings are explored further in the next chapter.

Chapter 5: Discussion, conclusion, and recommendations

5.1 Introduction

5.1.1 Conceptualising the study: A knowledge-in-policy framework

Some of the most interesting questions about knowledge in policy seem to be connected with questions about its movement.

(Freeman & Sturdy, 2015a, p. 14).

Policymaking in mental health has been conceptualised in this study as something of a knowledge problem for policymakers (Maybin, 2013), in which multiple knowledge inputs must be balanced within the context of health system complexities and constraints. There are also increasing demands on policymakers to ensure that policies are evidence based, to improve their efficiency, as well as to include a broader range of stakeholders in the decision-making process. However, these evidence-based knowledge inputs, and the perspectives of the public in relation to particular policy issues, may not always be aligned. Policy consultation is important as a democratic mandate, but also to ensure that policies speak to the needs and concerns of those 'on the ground'. While the transfer of knowledge in evidence-based policymaking has received much attention, the specific ways in which knowledge moves through a policy consultation process have yet to be understood. In addition, the ways in which knowledge moves back and forth between policy development and policy implementation spaces is a relatively under-researched area in LMIC contexts, while the link that consultation might provide between these inscribed and enacted spaces has not been extensively explored from a knowledge perspective.

The policymaking context in South Africa is a complex space, not least because of the serious challenges that public policies must address in our post-apartheid society (Gumede, 2008; Roux, 2002). This study has focused specifically on some key policy processes in this space – namely, evidence-based policymaking, public participation and policy consultation, and mental health policy development and implementation. I briefly outline again here what is known about each of these areas in the South African context, thereby highlighting the gaps that this study aimed to address. Evidence-based policymaking generally and in the health domain specifically is widely accepted as important. In the South African context, there is a growing body of research on the dynamics of this process which focusses on, for example, the broader gaps and opportunities for increasing uptake of evidence into policy (Funke et al., 2011; Marais & Matebesi, 2013; Strydom et al., 2010; Young et al., 2016). In

addition, at a more micro level, research has focused on ways of optimising more direct interactions and knowledge exchanges between researchers and policymakers (Gilson & McIntyre, 2008; Langlois et al., 2016; Naude et al., 2015). There are also efforts to understand and improve the link between policy development and policy implementation, although empirical research on this policy-implementation gap in the South African context remains scarce (Brynard, 2007; Erasmus, Orgill, Schneider, & Gilson, 2014; Gilson & Raphaely, 2008; Meessen et al., 2011).

Public participation in government decision-making – and policy consultation as a form of this – is another area in which multiple stakeholders with different knowledge interests come together to negotiate around these inputs. In South Africa, public participation is well legislated, capturing principles of participatory democracy and the rights of citizens to have a voice in decisions that affect them. Research on public participation in South Africa has occurred across diverse disciplines in relation to different policy and service-planning issues. This research has identified several approaches to public participation at different levels of government. In particular, the focus has been on the participation of civil society and communities in local governance structures and decision-making processes (Mbuyisa, 2013; Mubangizi & Gray, 2011; Piper & von Lieres, 2008).

What this research has highlighted is that the principles on which legislative mandates are based are difficult to operationalise and realise in practice (Buccus et al., 2008; Piper, 2011; Theron et al., 2007). Less is known, however, about processes at provincial and national levels concerning the development of national policies (Buccus et al., 2008). It might be expected that the complexities of engaging communities at more local governance sites are mirrored at national level and are perhaps even magnified the further away the decision-making process moves from local sites to 'the public'.

Mental health policymaking and implementation in South Africa is a relatively well-researched area (Draper et al., 2009; Flisher et al., 2007; Lund et al., 2008; Schneider et al., 2016), with a number of initiatives aimed at strengthening the mental health system and contributing to our understandings of how to optimise mental health service delivery to address the treatment gap (Lund et al., 2012; Marais & Petersen, 2015; Mugisha et al., 2017; Petersen et al., 2016; Petersen et al., 2017; Semrau et al., 2015). There are ongoing challenges in responding to the growing burden of mental illness against a complex landscape of communicable and non-communicable health needs and health system constraints, and these are hampering implementation of the *Mental Health Policy Framework and Strategic Plan 2013-2020* (Burgess, 2016; Schneider et al., 2016; van der Merwe, 2015). There also continue to be gaps between the sites of policy formulation at national level and policy implementation at provincial level, which further hinder implementation (McIntyre & Klugman, 2003). Although there is some local research highlighting the importance of participation in mental health policy development of service

providers (Burgess, 2016; Petersen, 2000) and service users (Kleintjes et al., 2010; Kleintjes et al., 2012; Kleintjes et al., 2013; Semrau et al., 2016), the actual mechanisms of this consultation have not been explored.

Conceptualising mental health policy consultation from a knowledge perspective illuminates the complexity of reconciling multiple knowledge inputs from diverse groups, as well as possible points of contestation between different kinds of knowledge from different sources. There is thus a need to understand how to integrate knowledge inputs to policy during consultation processes, particularly in contexts where stakeholder groups may have very different values to the scientific establishment, as well as to the environments in which the evidence is collected. Listening to and integrating these views into government decision-making has been an ongoing theme in local legislative and empirical guidance on public participation (Legislative Sector Support Project, 2013; Roefs & Liebenberg, 2000; Sebola, 2016; Theron et al., 2007) and in international best practice guidance on mental health policy development (WHO, 2007, 2009). However, these fail to provide detailed guidance on how to actually do this at a micro-process level. This is the gap that this study sought to address.

If it is accepted that mental health policy consultation is important, it follows that we need to better understand how to implement consultation processes that achieve the principles on which policy consultation is based. What kinds of participatory processes might balance these multiple – and often conflicting – voices and views in a way that gives space for all to be heard, and that simultaneously realises the value that all these views offer? How might we ensure that such processes have the potential to influence or at least inform policy? These were the questions that provided the impetus for this study. Considering the complexity of the context and of the knowledge inputs that must be reconciled, my contention was that policy consultation processes cannot just be 'business as usual'. Policy consultation thus far has been good at raising the profile of mental health and at getting many voices in the room, but not really giving consideration to what sorts of participatory process formats might be optimal, nor how to use and move knowledge through these processes (Horlick-Jones et al., 2007; Rowe & Frewer, 2005).

The South African mental health consultation summits offered a unique window on the interaction of all these dynamics within the context described above. The premise of this study was that attending to how knowledge moves through this process could go some way towards aligning the practices of consultation with the principles of consultation. Specifically, understanding how to design such processes so that the use and transfer of different kinds of knowledge is optimised has the potential to inform future policy consultation efforts that both enable meaningful participation and are responsive to the knowledge contributions made in these spaces.

The aim of this study was therefore to explore how a particular mental health policy consultation process informed policy by tracing the movement of different forms of knowledge through the process. The case used in this study was the national mental health consultation summit that was held in South Africa in April 2012, prior to the finalisation of the *Mental Health Policy Framework and Strategic Plan 2013-2020*. It was not my intention in this study to evaluate or comment on the success or failure of the policy consultation exercise *per se,* but rather to explore what examining the movement of knowledge might illuminate about the process. The importance of the role of knowledge and knowledge transfer in policy(making) was explored in the literature review, which highlighted that there is value in considering policy from a knowledge perspective. I used Freeman and Sturdy's (2015a) *embodied-enacted-inscribed* knowledge framework as the analytical lens in this study, as it was my contention that it spoke to the dilemma that policymakers face in reconciling the tension between abstract and particular forms of knowledge. The framework also emphasises the transformation and movement of knowledge from one form to another, which makes it a particularly useful framework for policy consultation processes.

Viewed through the lens of this framework, policy consultation is a site of knowledge enactment, where the embodied knowledge enacted by individuals engages with the inscribed knowledge contained in policy documents, creating new forms of embodied and inscribed knowledge that can move beyond these enacted spaces. A policy consultation event thus represents a microcosm in which the interaction of these three phases of knowledge can be studied. The *embodied-enacted-inscribed* framework was used in this study, then, not as an explanation, but "as a means of seeing what is to be explained" (Freeman & Sturdy, 2015b, p. 201). While previous research suggests that there is value in viewing mental health policy consultation through this lens (Freeman & Sturdy, 2015a, 2015b; Smith-Merry, 2012, 2015), the current study takes this research agenda forward by exploring its application in a developing country context. In the context of the dilemma facing policymakers in reconciling multiple knowledge inputs, this framework allows us to consider different forms of knowledge not as preceding nor as superior to one another, but rather as having unique characteristics that are "sometimes complementary and sometimes competing" (Freeman & Sturdy, 2015b, p. 214). It also highlights the importance of attending to the points at which knowledge transforms between embodied, enacted, and inscribed forms (Smith-Merry, 2015; Thunus, Cerfontaine, & Schoenaers, 2015).

5.1.2 Conducting the study: From *what* to *how* to *why*

At the start of this study, I outlined a rationale for the importance of this study in mental health in a developing country context. The study was contextualised in relation to bodies of work from which its key concepts were drawn. My own research study then proceeded through three levels of reflective

knowledge construction (Mezirow, 1991): i) content reflection (*what* happened); ii) process reflection (*how* it happened) and iii) premise reflection (*why* it happened) (Kreber & Cranton, 2000). Preliminary analysis comparing the draft pre-summit and final post-summit policy documents revealed that the policy did not seem to change in any substantive way following the consultation. This served as the point of departure for this study, prompting a more in-depth exploration of what happened at the consultation summits. This in-depth analysis of the consultation process allowed me to consider how this happened, in relation to three research questions: i) How were participants' embodied knowledges enacted and inscribed during the consultation process?; ii) How did the consultation process enable or constrain movement of knowledge from enacted to inscribed forms?; and iii) How did inscribed knowledge outputs move through points of abstraction to inform policy?

The preceding chapter has presented findings in relation to these three research questions, ending with a triangulated overview of how these questions have been addressed. These findings revealed a number of positive aspects of the mental health policy consultation process undertaken in South Africa. There was clearly significant investment in financial and human terms in getting mental health onto the policy agenda, as well as in engaging in extensive consultation around the policy through the provincial and national mental health summits. The consultation summits raised the profile of mental health and signalled the commitment of the Department of Health (DoH) to prioritise mental health as an important issue to be addressed. There was also high-level endorsement of the mental health policy at the summit, most notably from the Minister of Health and from the World Health Organization. In addition, the findings of this study suggest that no significant objections to the draft policy were raised at the national summit. However, the finding that the policy itself did not seem to change in any substantive way following the summit raised questions about what the purpose of the consultation process had been, and what had happened to the inputs made during the provincial and national summits.

The complexity of the policymaking process has been highlighted at various points throughout this study. It is acknowledged again here that a direct linear or causal link cannot be drawn between the content of a consultation process and the content of the policy that is adopted at the end of it. Use or influence of policy consultation inputs on policy is difficult to tease out (Abelson & Gauvin, 2006; Conklin, et al., 2015; Li et al., 2015; Rowe & Frewer, 2000). However, at the micro level of knowledge transfer, there does need to be a means of moving knowledge inputs from an enacted consultation space to where it can be seen and used by policymakers. If it is accepted that policy consultation is important as a form of public participation, among other things, then the inputs at consultation events need to at least have the *potential* to be used in policy, at least in instrumental ways. This, in turn, implies that knowledge inputs and outputs need to be optimised during this process (Rowe & Frewer,

2005). In the absence of this, it is difficult to see how consultation could be linked to policy, even indirectly. What occurs during the policy finalisation process in terms of what is prioritised, what is included, and what is excluded, is a matter beyond the consultation space, and beyond the scope of this study. There should nonetheless be a systematic process for moving knowledge through consultation and beyond, and a process for providing feedback regarding if and how this knowledge was used.

The findings of this study have provided some insights into how knowledge moves through a policy consultation process, and how viewing this process using the *embodied-enacted-inscribed* lens helps to illuminate the points at which careful attention must be paid to the engagement with different forms of knowledge. The findings also suggest that the detailed, contextual embodied knowledge that consultation processes are presumably organised to acquire may have value for certain elements of policy, in particular, the development of implementation plans. There are numerous indications in the findings that if knowledge is not attended to consciously in policy consultation, much of the value of both the consultation and the knowledges available through it might be lost. In this chapter, I reflect further on *why* this might have happened, and then consider what the findings mean in relation to the broader context of mental health policy consultation in developing countries.

5.1.3 Considering the why: Structure of this chapter

As mentioned above, this chapter provides a critical and conceptual interpretation of why what happened to knowledge during a consultation process happened in the way that it did, and what this means in the context of what we know about this issue. In the current chapter, I draw on the findings presented previously to offer a number of possible ways of understanding why this particular consultation – and specifically the movement of knowledge in this consultation – unfolded as it did. I then reflect on how these insights relate to the existing literature and draw on this literature to consider the implications of these findings – what they mean for knowledge in policy consultation. This I consider in conjunction with what the *embodied-enacted-inscribed* knowledge framework has illuminated about the role of knowledge in policy(making).

The structure of this chapter maps onto that of the sections in the findings chapter, which were organised according to the *embodied-enacted-inscribed* knowledge analytical framework. The discussion comprises three sections, making sense of the findings: i) at a micro (individual) level of embodied-enacted knowledge, ii) at a meso (process) level of enacted-inscribed knowledge, and iii) at a macro level of inscribed-inscribed knowledge and the movement of this knowledge beyond the policy consultation space. Each of these three sections is structured as follows. The relevant findings are broadly restated, reiterating why this was explored based on what had been highlighted in the

literature, and foregrounding relevant components of the knowledge framework in terms of how they relate to this level of policy consultation. I then offer and consider a number of possibilities, drawn from my findings, as to why this happened. For ease of reference, these are presented as an overview at the start of each section. Some of these speak more to policy consultation processes in and of themselves; others speak more to how knowledge seems to have been functioning in these spaces. What is clear is that both of these have an influence on the other. For each of these possibilities, I then explore what the findings of this study mean in relation to existing literature – whether they confirm or contradict previous work, or illuminate gaps. This is particularly important in case study research, as a means of showing the implications of this study's findings for the broader context of policy consultation and the role of knowledge in policy(making).

In the conclusion, I consider at a meta-level why these findings are important: what they tell us about policy consultation and, in turn, what they tell us about knowledge in policy. In particular, I outline the contribution that this study makes in the context of mental health policy consultation in developing countries. Following this, I consider a number of possible objections to this study on conceptual and methodological grounds, as a way of acknowledging the study's limitations. Implications for practice and recommendations for further research are then presented, followed by a chapter conclusion.

5.2 Policy consultation at the micro level: Embodied-enacted knowledge

Expertise, of all kinds, is necessarily embodied … In order to observe embodied knowledge, we must inevitably look at and infer how that knowledge is enacted.

(Freeman & Sturdy, 2015b, p. 203).

Overview

5.2.1 The exclusion of embodied experience: Under-representation of service users meant that there may have been fewer contributions of embodied experiential knowledge.

5.2.2 The implicit rules of enactment: Implicit rules of the game communicated to participants that making explicit knowledge claims was not permissible.

5.2.3 The assumption of shared knowledge: Participants were among familiar and similar communities of practice and could leave (shared) knowledge claims implicit.

5.2.4 An emphasis on enacted and inscribed forms: An emphasis on enacted and inscribed knowledge forms limited the expression of embodied knowledge.

The micro level of policy consultation – where individuals engage with policy documents and in discussion with one another – provides a window on how embodied knowledge comes to be enacted in these spaces. The focus in this study was on two particular forms of embodied knowledge – evidence-based (embrained) knowledge and experiential knowledge – and the ways in which these were enacted, responded to, and inscribed during group discussions. In the literature review, I presented research that emphasised the value of experiential and practical knowledge – that is, more tacit forms of embodied knowledge – in policy(making). The existing literature also highlighted several unique challenges associated with optimising this kind of knowledge, including the difficulty of eliciting and capturing tact knowledge, and the tendency for this knowledge to be considered less legitimate than more explicit, evidence-based knowledge. I considered it particularly important to focus on these more experiential or tacit forms of knowledge because of their likely use by mental health care practitioners and mental health service users in policy consultation spaces. In addition, there is little research on the ways in which people actually make contributions in these spaces, beyond the level of consultation methods employed (Horlick-Jones et al., 2007). Exploring how inputs are made at this micro level could therefore contribute to understandings of how knowledge functions in such spaces.

In this study, neither evidence-based knowledge nor experiential knowledge was found to have been explicitly drawn on to substantiate claims for or against policy proposals. Neither of these forms of embodied knowledge appeared more likely than the other to have been responded to or inscribed in group recommendations. Although these findings in some ways seemed to confirm the difficulties inherent in eliciting and capturing tacit embodied knowledge (Catt & Murphy, 2003; Smith-Merry, 2012), there were a number of surprising aspects in what was found. One was the relative lack of explicit reference to both evidence-based and experiential knowledge in these micro-level discussions. Another was that evidence-based knowledge did not seem to be favoured over experiential knowledge as a more legitimate knowledge source, which would have increased the likelihood of it being engaged with or recorded in recommendations. In the subsections that follow, I draw on a number of possibilities that emerged from the findings to understand why this might have occurred. Each of these is considered in relation to existing conceptual and empirical work.

5.2.1 The exclusion of embodied experience

The poor representation of mental health care service users at the national consultation summit may be one reason for the observed lack of explicit experiential knowledge drawn on during group discussions. This confirms other studies demonstrating a lack of service-user participation in policy development in LMICs (Abayneh et al., 2017; Gurung et al., 2017; Semrau et al., 2016), and in South Africa in particular (Kleintjes, 2010; Kleintjes et al., 2012). It was also evident in this study, as in other studies (Ocloo &

Matthews, 2016; Smith-Merry, 2015), that the limited service-user involvement in the consultation summit appeared to be somewhat tokenistic. This situation risks perpetuating the negative perceptions and stigma regarding service users from which such tokenistic involvement stems (Kleintjes et al., 2010).

In the context of South Africa's apartheid legacy, its legislative mandate for public participation (Buccus & Hicks, 2011; Nyalunga, 2006), and its strong constitutional focus on human rights (Republic of South Africa, 1996), it is disappointing that more emphasis was not placed on service-user participation in the mental health policy consultation summit. This is in spite of local and international recognition of the importance of service-user involvement in mental health policy and service planning (Kleintjes, 2012; Thornicroft & Tansella, 2005). Not only is attending to lay knowledge considered a measure of effectiveness in consultation (Rowe & Frewer, 2004), but the participation of service users can provide valuable perspectives on the lived realities of policy proposals (Jenkins, 2003; Noorani, 2013), as well as serve as a mechanism for service-user empowerment (Kleintjes et al., 2010; Kleintjes et al., 2012; Mezzina et al., 2006).

In contrast to studies showing that inputs from the public during policy consultation are more likely to be in embodied, experiential forms than in the factual or formal language of policy (Farina et al., 2012; Morrison & Dearden, 2013), this study did not find this to be the case. This may be, in part, because those who came with more experiential or practical kinds of knowledge felt that they needed to align their inputs with more formal or explicit knowledge forms in order for them – and their contributions – to be seen as legitimate. This aligns with previous findings highlighting implicit demands on service-user participants to professionalise their talk (Demszky & Nassehi, 2012; Enany et al., 2013), or to translate their experiences into "actionable, bureaucratic vocabulary" (Aronson, 1993, p. 371) in order to be heard. The efforts by Chairs to reframe participant inputs in the form of indicator-linked proposals or recommendations may also have contributed to this. This speaks to the further sidelining of service-user or lay participants through the silencing of embodied knowledge during policy consultation processes, echoing what Smith-Merry (2015, p. 36) found to be "new ambivalences that were emerging around the role of embodied knowledge within the mental health policy sphere".

Thus, one possibility for the infrequency of explicit claims in reference to embodied knowledge found in this study is the potential (and ongoing) sidelining and silencing of mental health care service users' inputs. There are implications in this regarding the implicit 'rules of the game' according to which participants are expected to contribute in specific ways to policy consultation processes. However, the finding that there was equally infrequent reference to evidence-based knowledge during the consultation discussions suggests that it was not just experiential embodied knowledge that was disallowed, whether implicitly or explicitly. As mentioned earlier, this was a particularly surprising

finding in light of the well-known dominance of evidence-based or expert knowledge over other knowledge forms. This might imply reliance on the implicit 'expertise' of the speaker, whereby participants did not appear to experience any need to back their claims.

Another discrepancy with respect to the relative lack of explicit reference to evidence-based knowledge claims is the emphasis that the national DoH places on developing policies that are evidence based. This is highlighted both by the Director General of Health's foreword in the mental health policy document, as well as the way in which policymakers made use of findings from a comprehensive research study on mental health in South Africa as the basis for the policy. The lack of consideration of evidence-informed proposals at the national summit seems contrary to this, particularly given this study's findings that what got captured and formulated into recommendations was more a result of individual-level influences and ad hoc processes than a considered weighing up of various knowledge inputs.

It has been emphasised in this study that different kinds of knowledge offer different kinds of value with respect to policy. There are also risks in attending to all knowledge as equally valid. If knowledge in policy consultation is to be more explicitly managed, there is a need for credibility criteria against which knowledge contributions might be assessed. An important first step towards this would be to ask participants to provide verification of their own claims (asking, for example, *How do you know that?),* in order for others to assess the relevance of such knowledge inputs for the policy issue at hand. In some ways, then, what got responded to and inscribed in enacted spaces in this case study seemed somewhat arbitrary, given that much of the talk in group discussions was classified as *Other* (for example, reiterating or countering statements made by others, or generic observations or opinions), with no explicit reference to knowledge claims to substantiate statements or justify proposals. Looking more closely at how knowledge was enacted might shed some light on why this was the case.

5.2.2 The implicit rules of enactment

Another explanation for why participants made few explicit evidence-based or experiential knowledge claims in this study is linked to implicit communication around the rules of engagement during the consultation process. The implicit rules of the game (Barnes, 2002) connected to the specific format adopted at this consultation summit may have allowed or disallowed particular forms of knowledge to be enacted. In addition, the "language games" (Wittgenstein, 1953, p. 592, in Morrison & Dearden, 2013, p. 181) inherent in such participatory processes allow for particular ways in which embodied knowledge can be enacted. This aligns with previous work showing that different forms of participation affect the ways in which people are able to participate (Barnes et al., 2003; Barnes et al., 2004; Young, 2000).

It is important to note here that only secondary sources were available for analysis, and that audio recordings of the group sessions are no substitute for first-person observations of the enacted spaces. It is therefore not possible to draw firm conclusions regarding what was explicitly or implicitly communicated to (and between) participants during group discussions. However, there were some indications in the findings that certain forms of input were more acceptable than others, and that certain groups of participants – in this case, service users – were only invited to contribute in prescribed forms (e.g. telling a story; reading out the declaration).

This might also go some way towards explaining why there were few explicit references to evidence-based knowledge during the summit discussions. The framing of each breakaway group session with formal presentations by experts in the relevant field may have already laid the 'evidence' groundwork around which contributions could take place. This certainly seemed to be the case for those groups in which participants used both the presentation and presenter as reference points throughout the discussion. Thus, participants allowed these presentations to do the work of evidence-based knowledge, such as legitimating certain proposals. It may also have been the case that these expert presentations served to communicate certain rules according to which contributions could be made, perhaps even *dis*allowing evidence-based claims from individual participants. Requests from Chairs to participants not to make speeches, but to rather to leave this to the experts, lend support to this. In other words, perhaps certain individuals – in this case, the presenters – were perceived to have certain rights to make evidence-based claims, while other participants were not. In this way, the implicit rules of enactment may have served as a form of surveillance and sanctioning that monitored and regulated how knowledge could be enacted in these formal conventionalised settings (Freeman & Sturdy, 2015a).

These findings seem to support Smith-Merry's (2015, p. 37) assertion that "enactment processes are thus critical to the transfer of knowledge through and between individuals, groups and sectors". This further suggests that one reason that the influence of consultation inputs on policy decisions is hard to ascertain is that such inputs may come in a form that is difficult to translate into policy; in turn, this affects their perceived legitimacy. However, this is not completely confirmed by the current study's findings, given that not many of the inputs seemed to come in this form. In fact, there was no evidence in this study of the dichotomy between evidence-based and experiential knowledge, nor of the prioritisation of the former over the latter. This suggests that there may have been other factors that influenced the movement of knowledge through the consultation process. Some of these are considered next.

5.2.3 The assumption of shared knowledge

The under-representation of service users at the summit and the implicit rules of the game communicated in the enacted spaces offer some explanations for the finding that participants seldom made explicit knowledge claims. This is despite the fact that appeals to both evidence and experience have been shown to be useful in persuading others on the merits of an argument or legitimacy of a position (Adams, 2014; Gabriel, 2004; Grundman & Stehr, 2012; Hornikz, 2005; Hurrell, 2005; McDonough, 2001; Polletta & Lee, 2006). The relative lack of such claims in this study stands in contrast to a number of other studies which have identified the use of explicit claims to motivate for particular positions or proposals. Cheng and Johnstone (2002), for example, found that people appealed to their own personal experience and gave reasons for policy claims much more often than for other forms of claims. In her study on knowledge and knowing in policy work, Maybin (2013, p. 3) found that policymakers make pragmatic use of knowledge claims – facts, figures and stories – to "generate support for policies and to defend decisions taken". However, Maybin's (2013) study was focused on policymakers themselves, and on how they used knowledge in their everyday work. The current study's finding that neither evidence-based nor experiential knowledge claims were frequently referenced during consultation discussions could also be because it was not necessary for participants to make these knowledge claims explicit. This is explored further below.

As mentioned earlier, there is little research on the ways that people actually engage or deliberate in policy discussions. The public participation literature tends to focus on process and outcome measures of effectiveness (Rowe & Frewer, 2000, 2004). Similarly, the research on deliberation in policy consultation has been more concerned with outcomes and effects than on how citizens actually deliberate, with a few notable exceptions (Adams, 2014; Polletta & Lee, 2006). However, considerations of participants' knowledge and responsiveness to other participants' recommendations are included as criteria for assessing the effectiveness of consultation processes (Abelson & Gauvin, 2006), as is providing participants with the opportunity to persuade others of their point of view (Abelson et al., 2003; Habermas, 1984).

In the absence of empirical or conceptual work on this issue, it is difficult to assess the tendency for participants in this study to make proposals or statements without explicit knowledge claim references. One possible explanation might be the implicit assumption of shared knowledge. Antaki and Leuder (1990, p. 279) studied the role of "claim-backing – the use of explanations to warrant the truth of what is said" in rhetoric and argumentation – and suggested that "the way people back claims reveals the mutual knowledge on which their appeals succeed or fail". While the point of making explicit claims or giving reasons might be to justify a particular position, Adams (2014) suggests that this may not be

necessary if speakers and listeners share the same background. He argues that "when talking with those who are similar to us, we can get away with implying large parts of our argument because others will be able to fill in the blanks" (Adams, 2014, p. 2).

In the current study's findings, there were indications that, while there were few service users at the summit, there were greater numbers of academics/researchers and practitioners – or individuals who occupied both roles. This was evident in the introductions that some groups engaged in during group sessions; it was also seen in the programme, as well as this study's interview participants' observations that particular voices or perspectives were strongly represented in both the policy and the implementation plan. It might be fair to assume, then, that the groups comprised somewhat familiar communities of practice – or, in Freeman and Sturdy's (2015a, p. 14) terms, "communities of knowers" – and that participants did not feel it necessary to link their statements or proposals back to explicit knowledge claims.

It is still my contention, however, that it is important for consultation participants to be enabled to draw on their embodied knowledge by making explicit knowledge claims, whether to evidence-based knowledge or experiential knowledge. This is in part because of arguments made earlier regarding the importance of enabling experiential knowledge inputs in the context of mental health care service-user involvement in policy consultation, as well as the value of such inputs for illuminating potential implementation challenges or opportunities. Furthermore, there are calls to establish credibility criteria for the use of experiential knowledge, in particular, in policy (Greenhalgh, 2016; Jones et al., 2012; Saltelli & Giampietro, 2015). One way of doing this might be to link claims explicitly to experience, so that listeners are able to assess the applicability of such claims to their own experience or contexts. This, in turn, suggests that the necessary conditions should be set up that would enable all participants in policy consultation processes to contribute their knowledge in ways that have value for policymakers (Morrison & Dearden, 2013; Petts, 2008).

However, there were indications in the findings of an awareness among Chairs of time constraints, as well as of certain restrictions that the microphone management format may have placed on the enactment of embodied knowledge. This may also have contributed to the relative absence of explicit knowledge claims in comparison with other forms of talk. This supports Adams' (2014, p. 20) contention that an:

> off the top of the head format … could constrain the ability of deliberators to use evidence effectively, [while] a format where participants have more time to think through an argument before presenting it might lead to different conversational dynamics … [and allow] deliberators to construct coherent arguments in support of their positions.

The format and facilitation of such processes is considered in more detail later. Another possible constraint on knowledge claims as an enactment of embodied knowledge may have been the emphasis in group discussions on getting to recommendations – that is, on inscribed knowledge. This is considered next.

5.2.4 An emphasis on enacted and inscribed knowledge forms

While evidence-based and experiential knowledge claims were not clearly evident in these findings, what emerged more clearly was that emphasis was placed on some *phases* of knowledge more than on others. Specifically, the emphasis was on the somewhat rapid transformation of enacted knowledge into inscribed knowledge. In other words, the pressure to produce recommendations and the limited time available to do this meant that the knowledge that was enacted during group discussions tended to be quickly transformed into a form that made it more amenable to inscription. This, together with what has been discussed above, might explain the relative lack of explicitly referenced experiential and evidence-based knowledge. It also might explain the surprising finding that the traditional evidence-experience dichotomy was not present.

Instead, it suggests that attending to phases of knowledge may be more important than being concerned with the legitimacy of evidence-based or experiential knowledges. In particular, if the goal of consultation is to draw on the knowledge that participants bring, more time and space need to be provided for enacted knowledge forms, before attending to how this enacted knowledge might be captured in inscribed form. It nonetheless still points to – perhaps even more so – the importance of creating processes that enable not only the enactment of embodied knowledge, but also the interactions and transformations between the three knowledge forms: embodied, enacted, and inscribed knowledge. In order to give input on draft policies, consultation participants must be afforded the chance to properly engage with the inscribed knowledge of this policy during discussions; this, in turn, might produce enacted knowledge that is of greater value to policymakers than embodied or inscribed knowledge alone.

To some extent, the focus on inscribed knowledge speaks to the purpose of policy consultation – the necessity of gathering and capturing a large amount of input. However, it seems that, in this particular consultation at least, more attention was paid to the *what* of what was captured than to the *how* of capturing it, and the extent to which the latter might have optimised use of valuable knowledges. Even where embodied knowledge interacted explicitly with inscribed knowledge in the creation of new enacted knowledge (e.g. through engaging with draft policy), this did not seem to have had any effect on the resulting inscribed (final) policy. As has been argued in this study, attending to the enactment

and inscription of experiential embodied knowledge is particularly important in the context of mental health (Morrison & Dearden, 2013).

In similar ways, embodied knowledge did not seem to move easily through the mental health consultation process in Smith-Merry's (2012, 2015) research which, she suggests, may have been because "crucial stages of the consultation entailed or relied on inscription" (Smith-Merry, 2015, p. 35). As a result, the forms of knowledge that were not easily inscribed – that is, embodied and enacted knowledge – were absent from the final policy document. Although the findings of this study showed that participants were making neither explicit evidence-based nor explicit experiential knowledge claims to substantiate their proposals, it is also the premise of this study that changing the structure and format of consultation processes might be more successful at enabling these kinds of knowledge. This, in turn, necessitates optimising such knowledge by finding ways of moving them through the process.

This highlights the importance of attending to the forms of knowledge enactment and inscription and, more specifically, to the points at which one form of knowledge is transformed into another. In the absence of this, both the conventional orientation towards inscription in policy consultation processes (Smith-Merry, 2012, 2015), as well as towards particular kinds of inscribed knowledge forms (e.g. formal reports), may marginalise "some types of knowledge from policy processes and, hand in hand with this, the identities and needs of those who hold that knowledge" (Smith-Merry, 2015, p. 38). Indeed, Freeman and Sturdy (2015a, p. 16) suggest that employing the *embodied-enacted-inscribed* knowledge framework as a lens on policy work can direct researchers to explore whether "different stages in the policy process are characterised by a greater or lesser extent of particular phases of knowledge and, if so, to ask why that might be the case".

The arguments considered here suggest that if we are to optimise the use of what participants bring as embodied knowledge inputs to a consultation process, we need to understand how different knowledge phases interact with one another during this process. There are a number of process-related elements that might enable or constrain this interaction – and particularly the transformation from enacted to inscribed knowledge. These are considered in more detail in the next section.

5.3 Policy consultation at the meso level: Enacted-inscribed knowledge

The focus on enactment … draws our attention to the importance of meetings as key sites for the creation, circulation and transformation of policy knowledge. … Our questions about enactment also enabled us to address the importance of what we came to think of as 'knowledge moments' – 'moment', here, indicating both a point in time and relationship of forces. … At each moment, enactment was to be inferred in the translation of knowledge from one form to another.

(Freeman & Sturdy, 2015b, pp. 206-211)

Overview

5.3.1 Opportunities for enactment of embodied knowledge: The format of the consultation limited opportunities for embodied knowledge to be enacted.

5.3.2 Attending to points of *embodied-enacted-inscribed* knowledge transfer: There was limited facilitation of knowledge engagement and transfer between the three forms of knowledge.

A focus on the meso level in policy consultation spaces shifts the focus from the individual and their embodied knowledge to the ways in which sites of enactment influence both the enacted knowledge created and the movement of enacted to inscribed knowledge. The importance of process-related elements was alluded to in the previous section. The analysis at the meso level of the national summit, then, was informed by the recognition that decisions about how consultation processes are structured and conducted can enable or constrain the enactment and inscription of embodied knowledge. In the analysis, I focused particularly on elements that I considered to have the potential to illuminate the intersection of different knowledge forms and their subsequent transformation in the creation of new embodied, enacted, or inscribed knowledge. This was partly guided by what the literature review had revealed to be important aspects of consultation processes. It was also based on the clear argument in the literature that policy consultation should at least hold the potential to influence policy; this, in turn, highlights the importance of attending to how participants' knowledge might be moved through the process in order to allow for – and optimise – this potential.

The findings showed that in a number of ways, the national summit structure and process constrained the transfer of embodied to enacted knowledge, and from enacted to inscribed knowledge. Tracing back to the finding that the policy did not seem to change substantively following the consultation – despite a great deal of input – these findings provide some insight into why this may have been the case. Possible explanations for this are explored here, towards understanding why engagement and transfer between these knowledge forms was not optimal. One immediate observation from these findings is that the Chairs of the breakaway group sessions faced something of the policymaker's dilemma highlighted

throughout this study, in terms of having to integrate not just multiple knowledge inputs, but also different knowledge forms (embodied, enacted, inscribed). Not only were these knowledge forms not always in agreement, they were also subject to the demand for summarisation in inscribed forms. In the absence of a clear basis for prioritising inputs, this is likely to have required Chairs to favour some inputs over others. They dealt with this dilemma in different ways, with varying consequences for the movement of knowledge from enacted to inscribed knowledge, in particular. The discussion in this section thus focuses on how process-related elements seemed to affect this transformation.

5.3.1 Opportunities for enactment of embodied knowledge

For embodied knowledge to transform into enacted knowledge, there need to be sufficient opportunities for enactment. There were a number of indications in the findings that such opportunities at the national consultation summit were limited. For one thing, the overall programme for the two-day event restricted the amount of time available for participants to engage with draft documents, and with one another, in order to produce new enacted knowledge of relevance to the mental health policy. Similarly, within the group sessions themselves, much time was taken up by formal presentations, leaving less time for interaction and discussion. This may also help to explain the 'rush' towards formulating recommendations – in other words, inscribed knowledge – discussed above.

Providing adequate time for participants to engage in policy consultation has been identified as an important criterion for measuring the effectiveness of such processes (Rowe & Frewer, 2000), as has allowing sufficient time to develop recommendations (Abelson & Gauvin, 2006). As shown in this study, however, in practice the reality is often quite different from normative ideals, perhaps owing to pragmatic and feasibility constraints on the process (Papadopoulos & Warin, 2007a). What took me months of in-depth analysis to make sense of during this research study had to be achieved in a few hours during the summit. However, I would argue that it is possible to achieve some form of middle ground, where pragmatic considerations can be balanced with optimising the contributions that participants make during policy consultation events.

The way in which breakaway groups were organised is also argued to have influenced the movement of knowledge through the process. The national summit process mirrored the tendency in policy consultation towards the normative (Elster, 1998; Habermas, 1984), structured along the lines of formal academic conferences, with Chairs and rapporteurs managing small group sessions. There was, of course, value in conducting the group sessions in a 'microphone management' format. Given the large number of participants at the summit, for example, some form of structure was necessary to facilitate the process and to achieve the summit's objective of producing a report with a feasible number of

recommendations. Certainly, structured decision-making has been identified as one of the process criteria that might increase the effectiveness of consultation (Rowe & Frewer, 2004). Similarly, structuring small group sessions around key issues arguably allowed for greater and more varied inputs than would have been possible in larger forums, which have been found to be largely ineffectual in influencing policy decisions (Shipley & Utz, 2011).

However, if knowledge is created in interaction, then the microphone management format of the group sessions also served to limit both opportunities for the creation of enacted knowledge as well as the nature of such knowledge. The facilitation by microphone meant that one person got to speak at a time, and one person – either the Chair or the facilitator – exerted control over who had access to the microphone, thereby restricting the turn-taking that might be found in ordinary conversation. In addition, one person – either the Chair or the rapporteur – decided on the importance of the message, although there did not appear to be any formal or systematic guidance regarding how to determine importance or priority of inputs. Although each group was successful in generating a number of recommendations, the group format may have resulted in these recommendations reflecting the loudest voices, or inputs that most easily lent themselves to summarisation and inscription. Although this may be, in part, an inevitable part of the processes when large groups convene in order to reach a summarised set of outputs, this kind of format meant that many other voices and knowledge inputs that might have contributed to the discussions – and therefore to the recommendations – were not provided with sufficient 'air time'.

If the purpose of consultation is genuinely to elicit participants' views on policy proposals under consideration, then it follows that the interactive nature of such processes should be optimised in order to draw on as much of participants' embodied knowledge as possible in the creation of new enacted and inscribed knowledge. This means attending to exclusion mechanisms that limit participation, including the setting, chosen methods of communication, and speaking time granted (Elberse et al., 2011). The findings of this study are in line with similar studies that have highlighted the importance of attending to process in enacted (consultation) spaces (Catt & Murphy, 2003; Smith-Merry, 2015), as well as to creative tools for both eliciting and capturing knowledge inputs (Gramberger, 2001; Shipley & Utz, 2011). Although these are likely to be more resource intensive, they are also more likely to achieve the goals of public participation (Cook, 2002).

Not only did the format of the consultation summit limit the potential for and value of enacted knowledge, the limits it placed on interaction between participants during discussions would likely have also constrained mutual exchange of knowledge. This confirms previous findings regarding the limits of conventional forms of participation (Morrison & Dearden, 2013). It is also surprising, given the

widespread recognition of the need to integrate multiple knowledge inputs in policy consultation, as well as the importance of managing knowledge and communication to achieve effectiveness in these processes (Horlick-Jones et al., 2007; Rowe & Frewer, 2005). Attending to the points at which knowledge interacts and transforms speaks not only to the transfer of knowledge from enacted spaces into inscribed forms (that can be moved beyond enacted spaces), but also to the transfer between different embodied knowledges. In turn, this highlights the importance of facilitation in optimising knowledge inputs in policy consultation. This is considered in more detail below.

5.3.2 Attending to points of *embodied-enacted-inscribed* knowledge transfer

Although breakaway groups largely followed a microphone management format, the findings suggest that the process for ensuring transfer of knowledge in and beyond these groups was not systematic. In particular, facilitation of small group discussions could have received more attention, with the aim of not just getting to an inscribed output, but also enabling the enactment and movement of knowledge through the process. Skilled facilitation has previously been identified as one of the key components of successful consultation (Gramberger, 2001; Morrison & Dearden, 2013), as well as a factor that increases the likelihood that policy consultation will have an influence on policy (Boivin et al., 2004; Emery et al., 2014; Li et al., 2015). However, this study shows that facilitation needs to go beyond managing process towards achieving outcomes, to being able to link and integrate multiple kinds of knowledge (Healey, 2007; Horlick-Jones et al., 2007; Restall et al., 2011), particularly to avoid the risk of such exercises becoming tokenistic (Ashwood et al., 2014). The notion of knowledge brokering is not new (e.g. Jones et al., 2012; Ward et al., 2009). Nonetheless, there appears to be a scarcity of research on micro-processes and how to actively integrate multiple knowledge forms into policy (Jones et al., 2012; Sedlačko & Staroňová, 2015). One notable exception is Rowe and Frewer's (2005) conceptualisation of policy consultation as a knowledge management process at this micro-level. They link facilitation in terms of eliciting the maximum and most relevant knowledge inputs from participants with facilitation in terms of processing, managing and aggregating such inputs across the process. This study illuminates again the importance of attending to such processes.

However, what the findings of this study suggest is that knowledge brokering should involve not just making links between participants, and between their knowledge inputs, but should also be able to facilitate transfer between different *phases* of knowledge – that is, between embodied, enacted, and inscribed knowledge. During the national summit group discussions, there was continual interplay between different knowledge forms, with participants engaging with inscribed knowledge, as well as enacted embodied knowledge, to create a new enacted knowledge space. A focus of previous work on knowledge brokering has been on managing the divergence between different knowledges and, in

particular, reconciling evidence-based inputs with experiential or lay inputs (Demszky & Nassehi, 2012; Epstein et al., 2012; Fazey et al., 2006). This study showed that there was less need for reconciling these kinds of knowledge inputs, and more need for an awareness of how knowledge moves between embodied, enacted, and inscribed forms – what Freeman and Sturdy (2015b, p. 211) call "knowledge moments" – as well as how to optimise this movement.

As mentioned earlier, the focus in group discussions at the summit was on formulating recommendations and producing an inscribed knowledge output. This form of knowledge is an important output of such discussions in that it is able to move beyond enacted spaces to be used by those who were not present in these spaces. I consider the possible influence of the forms of inscribed knowledge that resulted from group discussions in the next section. However, another way in which knowledge can move beyond enacted spaces is as embodied knowledge, in individuals. Although it is not possible to determine from the data available the extent to which this happened during the national summit, the somewhat stilted ways in which discussions unfolded as a result of the microphone management format seems likely to have constrained interaction and exchange of knowledge between individuals. There was little opportunity to follow through on or engage with points made by individual group members. In addition, with little explicit reference to evidence-based or experiential knowledge, there was perhaps less for other participants to link into as a reference point for their own knowledge and experience, limiting possibilities for the creation of new embodied knowledge.

This "inter-enactment" has previously been identified as important (Maybin, 2013, p. 101). The value of consultation in itself – in terms of the potential influence on participants themselves – has also been demonstrated (Hajer, 2005; Turnhout et al., 2010), including as a measure of effectiveness (Rowe & Frewer, 2004). This is particularly important when consultation is with marginalised groups, whose voices have previously gone unheard (Barnes et al., 2004) and for whom consultation might be a mechanism of empowerment (Barnes, 2009; Conklin et al., 2012; Kleintjes, 2012). The findings of this study highlight that this potential for mutual learning – an exchange of embodied knowledge through enactment – might be optimised by attending to the way in which such processes are structured and conducted. In Smith-Merry's (2015, p. 35) study of a mental health consultation process, for example, there was a "'trading' of embodied knowledge taking place between participants in the consultation process, which helped both in initial sense-making and in the implementation of the resulting policy within local communities of practice". In the context of the buy-in that is required from health care practitioners to integrate mental health into primary health care, there would likely be much value in optimising such exchanges. It also highlights the importance of having policymakers and planners participate in such events, which supports previous work in this area (Emery et al., 2014).

The discussion above has highlighted the importance of attending to process in order to facilitate the exchange of embodied knowledges. In particular, the microphone management format may have limited opportunities for this kind of knowledge movement. However, there were also indications in the findings that other points of knowledge engagement were neglected. The interaction between embodied knowledge and inscribed knowledge during group discussions was also inconsistent and largely limited. A draft policy document and a draft summit declaration were available for groups to review and comment on during the summit. The findings indicated that there was little engagement with the draft policy in particular and, where this did occur, much of the focus was on changing words or phrasing in the document. Despite having a draft summit document in which recommendations would be captured, there was therefore no explicit way of linking what groups added as recommendations to the end of this document with the content of the policy. There were indications in the findings that some of the contributions at the summit seem to have informed the identification of implementation priorities. The lack of engagement with the draft policy, then, suggests that what was ultimately inscribed in recommendations might have had more relevance for implementation. This link might have been strengthened had greater attention been paid to the interaction between embodied and inscribed knowledge that created new enacted knowledge – which, in turn, was transformed into inscribed knowledge (recommendations).

Similarly, these findings showed that there was no consistent process for transferring provincial summit recommendations for consideration at the national summit. The recommendations from the only three provinces that reported back at the plenary came in the form of enacted knowledge, with provincial representatives providing these in oral form. As Freeman and Sturdy (2015a) suggest, enacted knowledge, like gas, is transient at the site at which it is generated. In addition, there were indications in the findings that the follow-through of provincial feedback at the national summit was largely dependent on whether individuals who had participated in provincial summits were in attendance during group discussions and could ensure that these inputs were heard. This embodied knowledge, however, is also transient insofar as it requires the presence of the individual who embodies it.

In contrast, the advantage of inscribed knowledge is that it is stable and tangible, and therefore easily moved and used beyond the contexts in which it was generated – but only if procedures are in place for processing and transferring it between the spaces in which it is captured. Such procedures do not seem to have been in place between the provincial and national summits, nor between points of inscription at the national summit. There should therefore have been a more explicit way of ensuring that provincial recommendations were present in these groups so they could be engaged with – that is, as inscribed knowledge. This is particularly important given the findings discussed above that at least one objective of the national summit may have been to inform the implementation priorities, and provincial

departments of health are responsible for implementing the policy. The implications of this lack of follow-through from provincial summits are considered in more detail in the next section.

Once knowledge is enacted, it may become embodied once again within individuals, and in this way travel out of consultation spaces, as discussed above. However, this enacted knowledge must also be transferred into inscribed forms in order for it to move beyond policy consultation processes, and to be seen and used by policymakers tasked with integrating these inputs in policy decisions. I previously argued that there was an emphasis on inscribed knowledge at the national summit, more than on embodied and enacted knowledge. However, little attention seems to have been paid to the ways in which this inscribed knowledge was created – in other words, to the points of inscription. There do not seem to have been explicit instructions regarding what to capture or how to capture this, with the result that the ways in which participant inputs were captured into recommendations during discussions were largely dependent on each group's rapporteur. Some rapporteurs, for example, captured recommendations in the form of a PowerPoint presentation that they presented back to the group at the end of the breakaway session. Such a format may have allowed for more group members to engage with the provisional recommendations than a Word document that rapporteurs read out loud to the group.

This highlights again a gap in the literature regarding the process through which the transfer of knowledge in policy consultation spaces is enabled (Horlick-Jones et al., 2007). The *embodied-enacted-inscribed* framework captures the notion that knowledge moves and can be transformed through this movement (Sedlačko & Staroňová, 2015). The findings of this study suggest that if the value of this knowledge is to be optimally used in policy consultation spaces, the *interaction between* different forms of knowledge – the knowledge moments – need to be more consciously attended to.

In the discussion above, I have considered how process-related elements of the consultation summit affected the nature and form of new knowledge that was created, as well the movement of this knowledge. However, the potential of any knowledge contribution to influence policy was contingent on what happened to the inscribed knowledge once it left the enacted (group) spaces. The points of interaction between embodied, enacted, and inscribed forms discussed above may have been inconsequential if inscribed knowledge was not used beyond these spaces. The movement of inscribed knowledge through the consultation process is considered in the next section.

5.4 Policy consultation at the macro level: Inscribed knowledge and beyond

Insofar as we might think of the work of policy as the work of coordinating action, particular importance attaches to the role of inscriptions – and analysts and practitioners alike may learn much by observing just what knowledge finds its way into inscriptions for policy purposes, and by attending to and following the movement of those inscription through the policy world.

(Freeman & Sturdy, 2015a, p. 15)

Overview

5.4.1 The purpose of consultation: The consultation may have been more a rubber-stamping exercise or endorsement of policy, with no substantive changes to policy.

5.4.2 Forms of inscribed knowledge: The manner and forms in which inscribed knowledge was captured were not consistent and may have limited the knowledge inputs that could be transferred.

5.4.3 Abstraction of (inscribed) knowledge: The abstraction and summarisation of knowledge at each point of inscription resulted in the loss of more detailed knowledge contributions.

5.4.4 Movement of inscribed knowledge: Both forwards and backwards movements of inscribed knowledge through the consultation process were not systematic.

5.4.5 Policy(making) beyond the consultation space: Factors influencing policy decisions beyond the consultation space may have affected what inputs were and were not used to inform policy.

Inscribed knowledge is an important knowledge form at consultation events, as it is in this form that knowledge inputs from embodied and enacted sites are moved beyond these spaces to policymakers. I therefore focused, at the macro level, on exploring how inscribed knowledge was transferred from one point to the next through the consultation process. I was particularly interested in points of inscription and abstraction, and how transcribed knowledge inputs followed through from one point to the next. Tracing the follow-through of knowledge in this way could provide insight regarding why the content of the policy document did not change in any substantive way following the consultation. The analysis moved beyond the micro (individual) and meso (process) levels, to the macro level. This allowed me to explore what happened to inscribed knowledge outputs once these moved outside of summit breakaway groups.

The analysis at the macro level was informed by the review of literature that pointed to challenges with transferring knowledge inputs and outputs from policy consultation to the broader policy(making) arena. The policy consultation literature had indicated that the involvement of public participants in

policy decision-making may be somewhat tokenistic, particularly if there is no transparency or feedback regarding whether and how participants' contributions were used to inform policy (Cook, 2002). Even where the goals of public consultation are genuinely to engage in dialogue and mutual decision-making, the use of consultation inputs and outputs in policy(making) is difficult to determine (Li et al., 2015). From a knowledge perspective, there was evidence to suggest that there is an inevitable 'lost in translation' effect as knowledge moves from embodied and enacted forms – and is codified – into inscribed form (Freeman, 2009; Freeman & Sturdy, 2015b). In addition, previous work has demonstrated that much of the rich detail of embodied and enacted knowledge is lost in the summarisation of consultation reports (Smith-Merry, 2012). There were also indications in the literature that this may be because of a lack of systematic processes for transferring knowledge inputs, as well as because of problematic record-keeping and feedback mechanisms (Ashwood et al., 2014; Caluwaerts & Reuchamps, 2016; Horlick-Jones et al., 2007).

The findings showed that a substantial amount of valuable knowledge that was enacted at the national summit was lost at various points of inscription. If the kinds of knowledge inputs at the summit did not lend themselves to the kind of knowledge that must be captured in policy, this could go some way towards explaining why the policy did not seem to change following consultation. The more substantive alignment between consultation inputs and the implementation-related appendices suggests that consultation contributions could be optimised where there was less necessity for abstraction of detail, as is required in a policy document. There was also little follow-through of knowledge inputs through the consultation process into summit and policy outputs, as well as a lack of clear feedback regarding how the consultation outputs were used during the policy finalisation process.

In this section, I offer a number of possible explanations towards understanding why there appeared to be little follow-through of inscribed knowledge from the consultation. There were indications in the findings that this may have partly been because of what was happening to inscribed knowledge at the national summit itself, and partly because of factors beyond the consultation space – that is, macro-level factors that influence policy and policy consultation. As in the previous sections, for each of these possibilities, I illustrate how this was indicated in the findings, and how this relates to existing work in the relevant literature.

5.4.1 The purpose of consultation

The point of departure for this study was the finding that the policy did not change in any substantive way following the summit. At first glance, this suggested that the consultation process may have been more a rubber-stamping process than a genuine dialogue with participants regarding the proposed

policy. The conference style format resembled a form of public hearing – a public participation format commonly used in South Africa. Interestingly, this form of consultation has been described as "a formal process initiated by government in respect of endorsement of emerging legislation or in response to a particular challenge being confronted" (Motala et al., 2016, p. 190). As such, this consultation process was located more on the level of information exchange than on an exchange of power between citizens and government through mutual decision-making; this, as Arnstein (1969) argues, may have amounted to tokenistic participation. If this was the case, then it puts the findings discussed above into context – that is, if the outcomes were already predetermined, then how knowledge transfer was effected in and through enacted discussion spaces would have been inconsequential.

In addition to the lack of changes between the draft and final policy documents, there were a number of ways in which the findings pointed to the sense that the consultation outcome was at least partially predetermined. Firstly, the fact that a pre-drafted version of the summit declaration was available at the start of the summit points to this. In addition, the finding that each of the eleven recommendations added to the summit declaration at the end of the summit mapped roughly onto the predetermined themes of the breakaway groups – with the exception of child and adolescent mental health – also lends support to this. The finding that decisions regarding reducing the 125 recommendations made by breakaway groups to the eleven recommendations on the summit declaration were made behind closed doors – with no audio or documented recordings of this meeting – also suggests more of a top-down process, whereby government retains control over both decisions and decision-making. This confirms what other studies of health policymaking and consultation in South Africa have demonstrated (McIntyre & Klugman, 2003; Walker & Gilson, 2004).

The findings also showed that the pre-drafted summit declaration may have created the impression for participants that summit outcomes were already somewhat predetermined, which in turn would likely have influenced how they made their contributions. This could go some way towards explaining why explicit knowledge claims were infrequently made during discussions. As such, these findings are consistent with previous local and international research showing that consultation can leave participants feeling disempowered as a result of being co-opted into processes which already have predetermined outcomes (Buccus et al., 2008; Buccus & Hicks, 2011; Cheeseman & Smith, 2001; Manor, 2004; Theron et al., 2007). This consultation, then, did not seem to meet many of the IAP2's (2007, p. 1) principles of public participation – most notably that public participation should "include the promise that the public's contribution will influence the decision". Nor did it show evidence of outcome measures of effectiveness that speak to the consultation's influence on policy or decisions, such as that there should be specific changes to policy and practice or, at the very least, that public views should be incorporated into decision-making (Abelson & Gauvin, 2006; Rowe & Frewer, 2000).

This study also adds to research in South Africa showing that public participation in practice tends to be more tokenistic and less empowering than is promised in legislative mandates for public participation (Buccus et al., 2008). On some levels, this may be a capacity and feasibility issue more than disingenuous agendas on the part of government officials or departments. As Theron et al. (2007, p. 14) argue, the "seven IAP2 core values presuppose social and political conditions that usually do not exist in developing countries such as South Africa". Such constraints notwithstanding, the implications of tokenistic involvement in policy consultation has particularly negative ramifications in the context of mental health, as it may serve to further marginalise already vulnerable groups (Morrison & Dearden, 2013).

However, some have argued that the consulted public should not be led to believe that their inputs will have a direct influence on final decisions (Bishop & Davis, 2002; Kane & Bishop, 2002). In addition, there are other purposes for which consultation may be undertaken that go beyond incorporating public views into government decision-making; these include enabling civic engagement and building social connectedness (Kleintjes, 2012), or demonstrating a commitment to government accountability (Barnes et al., 2004). There was some evidence that the national consultation summit had positive consequences for mental health in South Africa in several ways, including raising the profile of mental health, and signalling government commitment to addressing the gaps in service delivery. The findings also suggested that the consultation may have simply endorsed the existing policy, as there were no indications in summit discussions or recommendations of significant deviations, contradictions, or objections to the draft policy content. Regarding this outcome at least, then, the consultation seemed to be effective in terms of the compatibility between participation recommendations and policy decisions (Conklin et al., 2012). The consultation may therefore have simply confirmed what policymakers were already going to do (Abelson & Gauvin, 2006).

Furthermore, the predetermined nature of some elements of this process may actually have helped to structure the consultation process, and allowed participants and groups to formulate action items that could be used to identify implementation priorities. This is confirmed by the finding that there was greater alignment of consultation inputs with implementation-related appendices than with policy changes. Of course, using this as a measure of effectiveness would depend on whom one spoke to, as other studies have suggested (McCluskey et al., 2004; Rowe & Frewer, 2004). While this may have helped officials organising the process to achieve their objectives, participants might have held different perspectives regarding opportunities for making contributions, as well as how these contributions were used, as suggested above. What this does mean, however, is that purpose and expectations should be clarified upfront (Kane & Bishop, 2002), and that there should be transparency and feedback regarding how decisions are made (Cook, 2002). This, in turn, points again to the importance of attending to the

form of inscribed knowledge that is produced at such events, as well as to the movement of inscribed knowledge through the process. These are discussed next.

5.4.2 Forms of inscribed knowledge

In the section above, I highlighted the importance of facilitation and knowledge brokering in linking different forms of knowledge. Here, I consider what the findings of this study have illuminated about the transformation from enacted to inscribed knowledge, and what effects the *form* of inscribed knowledge might have on the *nature* of the knowledge that is available for policymakers to use beyond the consultation space. If inscribed knowledge is emphasised as the predominant form of knowledge – as, in some ways, it must be in policy consultation – then we need to consider the form it takes, as well as what happens to it afterwards. If these are not attended to, then it seems unlikely that the purpose of policy consultation as a form of public participation will be achieved.

The capturing of group discussions and recommendations in inscribed form was done in two ways at the national summit – notetaking by rapporteurs and audio recordings – although the processes varied somewhat across groups. Some rapporteurs seemed to be taking notes throughout the discussion, while others only began capturing the discussions when groups began formulating recommendations. The transfer of enacted to inscribed knowledge, as well as the form that it took, was therefore largely determined by one or two participants. This may in part have been pragmatic, but it also demonstrates the importance of certain individuals over others in terms of who got to decide what got written down and what did not, as well as the way in which this was captured. The effects of this on how policy consultation influences policy more broadly are difficult to determine. However, it seems likely that certain voices, as well as certain knowledges, were 'inscribed out' of the final output in this way. This certainly seemed to be the case in terms of the finding that much of the detail in the participant contributions was lost in the transformation of enacted knowledge into inscribed knowledge. This may to some extent be inevitable during such a process; however, some recommendations are made at the end of this study regarding how participatory processes might be designed in order to circumvent it.

As mentioned earlier, research on the effectiveness of policy consultation has highlighted the importance of linking consultation inputs with policy decisions, in ways that demonstrate responsiveness to participants' recommendations (Pratchett, 1999, in Catt & Murphy, 2003; Rowe & Frewer, 2004). However, there is a gap in the consultation evaluation literature on the *mechanisms* for doing so. In particular, the specific ways in which consultation inputs are recorded and moved beyond the consultation space have not received sufficient attention. By drawing on the *embodied-enacted-*

inscribed knowledge framework as a lens through which to view consultation processes, the findings of this study have gone some way towards filling this gap.

On a broader level, there is also an absence of guidelines in South Africa on how consultation processes should be recorded (Marais et al., 2017). This study showed that there was variability in the form of records or reports from the provincial summits, as well as in how these were linked to the national summit process. There were also inconsistencies with respect to how such records were managed and the extent to which they were accessible to the public (Marais et al., 2017). Without systematic processes for documenting – or inscribing – such processes, it is difficult to see how public inputs are (or are not) incorporated into policy decisions. This affects the transparency of such processes and may serve to decrease rather than increase public trust in government (Abelson & Gauvin, 2006; Li et al., 2015).

The recording of breakaway group discussions in audio form is an interesting aspect to consider in terms of whether this represents a form of inscribed knowledge, and what purpose it served. In a sense, these recordings could be argued to represent an inscribed boundary object in the link they provided between consultation participants' knowledge and the knowledge that the technical task team and policymakers drew on to finalise the policy. There was no way of determining, from the data available, whether and how these recordings were subsequently used beyond the national summit. However, given that they represented over 40 hours of recordings, it seems reasonable to assume that policymakers would not have sat and listened to these during the finalisation process. It would have been interesting to explore whether and how the final policy – and in particular the priorities included on the implementation plan – would have been different had they done so. There are obvious practical and feasibility difficulties with this, which raises questions around why national summit proceedings were recorded in this way. Even the transcripts of those recordings, for example, which formed a substantive part of the data analysed in this study, required a great deal of time to make sense of, for someone who had not participated in the process.

This highlights the importance of attending to the form of inscribed knowledge in policy consultation. Previous research has demonstrated the value of boundary objects as mechanisms spanning boundaries across diverse bodies on knowledges in policy (Jones et al., 2012). Where knowledge brokering might represent a conscious attention to enactment, boundary objects represent a conscious attention to inscription. Boundary objects can facilitate enactment and integration of different knowledge forms (Clark et al., 2015; Paavola & Hakkarainen, 2009), as well as the transfer of enacted knowledge to inscribed knowledge (Yeh, 2003). Boundary objects could therefore expand on the range of available forms of inscribed knowledge that might be employed during policy consultation processes.

As flexible and physical representations of knowledge (Fominykh et al., 2016), boundary objects have the potential to overcome some of the challenges with codifying and capturing tacit embodied knowledge (Abuhimed et al. 2013; Rooke et al., 2009). As such, they also have potential to integrate knowledges in a way that ensures the detail and value of embodied knowledge are not lost (Morrison & Dearden, 2013; Trompette & Vinck, 2009). In the case of the mental health policy consultation explored here, the final inscribed output of the national summit was a very broadly phrased document, which was an abstracted representation of the knowledge contributions made at the summit. This summarisation and abstraction of knowledge, and its implications for policy consultation, are discussed next.

5.4.3 Abstraction of (inscribed) knowledge

There was clear evidence in the findings of the ways in which knowledge was abstracted and summarised at each point of inscription. This goes some way towards explaining why there appeared to be little follow-through of knowledge inputs through the process, and into policy outputs. In this section, I consider what effects this abstraction had and highlight why this matters in policy consultation and policymaking in general.

The summarisation of knowledge during the mental health consultation process was evident, first, in the emphasis in group discussions on keeping recommendations brief in both form and number, and on ensuring that these were concrete and actionable. It also became clear during this study that there was an obvious and significant gap between the detailed knowledge evident in the group discussion audio recordings and transcripts and the documented records of the consultation summit. This is consistent with previous studies showing a similar summarisation and abstraction of embodied knowledge as it moves through "the chain of consultation events and texts" (Smith-Merry, 2012, p. 140).

In some ways, this abstraction is necessary and inevitable, first, as a pragmatic part of a policy consultation process (Demszky & Nassehi, 2012), and second as an inevitable consequence of the codification of tacit embodied and enacted knowledge (Agrawal, 2002; Kingston, 2012a; Lam, 1998). Something of the emotion and expressiveness of embodied knowledge is invariably lost in the translation of such knowledge to inscribed forms (Freeman & Sturdy, 2015b). A degree of abstraction may therefore be unavoidable. However, I would add my voice to those who argue that if policy consultation is undertaken, it is presumably to draw in some way on public perspectives regarding proposed policies and, as such, there should be investment in optimising the valuable knowledge that

practitioners and service users have to offer towards enhancing these policies (Morrison & Dearden, 2013; Restall et al., 2001; Smith-Merry, 2012).

Another way in which the gap between consultation inputs and outputs was evident here was in the finding that more detail seemed to be captured in the implementation-related appendices than in the policy itself – although this component of the policy was never itself subject to further comment. This corroborates the assertion that the kinds of knowledge available at a consultation process may not be amenable to the form of inscribed knowledge that is required in *policy*, but that these might be more suitable for more detailed implementation plans. This consultation-implementation link is supported by the finding of the current study that where participants did make explicit reference to experiential knowledge claims during group discussions, they typically did this to highlight whether and how policy proposals would work 'on the ground'.

This has implications for policy consultation. For one thing, the purpose of the consultation and what it will be used for should be clarified upfront, as has been highlighted in the evaluation literature (Abelson & Gauvin, 2006; Webler, 1995). It may also require rethinking what policy consultation could be optimally used for, given the kinds of knowledge available here. This adds to research which has highlighted that policy consultation may be more effective if conducted at local levels (Emery et al., 2014), as well as research demonstrating that policy consultation may be used more as a mechanism for mobilising stakeholders towards the implementation of policy than as a means of adapting the policy itself (Sturdy, Smith-Merry, & Freeman, 2012). These findings also add to research suggesting that different forms of input might be more appropriate at different points in the policymaking process (Restall et al., 2011; Roberts, 2014).

The abstraction of knowledge also has implications for policy implementation, in particular, if we think about policymaking as representing a constant process of moving between phases of embodied, enacted, and inscribed knowledges. I have argued in this study that policymaking represents a knowledge problem for policymakers in terms of balancing the tension between abstract and particular forms of knowledge. While policy consultation must draw on particular forms of knowledge and transform these into the abstracted, inscribed knowledge of policy, the implementation of this policy requires transforming this inscribed knowledge back into enacted and embodied knowledge. There are problems, then, in not attending to the policy consultation-implementation link. These are highlighted further in the section below, in terms of movement of inscribed knowledge from provincial summits to national summit. The findings of this study also showed that inscribed knowledge underwent further abstraction and summarisation at each point of inscription as it moved through the consultation

process. This suggests that the *movement* of the inscribed knowledge through the process requires further attention. This is considered next.

5.4.4 Movement of inscribed knowledge

The discussion above has highlighted what the findings of this study have shown with regard to how knowledge moves from one form to another during a policy consultation. In this subsection, I consider how inscribed knowledge moved through the consultation process and beyond, in terms of how it might help to make sense of the lack of follow-through or influence of this consultation on policy. The findings suggest that both the forward and backward movement of inscribed knowledge through the consultation process was lacking: forward movement from provincial to national summits, and from breakaway groups through to the technical task team responsible for finalising the policy; backward movement was lacking in terms of providing feedback to consultation participants regarding how their inputs were used in the finalisation of the policy and identification of implementation priorities. The implications of this are considered further below.

The findings regarding how provincial summit reports moved – or rather, did not move – to and through the national summit demonstrate a lack of systematic processes for moving local-level knowledge to national level. Given that provinces are responsible for developing plans for the implementation of national policies, it seems particularly important to attend to how inscribed knowledge moves between provincial and national consultation events and back again. One of the consequences of a decentralised health system is that the development of policies at national level removes them from the provincial and local administrative structures tasked with implementing them, as well as from the communities who might participate in them (Buccus & Hicks, 2011; Jenkins, 2003; McIntyre & Klugman, 2003). This may have consequences for the effectiveness of policy implementation. Since this study was conducted, there have been indications that the implementation of the mental health policy has encountered a number of challenges (Burgess, 2016; Govender, 2017; Marais & Petersen, 2015; Rural Mental Health Campaign, 2015; Schneider et al., 2016). Although these difficulties may not be as a result of what occurred (or did not occur) during consultation, it is possible that attending to the link between provincial and national consultation processes may help to pre-empt potential challenges, particularly given the wide diversity in resources across provinces. This highlights the importance of adequate consultation processes for policy implementation (Jones et al., 2012; OECD, 2001).

The movement of inscribed knowledge from the breakaway groups to the inscribed knowledge captured in the final summit declaration occurred during a closed-door meeting, which does not appear to have been recorded or documented. The process through which the 125 group recommendations were

'transferred' to eleven summit declaration recommendations was thus not explicit. On a broader scale, there also does not appear to have been a systematic process for transferring inscribed knowledge beyond the national summit. Even members of the technical task team who finalised the policy did not seem to be clear regarding whether and how inscribed knowledge from the summits was used during the finalisation process. Thus, even if the transfer from embodied to enacted to inscribed knowledge during consultation events is carefully attended to, if processes for transferring these inscribed knowledge forms beyond the consultation space are not systematic, then the inputs and outputs of consultation processes have little potential to inform policy.

In addition to movement forwards from the policy consultation to policy finalisation, the findings of this study have demonstrated that the movement of inscribed knowledge back to those who participated in the consultation process was inadequate. For one thing, there was no feedback regarding how inputs were used to inform policy. Nor was there any further consultation regarding how priorities for implementation were identified, or the extent to which contributions during consultation had been used in doing so. There also does not seem to have been a systematic process for informing participants that the final policy had been adopted, nor where or how to access it. This is in contrast to arguments that participants should be provided with feedback regarding the results of consultation (Caluwaerts & Reuchamps, 2016; Cook, 2002; Kane & Bishop, 2002; Petts, 2008).

In addition, there is evidence that the transparency of a consultation process is one measure of its effectiveness (Rowe & Frewer, 2000, 2004). All of these measures would require substantial time and resources on the part of those responsible for policy consultations processes. This would include criteria or mechanisms for specifying the objectives and outcomes at the level of consultation distinct from the outcomes at the level of policy. One way of achieving this might be to establish a systematic process that is applied across all government departments, and establishing a team of people dedicated to assisting each department to implement such processes.

The findings of this study have shown that the potential of inscribed knowledge to perform the work of carrying knowledge to "many different individuals separated in time and/or space" (Freeman & Sturdy, 2015a, p. 10) is limited if a systematic process is not followed for moving it. Achieving such ends, in turn, requires some form of tracking public inputs through the decision-making process. In South Africa, however, as elsewhere, there seems to be a lack of systematic methods for collecting and managing the inputs at consultation events (Horlick-Jones et al., 2007; Marais et al., 2017). However, as has been emphasised throughout this study, determining the decision impact of policy consultation, as well as how inputs have been integrated with other forms of policy information, is no simple task (Emery et al., 2014; Li et al., 2015). This is in part because of challenges in teasing out the impact of the participation

process from other influential variables (Abelson & Gauvin, 2006; Conklin et al., 2012). This suggests that there are factors beyond the consultation space that may have influenced the potential for consultation inputs to inform policy. Some of these factors are considered in the section below.

5.4.5 Policy(making) beyond the consultation space

Policy consultation is only one element in a complex decision-making process. As has been highlighted in this study, consultation is undertaken for a number of reasons, which involve greater or lesser sharing of control over policy decisions. The draft policy that was available for review at the provincial and national summits was based on years of investment, including consideration of available evidence from an extensive research process. The finding that the policy content did not change in substantive ways following the summit, apart from the addition of implementation-related appendices, suggests that the purpose of this consultation may have been more to inform these implementation priorities than to make amendments to the policy. This in itself highlights that key decisions around the content of the policy happened outside of the consultation space – both prior to and following the provincial and national summits. As such, this study confirms that a good consultation process is not necessarily linked to a good policy outcome, and vice versa (Abelson & Gauvin, 2006).

There were indications in the findings that what was ultimately included in the policy, and particularly in the implementation plan, was based on decisions taken outside of the consultation space. As is the case with policymaking more generally, these decisions are likely to have been influenced by factors such as health system capacity and resource constraints, feasibility considerations, broader political and global agendas, and national and international best practice. The presence at the national summit of a key representative from the World Health Organization, for example, suggests that South Africa's mental health policy was influenced, at least to some extent, by the WHO's guidance on mental health system development. This is supported by the inclusion in the policy document of the pyramid of service organisation based on the WHO's recommendations for the organisation of mental health services (WHO, 2003) – an addition that occurred following the national summit. While this approach may be widely recognised as best practice, the literature review highlighted potential problems with adopting global mental health approaches in local contexts (Jakubec, 2004; Whitley, 2015).

The eight implementation priorities and related key activities included on the Strategic Plan were determined by the technical task team that was constituted to finalise the policy following the summit. Interview findings suggested that the voices of this team were strongly reflected in these priorities, with 'murkier' issues that are more difficult to operationalise (e.g. recovery principles) excluded. There was no further consultation on these implementation priorities prior to the adoption of the final policy. As

has been highlighted in this discussion, the lack of consultation around implementation priorities and the absence of a systematic process for linking provincial summit recommendations with national summit recommendations has potentially negative implications for policy implementation at provincial and district levels (Buccus & Hicks, 2011; McIntyre & Klugman, 2003). This suggests that, while policy decisions are necessarily based on a number of factors, the role of consultation in policy development should not be undervalued. As such, this study lends support to research highlighting the importance of policy consultation (Catt & Murphy, 2003; Florin & Dixon, 2004), and to research that underscores the value that consultation can have in enhancing policy implementation (McGee & Norton, 2000; Irvin & Stansbury, 2004; Walters et al., 2000). This is particularly the case if those involved in implementing policy are included in consultation processes (Ditlopo et al., 2014; Walker & Gilson, 2004).

The disconnect between national and provincial priorities is further highlighted by two issues that followed quite different paths through the provincial and national summits. Firstly, child and adolescent mental health was identified as a key issue for discussion at the national summit. All of the provincial summits had put forward recommendations regarding child and adolescent mental health, as did the national summit breakaway group tasked with discussing this issue. However, child and adolescent mental health was the one issue that was not included as a recommendation on the final summit declaration. It was also not identified as an implementation priority, nor included in the key activities relating to these priorities on the implementation plan. Only one statement relating to child and adolescent mental health was included in the Terms of Reference appendix added to the policy following the summit.

Conversely, one of the key implementation priorities identified by the technical task team was the establishment of district specialist mental health teams. While this was one of the recommendations put forward by the mental health systems breakaway group at the national summit, only one of the provincial summit reports referred to establishing such teams. There are indications that this is one of the biggest stumbling blocks to the implementation of the mental health policy (Burgess, 2016), which underscores the importance of linking the development of policy-related implementation priorities to local-level priorities and capacities (McIntyre & Klugman, 2003). These findings also further highlight the role of other factors beyond policy consultation that influenced policy decisions.

Other indications in the findings of the operation of influences outside of the consultation space were the predetermination of the ten topics for discussion at the national summit which, in turn, roughly corresponded with the eleven recommendations added to the final summit declaration. This suggests that the consultation output would have included recommendations around these issues regardless of the specific inputs from the breakaway groups. The fact that decisions around summarising the 125

group recommendations into eleven summit declaration recommendations were made in a closed-door meeting (that was not recorded in any way) suggests that decision-making authority in this consultation was retained by government officials. This, then, is consistent with models of public participation in which consultation falls somewhere in the middle of the information-exchange continuum, but where exchange of control between government and citizens is limited (Arnstein, 1969; Shand & Arnberg, 1996, in Bishop & Davis, 2002).

What these findings highlight is that knowledge contributions during a policy consultation process are among many knowledge inputs that policymakers weigh up in making policy decisions. However, this discussion has also demonstrated the important role of consultation, and in particular the ways in which the value that consultation can add to policy could be optimised by attending to how knowledge is used and moved through the process. The conclusion that follows will discuss the implications of this study's findings within the broader context of mental health policy consultation and, more specifically, in the context of mental health policy consultation in South Africa. I will also reflect on the contribution that this study has made by adopting the *embodied-enacted-inscribed* knowledge framework as a lens through which to view a policy consultation process.

5.5 Conclusion: Implications of this study for the knowledge problem of mental health policy consultation

In this section, I outline what contribution this study makes to what is currently known about knowledge in policy and about mental health policy consultation in South Africa. In doing so, I highlight the implications of key insights from this study for existing approaches to policy consultation. Several recommendations for policy and practice, as well as for further research, follow from these implications. These are explored later in section 5.7.

Policymaking generally and policy consultation in particular can be thought of in many ways. In this study, I have conceptualised policymaking as a knowledge problem, in that policymakers must balance multiple, and often competing, knowledge inputs in making policy decisions. Policy consultation in this view, then, represents (among other things) an exercise in knowledge management. Convening a policy consultation event – getting stakeholders together to discuss policy proposals – is a necessary but not sufficient step in ensuring that such a process is effective. However, while there is a large amount of research on what factors contribute to the effectiveness of policy consultation, the current literature

does not offer much guidance in terms of the micro-level processes through which contributions might be optimised towards enhancing policy and policy implementation.

In a low- and middle-income country like South Africa, there are certain unique challenges that policymakers face in mental health policy decision-making and policy consultation, not least of which are resource and capacity constraints, as well as local complexities involved in addressing mental illness. The national and provincial mental health summits held in South Africa in 2012 thus represented an opportunity to explore how knowledge contributions during policy consultation processes might influence policy within this unique context. The aim of this study was to explore how the mental health policy consultation process informed policy, by tracing the movement of knowledge through the consultation process. In doing so, several gaps were illuminated that might be addressed in future mental health policy consultation processes in South Africa. In addition, while the findings are localised within this particular context, they have a number of implications that may be relevant for policy consultation more broadly.

5.5.1 What gaps does this study address?

This research addresses gaps in the current literature on mental health policy consultation and on the role of knowledge in policymaking in several ways. It is the first in-depth, empirical investigation into the mental health policy consultation process that was undertaken in South Africa in 2012. The finding that the mental health policy did not change in any substantive way following the consultation has not previously been documented. The *embodied-enacted-inscribed* knowledge framework (Freeman & Sturdy, 2015a) was used as a lens through which to understand why this lack of change may have occurred. To the best of my knowledge, this study is the first attempt to apply this framework in a LMIC context and in the South African policy context specifically. It has shown that the conceptualisation of embodied, enacted, and inscribed knowledge has both relevance and value within this context. It has identified a number of gaps in the consultation process that have implications for those organising and participating in such processes in future. These are considered here. Specific recommendations for policy and practice are presented in section 5.7.

Given the lengthy lead-up to the adoption of the *Mental Health Policy Framework and Strategic Plan 2013-2020*, the national consultation summit was significant in a number of ways. The summit raised the profile of mental health in South Africa and demonstrated high-level endorsement of the mental health policy, as well as commitment to addressing the challenges facing mental health service provision across the country. Further, the findings suggest that the policy framework was generally considered to be a comprehensive policy at the time of its adoption. However, the study highlighted several gaps at

the intersection of knowledge and policy in consultation. These do not detract from these important developments, nor do they make a judgement on the effectiveness of the policy itself. Rather, the findings allow us to see how attending to points of engagement between different forms of knowledge during a policy consultation event might help to improve consultation practices, with potentially valuable implications for policy development and implementation.

The point of departure for this study was the finding that the mental health policy did not change in any substantive way following the national and provincial consultation summits. As such, the questions posed and analysis conducted in this study to explore why this might have occurred were in many ways geared towards identifying problems, or gaps, that may have contributed to the apparent lack of uptake. The findings largely confirmed, therefore, many of the challenges identified in the literature regarding policy consultation and the intersection of knowledge and policy. Freeman and Sturdy's (2015a) *embodied-enacted-inscribed* knowledge framework was used to make sense of a very complex process. In particular, this lens made it possible to highlight the importance of attending carefully to the points at which knowledge is transformed from one form to another as it moves through the consultation process: specifically, from embodied to enacted knowledge, from enacted to inscribed knowledge, and from inscribed to inscribed knowledge, both within and beyond the consultation space. This, in turn, helped to illuminate gaps at the micro level of policy consultation, and inform suggestions for how some of the known challenges might be addressed. In doing so, it has provided insights into how policy consultation might be approached differently in the future.

5.5.2 What contribution has this study made?

The extensive set of findings generated by this study has highlighted several key insights that contribute to existing knowledge and practices of mental health policy consultation in South Africa and, hopefully, this has implications for knowledge and policy practices more broadly. These are discussed in this subsection.

5.5.2.1 Insight into the South African mental health consultation summits

As the only study that has been conducted on the 2012 mental health policy consultation process in South Africa, this research contributes new scholarship to the local mental health policy development and policy consultation landscape. The lack of explicit influence of this consultation process on the mental health policy has several implications. The predetermined nature of some of the outcomes from the summits suggests that the purpose of the process may have been more to secure endorsement of the draft policy than to change it. This is consistent with the primarily tokenistic culture of public

participation in South Africa that is evident in previous research. While seeking endorsement of draft policies is not in itself negative, there are potentially negative consequences if this purpose is not communicated upfront. It may serve to erode public trust in government and leave participants in such processes feeling disillusioned and, at worst, disempowered or marginalised. It also suggests, as this study has shown, that this was a lost opportunity for realising the value of the knowledge contributions of summit participants for enhancing mental health policy.

5.5.2.2 Insight into participation in consultation processes at an individual level

This study adds to what is known about what forms of knowledge contributions might be privileged over others in policy generally and policy consultation in particular. Specifically, it raises questions about previously held views, firstly, that inputs backed by explicit knowledge claims would be more likely to be responded to or captured and, secondly, that evidence-based knowledge claims would be prioritised over experiential knowledge claims. What the findings of this study suggest, instead, is that framing knowledge inputs in ways that are easily transformed into inscribed knowledge forms may hold greater weight than the evidence, experience, or other types of claims on which such inputs are based. This has implications for individuals who participate in policy consultation processes. The more cynical implication is that how contributions are made is somewhat inconsequential, in that framing these on the basis of specific knowledge claims would not likely increase the influence of such contributions. The more generous conclusion, however, is that if we wish to optimise the value that different kinds of embodied knowledge – whether evidence-based, experiential, or other – might have for policy, it is worth attending to how knowledge contributions are made. This, in turn, suggests that there needs to be agreement among consultation participants regarding the implicit and explicit rules of the game, and the ways in which knowledge contributions will be enacted and used.

5.5.2.3 Insight into service-user participation in policy consultation in South Africa

Mental health service users in South Africa are, generally speaking, a disempowered and marginalised group, with limited capacity to engage meaningfully in policy consultation discussions, as they are currently structured. Despite recent studies documenting clear strategies for enabling service-user participation in policy development (e.g. Kleintjes, 2012), the findings of the current study show that such participation remains an elusive ideal. Not only were service users poorly represented at the consultation summits, the process was not structured in a way that might have enabled their knowledge contributions beyond merely tokenistic inputs. Indeed, the presence of a largely well-educated, arguably better-capacitated group of participants was not sufficient to ensure that that the consultation process had much influence on policy. This does not provide much hope that increasing the involvement of

those whose inputs might be framed in ways that are less amenable to inscription would have any greater chance of informing policy. These findings suggest that the 2012 consultation process was a missed opportunity for exploring how enabling greater service-user participation may have influenced policy. They also suggest that the ways in which future consultation processes are structured will need to be rethought if eliciting service users' embodied experiential knowledge contributions is a genuine goal and if the onus for achieving such goals is not placed solely on service users' capacity to 'professionalise' themselves and their contributions.

5.5.2.4 Insight into participatory processes for optimising knowledge transfer

This study has demonstrated that conventional forms of enactment and inscription in policy consultation may have limited value in optimising embodied knowledge contributions. The national consultation summit was a two-day event that took a particular format, similar to that of an academic conference, or a town hall or public meeting. What this kind of process seemed to be effective in doing was eliciting a set of recommendations, of varying degrees of detail, from a large number of people. If its purpose was to achieve consensus or minimise the potential for objection or disagreement, this process seems to have been successful. This kind of process was not effective, however, at enabling debate or greater engagement with the on-the-ground feasibility of draft policy proposals. It does not seem, as highlighted above, to have been an effective process for increasing the likelihood of impact on policy, which confirms previous research with regard to public participation methods of this kind. While the summits gave participants a (limited) chance to speak, the uptake of contributions seems to have been somewhat stochastic, largely dependent on individuals who facilitated and/or recorded and reported on discussions. The format of the process also limited opportunities for exchange of embodied knowledges, such that participants could learn from the experiences of others.

This study shows that participatory processes should be designed with greater attention to knowledge moments: to points of enactment and points of inscription. In other words, the management of knowledge – from eliciting to sense-making to capturing to transferring – should be a critical element of future consultation processes. In addition, the findings of this study suggest that the transfer of inscribed knowledge through the consultation process should be more systematic. Importantly, this applies both to the forward movement of inscribed knowledge from consultation summits to policymakers, as well as to the 'backward' movement of knowledge in the form of feedback from policymakers to consultation participants. This study suggests that the record keeping and access to information processes around policy consultation – processes that would increase transparency and accountability – continue to be problematic in South Africa, despite legislative mandates.

5.5.2.5 Insight into the policy development-consultation-implementation link

The findings of this study have also made a small contribution to understanding the link between policy consultation and policy implementation by suggesting that the local and the general/abstract need to be aligned for policy to work optimally. In particular, the findings illuminate how attending to *embodied-enacted-inscribed* knowledge moments in policy consultation might facilitate balancing the tension faced by policymakers in reconciling local knowledge with abstract/general knowledge inputs to policy. They also show that participants draw on experiential knowledge to highlight whether and how policy proposals would or would not work in implementation. This, in turn, provides insight with respect to how policy consultation might enhance policy implementation, through ensuring that local-level priorities are reflected in national policies.

However, the findings also show clearly that the disconnect between national and provincial authorities in terms of policy formulation is mirrored in policy consultation. There was no systematic process during the mental health consultation summits for linking provincial level inputs with national level inputs to the mental health policy. In addition, while the development of the implementation plan following the summit suggests that the consultation may have contributed towards this plan in important ways, the lack of further consultation on the implementation priorities identified during finalisation of the policy was a missed opportunity for strengthening the provincial-national link. This is problematic because, while policymaking authority rests with the national DoH in South Africa, policy implementation is the mandate of provincial health departments. As such, this study suggests that the transfer of knowledge from sites of implementation to sites of consultation, and back to implementation sites though inscribed policies, requires greater attention. In particular, a certain level of detail is needed for policies to be consistently implemented, while still allowing for a degree of flexibility to account for variations across local (provincial and district) contexts.

Providing a more detailed implementation plan, or manual, than the eight-point Strategic Plan, could therefore have both optimised the value of more detailed inputs during the consultation summits, as well as drawn on them to inform how the policy might be most effectively implemented. The knowledge inputs available at the summits could have given policymakers insight into challenges and opportunities encountered 'on the ground', ensuring that policy issues prioritised at national level corresponded with these realities. While implementation science offers guidance with regard to strengthening the policy-to-practice link, this body of work has not necessarily conceptualised the policy development-consultation-implementation link from a knowledge perspective. In particular, the findings of this study suggest that knowledge held at local (implementation) sites might be better mobilised towards enhancing policy by attending to how knowledge is managed through policy consultation processes.

5.5.2.6 Insight into policy consultation as embodied-enacted-inscribed knowledge

This study applied Freeman and Sturdy's (2015a) *embodied-enacted-inscribed* knowledge framework to a new area – that is, mental health policy consultation in a LMIC context – in order to problematise policy consultation from a knowledge-transfer perspective. The study also provided a novel opportunity to explore the applicability of this framework in the South African setting and thus adds to empirical work that adopts this particular explanatory lens. A key insight from this study is that it is not only different types of knowledge – such as evidence-based or experiential – that must be reconciled in policy(making), but also different forms (embodied, enacted, and inscribed). Just as evidence-based and experiential types of knowledge have particular advantages and disadvantages with respect to their role in policy, so too do embodied, enacted, and inscribed knowledges. Placing emphasis on one form – such as inscribed knowledge – risks limiting the potential value that other forms have to offer policy and policymakers. Recognising the value of attending to these different knowledge forms in policy consultation illuminates potential conceptual and pragmatic ways of optimising future mental health consultation processes in South Africa. These are explored further in section 5.7, as specific recommendations for policy and practice.

5.5.3 Why are these contributions important?

In concluding this study, I argue that attending to knowledge forms and movement might help to align consultation principles with consultation practices. This is not to suggest that one type of 'process' would fit all; the interaction of contextual and individual level influences is an important factor in any policy consultation process. Rather, I suggest that using this knowledge lens to illuminate points at which knowledge use and movement could be optimised would be of value. Furthermore, being able to optimise use of participants' embodied knowledge and its interaction with the inscribed knowledge of policy in enacted spaces of consultation could potentially enhance the policy-implementation link. More specifically, I propose that attending to the specific ways in which knowledge is transformed and moved through a policy consultation process, from the individual to the abstract, has the potential to enhance the value that consultation offers policymakers in policy formulation. In addition, it holds the potential to enhance the movement of knowledge back through these levels, from the abstract level of an inscribed policy document, through enactment by and impact on individuals at the policy implementation level.

The policy-as-knowledge-problem dilemma posed in this study is one that faces policymakers everywhere. The findings of this study have suggested that constraints on the movement of embodied,

enacted, and inscribed knowledge through a policy consultation process are not necessarily that different across developed and developing country contexts. However, I would argue that the unique challenges facing the mental health care system in South Africa magnify the ramifications of not attending sufficiently to the ways in which knowledge contributions are facilitated during policy consultation. If it is accepted that policy consultation is important and therefore that contributions to these processes should be optimised, then knowledge inputs at the micro level of knowledge transformation and transfer need to be better understood. This is particularly important in mental health contexts in developing countries because of the complexities of knowledge inputs that policymakers must reconcile in formulating locally relevant policies. It is also important because of the potential that consultation holds as an empowering or disempowering space for mental health care service users.

If consultation practices do not enable multiple types and forms of knowledges to at least have the potential to inform policy – and particularly implementation priorities – then the gap between national-level processes of decision-making and what happens on the ground will continue to be difficult to reconcile, with implications for those providing health care and for those who live with and care for people with mental illness. Such elements of South Africa's mental health system make it even more critical to attend to the way that knowledge is used and moved in developing mental health policies and plans. It is hoped that this study has made a contribution towards improving future mental health policy consultation processes in South Africa. Implications for practice and recommendations for further research are presented below, after conceptual and methodological limitations of this study have been discussed.

5.6 Plausible objections

I have found it useful to conceive of the study limitations as 'plausible objections' that might be levelled against relevant components of the research, on conceptual, pragmatic, and/or methodological grounds. On a conceptual level, I have attempted to ensure that the way in which I have understood and applied the *embodied-enacted-inscribed* knowledge framework is an authentic an account of how these concepts were originally conceived; I did this by engaging closely with the research that has both conceptualised and applied this framework in policy work. Some of the methodological limitations of this study and measures taken to offset them have already been discussed in Chapter 3 (methodology) when reviewing the trustworthiness of the study. In addition, I consider further potential objections in this section.

5.6.1 Conceptual limitations

- The pragmatic paradigm has been criticised for being a catch-all approach that allows researchers to justify doing 'whatever works'. I have tried to guard against this by considering carefully how it fits with the qualitative case study research employed here, and carefully testing and applying the epistemological assumptions of this paradigm at relevant points in the study (for example, the development of the research questions, and the interpretation of findings).

- This study has explored how knowledge moved through a particular consultation process by tracing, in-depth, whether and how each individual knowledge input was transferred across various points in the process. I have, however, taken care to highlight that it is neither feasible nor even desirable to use all knowledge contributions from a consultation event in the final policy output. For one thing, credibility of knowledge inputs needs to be established. For another, the policy does need to be a broadly applicable directive, and would be based on multiple considerations. However, the premise of this study has been that if policy consultation is undertaken, this should be done with a genuine intention to attend to and consider knowledge inputs during these processes, particularly to avoid it being a tokenistic or rubber-stamping exercise.

- The national mental health summit followed a specific format: in particular, a more formal, academic-style conference style, with plenary sessions and breakaway group sessions. This may have offered a somewhat artificial representation of a truly local process in the South African context, as in many ways it resembled processes conducted in other (high-income) contexts. As such, the insights gained by analysing this process through the *embodied-enacted-inscribed* knowledge framework may not be fully applicable to more locally specific consultation formats, such as *imbizo*, for example. However, this is part of the argument on which this study is based – that processes need to be designed differently to take both general and local kinds of knowledge inputs into account.

- The use of the *embodied-enacted-inscribed* knowledge framework in some ways assumes that those on the ground – whether service providers, service users, or provincial and district managers – always have an understanding of possible alternative ways of organising services that could improve access to care. However, there are indications, for example, that there are negative attitudes towards task shifting that stem from stigmatising attitudes towards mental

health service users (Burgess, 2016), rather than the experience that this is necessarily an unrealistic policy proposal in practice. It could be argued that uncritically applying the knowledge framework to policy consultation in contexts with low levels of mental health literacy and high levels of stigma may risk perpetuating such patterns, rather than ameliorating them.

- The study of this policy consultation process could have been approached from a number of different angles, using many different lenses. The *embodied-enacted-inscribed* knowledge framework was employed as an analytical lens in this study, thereby drawing clear boundaries around what I looked at and how I looked at it. This inevitably limited my interpretations of the data to a particular knowledge-based focus, which may have resulted in missing other valuable insights that the data may have yielded.

- Related to this, the way in which I have approached knowledge creation and transfer in this study could be argued to be at a somewhat surface or simplistic level. I was aware that my particular application of the *embodied-enacted-inscribed* knowledge framework could be argued to be a 'one-dimensional' retrospective analysis of documents that were 'decontextualized'. This study did not, for example, consider the ways in which knowledge constructs the social world, and how power operates within and through this. However, the aim of this study and of policy consultation generally is to capture knowledge in some way so that it might be moved beyond the process to have the potential for use. This knowledge lens provides a useful way to *start* thinking about the process. As Freeman and Sturdy (2015a, pp. 2-3) have asserted, this schema "says almost nothing about the content or meaning of knowledge or, except in passing, about the way in which it is organised and how this might relate to questions of power and social ordering". Their aim with the schema was to "provide a basic observational language" (Freeman & Sturdy, 2015a, p. 8) that is of value in "helping us to see and think about the role of knowledge in policy" (Freeman & Sturdy, 2015a, p. 14). This is what I have attempted to do in the current study, in relation to policy consultation in mental health.

- One of the issues highlighted in this study and confirmed by the findings is the importance and yet neglect of creating enabling spaces and processes for the participation of mental health care service users in policy consultation. This might have been better contextualised had it been discussed in relation to the literature around the participation of people with disabilities more generally and how mental health policy consultation processes align with the United Nations Convention on the Rights of Persons with Disabilities. This limited the extent to which the

current study's findings could be contextualised and compared across different kinds of participatory processes.

5.6.2 Methodological and pragmatic limitations

- In this study, the limited access that I had to data and information regarding the overall consultation process is likely to have limited what could be inferred from the findings. This includes not only the limited access I had to reports from the provincial summits, for example, but also the limited responses I received in relation to my requests for participants who had been involved in the summits to participate in my research. In particular, if I had been able to include those who had been instrumental in organising the summits and in developing the policy, this would have added value to the findings of this study, as well as the insights that could be drawn from it.

- Related to this, the small number of interview participants included in this study has likely provided a somewhat limited perspective of the consultation process. It would also have been of value to test out with additional *consultation summit* participants the insights that were emerging during the analysis in terms of embodied, enacted, and inscribed knowledge, as well as the utility of conceptualising the process in this way.

- In addition, the retrospective nature of this study did not allow me to go back and test out some of the emerging conceptual and pragmatic conclusions being drawn. This will be an important recommendation in terms of further research. As such, I had to make inferences about the process, and the use and movement of knowledge during it, based largely on the documents and transcript recordings from the national summit, which limited what I could 'observe' about the process.

- I believe it would have added value to this study had I been able to delineate the boundaries of this case beyond what ultimately ended up being an in-depth analysis of the national summit in particular. Tracing further backwards and forwards in time and process from the provincial and national summits could have provided a more complete understanding of the movement of knowledge through the development of the policy itself. This, in turn, may have shed light on some of the findings of the current study, such as the lack of substantive changes between the pre-summit and post-summit versions of the mental health policy. This would also have provided greater contextual links for the application of the *embodied-enacted-inscribed*

knowledge framework and the broader influences on the use of knowledge in the development of the mental health policy.

- Related to the above, a further limitation of the narrow focus of this study on a particular *mental health* policy consultation process is that it precludes comparison across other policy consultation contexts and specifically in relation to other kinds of policy – such as other health policies, education policies, and so on. This limits the extent to which the conclusions regarding how particular forms of embodied, enacted, and inscribed knowledge moved or did not move through this consultation process might be applicable to other policy consultation processes. It leaves unanswered questions about whether the emphasis on inscribed forms of knowledge at the expense of embodied and enacted knowledge, for example, might also be identified in consultations around other health policies, or whether this is specific to the mental health context and to mental health knowledges.

- A further methodological difficulty in this study was in the coding and comparison across documents from more detailed inputs to more general recommendations. This required a level of generosity when 'matching' participant contributions to more abstracted generalisations. I realised, however, that this was as much a finding as it was a limitation, insofar as it gave me insight into the dilemma of reconciling the particular with the abstract facing both Chairs and rapporteurs at the summit, as well as policymakers themselves. This dilemma has been highlighted throughout this study.

In the next section, some of these limitations are drawn on in making recommendations for further empirical and conceptual work in the knowledge-in-policy and policy consultation fields.

5.7 Recommendations

In this study, I undertook to contribute to scholarship on mental health policy consultation, and the specific role of knowledge in such processes. In this section, I put forward recommendations, based on the findings of this study, to extend that contribution into policy and practice, and to highlight avenues for further research.

5.7.1 Recommendations for practice

The findings of this study allow me to make some recommendations for how the knowledge problem in mental health policy consultation might be addressed in future such processes. In line with how the findings have been understood on micro, meso and macro levels, recommendations are made for how consultation practices might be adapted at each of these levels to allow for optimisation of knowledge and knowledge movement through these processes.

5.7.1.1 Recommendations at micro/individual level

- **Link explicit (experiential) knowledge claims with policy proposals**

On a micro level, we saw how consultation participants made (few) explicit references to experiential and evidence-based knowledge which, in turn, may have limited the transfer of embodied knowledge to enacted knowledge (and therefore, to inscribed knowledge). The exclusion of embodied experiential knowledge at both explicit (few service users) and implicit (few experiential knowledge claims) levels was identified as particularly problematic in the context of mental health. As such, it is recommended that there needs to be better use of experiential knowledge in consultation. This has implications for participants in these processes, as well as for policymakers, as organisers of future consultation events. On an individual level, it is recommended that participants make contributions to consultation discussions that are explicitly linked to both the content of draft policy documents, as well as to knowledge claims that would allow for such contributions to be warranted. Process-related aspects that may improve the use of experiential knowledge are outlined further in section 5.7.1.2.

- **Enable greater service user participation**

The recommendation to make explicit knowledge claims also has implications for mental health service users and service-user advocacy movements in South Africa in terms of capacitating service-user participants to engage with the inscribed knowledge of policy and to articulate (enact) their experiential knowledge in relation to policy proposals. Findings have also shown that mental health service users continue to be under-represented in such processes. Greater efforts must be made in future mental health consultation processes to not only include but also enable service users to participate. This includes making the necessary resources available to support service-user participants.

- **Ensure upfront agreement about the enactment and inscription of knowledge contributions**

The findings of this study suggest that an emphasis on enacted and particularly inscribed knowledge forms may have contributed to the implicit 'rules of the game' that were communicated to participants. This may have had the effect of communicating to participants that making explicit knowledge claims was not permissible. Thus, instructions to consultation participants need to be much clearer and should involve greater inputs by participants themselves as to how best to navigate through the intersections of *embodied-enacted-inscribed* knowledge. There should be upfront and explicit agreement on making knowledge contributions, as well as how these will be managed and captured during the process. This may help to counter implicit sanctioning by participants, as well as by Chairs and rapporteurs, of the acceptability of certain kinds of knowledge inputs, or, importantly as shown by this study, certain *forms* of knowledge – specifically, enacted knowledge, as it is more amenable to inscription.

However, this study has also argued that the onus should not rest with participants to ensure that inputs are optimised, particularly in the case of more marginalised groups who may not have the capacity to engage with such processes in conventional ways. Requiring participants to professionalise themselves and their knowledge inputs risks the loss of important embodied-experiential knowledge that may have valuable implications for implementation. Ensuring that the circumstances allow for elicitation and enactment of embodied knowledge, as well as for the engagement of different forms of knowledge (for example, of participants' embodied knowledge with inscribed knowledge in draft policies) is strongly linked to the way in which such processes are structured and facilitated. Recommendations regarding consultation processes at this meso level, are considered next.

5.7.1.2 Recommendations at meso-process level

- **Clearly communicate the purpose of the consultation**

The findings of this study suggest that the purpose of the mental health summits may have been more to secure endorsement of the draft policy than to enable debate or elicit objections that may provide direction for how the policy should change. The availability of a draft summit outcome (declaration) at the start of the national summit may have been an implicit communication to participants that the outcomes were predetermined. In future consultation processes, the purpose of the consultation needs to be clearly communicated to all participants. There were also indications in the findings that the purpose of the summit may have been to inform the implementation plan; however, this was also not made clear to participants. It is recommended that clarification of purpose in future consultations

should thus also include transparency regarding how consultation contributions are intended to be used, as well as the limits and constraints on this.

- **Adapt the format of participatory processes to optimise knowledge contributions**

This study has shown that conventional forms of policy consultation may not provide optimal spaces for the enactment and inscription of knowledge. Several possible consultation design processes were identified in the literature that may optimise authentic engagement, as well as follow-through of inputs. The applicability of such processes in low-resource settings would need to be carefully considered. One form of participatory process that holds promise is the open-space design format. This can accommodate large numbers of people while simultaneously allowing for greater interaction between participants, as well as engagement with policy proposals on the table.

This study has also highlighted the necessity for trained facilitators, who may act as knowledge brokers in facilitating engagement between participants with diverse knowledge inputs. However, the findings of this study have clearly shown that a critical element of this facilitation is the ability to make sense of and capture the detailed inputs that participants make. Such facilitation, then, would be a delicate balance between ensuring sufficient opportunities for the enactment of embodied knowledge, ensuring opportunities for engagement with inscribed knowledge, and ensuring that the inscribed knowledge form adequately captures inputs.

The use of different forms of knowledge artefacts or boundary objects – such as story boards, concept maps, or flipcharts – may be explored here. Together with an open-space design process, these may allow for more participants to have greater involvement in the transfer of embodied and enacted knowledge to inscribed knowledge which, in turn, can be transferred outside of the enacted space to be used by policymakers. They also have the potential to counter some of the abstraction and summarisation evident in this study, such that the value of more detailed knowledge is not lost in inscription.

- **Implement systematic processes for capturing and transferring knowledge**

Findings indicated that the processes for capturing knowledge contributions during group discussions varied widely, with much of what got captured being dependent on individual-level influences. Attending to process and facilitation, as discussed above, could go some way towards ensuring that inscribed knowledge reflects the voices of those who participated. However, the findings of this study also suggest that more attention should be paid to points at which one form of inscribed knowledge

(e.g. the group recommendations) is transferred to another form of inscribed knowledge (e.g. the summit declaration recommendations). The extent of abstraction and summarisation that occurred at these points of inscription was substantial. In addition, there was also no process for documenting how decisions were made about what got captured at this more abstracted level. These aspects need to be attended to in future consultation events.

5.7.1.3 Recommendations at macro-process level

- **Ensure stronger links between provincial and national consultation processes**

The findings of this study clearly demonstrate that the link between provincial and national policy consultation processes needs to be improved. There was inconsistent follow-through of knowledge contributions from provincial summits to the national summit. The likelihood of provincial recommendations being heard at the national summit was dependent on the presence of individuals who had participated in these provincial events at the national summit group discussions. It also depended on the attendance of provincial representatives at the national summit to give feedback. Such embodied knowledge is of value; it is also, however, temporary in the sense that it is dependent on the presence of individuals to be conveyed. As such, processes for transferring provincial consultation outputs to national consultation events need to be more systematically managed. This extends, too, to the ways in which provincial feedback is captured during provincial events, as these findings demonstrated many inconsistencies in this regard.

In addition, this study has shown that provinces, like national summit participants, were not consulted further on the identification of implementation priorities. This seems to be a significant oversight, given that implementation of policies is managed at provincial and district levels. It reinforces the disconnect between provincial- and national-level decision-making. There were indications in this study that the purpose of the national summit may have been to inform implementation priorities. There were also indications that the implementation-related appendices added to the policy following the summit captured more of the detailed knowledge from the summit. As such, it is recommended that future consultation events be held at more local levels, with the explicit objective of gathering inputs on how the policy might work on the ground, and of identifying priorities for implementation that are locally relevant and feasible.

- **Establish mechanisms for feedback**

Following the provincial and national summits, there was no further consultation prior to the adoption and roll-out of the policy. This was particularly evident in the lack of further consultation regarding the identification of implementation priorities. It is recommended that policy consultation should be viewed as a process, and not a once-off event. This would involve establishing mechanisms through which ongoing consultation can occur. In terms of consultation on implementation plans and priorities, this may be more appropriate at more local (provincial and district) levels. Linked to this, it is also recommended that movement of knowledge 'backwards' to participants in terms of feedback regarding how inputs were used in finalising the policy needs to more systematic. Ensuring that systematic record-keeping processes are in place, as well as processes for providing access to information, could go some way towards this.

5.7.2 Recommendations for further research

Areas for further research follow automatically from some of the practical recommendations presented above. The limitations of this study also point to ways in which future studies may build on and improve this research.

5.7.2.1 Recommendations on knowledge and knowledge transfer

- **Build on empirical work using the *embodied-enacted-inscribed* knowledge framework**

The *embodied-enacted-inscribed* knowledge framework has been a useful lens through which to make sense of the use and movement of knowledge through a policy consultation process. This study has shown that this framework has relevance in an LMIC context, and in South Africa particularly. More research is needed to expand on this work. Future research may include qualitative studies which explore participants' and policymakers' perspectives on the utility of thinking of contributions to policy consultation in this way in order to optimise contributions. The framework might also be applied to other areas of policy work in South Africa, extending, for example, Maybin's (2013) study of how policymakers use knowledge in their everyday work. This would allow for an exploration of how policymakers utilise and balance multiple (and often competing) knowledge inputs when drafting and finalising policy documents. The narrow focus on a *mental health* policy consultation process, discussed as a methodological limitation above, might also be extended in future studies to include comparison across different policy contexts – such as other health policies. Findings of such studies could illuminate whether the patterns of movement of different forms of knowledge identified in the current study are

similar or different in consultation processes around different kinds of policies, which incorporate different kinds of knowledge/s.

- **Explore the ways in which participants make knowledge inputs to consultation discussions**

A surprising finding of this study was that consultation participants did not seem to make explicit knowledge claims during consultation discussions. In addition, whether such claims were evidence based or experiential did not seem to increase the likelihood of uptake. More research is needed to explore how participants make contributions during consultation discussions, as well as their perspectives on what forms of contribution are perceived to be most valuable or effective. Observational research may be of particular value here.

- **Develop credibility criteria for multiple knowledge inputs**

A strong argument has been made in this study for legitimising and using embodied experiential forms of knowledge in policy consultation. The value that different types of knowledge (such as evidence-based knowledge and experiential knowledge) might offer at different points in the policymaking process has also been highlighted. It is important, however, to be able to assess the credibility of more experiential and practical knowledge forms, while optimising the value they add. Research is needed to develop and test possible credibility criteria against which knowledge inputs that have not been empirically tested might be evaluated.

5.7.2.2 Recommendations on policy consultation processes

- **Implement and test alternative forms of participatory processes**

An immediate area for further research would be the implementation and assessment of alternative forms of participatory processes, such as open-space technology design formats, as well as the use of different forms of boundary objects during such processes. I can imagine a model that may be developed which employs various strategies to address the gaps highlighted by the findings of this study. Some of these strategies have been outlined in section 5.7.1.2 above. Implementing and testing this model in various policy areas in a South African context would be a valuable avenue for future studies to pursue. In particular, attention could be paid to how such processes might be structured in ways that allow for consideration of the 'implementability' of policy proposals, towards more explicitly identifying implementation barriers and opportunities. This would need to be done with an awareness of the effects that processes relating to "invited spaces" and "invented spaces" of public engagement

(Cornwall, 2002, p. 17) in South Africa have had on both the public and the decisions that such processes have been designed to influence.

- **Explore effects of different consultation processes on mental health service-user participation**

Although the importance of including mental health service users in policy consultations is widely accepted, this study suggests that this has not necessarily resulted in practice changes at the level of policymaking. This may be, in part, because of difficulties accessing service users and service-user groups who may be able to participate in such processes. While clear research exists regarding strategies that could be implemented to increase service-user participation in policy development in South Africa, much of this focuses on building capacities (on various levels) that empower service users to have a stronger voice in such processes. I would approach this from another angle, and explore how adapting the format of consultation processes, as outlined above, might in itself provide an empowerment-through-engagement opportunity. The feasibility and applicability of this hypothesis, however, would need to be empirically investigated.

- **Conduct research into more local-level (provincial and district) consultation processes**

It would have been interesting to explore in this study whether the pattern of knowledge use and movement that emerged during the national mental health summit was mirrored at the provincial levels. Comparative research might be conducted into this. Of more relevance, however, would be to utilise policy consultation processes that are currently being undertaken, or will be undertaken in future, to explore differences in knowledge management at provincial and national levels. This, in turn, might identify gaps that could be addressed and adapted for local relevance.

5.8 Conclusion

This concluding section summarises what has been presented in this chapter. This case study explored the movement of knowledge during a mental health policy consultation process in South Africa in order to better understand how such processes inform policy. The study has posed and answered key questions regarding the role of knowledge in mental health policy consultation in developing country contexts. Using Freeman and Sturdy's (2015a) *embodied-enacted-inscribed* knowledge schema as an analytical framework, the study mapped how knowledge moved from the embodied (particular) to the inscribed (abstract) through enacted consultative spaces.

The findings showed that the consultation process used for the current mental health policy was not able to adequately transfer participants' knowledge and experiences into policy outputs. In particular, it illuminated the difficulty of moving embodied knowledge inputs to abstracted inscribed knowledge without losing much of the contextual value that such embodied knowledge can bring to policy discussions. As such, it has suggested that this difficulty of moving from the particular to the abstract is mirrored across different levels of the policy development-consultation-implementation process, and, as highlighted above, is particularly problematic in mental health and developing country contexts.

Recognising policymaking and policy consultation as a knowledge problem calls attention to the fact that there are multiple knowledge inputs that contribute to policy. Research evidence is one of these, which in itself comes in multiple, often competing and contested, forms. Practical knowledge and experiential knowledge of those affected by mental illness are others. These are in addition to the other knowledge inputs that policymakers must hold and balance in policy decision-making, such as international best practices and local feasibilities. Some elements of these knowledges will hold more weight than others at different times, in different contexts, and in relation to different policy issues. This study is not arguing for privileging or valuing one form of knowledge over another. It is, however, calling for closer attention to be paid to how knowledge is used and moved through consultation processes, in order to optimise the value of such knowledge for policy and policy implementation.

Epilogue: Reflections on the research process

This study centres around the conceptualisation of policy consultation in mental health as something of a knowledge problem for policymakers. In parallel, this PhD process has represented something of a knowledge problem for me. In relevant sections of this thesis (particularly sections 3.2 and 3.8), I have referred to the role of researcher reflexivity in enhancing the trustworthiness of qualitative research. I have been explicit about my epistemological position as part of engaging in the epistemological reflexivity referred to by Willig (2008). In this section I offer some final reflections regarding how I have engaged with the topic (mental health policy consultation) and the methodology, as well as with different forms of knowledge over the course of the PhD journey. This is intended to complement epistemological reflexivity with what Willig (2008) refers to as personal reflexivity.

My journey through this research process towards the "threshold of doctorateness" (Bitzer, 2014, p. 39) has been a curious and often conflicted engagement with experiential and evidence-based, and embodied, enacted, and inscribed knowledges. As mentioned in section 3.2, my methodological experiences at the start of my PhD had been primarily quantitative, which provided a sort of orderly comfort in my academic work. In some senses, then, I subscribed quite strongly to the 'truth' of evidence-based knowledge and the inscribed forms of knowledge that tend to characterise academic work. In contrast, in my professional and personal experiences in the mental health field, I was more comfortable with interpretive uncertainties and possibilities. The value of experiential knowledge was clearest to me here, in my work as a psychologist and in my own experiences as a mental health care service user.

Throughout this research I grappled with the tension between these different kinds of knowledges – quantitative and qualitative, abstract and particular, objective and subjective, evidence-based and experiential – in ways that mirrored the policymaker's knowledge dilemma which I ultimately came to foreground as a central component of this study. I believe that this shaped the methodological and analytical decisions I made along the way, and is demonstrated in the analytical-descriptive way in which I have presented the findings, as well as in the application of the *embodied-enacted-inscribed* framework as an analytical ('ordering') lens. I came to realise that if I was going to complete this doctorate, I had to learn to be okay with sitting somewhere in the middle of multiple – often conflicting – knowledges, and to learn to be okay with the 'messiness' of qualitative data and the uncertainties of qualitative, interpretive research. As someone who does not like *not knowing*, then, this research process turned out to be as much a personal transformation through the three levels of reflective

learning as this research study itself was positioned: from the factual (content: *what*) to the interpretive (process: *how*) to the conceptual (premise: *why*) (Kreber & Cranton, 2000; Mezirow, 1991).

Finding my own voice as a researcher during this process, and feeling confident in making my own legitimate knowledge claims, has been what I have come to see as a site of struggle between embodied, enacted, and inscribed forms of knowledge. Learning to trust my own embodied and enacted knowledge has been, at times, a painful transformation. I realised that I, too, placed too much emphasis on inscribed knowledge – at first, on the inscribed knowledge produced by other academics and then on (impatiently) wanting to produce my own inscribed knowledge outputs. Although the knowledge appearing on the pages here would be considered explicit, formal, and inscribed, it did not always exist in that form. For much of the time spent on and in this research, I was fairly certain that I was empty of knowledge, unable to internalise the knowledge of others that I was reading or to connect with my own ideas about what I was coming to know. At times it felt as though I would never be able to speak or write with any authority on my own research topic. As it turns out, I had more than enough to say, but the source of that knowledge remains a somewhat enigmatic mix of its embodied, enacted, and inscribed forms.

At the end of this research journey, I find myself again (still, perhaps?) in the uncomfortable position of *not knowing*. Based on what I found in this study, I am more convinced than ever of the importance of attending to and capturing the embodied experiential knowledges of mental health service users and practitioners, among others, in mental health policy consultations. I have been able to make some practical recommendations regarding how to go about doing this in future consultation processes. In many ways, however, the findings seemed to highlight gaps as much as they illuminated solutions. On the threshold of doctorateness, then, I can perhaps put my "hands on [my] hips" as a researcher (Kamler & Thomson, 2014, p. 34) and position myself with more certainty as an embodied knower, while fully aware that the translation of that embodied knowledge into enacted and inscribed knowledge will always only be impartial and incomplete, open to the possibility of both confirmation and contradiction in interpretation.

References

Abayneh, S., Lempp, H., Alem, A., Alemayehu, D., Eshetu, T., Lund, C., Semrau, M., Thornicroft, G., & Hanlon, C. (2017). Service user involvement in mental health system strengthening in a rural African setting: Qualitative study. *BMC Psychiatry*, *17*, 187. doi:10.1186/s12888-017-1352-9

Abels, G. (2007). Citizen involvement in public policy-making. Does it improve democratic legitimacy and accountability? The case of pTA. *Interdisciplinary Information Sciences*, *13*, 103-116. doi:10.4036/iis.2007.103

Abelson, J., Forest, P. G., Casebeer, A., Mackean, G., Maloff, B., Musto, R., . . . Cogdon, A. (2004). *Towards more meaningful, informed, and effective public consultation.* Ottawa: Canadian Health Services Research Foundation.

Abelson, J., Forest, P. G., Eyles, J., Smith, P., Martin, E., & Gauvin, F. P. (2003). Deliberations about deliberative methods: Issues in the design and evaluation of public participation processes. *Social Science and Medicine*, *57*, 239-251. doi:10.1016/S0277-9536(02)00343-X

Abelson, J., & Gauvin, F. P. (2004). *Transparency, trust and citizen engagement: What Canadians are saying about accountability.* Ottawa: Canadian Policy Research Networks.

Abelson, J., & Gauvin, F. P. (2006). *Assessing the impacts of public participation: Concepts, evidence and policy implications.* CPRN research report P|06 Public Involvement Network. Ottawa: Canadian Policy Research Networks.

Abidi, S. S. R., Cheah, Y. N., & Curran, J. (2005). A knowledge creation info-structure to acquire and crystallize the tacit knowledge of health-care experts. *IEEE Transactions on Information Technology in Biomedicine*, *9*, 193-204. doi:10.1109/TITB.2005.847188

Abuhimed, D., Beheshti, J., Cole, C., AlGhamdi, M. J., & Lamoureux, I. (2013). Knowledge artefacts: Lessons learned and stories as a means to transfer knowledge amongst cohorts of high school students working on an inquiry-based project. *Proceedings of the American Society for Information Science and Technology*, *50*, 1. doi:10.1002/meet.14505001146

Adams, B. E. (2014). Reason-giving in deliberative forums. *Journal of Public Deliberation, 10*, Article 6. Retrieved from http://www.publicdeliberation.net/jpd/vol10/iss2/art6

Agrawal, A. (2002). Indigenous knowledge and the politics of classification. *International Social Science Journal, 54,* 287-297. doi:10.1111/1468-2451.00382

Aho, K. (2008). Medicalizing mental health: A phenomenological alternative. *Journal of Medical Humanities*, *29*, 243-259. doi:10.1007/s10912-008-9065-1

Aikins, A. D., Unwin, N., Agyemang, C., Allotey, P., Campbell, C., & Arhinful, D. (2010). Tackling Africa's chronic disease burden: From the local to the global. *Globalization and Health*, *6*, 5. doi:10.1186/1744-8603-6-5

Al-Hawamdeh, S. (2002). Knowledge management: Re-thinking information management and facing the

challenge of managing tacit knowledge. *Information Research, 8*, 1-20. Retrieved from http://www.informationr.net/ir/8-1/paper143.html

Almeida, C., & Bascolo, E. (2006). Use of research results in policy decision-making, formulation, and implementation: A review of the literature. *Cadernos de Saúde Pública*, *22*(Supp.), S7-S19. doi:10.1590/S0102-311X2006001300002

Antaki, C., & Leudar, I. (1990). Claim-backing and other explanatory genres in talk. *Journal of Language and Social Psychology*, *9*, 279-292. doi:10.1177/0261927X9094004

Araya, R. (2009). Invited commentary on mental health research priorities in low- and middle-income countries. *The British Journal of Psychiatry*, *195*, 364-365. doi:10.1192/bjp.bp.109.067793

Arnstein, S.R. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners, 35,* 216-224. doi:10.1080/01944366908977225

Aronson, J. K. (1993). Giving consumers a say in policy development: Influencing policy or just being heard? *Canadian Public Policy/Analyse de Politiques*, *19*, 367-378. doi:10.2307/3551384

Ashwood, L., Harden, N., Bell, M. M., & Bland, W. (2014). Linked and situated: Grounded knowledge. *Rural Sociology*, *79*, 427-452. doi:10.1111/ruso.12042

Asmall, S., & Mahomed, O. (2013). *Integrated chronic disease management manual.* Pretoria: Department of Health.

Atkins, J., & Finlayson, A. (2013). "… A 40-year-old black man made the point to me": Everyday knowledge and the performance of leadership in contemporary British politics. *Political Studies*, *61*, 162-177. doi:10.1111/j.1467-9248.2012.00953.x

Babbie, E., & Mouton, J. (2001). *The practice of social research* (8th ed.). Oxford: Oxford University Press.

Baccaro, L., & Papadakis, K. (2008). *The promise and perils of participatory policy making*. Geneva: International Institute for Labour Studies.

Bacchi, C. (2009). *Analysing policy: What's the problem represented to be?* French's Forest, NSW: Pearson Australia.

Baillergeau, E., & Duyvendak, J.W. (2016). Experiential knowledge as a resource for coping with uncertainty: Evidence and examples from the Netherlands. *Health, Risk and Society*, *18*, 407-426. doi:10.1080/13698575.2016.1269878

Bakhurst, D., & Sypnowich, C. (1995). Introduction: Problems of the social self. In D. Bakhurst & C. Sypnowich (Eds.), *The social self* (pp. 1-17). London: Sage.

Barnes, M. (2002). Bringing difference into deliberation? Disabled people, survivors and local governance. *Policy and Politics*, *30*, 319-331. doi:10.1332/030557302760094694

Barnes, M. (2008). Passionate participation: Emotional experiences and expressions in deliberative forums. *Critical Social Policy*, *28*, 461-481. doi:10.1177/0261018308095280

Barnes, M. (2009). Researching public participation. *Local Government Studies*, *25*, 60-75.

doi:10.1080/03003939908433967

Barnes, M., Knops, A., Newman, J., & Sullivan, H. (2004). The micro-politics of deliberation: Case studies in public participation. *Contemporary Politics*, *10*, 93-110. doi:10.1080/1356977042000278756

Barnes, M., Newman, J., Knops, A., & Sullivan, H. (2003). Constituting 'the public' in public participation. *Public Administration*, *81*, 379-399. doi:10.1111/1467-9299.00352

Barsdorf, N. (2012). *South Africa's duty to support health research for the global poor* (Unpublished doctoral thesis). Centre for International Health, University of Bergen, Bergen, Norway.

Bedard, P. O., & Ouimet, M. (2016). Persistent misunderstandings about evidence-based (sorry: informed!) policy-making. *Archives of Public Health*, *74*, 1-6. doi:10.1186/s13690-016-0142-z

Beierle, T. C. (1998). *Public participation in environmental decisions: An evaluative framework using social goals*. Discussion paper 99-06. Washington, DC: Resources for the Future.

Belcher, D., & Hirvela, A. (2005). Writing the qualitative dissertation: What motivates and sustains commitment to a fuzzy genre? *Journal of English for Academic Purposes, 4,* 187-205. doi:10.1016/j.jeap.2004.07.010

Bennett, G., & Jessani, N. (Eds.). (2011). *The knowledge translation toolkit: Bridging the know-do gap: A resource for researchers*. Ottawa and Los Angeles: International Development Research Centre and Sage.

Bentall, R. P. (2009). *Doctoring the mind: Why psychiatric treatments fail*. London: Penguin Books.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*, 219-234. doi:10.1177/1468794112468475

Bishop, P., & Davis, G. (2002). Mapping public participation in policy choices. *Australian Journal of Public Administration*, *61*, 14-29. doi:10.1111/1467-8500.00255

Bitzer, E. (2014). Learning the language of the doctorate: Doctorateness as a threshold concept in doctoral literacy. *Per Lingum*, *30*, 39-52. doi:10.5785/30-3-585

Blackler, F. (1995). Knowledge, knowledge work and organizations: An overview and interpretation. *Organization Studies*, *16*, 1021-1046. doi:10.1177/017084069501600605

Boivin, A., Lehoux, P., Burgers, J., & Grol, R. (2014). What are the key ingredients for effective public involvement in health care improvement and policy decisions? A randomized trial process evaluation. *The Milbank Quarterly*, *92*, 319-350. doi:10.1111/1468-0009.12060

Boswell, C. (2008). The political functions of expert knowledge: Knowledge and legitimation in European Union immigration policy. *Journal of European Public Policy*, *15*, 471-488. doi:10.1080/13501760801996634

Bowen, S., & Zwi, A. (2005). Pathways to "evidence-informed" policy and practice: A framework for action. *PLoS Medicine*, *2*, e166. doi:10.1371/journal.pmed.0020166

Brackertz, N., & Meredyth, D. (2009). Community consultation in Victorian local government: A case of

mixing metaphors. *The Australian Journal of Public Administration*, *68*, 152-166. doi:10.1111/j.1467-8500.2009.00627.x

Bradshaw, D., Steyn, K., Levitt, N., & Nojilana, B. (2011). *Non-communicable diseases: A race against time.* Cape Town: Medical Research Council.

Braun, V., & Clark, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3,* 77-101. doi:10.1191/1478088706qp063oa

Bresnan, M., Edelman, L., Newell, S., Scarbrough, H., & Swan, J. (2003). Social practices and the management of knowledge in project environments. *International Journal of Project Management*, *21*, 157-166. doi:10.1016/S0263-7863(02)00090-X

Briand, M. (2007). Democracy at the core: Recalling participation's raison d'Être. *International Journal for Public Participation, 1*. Retrieved from http://www.iap2.org

Brock, K., Cornwall, A., & Gaventa, J. (2001). *Power, knowledge and political spaces in the framing of poverty policy.* Working Paper 143. Brighton, Sussex: Institute of Development Studies.

Brocki, J., & Wearden, A. (2006). A critical evaluation of the use of Interpretative Phenomenological Analysis (IPA) in health psychology. *Psychology and Health, 21*, 87-108. doi:10.1080/14768320500230185

Brophy, L., & Savy, P. (2011). Broadening the evidence base of mental health policy and practice. *Health Sociology Review*, *20*, 229-234. doi:10.5172/hesr.2011.20.2.229

Brosnan, C. (2016). Epistemic cultures in complementary medicine: Knowledge-making in university departments of osteopathy and Chinese medicine. *Health Sociology Review*, *25*, 171-186. doi:10.1080/14461242.2016.1171161

Brown, J. (2014). Evaluating participatory initiatives in South Africa: Not just process but outcomes too. *SAGE Open, April-June*, 1-16. doi:10.1177/2158244014531966

Brown, P. A. (2008). A review of the literature on case study research. *Canadian Journal for New Scholars in Education*, *1*, 1-13.

Bryman, A. (2006). Paradigm peace and the implications for quality. *International Journal of Social Research Methodology*, *9*, 111-126. doi:10.1080/13645570600595280

Brynard, P. A. (2007). The policy gap in South Africa. *Journal of Public Administration, 42*, 358-365. Retrieved from http://hdl.handle.net/2263/3910

Buccus, I., Hemson, D., Hicks, J., & Piper, L. (2008). Community development and engagement with local governance in South Africa. *Community Development Journal*, *43*, 297-311. doi:10.1093/cdj/bsn011

Buccus, I., & Hicks, J. (2011). Civil society and participatory policy making in South Africa: Gaps and opportunities. In J. Daniel, P. Naidoo, D. Pillay, & R. Southall (Eds.), *New South African review 2: New paths, old compromises* (pp. 100-118). Johannesburg: Wits University Press.

Bullock, H., Watson, A., & Goering, P. (2010). Building for success: Mental health research with an

integrated knowledge translation approach. *Canadian Journal of Community Mental Health*, *29*, 9-21. doi:10.7870/cjcmh-2010-0031

Burall, S. (2012). *Two things you need to know about public engagement*. Published online 9 March, 2012. Retrieved from https://www.involve.org.uk/2012/03/09/two-things-you-need-to-know-about-public-engagement/

Burgess, R. A. (2016). Policy, power, stigma and silence: Exploring the complexities of a primary mental health care model in a rural South African setting. *Transcultural Psychiatry*, *53*, 719-742. doi:10.1177/1363461516679056

Burnard, P., Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Analysing and presenting qualitative data. *British Dental Journal*, *204*, 428-432. doi:10.1038/sj.bdj.2008.292

Burns, J. K. (2011). The mental health gap in South Africa: A human rights issue. *The Equal Rights Review*, *6*, 99-113.

Buse, K., Dickinson, C., Gilson, L., & Murray, S. F. (2008). How can the analysis of power and process in policy-making improve health outcomes? *World Hospitals and Health Services*, *45*, 4-8. Retrieved from https://www.ihf-fih.org/

Buse, K., Mays, N., & Walt, G. (2012). *Making health policy* (2nd ed.). Maidenhead, Berkshire: Open University Press.

Caluwaerts, D., & Reuchamps, M. (2016). Generating democratic legitimacy through deliberative innovations: The role of embeddedness and disruptiveness. *Representation*, *52*, 13-27. doi:10.1080/00344893.2016.1244111

Caron-Flinterman, J. F., Broerse, J. E. W., & Bunders, J. F. G. (2005). The experiential knowledge of patients: A new resource for biomedical research? *Social Science and Medicine*, *60*, 2575-2584. doi:10.1016/j.socscimed.2004.11.023

Carter, P., Beech, R., Coxon, D., Thomas, M. J., & Jinks, C. (2013). Mobilising the experiential knowledge of clinicians, patients and carers for applied health-care research. *Contemporary Social Science*, *8*, 307-320. doi:10.1080/21582041.2013.767468

Catt, H., & Murphy, M. (2003). What voice for the people? Categorising methods of public consultation. *Australian Journal of Political Science*, *38*, 407-421. doi:10.1080/1036114032000133967

Cheeseman, G., & Smith, H. (2001). Public consultation or political choreography? The Howard Government's quest for community views on defence policy. *Australian Journal of International Affairs*, *55*, 83-100. doi:10.1080/10357710120055094

Cheng, M. S., & Johnstone, B. (2002). Reasons for reason-giving in a public opinion survey. *Argumentation*, *16*, 401-420. doi:10.1023/A:1021138703400

Chipps, J., & Ramlall, S. (2012). Research in lower middle income countries – recommendations for a national mental health research agenda in South Africa. *African Journal of Psychiatry*, *15*, 432-435. doi:10.4314/ajpsy.v15i6.55

Clapper, V. A. (1996). Advantages and disadvantages of citizen participation. In K. Bekker (Ed.), *Citizen participation in local government* (pp. 66-78). Pretoria: Van Schaik.

Clark, J. (2014). Medicalization of global health 2: The medicalization of global mental health. *Global Health Action, 7*, 24000. doi:10.3402/gha.v7.24000

Clark, J. K., Kaiser, M. L., Hicks, R., Hoy, C., Rogers, C., & Spees, C. K. (2015). Community-university engagement via a boundary object: The case of food mapping in Columbus, Ohio. *Journal of Public Scholarship in Higher Education, 5,* 126-142.

Classen, S. I. (2010). *Using storytelling to elicit tacit knowledge from subject matter experts in an organization* (Unpublished master's thesis). University of the Western Cape, Cape Town, South Africa.

Cohen, L., Manion, L., & Morrison, K. (2010). *Research methods in education* (6th ed.). New York, NY: Routledge.

Colebatch, H. K. (2006). What work makes policy? *Policy Science, 39*, 309-321. doi:10.1007/s11077-006-9025-4

Collins, H. M. (1993). The structure of knowledge. *Social Research, 60*, 95-116.

Collins, H. M., & Evans, R. (2002). The third wave of science studies: Studies of expertise and experience. *Social Studies of Science*, *32*, 235-296. doi:10.1177/0306312702032002003

Conklin, A., Morris, Z., & Nolte, E. (2012). What is the evidence base for public involvement in health-care policy?: Results of a systematic scoping review. *Health Expectations*, *18*, 153-165. doi:10.1111/hex.12038

Cook, D. (2002). Consultation, for a change? Engaging users and communities in the policy process. *Social Policy and Administration*, *36*, 516-531. doi:10.1111/1467-9515.00300

Cornwall, A. (2002). *Making spaces, changing places: Situating participation in development.* IDS Working paper series 170. Brighton: CDRC, IDS. Retrieved from https://opendocs.ids.ac.uk/opendocs/handle/123456789/3932

Court, J., & Young, J. (2004). *Bridging research and policy in international development: An analytical and practical framework*. RAPID Briefing Paper 1, London: ODI.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). London: Sage.

Cronin, G. P., & Sadan, M. (2015). Use of evidence in policy making in South Africa: An exploratory study of attitudes of senior government officials. *African Evaluation Journal*, *3*, 1-10. doi:10.4102/aej.v3i1.145

Crowe, M. (2000). Constructing normality: A discourse analysis of the DSM-IV. *Journal of Psychiatric and Mental Health Nursing, 7,* 69-77. doi:10.1046/j.1365-2850.2000.00261.x

Crowther, H., Lipworth, W., & Kerridge, I. (2011). Evidence-based medicine and epistemological

imperialism: Narrowing the divide between evidence and illness. *Journal of Evaluation in Clinical Practice*, *17*, 868-872. doi:10.1111/j.1365-2753.2011.01723.x

Davidson, L., Drake, R. E., Schmutte, T., Dinzeo, T., & Andres-Hyman, R. (2009). Oil and water or oil and vinegar? Evidence-based medicine meets recovery. *Community Mental Health*, *45*, 323-332. doi:10.1007/s10597-009-9228-1

Davies, H. T. O., Nutley, S. M., & Walter, I. (2008). Why 'knowledge transfer' is misconceived for applied social science. *Journal of Health Services Research and Policy*, *13*, 188-190. doi:10.1258/jhsrp.2008.008055

Davis, G. (1997). Rethinking policy making: A new role for consultation? *Administration*, *45*, 26-47.

Daviter, F. (2015). The political use of knowledge in the policy process. *Policy Science*, *48*, 491-505. doi:10.1007/s11077-015-9232-y

Deaton, A. S. (2009*). Instruments of development: Randomization in the tropics and the search for the elusive keys to economic development.* Working Paper 14690. Cambridge, MA: National Bureau of Economic Research. Retrieved from http://www.nber.org/papers/w14690

DeForge, R., & Shaw, J. (2012). Back- and foregrounding ontology: Exploring the linkages between critical realism, pragmatism, and methodologies in health and rehabilitation sciences. *Nursing Inquiry*, *19*, 83-95. doi:10.1111/j.1440-1800.2011.00550.x

Degeling, C., Carter, S. M., & Rychetnik, L. (2015). Which public and why deliberate? A scoping review of public deliberation in public health and health policy research. *Social Science and Medicine*, *131*, 114-121. doi:10.1016/j.socscimed.2015.03.009

Demszky, A., & Nassehi, A. (2012). Perpetual loss and gain: Translation, estrangement and cyclical recurrence of experience-based knowledge in public action. *Policy and Society*, *31*, 169-181. doi:10.1016/j.polsoc.2012.04.006

Denning, S. (2004). Telling tales. *Harvard Business Review*, *82*, 122-129. Retrieved from https://hbr.org/2004/05/telling-tales

Denscombe, M. (1998). *The good research guide: For small-scale social research projects.* Buckingham: Open University Press.

Denzin, N. K. (1970). *The research act in sociology: A theoretical introduction to sociological methods*. London: Butterworths.

Department of Provincial and Local Government, South Africa. (2007). *National policy framework for public participation*. Pretoria: Department of Local and Provincial Government.

Department of Health. (1997). *White paper for the transformation of the health system in South Africa.* Pretoria: Department of Health.

Department of Health. (2013). *National mental health policy framework and strategic plan 2013-2020.* Pretoria: Department of Health.

De Vries, A. K., & Klazinga, N. S. (2006). Mental health reform in post-conflict areas: A policy analysis

based on experiences in Bosnia Herzegovina and Kosovo. *European Journal of Public Health*, *16*, 246-251. doi:10.1093/eurpub/cki092

De Weerd-Nederhof, P. C. (2001). Qualitative case study research: The case of a PhD research project on organising and managing new product development systems. *Management Decision, 39,* 513-538. doi:10.1108/EUM0000000005805

Ditlopo, P., Blaauw, D., Penn-Kekana, L., & Rispel, L. C. (2014). Contestations and complexities of nurses' participation in policy-making in South Africa. *Global Health Action*, *7*. doi:10.3402/gha.v7.25327

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research and Policy*, *10*, 45-53. doi:10.1177/135581960501000110

Draper, C. E., Lund, C., Kleintjes, S., Funk, M., Omar, M., Flisher, A. J., & the MHaPP Research Programme Consortium. (2009). Mental health policy in South Africa: Development process and content. *Health Policy and Planning*, *24*, 342-356. doi:10.1093/heapol/czp027

Dresing, T., Pehl, T., & Schmieder, C. (2015). *Manual on transcription. Transcription conventions, software guides and practical hints for qualitative researchers* (3rd Eng. Ed.). Retrieved from http://www.audiotranskription.de/english/transcription-practicalguide.htm

Durrheim, K. (2006). Research design. In M. TerreBlanche, K. Durrheim, & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 33-59). Cape Town: UCT Press.

Dyer, C. (1995). *Beginning research in psychology.* Oxford: Blackwell.

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R. . . . Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *Lancet*, *378*, 1592-1603. doi:10.1016/S0140-6736(11)60891-X

Ebrahim, S., & Smith, G.D. (2001). Exporting failure? Coronary heart disease and stroke in developing countries. *International Journal of Epidemiology*, *30*, 201-205. doi:10.1093/ije/30.2.201

Econex. (2009). *South Africa's burden of disease*. NHI Note 2, October 2009. Cape Town: Econex.

Ekurhuleni Declaration on Mental Health. (2012). *African Journal of Psychiatry*, *15*(6), 381-383. Retrieved from http://hdl.handle.net/10520/EJC127145

Elberse, J. E., Caron-Flinterman, F., & Broerse, J. E. W. (2011). Patient-expert partnerships in research: How to stimulate inclusion of patient perspectives. *Health Expectations*, *14*, 225-239. doi:10.1111/j.1369-7625.2010.00647.x

El-Jardali, F., Ataya, N., Jamal, D., & Jaafar, M. (2012). A multi-faceted approach to promote knowledge translation platforms in eastern Mediterranean countries: Climate for evidence-informed policy. *Health Research Policy and Systems*, *10*, 15. doi:10.1186/1478-4505-10-15

Elster, J. (1998). Introduction. In J. Elster (Ed.), *Deliberative democracy* (pp. 1-18). New York, NY: Cambridge University Press.

Emad, G., & Roth, W. M. (2009). Policy as boundary object: A new way to look at educational policy design and implementation. *Vocations and Learning*, *2*, 19-35. doi:10.1007/s12186-008-9015-0

Emery, S. B., Mulder, H. A. J., & Frewer, L. J. (2014). Maximising the policy impacts of public engagements: A European study. *Science, Technology and Human Values*, *40*, 421-444. doi:10.1177/0162243914550319

Enany, N. E., Currie, G., & Lockett, A. (2013). A paradox in healthcare service development: Professionalization of service users. *Social Science and Medicine*, *80*, 24-30. doi:10.1016/j.socscimed.2013.01.004

Entwistle, V. A., & Watt, I. S. (2013). Treating patients as persons: A capabilities approach to support delivery of person-centered care. *The American Journal of Bioethics*, *13*, 29-39. doi:10.1080/15265161.2013.802060

Epstein, D., Heidt, J., & Farina, C.R. (2012). The value of words: Narrative as evidence in policymaking. *Evidence and Policy, 10*, 243-258. doi:10.1332/174426514X13990325021128

Erasmus, E., Orgill, M., Schneider, H., & Gilson, L. (2014). Mapping the existing body of health policy implementation research in lower income settings: What is covered and what are the gaps? *Health Policy and Planning*, *4*, 111135-11150. doi:10.1093/heapol/czu063

Farina, C. R., Epstein, D., Heidt, J., & Newhart, M. J. (2012). Knowledge in the people: Rethinking "value" in public rulemaking participation. *Cornell e-Rulemaking Initiative Publications*. Paper 1. Retrieved from http://scholarship.law.cornell.edu/ceri/1

Farmer, T., Robinson, K., Elliott, S. J., & Eyles, J. (2006). Developing and implementing a triangulation protocol for qualitative health research. *Qualitative Health Research*, *16*, 377-394. doi:10.1177/1049732305285708

Fazey, J., Fazey, J. A., Salisbury, J. G., Lindenmayer, D. B., & Dovers, S. (2006). The nature and role of experiential knowledge for environmental conservation. *Environmental Conservation*, *33*, 1-10. doi:10.1017/S037689290600275X

Feilzer, M. Y. (2009). Doing mixed methods research pragmatically: Implications for the rediscovery of pragmatism as a research paradigm. *Journal of Mixed Methods Research*, *4*, 1-11. doi:10.1177/1558689809349691

Feldman, M. S., Khademian, A. M., Ingram, H., & Schneider, A. S. (2006). Ways of knowing and inclusive management practices. *Public Administration Review*, *66*, 89-99. doi:10.1111/j.1540-6210.2006.00669.x

Fernando, G. A. (2012). The roads less traveled: Mapping some pathways on the global mental health research roadmap. *Transcultural Psychiatry*, *49*, 396-417. doi:10.1177/1363461512447137

Flisher, A. J., Lund, C., Funk, M., Banda, M., Bhana, A., Doku, V., Drew, N., Kigozi, F. N., Knapp, M., Omar, M., Petersen, I., & Green, A. (2007). Mental health policy development and implementation in

four African countries. *Journal of Health Psychology*, *12*, 505-516. doi:10.1177/1359105307076237

Florin, D., & Dixon, J. (2004). Public involvement in health care. *British Medical Journal*, *328*, 159-161.

Fominykh, M., Prasolova-Forland, E., Divitini, M., & Petersen, S. A. (2016). Boundary objects in collaborative work and learning. *Information Systems Frontiers*, *18*, 85-102. doi:10.1007/s10796-015-9579-9

Fortin, E. (2009). *Strategising consultation: Government, approaches to legitimising land tenure reform policies in post-apartheid South Africa*. BWPI working paper 90. Manchester: Brooks World Poverty Institute. Retrieved from http://hummedia.manchester.ac.uk/institutes/gdi/publications/workingpapers/bwpi/bwpi-wp-9009.pdf

Frambach, J. M., van der Vleuten, C. P. M., & Durning, S. J. (2013). AM last page: Quality criteria in qualitative and quantitative research. *Academic Medicine*, *88*, 552. doi:10.1097/ACM.0b013e31828abf7f

Freeman, M. (2000). Using all opportunities for improving mental health – examples from South Africa. *Bulletin of the World Health Organization*, *78*, 508-510.

Freeman, R. (2007). Epistemological bricolage: How practitioners make sense of learning. *Administration and Society*, *39*, 476-496. doi:10.1177/0095399707301857

Freeman, R. (2009). What is 'translation'? *Evidence and Policy*, *5*, 429-447. doi:10.1332/174426409X478770

Freeman, R., & Sturdy, S. (2015a). Introduction: Knowledge in policy – embodied, inscribed, enacted. In R. Freeman, & S. Sturdy (Eds.), *Knowledge in policy: Embodied inscribed enacted* (pp. 1-20). Bristol: Policy Press.

Freeman, R., & Sturdy, S. (2015b). Knowledge and policy in research and practice. In R. Freeman, & S. Sturdy (Eds.), *Knowledge in policy: Embodied inscribed enacted* (pp. 201-218). Bristol: Policy Press.

Funke, N., Nienaber, S., & Henwood, R. (2011). Scientists as lobbyists? How science can make its voice heard in the South African policy-making arena. *Journal of Public Affairs*, *11*, 287-296. doi:10.1002/pa.421

Gabriel, Y. (2004). The voice of experience and the voice of the expert – can they speak to each other? In B. Hurwitz, T. Greenhalgh, & V. Skultans (Eds.), *Narrative research in health and illness* (pp. 168-186). Massachusetts: Blackwell Publishing.

Gale, N.K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*, 117-124. doi:10.1186/1471-2288-13-117

Gask, L., & Coventry, P. (2012). Person-centred mental health care: The challenge of implementation.

Epidemiology and Psychiatric Sciences, *21*, 139-144. doi:10.1017/S2045796012000078

Gilson, L. (2012a). Introduction to health policy and systems research. In L. Gilson (Ed.), *Health policy and systems research: A methodology reader* (pp. 21-40). Geneva: World Health Organization.

Gilson, L. (2012b). Doing health policy and systems research: Key steps in the process. In L. Gilson (Ed.), *Health policy and systems research: A methodology reader* (pp. 43-60). Geneva: World Health Organization.

Gilson, L., Hanson, K., Sheikh, K., Agyepong, I. A., Ssengooba, F., & Bennett, S. (2011). Building the field of health policy and systems research: Social science matters. *PLoS Medicine*, *8*, e1001079. doi:10.1371/journal.pmed.1001079

Gilson, L., & McIntyre, D. (2008). The interface between research and policy: Experience from South Africa. *Social Science and Medicine*, *67*, 748-759. doi:10.1016/j.socscimed.2008.02.005

Gilson, L., & Raphaely, N. (2008). The terrain of health policy analysis in low and middle income countries: A review of published literature 1994-2007. *Health Policy and Planning*, *23*, 294-307. doi:10.1093/heapol/czn019

Glasby, J., & Beresford, P. (2006). Who knows best? Evidence-based practice and the service user contribution. *Critical Social Policy*, *26*, 268-284. doi:10.1177/0261018306059775

Glover, H. (2005). Guest editorial: Recovery based service delivery: Are we ready to transform the words into a paradigm shift? *Australian e-Journal for the Advancement of Mental Health*, *4*, 179-182. doi:10.5172/jamh.4.3.179

Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems, 21*, 135-146. doi:10.1057/ejis.2011.54

Goldner, E. M., Jenkins, E. K., & Fisher, B. (2014). A narrative review of recent developments in knowledge translation and implications for mental health care providers. *Canadian Journal of Psychiatry*, *59*, 160-169. doi:10.1177/070674371405900308

Govender, C. (2017). The deaths of 94 mental health care users in Gauteng, South Africa. *Frontiers in Public Health*, *5*, 1-2. doi:10.3389/fpubh.2017.00126

Graham, I. D., Logan, J., Harrison, R. N., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Professions*, *26*, 13-24. doi:10.1002/chp.47

Gramberger, M. (2001). *Citizens as partners: OECD handbook on information, consultation, and public participation in policy-making*. Paris: Organisation for Economic Cooperation and Development.

Greenhalgh, T. (2016). *Cultural contexts of health: The use of narrative research in the health sector*. Health Evidence Network Synthesis Report 49. Copenhagen: World Health Organization.

Greenhalgh, T., & Russell, J. (2009). Evidence-based policymaking: A critique. *Perspectives in Biology and Medicine*, *52*, 304-318. doi:10.1353/pbm.0.0085

Greenhalgh, T., & Wieringa, S. (2011). Is it time to drop the 'knowledge translation' metaphor? A critical

literature review. *Journal of the Royal Society of Medicine*, *104*, 501-509. doi:10.1258/jrsm.2011.110285

Grimmelikhuijsen, S. (2012). Linking transparency, knowledge and citizen trust in government: An experiment. *International Review of Administrative Sciences*, *78*, 50-73. doi:10.1177/0020852311429667

Gross, C. (2007). Community perspectives of wind energy in Australia: The application of a justice and community fairness framework to increase social acceptance. *Energy Policy*, *35*, 2727-2736. doi:10.1016/j.enpol.2006.12.013

Grundmann, R., & Stehr, N. (2012). *The power of scientific knowledge: From research to public policy.* Cambridge: Cambridge University Press.

Guisinger, S., & Blatt, S. J. (1994). Individuality and relatedness: Evolution of a fundamental dialectic. *American Psychologist*, *49*, 104-111. doi:10.1037/0003-066X.49.2.104

Gumede, V. (2008). Public policy making in a post-apartheid South Africa: A preliminary perspective. *Africanus*, *38*, 7-23.

Gurung, D., Upadhyaya, N., Magar, J., Giri, N. P., Hanlon, C., & Jordans, M. J. D. (2017). Service user and care giver involvement in mental health system strengthening in Nepal: A qualitative study on barriers and facilitating factors. *International Journal of Mental Health Systems*, *11*:30. doi:10.1186/s13033-017-0139-1

Habermas, J. (1984). *Theory of communicative action* (Vol. 1)*: Reason and the rationalisation of society*. Boston, MA: Beacon Press.

Hajer, M. A. (2005). Setting the stage: A dramaturgy of policy deliberation. *Administration Society*, *36*, 624-647. doi:10.1177/0095399704270586

Hall, J. N. (2013). Pragmatism, evidence, and mixed methods evaluation. In D. M. Mertens, & S. Hess-Biber (Eds.), *Mixed methods and credibility of evidence in evaluation: New Directions for Evaluation, 138,* 15-26.

Hamel, J. (1993). *Case study methods*. London: Sage.

Hampton, G. (2004). Enhancing public participation through narrative analysis. *Policy Sciences*, *37*, 261-276. doi:10.1007/s11077-005-1763-1

Hampton, G. (2009). Narrative policy analysis and the integration of public involvement in decision making. *Policy Science*, *42*, 227-242. doi:10.1007/s11077-009-9087-1

Hannah, D. R., & Lautsch, B. A. (2011). Counting in qualitative research: Why to conduct it, when to avoid it, and when to closet it. *Journal of Management Inquiry*, *20*, 14-22. doi:10.1177/1056492610375988

Hanney, S. R., Gonzalez-Block, M. A., Buston, M. J., & Kogan, M. (2003). The utilisation of health research in policy-making: Concepts, examples and methods of assessment. *Health Research Policy and Systems*, *1*:2. doi:10.1186/1478-4505-1-2

Hansen, M. T., Nohira, N., & Tierney, T. J. (1999). What's your strategy for managing knowledge? *Harvard Business Review*, *77*, 106-116. Retrieved from https://hbr.org/1999/03/whats-your-strategy-for-managing-knowledge

Harding, E., Walt, S., & Scrutton, J. (2015). *The state of play in person-centred care*. London: The Health Policy Partnership.

Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientations. *Forum: Qualitative Social Research*, *18*, 1-12. doi:10.17169/fqs-18.1.2655

Harvey, M. (2009). Drama, talk, and emotion: Omitted aspects of public participation. *Science, Technology and Human Values*, *34*, 139-161. doi:10.1177/0162243907309632

Head, B. W. (2010). Editorial: Reconsidering evidence-based policy: Key issues and challenges. *Policy and Society*, *29*, 77-94. doi:10.1016/j.polsoc.2010.03.001

Healey, P. (2007). *Urban complexity and spatial strategies: Towards a relational planning for our times*. London: Routledge.

Henning, E. (2004). *Finding your way in qualitative research*. Pretoria: Van Schaik.

Heslehurst, N., Dinsdale, S., Sedgewick, G., Simpson, H., Sen, S., Summerbell, C. D., & Rankin, J. (2015). An evaluation of the implementation of maternal obesity pathways of care: A mixed methods study with data integration. *PLoS ONE*, *10*, e0127122. doi:10.1371/journal.pone.0127122

Hildreth, P.M., & Kimble, C. (2002). The duality of knowledge. *Information Research, 8*, 1-18.

Holmes, D., Murray, S. J., Perron, A., & Rail, G. (2006). Deconstructing the evidence-based discourse in health sciences: Truth, power and fascism. *International Journal of Evidence-Based Healthcare*, *4*, 180-186. doi:10.1111/j.1479-6988.2006.00041.x

Hoppers, C. A. O. (2002). Indigenous knowledge and the integration of knowledge systems. In C. A. O. Hoppers (Ed.), *Indigenous knowledge and the integration of knowledge systems: Towards a philosophy of articulation* (pp. 2-23). Cape Town: New Africa Books.

Horlick-Jones, T., Rowe, G., & Walls, J. (2007). Citizen engagement process as information systems: The role of knowledge and the concept of translation quality. *Public Understanding of Science, 16*, 259-278. doi:10.1177/0963662506074792

Hornikz, J. (2005). A review of experimental research on the relative persuasiveness of anecdotal, statistical, causal, and expert evidence. *Studies in Communication Sciences, 5*, 206-216.

Horton, R. (2007). Launching a new movement for mental health. *Lancet, 370*, 806. doi:10.1016/S01406736(07)61243-4

Houghton, C., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher, 20,* 12-17.

Hsieh, H.F., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*, 1277-1288. doi:10.1177/1049732305276687

Hummelvoll, J. K., Karlsson, B., & Borg, M. (2015). Recovery and person-centredness in mental health services: roots of the concepts and implications for practice. *International Practice Development Journal, 5*, 1-7.

Hurrell, C. (2005). Shaping policy discourse in the public sphere: Evaluating civil speech in an online consultation. *The Electronic Journal of e-Government, 3,* 67-76.

Hussain, F., & Raza, S. A. (2004). A knowledge management framework to operationalize experiential knowledge: Mapping tacit medical knowledge with explicit practice guidelines. *National Conference on Emerging Technologies*, 93-99.

Hutchinson, K. J., & Rogers, W. A. (2012). Challenging the epistemological foundations of EBM: what kind of knowledge does clinical practice require? *Journal of Evaluation in Clinical Practice, 18*, 984-991. doi:10.1111/j.1365-2753.2012.01905.x

Hyder, A. A., Bloom, G., Leach, M., Syed, S. B., Peters, D. H., & Future Health Systems: Innovations for Equity. (2007). Exploring health systems research and its influence on policy processes in low income countries. *BMC Public Health, 7:* 309. doi:10.1186/1471-2458-7-309

Ihuah, P. W., & Eaton, D. (2013). The pragmatic research approach: A framework for sustainable management of public housing estates in Nigeria. *Journal of the US-China Public Administration*, *10*, 933-944.

IJsselmuiden, C., Marais, D. L., Becerra-Posada, F., & Ghannem, H. (2012). Africa's neglected area of human resources for health research – the way forward. *South African Medical Journal, 102*, 228-233.

Ingleby, D. (2014). How 'evidence-based' is the Movement for Global Mental Health? *Disability and the Global South*, *1*, 203-226.

International Association for Public Participation (IAP2) (n.d.). *IAP2 public participation spectrum.* Louisville, CO: International Association for Public Participation. Retrieved from www.iap2.org

International Association for Public Participation (IAP2). (2007). *IAP2 core values of public participation.* Louisville, CO: International Association for Public Participation. Retrieved from www.iap2.org

Irvin, R. A., & Stansbury, J. (2004). Citizen participation in decision making: Is it worth the effort? *Public Administration Review*, *64*, 56-65. doi:10.1111/j.1540-6210.2004.00346.x

Issitt, M., & Spence, J. (2005). Practitioner knowledge and the problem of evidence based research policy and practice. *Youth and Policy*, *88*, 63-82.

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., . . . Saxena, S. (2007). Mental health systems in countries: where are we now? *Lancet*, *370*, 1061-1077. doi:10.1016/S01406736(07)61241-0

Jakubec, S. (2004). The 'World Mental Health' framework: Dominant discourses in mental health and international development. *Canadian Journal of Community Mental Health*, *23*, 23-38. doi:10.7870/cjcmh-2004-0011

Jenkins, R. (2003). Supporting governments to adopt mental health policies. *World Psychiatry*, *2*, 14-19. doi:10.1108/13619322200500008

Jenkins, R., Baingana, F., Belkin, G., Borowitz, M., Daly, A., Francis, P., . . . Sadiq, S. (2010). Mental health and the development agenda in Sub-Saharan Africa. *Psychiatric Services*, *61*, 229-234. doi:10.1176/ps.2010.61.3.229

Joly, P. B., & Kaufmann, A. (2008). Lost in translation? The need for 'upstream engagement' with nanotechnology on trial. *Science as Culture*, *17*, 225-247. doi:10.1080/09505430802280727

Jones, H. (2009). *Policy-making as discourse: A review of recent knowledge-to-policy literature.* A Joint IKM Emergent-ODI Working Paper No. 5. Bonn: IKM Emergent Research Programme.

Jones, H., Jones, N., Shaxson, L., & Walker, D. (2012). *Knowledge, policy and power in international development: A practical guide.* Bristol: The Policy Press.

Jones, N., Datta, A., & Jones, H. (2009). *Knowledge, policy and power: Six dimensions of the knowledge–development policy interface.* London: Overseas Development Institute.

Jones, N., Jones, H., & Walsh, C. (2008). *Political science? Strengthening science – policy dialogue in developing countries.* Working Paper 294: Results of ODI research presented in preliminary form for discussion and critical comment. London: Overseas Development Institute.

Jones, N., & Walsh, C. (2008). *Policy briefs as a communication tool for development research*. Overseas Development Institute Background Note. Retrieved from https://www.odi.org/resources/docs/594.pdf

Jones, T., & Newburn, T. (2001). *Widening access: Improving police relations with hard to reach groups*. Police Research Series Paper 138. London: Home Office Policing and Reducing Crime Unit. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.600.9600&rep=rep1&type=pdf

Kalid, K. S. B. (2010). Transfer knowledge using stories: A Malaysian university case study. *Journal of Knowledge Management Practice*, *11*, 1-10.

Kamler, B., & Thomson, P. (2014). *Helping doctoral students write: Pedagogies for supervision* (2nd ed.). New York: Routledge.

Kane, J., & Bishop, P. (2002). Consultation and contest: The danger of mixing modes. *Australian Journal of Public Administration*, *61*, 87-94. doi:10.1111/1467-8500.00261

Khandelwal, S., Avode, G., Baingana, F., Conde, B., Cruz, M., Deva, P., . . . Jenkins, R. (2010). Mental and neurological health research priorities setting in developing countries. *Social Psychiatry and Psychiatric Epidemiology*, *45*, 487-495. doi:10.1007/s00127-009-0089-2

Khokhar, T., & Serajuddin, U. (2015). *Should we continue to use the term "developing world"?* World Bank Data Blog, 16 November 2015. Retrieved from https://blogs.worldbank.org/opendata/should-we-continue-use-term-developing-world

King, C. S., Feltey, K. M., & O'Neill Susel, B. (1998). The question of participation: Toward authentic

public participation in public administration. *Public Administration Review*, *58*, 317-326.

Kingdon, J. W. (2003). *Agendas, alternatives, and public policies.* New York: Longman.

Kingston, J. K. C. (2012a). Tacit knowledge: Capture, sharing, and unwritten assumptions. *Journal of Knowledge Management Practice, 13*, 1-11.

Kingston, J. K. C. (2012b). Choosing a knowledge dissemination approach. *Knowledge and Process Management, 19*, 160-170. doi:10.1002/kpm.1391

Kirmayer, L. J., & Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcultural Psychiatry*, *51*, 759-776. doi:10.1177/1363461514557202

Kirmayer, L. J., & Swartz, L. (2014). Culture and global mental health. In V. Patel, H. Minas, A. Cohen, & M. J. Prince (Eds.), *Global mental health: Principles and practice* (pp. 41-62). Oxford: Oxford University Press.

Kirschner, S. R. (2013). Diagnosis and its discontents: Critical perspectives on psychiatric nosology and the DSM. *Feminism and Psychology*, *23*, 10-28. doi:10.1177/0959353512467963

Kivinen, O., & Piiroinen, T. (2004). The relevance of ontological commitments in social sciences: Realist and pragmatist viewpoints. *Journal for the Theory of Social Behaviour*, *34*, 231-248. doi:10.1111/j.0021-8308.2004.00246.x

Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkley, CA: University of California Press.

Kleintjes, S. R. (2012). *Participation of people with psychosocial disability in mental health policy development in South Africa* (Unpublished doctoral thesis). University of Cape Town, Cape Town, South Africa.

Kleintjes, S., Lund, C., Swartz, L., Flisher, A., & the MHAPP research programme consortium. (2010). Mental health care user participation in mental health policy development and implementation in South Africa. *International Review of Psychiatry*, *22*, 568-577. doi:10.3109/09540261.2010.536153

Kleintjes, S., Lund, C., & Swartz, L. (2012). South African mental health care service user views on priorities for supporting recovery: Implications for policy and service development. *Disability and Rehabilitation*, *34*, 2272-2280. doi:10.3109/09638288.2012.681005

Kleintjes, S., Lund, C., & Swartz, L. (2013). Barriers to the participation of people with psychosocial disability in mental health policy development in South Africa: A qualitative study of perspectives of policy makers, professionals, religious leaders and academics. *BMC International Health and Human Rights*, *13*:17. doi:10.1186/1472-698X-13-17

Kothari, A. R., Bickford, J. J., Edwards, N., Dobbins, M. J., & Meyer, M. (2011). Uncovering tacit knowledge: A pilot study to broaden the concept of knowledge in knowledge translation. *BMC Health Services Research*, *11*:198. doi:10.1186/1472-6963-11-198

Kothari, A., Birch, S., & Charles, C. (2005). "Interaction" and research utilisation in health policies and

programs: Does it work? *Health Policy*, *71*, 117-125. doi:10.1016/j.healthpol.2004.03.010

Kothari, A., Rudman, D., Dobbins, M., Rouse, M., Sibbald, S., & Edwards, N. (2012). The use of tacit and explicit knowledge in public health: A qualitative study. *Implementation Science*, *7*: 20. doi:10.1186/1748-5908-7-20

Kreber, C., & Cranton, P.A. (2000). Exploring the scholarship of teaching. *Journal of Higher Education*, *71*, 476-495. doi:10.2307/2649149

Kuruvilla, S., & Dorstewitz, P. (2010). There is no 'point' in decision-making: A model of transactive rationality for public policy and administration. *Policy Science*, *43*, 263-287. doi:10.1007/s11077-009-9098-y

Labov, W., & Waletsky, J. (1967). Narrative analysis: Oral versions of personal experience. In J. Helm (Ed.), *Essays on the verbal and visual arts* (pp. 12-44). Seattle, WA: University of Washington Press.

Lam, A. (1998). *Tacit knowledge, organisational learning and innovation: A societal perspective.* Danish Research Unit for Industrial Dynamics (DRUID) Working Paper No. 98-22. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.199.5378&rep=rep1&type=pdf

Lancet Global Mental Health Group. (2007). Scale up services for mental disorders: A call for action. *Lancet*, *370*, 1241-1252. doi:10.1016/S01406736(07)61242-2

Landry, R., Amara, N., Pablos-Mendez, A., Shademani, R., & Gold, I. (2006). The knowledge-value chain: A conceptual framework for knowledge translation in health. *Bulletin of the World Health Organization*, *84*, 597-602. doi:10.1590/S0042-96862006000800009

Langlois, E. V., Montekio, V. B., Young, T., Song, K., Alcalde-Rabanal, J., & Tran, N. (2016). Enhancing evidence informed policymaking in complex health systems: Lessons from multi-site collaborative approaches. *Health Policy and Systems*, *14*: 20. doi:10.1186/s12961-016-0089-0

Lauber, T. B., & Knuth, B. A. (1999). Measuring fairness in citizen participation: A case study of moose management. *Society and Natural Resources: An International Journal*, *12*, 19-37. doi:10.1080/089419299279867

Leech, N. L., & Onwuegbuzie, A. J. (2011). Beyond constant comparison qualitative data analysis: Using NVivo. *School Psychology Quarterly*, *26*, 70-84. doi:10.1037/a0022711

Legislative Sector Support (LSS) Project Team. (2013). *Public participation framework for the South African legislative sector*. Pretoria: Legislative Sector South Africa.

Li, K. K., Abelson, J., Giacomini, M., & Contrandriopoulos, D. (2015). Conceptualising the use of public involvement in health policy decision-making. *Social Science and Medicine*, *138*, 14-21. doi:10.1016/j.socscimed.2015.05.023

Licht, J. D. (2011). Do we really want to know? The potentially negative effect of transparency in decision making on perceived legitimacy. *Scandinavian Political Studies*, *34*, 183-201. doi:10.1111/j.1467-9477.2011.00268.x

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lindblom, C. E. (1959). The science of muddling through. *Public Administration Review*, *19*, 79-88. doi:10.2307/973677

Lipsky, M. (1980). *Street level bureaucracy: Dilemmas of the individual in public services*. New York, NY: Russell Sage Foundation.

Little, M. (2003). "Better than numbers …" A gentle critique of evidence-based medicine. *ANZ Journal of Surgery*, *73*, 177-182. doi:10.1046/j.1445-1433.2002.02563.x

Lund, C., Kleintjes, S., Campbell-Hall, V., Mjadu, S., Petersen, I., Bhana, A., . . . Flisher, A. J. (2008). *Mental health policy development and implementation in South Africa: A situation analysis. Phase 1 Country report.* Cape Town: Mental Health and Poverty Project.

Lund, C., Kleintjes, S., Kakuma, R., Flisher, A. J., & MHaPP Research Programme Consortium (2010). Public sector mental health systems in South Africa: Inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology, 45*, 393–404. doi:10.1007/s00127-009-0078-5

Lund, C., Stein, D. J., Corrigall, J., Bradshaw, D., Schneider, M., & Flisher, A. J. (2008). Editorial: Mental health is integral to public health: A call to scale up evidence-based services and develop mental health research. *South African Medical Journal*, *98*, 444-445.

Lund, C., Tomlinson, M., de Silva, M., Fekadu, A., Shidhaye, R., Jordans, M., . . . Patel, V. (2012). PRIME: A programme to reduce the treatment gap for mental disorders in five low- and middle-income countries. *PLoS Medicine*, *90*, e1001359. doi:10.1371/journal.pmed.1001359

Lustig, N. (2016). Inequality and fiscal redistribution in middle income countries: Brazil, Chile, Colombia, Indonesia, Mexico, Peru and South Africa*. Journal of Globalization and Development*, *7*, 17-60. doi:10.1515/jgd-2016-0015

Mahomed, O. H., & Asmall, S. (2015). Development and implementation of an integrated chronic disease model in South Africa: Lessons in the management of change through improving the quality of clinical practice. *International Journal of Integrated Care*, *15*, 1-13.

Mangalore, R., Knapp, M., & McDaid, D. (2012). Mental health economics, mental health policies, and human rights*.* In M. Dudley, D. Silove, & F. Gale (Eds.), *Mental health and human rights: Vision, praxis and courage* (pp. 149-161). Oxford: Oxford University Press.

Manor, J. (2004). Democratisation with inclusion: Political reforms and people's empowerment at the grassroots. *Journal of Human Development*, *5*, 5-29. doi:10.1080/1464988031000166019 3

Manzano, A. (2016). The craft of interviewing in realist evaluation. *Evaluation*, *22*, 342-360. doi:10.1177/1356389016638615

Marais, D. L., & Petersen, I. (2015). Health system governance to support integrated mental health care in South Africa: Challenges and opportunities. *International Journal of Mental Health Systems*, *9*:14. doi:10.1186/s13033-015-0004-z

Marais, D. L., Quayle, M., & Burns, J. (2017). The role of access to information in enabling transparency and public participation in governance: A case study of access to policy consultation records in South Africa. *African Journal of Public Affairs*, *9*, 36-49. Retrieved from http://hdl.handle.net/2263/61229

Marais, L., & Matebesi, Z. (2013). Evidence-based policy development in South Africa: The case of provincial growth and development strategies. *Urban Forum*, *24*, 357-371. doi:10.1007/s12132-012-9179-4

Mari, J. D., Bressan, R. A., Almeida-Filho, N., Gerolin, J., Sharan, P., & Saxena, S. (2006). Mental health research in Brazil: Policies, infrastructure, financing and human resources. *Review Saude Publica*, *40*, 161-169. doi:10.1590/S0034-89102006000100024

Marres, N. (2007). The issues deserve more credit: Pragmatist contributions to the study of public involvement in controversy. *Social Studies of Science*, *37*, 759-780. doi:10.1177/0306312706077367

Martin, G. P. (2008). 'Ordinary people only': Knowledge, representativeness, and the publics of public participation in healthcare. *Sociology of Health and Illness*, *30*, 35-54. doi:10.1111/j.1467-9566.2007.01027.x

Martin, G. P. (2009). Public and user participation in public service delivery: Tensions in policy and practice. *Sociology Compass*, *3*, 310-326. doi:10.1111/j.1751-9020.2009.00200.x

Martin, G. P. (2012). Public deliberation in action: Emotion, inclusion and exclusion in participatory decision making. *Critical Social Policy*, *32*, 163-183. doi:10.1177/0261018311420276

Mauthner, N. S., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, *37*, 413-431. doi:10.1177/00380385030373002

Maxwell, J.A. (2004). Using qualitative methods for causal explanation. *Field Methods, 16,* 243-264. doi:10.1177/1525822X04266831

Maxwell, J. A. (2012). *A realist approach for qualitative research*. Thousand Oaks, CA: Sage.

Maxwell, J. A. (2013). *Qualitative research design: An interactive design* (3rd ed.). Los Angeles, CA: Sage.

Maybin, J. C. (2013). *Knowledge and knowing in policy work: A case study of civil servants in England's Department of Health* (Unpublished doctoral thesis). Edinburgh, University of Edinburgh, Scotland.

Mayosi, B. M., Flisher, A. J., Lalloo, U. G., Sitas, F., Tollman, S. M., & Bradshaw, D. (2009). The burden of non-communicable diseases in South Africa. *Lancet*, *374*, 934-947. doi:10.1016/S0140-6736(09)61087-4

Mayosi, B. M., Lawn, J. E., van Niekerk, A., Bradshaw, D., Abdool Karim, S. S., Coovadia, H. M., & Lancet South Africa team. (2012). Health in South Africa: Changes and challenges since 2009. *Lancet*, *380,* 2029-2043. doi:10.1016/ S0140-6736(12)61814-5

Mbuyisa, S. (2013). Public participation as participatory conflict resolution: Shortcomings and best

practices at the local level in South Africa. *African Journal on Conflict Resolution*, *13*, 115-140.

McClellan, S. E. (2012). *Planning for a postmodern era: Storytelling, public participation, and the limits of ordinary democracy* (Unpublished doctoral thesis). University of Colorado, Colorado, United States.

McCluskey, M. R., Deshpande, S., Shah, D. V., & McLeod, D. M. (2004). The efficacy gap and political participation: When political influence fails to meet expectations. *International Journal of Public Opinion Research*, *16*, 437-455. doi:10.1093/ijpor/edh038

McCunn, S., & Robinson, K. (2009, June). *What works in moving experiential knowledge into policy and practice. A focus on social determinants and mental health*. Learnings from March 2009 Knowledge Exchange Forum, Canadian Public Health Association Conference, Winnipeg, MB, Canada. Retrieved from http://resources.cpha.ca/CPHA/Conf/Data/2009/A09-273e.pdf

McDaid, S. (2009). An equality of condition framework for user involvement in mental health policy and planning: Evidence from participatory action research. *Disability and Society*, *24*, 461-474. doi:10.1080/09687590902879064

McDaid, D., Knapp, M., & Raja, S. (2008). Barriers in the mind: Promoting an economic case for mental health in low- and middle-income countries. *World Psychiatry*, *7*, 79-86. doi:10.1002/j.2051-5545.2008.tb00160.x

McDonough, J. E. (2001). Using and misusing anecdote in policy making. *Health Affairs*, *20*, 207-212. doi:10.1377/hlthaff.20.1.207

McGee, R., & Norton, A. (2000). *Participation in poverty reduction strategies: A synthesis of experience with participatory approaches to policy design, implementation and monitoring*. IDS working paper series 109. Brighton: Institute of Development Studies. Retrieved from https://www.odi.org/publications/1504-participation-poverty-reduction-strategies-participatory-approaches-policy-design-implemenation-monitoring

McIntyre, D., & Klugman, B. (2003). The human face of decentralisation and integration of health services: Experience from South Africa. *Reproductive Health Matters*, *11*, 108-119.

Meessen, B., Kouanda, S., Musango, L., Richard, F., Ridde, V., & Soucat, A. (2011). Communities of practice: The missing link for knowledge management on implementation issues in low-income countries? *Tropical Medicine and International Health*, *16*, 1007-1014. doi:10.1111/j.1365-3156.2011.02794.x

Meijer, P. C., Verloop, N., & Beijard, D. (2002). Multi-method triangulation in qualitative study on teachers' practical knowledge: An attempt to increase internal validity. *Quality and Quantity*, *36*, 145-167. doi:10.1023/A:1014984232147

Mendizabal, E. (2013). Research uptake: What is it and can it be measured? *On think tanks: Independent research, ideas and advice*. Retrieved from https://onthinktanks.org/articles/research-uptake-what-is-it-and-can-it-be-measured/

Merriam, S. B. (1991). *Case study research in education: A qualitative approach.* San Francisco, CA: Jossey-Bass.

Merriam, S. B. (1998). *Qualitative research and case study applications in education.* San Francisco, CA: Jossey-Bass.

Mezirow, J. (1991). *Transformative dimensions of adult learning*. San Francisco, CA: Jossey-Bass.

Mezzina, R., Borg, M., Marin, I., Sells, D., Topor, A., & Davidson, L. (2006). From participation to citizenship: How to regain a role, a status, and a life in the process of recovery. *American Journal of Psychiatric Rehabilitation*, *9*, 39-61. doi:10.1080/15487760500339428

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Minas, H., & Cohen, A. (2007). Why focus on mental health systems? *International Journal of Mental Health Systems, 1*:1. doi:10.1186/1752-4458-1-1

Mitton, C., Adair, C. E., McKenzie, E., Patten, S. B., & Perry, B. W. (2007). Knowledge transfer and exchange: Review and synthesis of the literature. *Milbank Quarterly, 85*, 729-768. doi:10.1111/j.1468-0009.2007.00506.x

Mkhize, N. (2004). Sociocultural approaches to psychology: Dialogism and African conceptions of the self. In D. Hook, N. Mkhize, P. Kiguwa, & A. Collins (Eds.), *Critical psychology* (pp. 53-83). Lansdowne, Cape Town: University of Cape Town Press.

Moore, A., & Stilgoe, J. (2009). Experts and anecdotes: The role of 'anecdotal evidence' in public scientific controversies. *Science, Technology and Human Values*, *34*, 654-677. doi:10.1177/0162243908329382

Moran-Ellis, J., Alexander, V. D., Cronin, A., Dickinson, M., Fielding, J., Sleney, J., & Thomas, H. (2006). Triangulation and integration: Processes, claims and implications. *Qualitative Research*, *6*, 45-59. doi:10.1177/1468794106058870

Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*, *1*, 48-76. doi:10.1177/2345678906292462

Morgan, D. L. (2014). Pragmatism as a paradigm for social research. *Qualitative Inquiry*, *20*, 1045-1053. doi:10.1177/1077800413513733

Morrison, C., & Dearden, A. (2013). Beyond tokenistic participation: Using representational artefacts to enable meaningful public participation in health service design. *Health Policy*, *112*, 179-186. doi:10.1016/j.healthpol.2013.05.008

Morse, J. M., Barrett, M., Myan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, *1*, 1-19. doi:10.1177/160940690200100202

Motala, S., Ngandu, S., Jonas, S., Gwenhure, Y., Verryn, A., Sausi, K., . . . Ratlabyana, L. (2016). Enhancing

active citizenry engagement in South Africa. In B. Magongo (Ed.), *Enhancing civil society participation in the South African development agenda: The role of civil society organisations* (pp. 183-202). Johannesburg: National Development Agency.

Mpofu, E. (2002). Psychology in sub-Saharan Africa: Challenges, prospects and promises. *International Journal of Psychology*, *37*, 179-186. doi:10.1080/0020759024400006

Mubangizi, B. C., & Gray, M. (2011). Putting the 'public' into public service delivery for social welfare in South Africa. *International Journal of Social Welfare*, *20*, 212-219. doi:10.1111/j.1468-2397.2010.00760.x

Mugisha, J., Abdulmalik, J., Hanlon, C., Petersen, I., Lund, C., Upadhaya, N., . . . Kigozi, F. (2017). Health systems context(s) for integrating mental health into primary health care in six Emerald countries: A situation analysis. *International Journal of Mental Health Systems*, *11*. doi:10.1186/s13033-016-0114-2

Mullan, F. (1999). Me and the system: The personal essay and health policy. *Health Affairs*, *18*, 118-124.

Mullen, C., Hughes, D., & Vincent-Jones, P. (2011). The democratic potential of public participation: Healthcare governance in England. *Social and Legal Studies*, *20*, 21-38. doi:10.1177/0964663910391349

Murray, C. J., Vos, T., Lozano. R., Naghavi, M., Flaxman, A. D., Michaud, C., . . . Lopez, A. D. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, *380*, 2197-2223. doi:10.1016/S0140-6736(12)61689-4

National Health Research Committee (NHRC) (2011). *2011 national health research summit report*. Pretoria: Department of Health.

Naude, C. E., Zani, B., Ongolo-Zogo, P., Wiysonge, C. S., Dudley, L., Kredo, T., . . . Young, T. (2015). Research evidence and policy: qualitative study in selected provinces in South Africa and Cameroon. *Implementation Science*, *10*. doi:10.1186/s13012-015-0315-0

Ndetei, D. (2008). Sharing mental health research resources in Africa – the place of all inclusive consortia. *African Journal of Psychiatry*, *1*, 1-3.

Newell, S. (2003). Knowledge transfer and learning: Problems of knowledge transfer associated with trying to short-circuit the learning cycle. *Journal of Information Systems and Technology Management*, *2*, 275-290. doi:10.4301/S1807-17752005000300003

Ngo, V. K., Rubinstein, A., Ganju, V., Kanellis, P., Loza, N., Rabadan-Diehl, C., & Daar, A. S. (2013). Grand challenges: Integrating mental health care into the non-communicable disease agenda. *PLoS Medicine*, *10:* 5, e1001443. doi:10.1371/journal.pmed.1001443

Ngui, E., Khasakhala, L., Ndetei. D., & Weiss Roberts, L. (2010). Mental disorders, health inequalities and ethics: A global perspective. *International Review of Psychiatry*, *22*, 235-244. doi:10.3109/09540261.2010.485273

Nonaka, I., & Takeuchi, H. (1995). *The knowledge-creating company: How Japanese companies create the dynamics of innovation*. Oxford: Oxford University Press.

Noorani, T. (2013). Service user involvement, authority and the 'expert-by-experience' in mental health. *Journal of Political Power*, *6*, 49-68. doi:10.1080/2158379X.2013.774979

Nutley, S., Walter, I., & Davies, H. T. O. (2003). From knowing to doing: A framework for understanding the evidence-into-practice agenda. *Evaluation*, *9*, 125-148. doi:10.1177/1356389003009002002

Nutley, S. M., Walter, I., & Davies, H. T. O. (2007). *Using evidence: How research can inform public services*. Bristol: The Policy Press.

Nyalunga, D. (2006). An enabling environment for public participation in local government. *International NGO Journal*, *1*. Retrieved from https://localdemocracy.net/2006/01/01/an-enabling-environment-for-public-participation-in-local-government/

Oades, L.G. (2011). Responding to the challenge of mental health recovery policy. In L. LAbate (Ed.), *Mental illnesses – evaluation, treatments and implications* (pp. 391-406). Retrieved from https://www.intechopen.com/books/mental-illnesses-evaluation-treatments-and-implications

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *British Medical Journal Quality & Safety*, *25*, 565-568. doi:10.1136/bmjqs-2015-004839

O'Connor, D. (2005). Participatory processes: Creating a "marketplace of ideas" with Open Space Technology. *Public Sector Innovation Journal*, *10*, 1-15.

Oliver, S. R., Rees, R. W., Clarke-Jones, L., Milne, R., Oakley, A. R., Gabbay, J., . . . Gyte, G. (2008). A multidimensional conceptual framework for analysing public involvement in health services. *Health Expectations*, *11*, 72-84. doi:10.1111/j.1369-7625.2007.00476.x

Omar, M. A. Green, A. T., Bird, P. K., Mirzoev, T., Flisher, A. J., Kigozi, F., . . . Mental Health and Poverty Research Programme Consortium (MHaPP). (2010). Mental health policy process: A comparative study of Ghana, South Africa, Uganda and Zambia. *International Journal of Mental Health Systems*, *4*:24. doi:10.1186/1752-4458-4-24

Organisation for Economic Cooperation and Development (OECD). (2001). *Engaging citizens in policy-making: Information, consultation and public consultation.* PUMA Policy Brief, 10. Paris: Organisation for Economic Cooperation and Development.

Organisation for Economic Cooperation and Development (OECD). (2010). *Better regulation in Europe*. Paris: Organisation for Economic Cooperation and Development.

Owen, H. (1993). *Open Space Technology: A user's guide*. Pontiac, MD. Retrieved from https://elementaleducation.com/wp-content/uploads/temp/OpenSpaceTechnology--UsersGuide.pdf

Paavola, S., & Hakkarainen, K. (2009). From meaning making to joint construction of knowledge

practices and artefacts: A trialogical approach to CSCL. In C. O'Malley, D. Suthers, P. Reimann, & A. Dimitracopoulou (Eds.), *Computer supported collaborative learning practices: CSCL2009 Conference Proceedings* (pp. 83-92). Rhodes, Creek: International Society of the Learning Sciences (ISLS).

Papadopoulos, Y., & Warin, P. (2007a). Are innovative, participatory and deliberative procedures in policy making democratic and effective? *European Journal of Political Research*, *46*, 445-472. doi:10.1111/j.1475-6765.2007.00696.x

Papadopoulos, Y., & Warin, P. (2007b). Major findings and paths for research: A concluding note. *European Journal of Political Research*, *46*, 591-605. doi:10.1111/j.1475-6765.2007.00700.x

Pang, T., Saduna, R., Hanney, S., Bhutta, Z. A., Hyder, A. A., & Simon, J. (2003). Knowledge for better health: A conceptual framework and foundation for health systems research. *Bulletin of the World Health Organization*, *81*, 815-820.

Parker, J. S. (2014). Recovery in mental health. *South African Medical Journal*, *104*, 77. doi:10.7196/SAMJ.7732

Parkhurst, J. (2016). *The politics of evidence: From evidence-based policy to the good governance of evidence*. London: Routledge.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., . . . van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet*, *370*, 991-1005. doi:10.1016/S0140-6736(07)61240-9

Patel, V., Belkin, G. S., Chockalingam, A., Cooper, J., Saxena, S., & Unutzer, J. (2013). Grand challenges: Integrating mental health services into priority health care platforms. *PLoS Medicine*, *10*, e1001448. doi:10.1371/journal.pmed.1001448

Patel, V., Chisholm, D., Parikh, R., Chalrson, F. J., Degenhardt, L., Dua, T., . . . DCP MNSA Author Group. (2016). Addressing the burden of mental, neurological, and substance use disorders: Key messages from Disease Control Priorities, 3rd edition. *Lancet*, *387*, 1672-1685. doi:10.1016/S0140-6736(15)00390-6

Patel, V., Collins, P. Y., Copeland, J., Kakuma, R., Katontoka, S., Lamichhane, J., . . . Skeen, S. (2011). The movement for global mental health. *The British Journal of Psychiatry*, *198*, 88-90. doi:10.1192/bjp.bp.109.074518

Patnaik, E. (2013). Reflexivity: Situating the researcher in qualitative research. *Humanities and Social Science Studies*, *2*, 98-106.

Patton, M. Q. (2003). Qualitative evaluation checklist. *Evaluation Checklists Project*. Retrieved from https://wmich.edu/evaluation/checklists

Pawson, R. (2006). *Evidence-based policy: A realist perspective.* London: Sage.

Perret, R., Borges, M. R. S., & Santoro, F. M. (2004). Applying group storytelling in knowledge

management. In G. J. de Vreede, L. A. Guerrero, & G. Marín Raventós (Eds.), *Groupware: Design, implementation, and use*. CRIWG 2004. Lecture Notes in Computer Science, Vol. 3198. Springer, Berlin, Heidelberg. doi:10.1007/978-3-540-30112-7_4

Petersen, I. (1998). Comprehensive integrated primary mental health care in South Africa: The need for a shift in the discourse of care. *South African Journal of Psychology*, *28*, 321-334. doi:10.1177/008124639802800402

Petersen. I. (2000). Comprehensive integrated primary mental health care for South Africa: Pipedream or possibility? *Social Science and Medicine, 51,* 321-334. doi:10.1016/S0277-9536(99)00456-6

Petersen, I., Fairall, L., Bhana, A., Kathree, T., Selohilwe, O., Brooke-Sumner, C., . . . Patel., V. (2016). Integrating mental health into chronic care in South Africa: The development of a district mental healthcare plan. *The British Journal of Psychiatry*, *208*, S29-S38. doi:10.1192/bjp.bp.114.153726

Petersen, I., Lund, C., Bhana, A., & Flisher, A. J. (2012). A task-shifting approach to primary mental health care for adults in South Africa: Human resource requirements and costs for rural settings. *Health Policy and Planning, 27,* 42-51. doi:10.1093/heapol/czr012

Petersen, I., Marais, D., Abdulmalik, J., Ahuja, S., Alem, A., Chisholm, D., . . . Thornicroft, G. (2017). Strengthening mental health system governance in six low- and middle-income countries in Africa and South Asia: Challenges, needs and potential strategies. *Health Policy and Planning*, *32*, 699-709. doi:10.1093/heapol/czx014

Petticrew, M., Platt, S., McCollam, A., Wilson, S., & Thomas, S. (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. doi:10.1186/1471-2458-8-314

Petts, J. (2008). Public engagement to build trust: False hopes? *Journal of Risk Research*, *11*, 821-835. doi:10.1080/13669870701715592

Phaladze, N. A. (2003). The role of nurses in the human immunodeficiency virus/acquired immune deficiency syndrome policy process in Botswana. *International Nursing Review*, *50*, 22-32. doi:10.1046/j.1466-7657.2003.00167.x

Piantanida, M., & Garman, N. B. (2010). Writing research. In P. Thomson, & M. Walker (Eds.). *The Routledge doctoral student's companion: Getting to grips with research in education and the social sciences* (pp. 244-255). New York: Routledge.

Piper, L. (2011). Not waiting for Jackie O: Lessons for public participation advocacy in South Africa. *Africanus, 41,* 30-42.

Piper, L., & von Lieres, B. (2008). Inviting failure: Citizen participation and local governance in South Africa. *Citizen DRC Special Issue*, *1*, 1-22.

Polanyi, M. (1967). *The tacit dimension*. London: Routledge.

Polletta, F., & Lee, J. (2006). Is telling stories good for democracy? Rhetoric in public deliberation after 9/11. *American Sociological Review*, *71*, 699-723. doi:10.1177/000312240607100501

Pope, C. (2003). Resisting evidence: The study of evidence-based medicine as a contemporary social movement. *Health: An interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *7*, 267-282. doi:10.1177/1363459303007003002

Quick, K. S., & Feldman, M. S. (2011). Distinguishing participation and inclusion. *Journal of Planning Education and Research*, *31*, 272-290. doi:10.1177/0739456X11410979

Ranucci, R. A., & Souder, D. (2015). Facilitating tacit knowledge transfer: routine compatibility, trustworthiness, and integration in M&As. *Journal of Knowledge Management*, *19*, 257-276. doi:10.1108/JKM-06-2014-0260

Razzouk, D., Sharan, P., Gallo, C., Gureje, O., Lamberte, E. E., Mari, J. D., & WHO-Global Forum for Health Research – Mental Health Research Mapping Project Group. (2010). Scarcity and inequality of mental health research resources in low- and middle-income countries: A global survey. *Health Policy*, *94*, 211-220. doi:10.1016/j.healthpol.2009.09.009

Republic of South Africa. (1996). *Constitution of the Republic of South Africa.* As adopted on 8 May 1996 and amended on 11 October 1996 by the Constitutional Assembly. Pretoria: Parliament of South Africa, Republic of South Africa. Retrieved from http://www.justice.gov.za/legislation/constitution/SAConstitution-web-eng.pdf

Restall, G. (2013). Conceptualising the outcomes of involving people who use mental health services in policy development. *Health Expectations*, *18*, 1167-1179. doi:10.1111/hex.12091

Restall, G., Cooper, J. E., & Kaufert, J. M. (2011). Pathways to translating experiential knowledge to mental health policy. *Psychiatric Rehabilitation Journal*, *35*, 29-36. doi:10.2975/35.1.2011.29.36

Restall, G., & Strutt, C. (2008). Participation in planning and evaluating mental health services: Building capacity. *Psychiatric Rehabilitation Journal*, *31*, 234-238. doi:10.2975/31.3.2008.234.238

Rinehart, R. (2016). The north/south paradigm in global mental health: Definitions and interventions. *Princeton Journal of Bioethics, 15 August 2016*. Retrieved from http://pjb.mycpanel2.princeton.edu/wp/index.php/2016/08/15/the-northsouth-paradigm-in-global-mental-health-definitions-and-interventions/

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman, & R.G. Burgess (Eds.), *Analyzing qualitative data* (pp. 173-194). London: Routledge.

Roberts, M. (2014). Making drug policy together: Reflections on evidence, engagement and participation. *International Journal of Drug Policy*, *25*, 952-956. doi:10.1016/j.drugpo.2014.04.014

Roberts, N. (2004). Public deliberation in an age of direct citizen participation. *American Review of Public Administration*, *34*, 315-353. doi:10.1177/0275074004269288

Robson, C. (2002). *Real world research* (2nd ed.). Oxford: Blackwell.

Roefs, M. M. I., & Liebenberg, J. C. R. (2000). Public participation in South Africa as we enter the 21st

century. In Y. G. Muthlen, M. M. Khosa, & B. Magubane (Eds.), *Democracy and governance review: Mandela's legacy 1994-1999* (pp. 279-315). Pretoria: Human Sciences Research Council.

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, *53*, 304-310. doi:10.1111/j.1365-2648.2006.03727.x

Rooke, C. N., Rooke, J., Koskela, L., & Tzortzopoulos, P. (2009). Accounting for knowledge embedded in physical objects and environments: The role of artefacts in transferring knowledge. In *International Built and Human Environment Research Week (IRW) 2009: 9th International Post-Graduate Research Conference (IPGRC)* (pp. 286-298). University of Salford, Manchester, United Kingdom.

Rose, D., Thornicroft, G., & Slade, M. (2006). Who decides what evidence is? Developing a multiple perspectives paradigm in mental health. *Acta Psychiatrica Scandinavica*, *113* (Suppl. 429), 109-114. doi:10.1111/j.1600-0447.2005.00727.x

Rosiek, J. L. (2013). Pragmatism and post-qualitative futures. *International Journal of Qualitative Studies in Education*, *26*, 692-705. doi:10.1080/09518398.2013.788758

Roux, N. L. (2002). Public policy-making and policy analysis in South Africa amidst transformation, change and globalisation: Views on participants and role players in the policy analytic procedure. *Journal of Public Administration*, *37*, 418-437.

Rowe, G., & Frewer, L. J. (2000). Public participation methods: A framework for evaluation. *Science, Technology and Human Values*, *25*, 3-29. doi:10.1177/016224390002500101

Rowe, G., & Frewer, L. J. (2004). Evaluating public-participation exercises: A research agenda. *Science, Technology and Human Values*, *29*, 512-556. doi:10.1177/0162243903259197

Rowe, G., & Frewer, L. J. (2005). A typology of public engagement mechanisms. *Science, Technology and Human Values, 30*, 251-290. doi:10.1177/0162243904271724

Rural Mental Health Campaign. (2015). *The Rural Mental Health Campaign report: A call to action*. Johannesburg: Rural Mental Health Campaign.

Russell, J., Greenhalgh, T., Byme, E., & McDonnell, J. (2008). Recognizing rhetoric in health care policy analysis. *Journal of Health Services Research and Policy*, *13*, 40-46. doi:10.1258/jhsrp.2007.006029

Russo, J., & Beresford, P. (2015). Between exclusion and colonisation: Seeking a place for mad people's knowledge in academia. *Disability and Society*, *30*, 153-157. doi:10.1080/09687599.2014.957925

Ryle, G. (1949). *The concept of mind.* London: Hutchinson.

Sabatier, P. A. (1987). Knowledge, policy-oriented learning, and policy change. An advocacy coalition framework. *Knowledge: Creation, Diffusion and Utilization*, *8*, 649-692. doi:10.1177/0164025987008004005

Sale, J. E. M., & Brazil, K. (2004). A strategy to identify critical appraisal criteria for primary mixed-

method studies. *Quality and Quantity*, *38*, 351-365. doi:10.1023/B:QUQU.0000043126.25329.85

Sale, J. E. M., Lohfeld, L. H., & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed-methods research. *Quality and Quantity*, *36*, 43-53. doi:10.1023/A:1014301607592

Saltelli, A., & Giampietro, M. (2015). *What is wrong with evidence based policy and how can it be improved?* Draft submitted for a special issue on FUTURES, August 2015. Retrieved from www.andreasaltelli.eu/file/repository/temp.pdf

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and Health*, *23*, 334-340. doi:10.1002/1098-240X(200008)23:4

Sanderson, I. (2000). Evaluation in complex policy systems. *Evaluation*, *6*, 433–454. doi:10.1177/13563890022209415

Sandfort, J., & Quick, K. (2017). Deliberative technology: A holistic lens for interpreting resources and dynamics in deliberation. *Journal of Public Deliberation*, *13*, 1-32.

Saraceno, B. (2007). Mental health systems research is urgently needed. *International Journal of Mental Health Systems*, *1*:2. doi:10.1186/1752-4458-1-2

Saxena, S., & Maulik, P. K. (2003). Mental health services in low- and middle-income countries: An overview. *Current Opinion in Psychiatry*, *16*, 437-442. doi:10.1097/01.yco.0000079213.36371.89

Saxena, S., Maulik, P. M., Sharan, P., Levav, I., & Saraceno, B. (2004). Brief report - mental health research on low- and middle-income countries in indexed journals: A preliminary assessment. *The Journal of Mental Health Policy and Economics*, *7*, 127-131.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *Lancet*, *370*, 878-889. doi:10.1016/S0140-6736(07)61239-2

Schneider, M., Docrat, S., Onah, M., Tomlinson, M., Baron, E., . . . Lund, C. (2016). Integrating mental health into South Africa's health system: Current status and way forward. *South African Health Review* (pp. 153-163). Durban: Health Systems Trust.

Schorr, L. B. (2003). *Determining 'what works' in social programs and social policies: Towards a more inclusive knowledge base*. Washington, DC: Brookings Institution.

Scott, R. (2009). *An analysis of public participation in the South African legislative sector* (Unpublished master's thesis). Stellenbosch University, Stellenbosch, South Africa.

Sebola, M. P. (2016). Public participation in South Africa's policy decision-making process: The mass and the elite choices. *International Public Administration Review*, *14*, 55-73. doi:10.17573/ipar.2016.1.03

Sedlačko, M., & Staroňová, K. (2015). An overview of discourses on knowledge in policy: Thinking knowledge, policy and conflict together. *Central European Journal of Public Policy*, *9*, 10-53. doi:10.1515/cejpp-2016-0011

Semrau, M., Evans-Lacko, S., Alem, A., Ayuso-Mateos, J. L., Chisholm, D., Gureje, O., . . . Thornicroft, G.

(2015). Strengthening mental health systems in low- and middle-income countries: The Emerald programme. *BMC Medicine*, *13*. doi:10.1186/s12916-015-0309-4

Semrau, M., Lempp, H., Keynejad, R., Evans-Lacko, S., Mugisha, J., Raja, S., . . . Hanlon, C. (2016). Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: systematic review. *BMC Health Services Research*, *16*. doi:10.1186/s12913-016-1323-8

Senkubuge, F., & Mayosi, B. M. (2012). The state of the national health research system in South Africa. In A. Padarath, & R. English (Eds.), *South African Health Review 2012/2013* (pp. 141-150). Durban: Health Systems Trust. Retrieved from http://www.hst.org.za/publications/Pages/HSTSouthAfricanHealthReview.aspx

Shah, A., & Beinecke. R. H. (2009). Global mental health needs, services, barriers, and challenges. *International Journal of Mental Health*, *38*, 14-29. doi:10.2753/IMH0020-7411380102

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*, 63-75. doi:10.3233/EFI-2004-22201

Shiffman, J., & Smith, S. (2007). Generation of political priority for global health initiatives: A framework and case study of maternal mortality. *Lancet*, *370*, 1370-1379. doi:10.1016/S0140-6736(07)61579-7

Shipley, R., & Utz, S. (2012). Making it count: a review of the value and techniques for public consultation. *Journal of Planning Literature*, *00*, 1-21. doi:10.1177/0885412211413133

Shore, C., & Wright, S. (1997). Policy: A new field of anthropology. In C. Shore, & S. Wright (Eds.), *Anthropology of policy: Critical perspectives on governance and power* (pp. 3-39). London: Routledge.

Shortall, S. (2013). Using evidence in policy: The importance of mediating beliefs and practices. *Sociologia Ruralis*, *53*, 349-368. doi:10.1111/soru.12015

Shulz, M., & Jobe, L.A. (2001). Codification and tacitness as knowledge management strategies: An empirical exploration. *Journal of High Technology Management Research*, *12*, 139-165. doi:10.1016/S1047-8310(00)00043-2

Silverman, D., & Marvasti, A. (2008). *Doing qualitative research: A comprehensive guide*. Thousand Oaks, CA: Sage.

Small, M. F. (2006). *The culture of our discontent: Beyond the medical model of mental illness*. Washington: Joseph Henry Press.

Smith, L. (2011). The limits of public participation in strengthening public accountability: A reflection on the 'Citizens' Voice' Initiative in South Africa. *Journal of Asian and African Studies, 46*, 504-517. doi:10.1177/0021909611403708

Smith-Merry, J. (2012). Experiential knowledge in action: Consulting practitioners for policy change. *Policy and Society*, *31*, 131-143. doi:10.1016/j.polsoc.2012.04.002

Smith-Merry, J. (2015). Seeing knowledge in mental health in Scotland. In R. Freeman & S. Sturdy (Eds.), *Knowledge in policy: Embodied, inscribed, enacted* (pp. 21-41). Bristol: Policy Press.

Srivastava, A., & Thomson, S. B. (2009). Framework analysis: A qualitative methodology for applied policy research. *Journal of Administration and Governance*, *4*, 72-79.

Ssengooba, F., Atuyambe, L., Kiwanuka, S. N., Puvanachandra, P., Glass, N., & Hyder, A. A. (2011). Research translation to inform national health policies: learning from multiple perspectives in Uganda. *International Health and Human Rights*, *11*(Suppl 1), S13. doi:10.1186/1472-698X-11-S1-S13

Star, S. L. (2010). This is not a boundary object: Reflections on the origin of a concept. *Science Technology Human Values*, *35*, 601-617. doi:10.1177/0162243910377624

Star, S. L., & Griesemer, J. R. (1989). Institutional ecology, 'translations' and boundary objects: Amateurs and professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. *Social Studies of Science*, *19*, 387-420.

Stein, D. J., Seedat, S., Iversen, A., & Wessely, S. (2007). Post-traumatic stress disorder: Medicine and politics. *Lancet*, *369*, 139-144. doi:10.1016/S0140-6736(07)60075-0

Storm, M., & Edwards, A. (2013). Models of user involvement in the mental health context: Intentions and implementation challenges. *Psychiatric Quarterly*, *84*, 313-327. doi:10.1007/s11126-012-9247-x

Strydom, W., Funke, N., Nienaber, S., Nortje, K., & Steyn, M. (2010). Evidence-based policymaking: A review. *South African Journal of Science, 106*, 1-9. doi:10.4102/sajs.v106i5/6.249

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*, *26*, 532-554. doi:10.1093/shm/hkt009

Sturdy, S., Smith-Merry, J., & Freeman, R. (2012). Stakeholder consultation as social mobilisation: Framing Scottish mental health policy. *Social Policy and Administration*, *46*, 823-844. doi:10.1111/j.1467-9515.2012.00848.x

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *British Medical Journal, 336,* 992-994. doi:10.1136/bmj.39513.441030.AD

Summerfield, D. (2012). Afterword: Against "global mental health". *Transcultural Psychiatry*, *49*, 519-530. doi:10.1177/1363461512454701

Sutcliffe, S., & Court, J. (2005, November). Evidence-based policymaking: What is it? How does it work? What relevance for developing countries? *ODI: Shaping policy for development*. Retrieved from https://www.odi.org/publications/2804-evidence-based-policymaking-work-relevance-developing-countries

Swartz, L., Tomlinson, M., & Landman, M. (2004). Evidence, policies and practices: Continuities and

discontinuities in mental health promotion in a developing country. *International Journal of Mental Health Promotion*, *6*, 33-38. doi:10.1080/14623730.2004.9721922

Tangwa, G. B. (2000). The traditional African perception of a person: Some implications for bioethics. *Hastings Center Report*, *30*, 39-43.

Theron, F., Ceaser, N., & Davids, I. (2007). Participation according to IAP2 principles: Opportunity or challenge for integrated development planning in South Africa? *International Association for Public Participation*, *1*(1). Retrieved from www.iap2.org

Thomas, J. C. (1990). Public involvement in public management: Adapting and testing a borrowed theory. *Public Administration Review*, *50*, 435-445.

Thomas, J. C. (1993). Public involvement and governmental effectiveness: A decision-making model for public managers. *Administrative Science and Society*, *24*, 444-469. doi:10.1177/009539979302400402

Thomas, P., Bracken, P., & Timimi, S. (2012). The limits of evidence-based medicine in psychiatry. *Philosophy, Psychiatry and Psychology*, *19*, 295-308. doi:10.1353/ppp.2012.0058

Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiologia e Psichiatria Sociale, 14*, 1-3. doi:10.1017/S1121189X00001858

Thunus, S., Cerfontaine, G., & Schoenaers. F. (2015). Knowledge work: Organising mental health care networks in Belgium. In R. Freeman, & S. Sturdy (Eds.), *Knowledge in policy: Embodied inscribed enacted* (pp. 179-200). Bristol: Policy Press.

Tomlinson, M., & Lund, C. (2012). Why does mental health not get the attention it deserves? An application of the Shiffman and Smith Framework. *PLoS Medicine, 9,* e1001178. doi:10.1371/journal.pmed.1001178

Tribe, R. (2014). Culture, politics and global mental health. *Disability and the Global South*, *1*, 251-265.

Tritter, J. Q., & McCallum, A. (2006). The snakes and ladders of user involvement: Moving beyond Arnstein. *Health Policy*, *76*, 156-168. doi:10.1016/j.healthpol.2005.05.008

Trivedi, P. (2014). Nothing about us without us – a user/survivor perspective of global mental health. *International Review of Psychiatry*, *26*, 544-550. doi:10.3109/09540261.2014.955087

Trompette, P., & Vinck, D. (2009). Revisiting the notion of boundary object. *Revue D'anthropologie des Connaissances*, *3*, 3-25. doi:10.3917/rac.006.0003

Turnhout, E., van Bommel, S., & Aarts, N. (2010). How participation creates citizens: Participatory governance as performative practice. *Ecology and Society*, *15*:26. Retrieved from http://www.ecologyandsociety.org/vol15/iss4/art26/

United Nations (2017). *The Sustainable Development Goals report 2017*. New York: United Nations. Retrieved from https://unstats.un.org/sdgs/report/2017/

Unwin, N., Setel, P., Rashid, S., Mugusi, F., Mbanya, J-C., Kitange, H., . . . Alberti, K. G. M. M. (2001).

Noncommunicable diseases in sub-Saharan Africa: Where do they feature in the health research agenda? *Bulletin of the World Health Organization*, *79*, 947-953.

van der Merwe, M. (2015). Psychiatry in distress: How far has South Africa progressed in supporting mental health? *Daily Maverick*, 15 July 2015. Retrieved April 9, 2017 from https://www.dailymaverick.co.za/article/2015-07-15-psychiatry-in-distress-how-far-has-south-africa-progressed-in-supporting-mental-health/#.WOobiYh97IU

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, *15*, 398-405. doi:10.1111/nhs.12048

Venn, D. (n.d.). *Essay: Confronting the monoculture of scientific knowledge.* Retrieved from http://www.knowledgemobilization.net/essay-by-david-venn-confronting-the-monoculture-of-scientific-knowledge/

Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. *Lancet Psychiatry*, *3*, 171-178. doi:10.1016/S2215-0366(15)00505-2

Volmink, J. (2005). Editorial: Addressing inequalities in research capacity in Africa. *British Medical Journal*, *331*, 705-706.

Wagner, R. K., & Sternberg, R. J. (1986). Tacit knowledge and intelligence in the everyday world. In R. J. Sternberg, & R. K. Wagner (Eds.), *Practical intelligence: Nature and origins of competence in the everyday world* (pp. 51-83). Cambridge: Cambridge University Press.

Walker, L., & Gilson, L. (2004). "We are bitter but we are satisfied": Nurses as street-level bureaucrats in South Africa. *Social Science and Medicine*, *59*, 1251-1261. doi:10.1016/j.socscimed.2003.12.020

Walt, G. (1994). *Health policy: An introduction to process and power.* London: Zed Books.

Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, *9*, 353-370. doi:10.1093/heapol/9.4.353

Walt, G., Shiffman, J., Schnieder, H., Murray, S.F., Brugha, R., & Gilson, L. (2008). 'Doing' health policy analysis: Methodological and conceptual reflections and challenges. *Health Policy and Planning*, *23*, 308-317. doi:10.1093/heapol/czn024

Walters, L. C., Aydelotte, J., & Miller, J. (2000). Putting more public in policy analysis. *Public Administration Review*, *60*, 349-359. doi:10.1111/0033-3352.00097

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., . . . Wells, J.E. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet*, *370*, 841-850. doi:10.1016/S0140-6736(07)61414-7

Wang, X., & Wart, M. W. (2007). When public participation in administration leads to trust: An empirical assessment of managers' perceptions. *Public Administration Review*, *67*, 265-278. doi:10.1111/j.1540-6210.2007.00712.x

Ward, V., House, A., & Hamer, S. (2009). Developing a framework for transferring knowledge into action:

A thematic analysis of the literature. *Journal of Health Services Research and Policy*, *14*, 156-164. doi:10.1258/jhsrp.2009.008120

Webler, T. (1995). "Right" discourse in citizen participation: An evaluative yardstick. In O. Renn, T. Webler, & P. Wiedemann (Eds.), *Fairness and competence in citizen participation: Evaluating models for environmental discourse* (pp. 35-86). Dordrecht: Springer.

Webler, T., Tuler, S., & Krueger, R. (2001). What is a good public participation process? Five perspectives from the public. *Environmental Management*, *27*, 435-450. doi:10.1007/s002670010160

Weiss, C. H. (1979). The many meanings of research utilization. *Public Administration Review*, *39*, 426-431. doi:10.2307/3109916

Weiss, C. (1998). Have we learned anything new about the use of evaluation? *American Journal of Evaluation*, *19*, 21-33. doi:10.1177/109821409801900103

Weiss, C. (1999). The interface between evaluation and public policy. *Evaluation*, *5*, 468-486.

White, M. D., & Marsh, E. E. (2006). Content analysis: A flexible methodology. *Library Trends*, *55*, 22-45. doi:10.1353/lib.2006.0053

Whitley, R. (2015). Global mental health: Concepts, conflicts and controversies. *Epidemiology and Psychiatric Services*, *24*, 285-291. doi:10.1017/S2045796015000451

Williams, D. (2011). *Qualitative inquiry in daily life: Exploring qualitative thought*. Retrieved from https://qualitativeinquirydailylife.wordpress.com

Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H., & Kessler, R. C. (2008). Twelve month mental disorders in South Africa: Prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine*, *38,* 211-220. doi:10.1017/S0033291707001420

Williams, I., & Glasby, J. (2010). Making 'what works' work: The use of knowledge in UK health and social care decision-making. *Policy and Society*, *29*, 95-102. doi:10.1016/j.polsoc.2010.03.002

Williamson, A., & Fung, A. (2004). Public deliberation: Where we are and where can we go? *National Civic Review*, *4*, 3-14. doi:10.1002/ncr.66

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Berkshire: Open University of Press.

Wolcott, H. F. (1994). *Transforming qualitative data: Description, analysis and interpretation.* Thousand Oaks, CA: Sage.

World Bank Data Team (2017). *New country classifications by income level: 2017-2018.* The DATA blog, 1 July 2017. Retrieved from https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2017-2018

World Health Organization (WHO) (2001). *World Health Report 2001: Mental health: New understanding, new hope*. Geneva: WHO.

World Health Organization (WHO) (2003). *Investing in mental health*. Geneva: WHO.

World Health Organization (WHO) (2005). *Mental health policy, plans and programmes*. Geneva: WHO.

World Health Organization (WHO) (2006). *Bridging the 'know-do' gap: Meeting on knowledge translation in global health*, 10-12 October, Geneva, Switzerland. Geneva: WHO.

World Health Organization (WHO) (2007). *Mental health policies and action plans: Key issues and basic definitions*. Geneva: WHO.

World Health Organization (WHO) (2008). *Integrating mental health into primary care: A global perspective*. Geneva: WHO.

World Health Organization (WHO) (2009). *Improving health systems and services for mental health*. Geneva: WHO.

World Health Organization (WHO) (2011). *World Health Organization mental health atlas*. Geneva: WHO.

World Health Organization (WHO) (2013). *Mental health action plan 2013-2020.* Geneva: WHO.

World Health Organization (WHO) (2016). *Framework on integrated, people-centred health services*. Geneva: WHO.

World Health Organization (WHO) (2017). *Depression and other mental disorders: Global health estimates*. Geneva: WHO.

Yazan, B. (2015). Three approaches to case study methods in education: Yin, Merriam, and Stake. *The Qualitative Report*, *20*, 134-152.

Yeh, H. Y. (2013). Boundary objects and public deliberation: Analyzing the management of boundary tensions in the consensus conference. *Journal of Public Deliberation*, *9*, 1-32.

Yin, R. K. (1994). *Case study research: Design and methods* (2nd ed.). London: Sage.

Young, I. M. (1990). *Justice and the politics of difference.* Princeton: Princeton University Press.

Young, I. M. (2000). *Inclusion and democracy*. Oxford: Oxford University Press.

Young, T., Garner, P., Clarke, M., & Volmink, J. (2016). Evidence-based health care and policy in Africa: Past, present, and future. *Journal of Clinical Epidemiology*, *83*, 24-30. doi:10.1016/j.jclinepi.2016.06.006

Appendices

Appendix 1: Information and consent sheet for interview participants

Date:

Dear (name to be completed upon identification of individual participants) ……..

My name is Debbie Marais, a PhD student in the Department of Psychiatry at the University of KwaZulu-Natal (tel: 082 938 8378, email: debraleighmarais@gmail.com). My supervisor is Prof Jonathan Burns (tel: 031-260-4321, email: burns@ukzn.ac.za).

You are being invited to consider participating in a study that involves interviews to explore assumptions underpinning the policy making process for mental health, and to identify the types of knowledges that get privileged over others in evidence-based policy making. The aim and purpose of this research is to explore the process of policy making in mental health in South Africa (including the national mental health summit at which you represented your organisation) and the approach that the new policy takes towards mental health care. The study is expected to enrol between five and eight participants who have been purposively selected based on their involvement in the consultations around South Africa's mental health policy and their inputs into this policy.

The study will involve an interview with you, either face-to-face or telephonically. Interviews are expected to take approximately an hour and, with your permission, will be recorded on audiotape for transcription and analysis. At your request, I will send you an overview of the policy document to serve as a refresher of its content, prior to our interview. A research assistant will be employed to assist with transcription of the interviews. No identifying details will be given to this assistant. Transcripts will be given identifying codes (linked to your demographic details but not to your name) and will be securely stored. Electronic records will be password protected.

Your participation in this study is entirely voluntary. Should you choose to participate in this study, you will be free to withdraw from the study at any stage. The study is considered to be of relatively low risk: no direct risks or potentially harmful consequences of participation in this study are anticipated. The only anticipated cost to you for your participation will be your time. No remuneration will be offered. There will be no direct benefits to you as a result of your participation. However, an account of how certain types of knowledge (evidence) are prioritised in the policy making process may yield recommendations for using 'evidence' in mental health policy development that may be useful to all those engaged in the research-policy interface.

There may be publications or conference presentations that result from this research. To ensure confidentiality, you will be assigned a pseudonym when referring to you in the text of this study report. As such, no information that might result in you being identified will be included in this thesis, or any future publications, presentations or reports that result from this research. However, because this is a qualitative study, there is the possibility that you could be identified by yourself or a third party on reading the thesis or subsequent publications, based on excerpt statements made by you. Furthermore, due to the limited number of participants who could be interviewed for this research, you may be

identified due to your role or involvement in policy decision making. The risk to you should this occur is considered to be minimal.

Cross-checking the written transcript of your interview with you is considered an important part of ensuring credibility of the research results. This will give you the opportunity to refute any inaccurate portrayal of your statements.

This study has been ethically reviewed and approved by the UKZN Biomedical Research Ethics Committee (approval number BE276/12). In the event of any problems or concerns/questions, you may contact the researcher, Debbie Marais, by telephone (082-938-8378) or email (debraleighmarais@gmail.com), or the UKZN Biomedical Research Ethics Committee, contact details as follows:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban, 4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

CONSENT

I, _____, have been fully informed about the study entitled, *A critical interpretive analysis of evidence-based policy making in mental health,* by _____.

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without any undue consequences to myself. I understand that my interview will be audio-taped for transcription and analysis. I understand that my responses will, as far as possible, be kept confidential. I am aware that I may be contacted by the researcher, Debbie Marais, following my interview, to cross-check the accuracy of my responses as recorded on the interview transcript.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher, Debbie Marais, by telephone (082-938-8378) or email (debraleighmarais@gmail.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**
(Where applicable)

Appendix 2: Interview schedule

A. PROCESS OF POLICY DEVELOPMENT

1. Explore what they know about the process of formulating the draft policy pre-consultation – who was involved, what the impetus was, who drove the process, what is was based on etc.

2. What was your experience of the consultation process around the development of this policy?

    - Explore how they came to be involved
    - Explore which summits they attended – if they did not attend provincial / national, why not

3. How representative did you find the summit/s?

4. How much influence do you feel the debates and consultations around the policy had on its content?

5. What would you have changed if you were in charge of the policy development process?

B. CONTENT OF POLICY

:

6. How do you see the problem of mental health as compared with other health problems in the country?

7. How much of a priority is do you think mental health is for government?

8. There are a lot of social and other factors that impact on mental health in this country. What do you see as the most significant causes or risks of mental ill health?

9. [What do you think are the greatest needs of users of mental health services?]

10. What do you think are the major issues (/ problems) that this policy seeks to address?

11. From what you know about the policy, does the policy represent a major shift from previous approaches to MH in South Africa? In what ways?

12. What do you see as the biggest positives of this policy? (or the mental health care approach being adopted in this policy – i.e. deinstitutionalisation and integration into primary health care)

13. What do you think are the gaps in this policy?
    Prompt: are there any perspectives that you think might be missing / not sufficiently covered by the policy / approach to MH?

14. What challenges do you anticipate in the implementation of this policy?

Appendix 3: Requesting summit records: Issues of transparency (publication)

The role of access to information in enabling transparency and public participation in governance: A case study of access to policy consultation records in South Africa

Citation: Marais, D.L., Quayle, M., & Burns, J. (2017). The role of access to information in enabling transparency and public participation in governance: A case study of access to policy consultation records in South Africa. *African Journal of Public Affairs, 9*, 36-49.

Abstract

The operationalisation of good governance principles such as transparency and public participation depends largely on the degree of access that citizens have to government information. This paper is based on the notion that citizens should be informed about what government is or does (transparency) and provided with sufficient opportunities to influence this (public participation). Both of these depend on the provision of reliable information before, during and after policy consultation. The paper explores how transparency may be operationalised through access to information and how this is implemented in South Africa through the Promotion of Access to Information Act. It then focuses on policy consultation as a mechanism for government transparency that can only function adequately if the public has access to information concerning both the policy and the consultation process. This case study documents an attempt to obtain records concerning public consultation on mental health policy from a number of South African government departments. Findings suggest that access to information is variably applied across national and provincial Departments of Health, and that legislation regarding the transparency of policy consultations appears contradictory. Based on these experiences, we reflect on potential tensions between the accountability and transparency functions of access to information and public participation in policy making (vis-à-vis policy consultation), and how these tensions can obstruct public participation. We recommend that guidelines be established regarding systemic procedures for taking and keeping records on public consultations.

Keywords: access to information, transparency, public participation, policy consultation, South Africa

Introduction

In recent years, the manner in which government interacts with its citizens in the performance of governmental duties and administration has been an increasingly contentious issue in South Africa (Netswera & Kgalane, 2014). Globally, this is matched by calls for greater government transparency, accountability, and citizen engagement through participation and inclusion as fundamental principles of good democratic governance (Abelson & Gauvin, 2004; Cloete & Auriacombe, 2007; Siddiqi *et al*., 2009). Varying degrees of emphasis have been placed on each of these good governance principles with respect to their role in building public trust (Grimmelikhuijsen, 2012; Wang & Van Wart, 2007). While frequently presented as a unified agenda, there are underlying tensions when applying these values in practice, as they compete with one another for attention and resources (Carothers & Brechenmacher, 2014). In this paper, transparency and public participation are de-linked from accountability in order to treat the former principles as essential elements for public trust in their own right. In our view, accountability introduces an element of evaluation (for example, to requests for access to government information) that may serve more to obstruct than facilitate the realisation of transparency and public

participation. This paper documents a process of attempting to obtain records concerning public consultation on mental health policy from a number of South African government departments and, based on these experiences, reflects on potential tensions between the accountability and transparency functions of access to information and public participation in policy making – *vis-à-vis* policy consultation.

The operationalisation of good governance principles such as transparency and participation depends largely on the degree of access that citizens have to government information. Citizens need means to engage with governments and to assess, through access to relevant and timely information, the extent to which governments are performing the responsibilities of public office effectively and efficiently. If governments are to be transparent about how and why decisions are made, they need to both give citizens the opportunity to contribute to the process, and provide relevant information regarding those decisions. In particular, democratic policy making should be conducted transparently (Cloete & Auriacombe, 2007; Head, 2010) and should allow opportunities for the public to contribute to those policies (Mutula & Wamkoya, 2009). Our premise in this paper is based on the idea that public trust will be compromised if citizens do not know what government is or does (transparency) and are not provided with sufficient opportunities to influence this (public participation). Both of these rely to a certain extent on the timely and reliable provision of information about policies and policy making processes.

Literature review

Operationalising transparency vis-à-vis access to information

In assessing transparency *vis-à-vis* access to information, one needs to consider both the nature of the information itself – relevance, quality, consistency and so on – as well as the conditions surrounding the provision of such information, including the processes and procedures for recording, storing, granting access, and retrieval. This requires governments to have both the will and the capacity to keep appropriate, reliable records, and to respond to and process requests for such records in a timeous manner. If any of these elements are not present, the potential for transparency is weakened. Irrelevant information can mask important issues and may divert attention away from critical issues, while information that is incomplete or of poor quality can erode confidence in the validity of the information provided (Cloete & Auriacombe, 2008). The manner and consistency with which the information is compiled also impacts on the reliability and quality of such information. Information regarding a consultation process, for example, should be comprehensive enough for the reader to determine how and why decisions resulting from such a process were made. Furthermore, if governments are unable to locate and retrieve records that concern government services and decisions, this will affect citizens' trust in government (Wamkoya, 2012). In summary, the usability of information is largely dependent on the nature of the information (Cloete & Auriacombe, 2007), as well as on how governments are able to manage such information and to process requests for this information.

An important first step towards operationalising transparency is drafting and implementing freedom of information legislation. In South Africa, the right of access to information is enshrined in the Constitution of the Republic of South Africa (Republic of South Africa, 1996) and enacted through the Promotion of Access to Information Act (PAIA) (Republic of South Africa 2000). The PAIA sets South Africa apart by making it one of the first and few countries in Africa to have access to information

legislation (Wamukoya, 2012). Since the implementation of PAIA in 2002, however, various reports documenting requests for information under PAIA have highlighted a number of weaknesses in both the capacity and willingness of government departments to implement it (see, for example, Cloete & Auriacombe, 2008; Darch & Underwood, 2005; Harris, 2004; McKinley, 2003; ODAC, 2003; Peekhaus, 2011; SAHRC, 2003, 2009). Many bodies – both public and private – have neither the resources nor the capacity to carry out the obligations required by PAIA. However, notwithstanding the obvious insufficiencies in institutional resources, *capacity* to comply and *willingness* to comply have tended to become confounded, such that "a secretive civil servant can credibly claim a lack of resources as a strategy for the effective denial of access" (Darch & Underwood, 2005, p. 78). A number of bureaucratic tactics may be employed to thwart public access to information, including outright refusal to deal with such requests to begin with – what the Open Democracy Advice Centre refers to as "mute refusal" (ODAC 2003, p. 1). ODAC's (2003) monitoring study of PAIA revealed that over half of requests for information were simply ignored. This occurs in a context of lack of buy-in by senior management to the principles and spirit of PAIA, which Peekhaus (2011, p. 544) argues has resulted in "the internalisation of a mindset among some personnel that equates information sharing with risk and vulnerability for their employer."

This may in part be because the way in which we talk about access to information is by linking transparency with accountability, such that public officials may find themselves unable to be transparent without some sense of being evaluated or criticised. (Through Google searches on 25/09/2015, it was established that transparency co-occurs with the word accountability about 10% of the time when the search is on international sites. When the search is restricted to .za domains (South Africa), this percentage jumps to 50%. On .gov.za searches (South Africa government websites), transparency co-occurs with accountability up to 75% of the time). Invoking legislation such as PAIA may be seen as the sanctioning mechanism that could trigger accountability concerns, even when such requests are made in the interests of enhancing public participation. Such suspicion and distrust has resulted in the widely held idea – and practice – that "mere suspicion on the part of an information officer that a request (is) motivated by ill intention constitute(s) sufficient grounds for refusal" (Nassimbeni, 2005, in Darch & Underwood, 2005, p. 82). This occurs despite that fact that, at least in requests for public records, the Act is clear that the reasons for such requests should not influence granting of access. Where state suspicion about the use of information against the government takes precedence over the right of the public to access to information, it is likely that requesters may be put off from invoking PAIA for fear of these being experienced as 'strong arm' tactics and thus eliciting a hostile response (Dick, 2005; Open Society Justice Initiative, 2006; Peekhaus, 2011). This leaves citizens in a situation where invoking PAIA may get a negative response, if any response at all, while not invoking PAIA to request information may similarly receive a negative or non-response, with no recourse to appeal.

The PAIA distinguishes between access to records held in a public capacity versus those held in a private capacity, thereby imposing more stringent standards of transparency and accountability on the public sector (Bosch, 2006). Importantly, this distinction also removes the obligation on those seeking information from the public sector to justify such requests for information (Cloete & Auriacombe, 2008; Peekhaus, 2011). There are of course grounds for public officials to refuse requests for information; PAIA outlines a number of such conditions, including protection of privacy of a third party (private person), protection of certain records of the South African Revenue Service, protection of the safety of individuals or property, and defence, security and international relations of the Republic (PAIA, 2000). In

addition, PAIA very clearly states that, regardless of the reasons for refusal of a request for information, this must be communicated to the applicant (PAIA, 2000). While it is expected that there are reasonable conditions under which refusal to grant access to information may be warranted, section 44 of PAIA, *Operations of Public Bodies*, under *Grounds for Refusal of Access to Records,* is perplexing. This section states that "an information officer of a public body may refuse a request for access to a record of that body if the record contains…an account of a consultation, discussion or deliberation that has occurred, including, but not limited to, minutes of a meeting, for the purpose of assisting to formulate a policy or take a decision in the exercise of a power or performance of a duty conferred or imposed by law" (Republic of South Africa 2000, p. 36). This seems to suggest that requests for access to records of public consultations about public policies may be refused. Given that public participation in government decision making is actively pursued by the South African government (see further discussion on this below), and given that public consultations are a means of increasing government transparency in policy making, this clause seems controversial. If records of public consultations by public bodies regarding public policies are not available to the public, it raises questions around what is meant by *public* and what is meant by *consultation*. Inclusiveness, shared responsibility, openness throughout the process, access, transparency, and respect for public input are also principles behind public consultation in South Africa (De Villiers, 2001, pp. 159-160). And yet, the PAIA clause regarding access to records of public consultation seems contradictory to these principles. It is necessary to therefore briefly consider the place of public participation in South Africa. – Reviewers comment: More explanatory literature need to be infused. Deal more with the FOI ACT and expand

Operationalising transparency vis-à-vis public participation in governance through policy consultation

Policy consultation and public participation in political decision making are ways in which governments can ensure transparency (Abelson & Gauvin, 2006; OECD, 2010). Understandings of public participation, and corresponding methods of engagement, vary widely (for typologies of public participation, see Coleman & Gotze, 2001; Rowe & Frewer, 2005; Shipley & Utz, 2012). If public participation is understood as information provision, examples include access to public records and government gazettes; if public participation is understood as consultation, examples expand to more two-way processes such as inviting commentary on draft legislation or public opinion surveys (Coleman & Gotze, 2001). Each of these approaches relies to a greater or lesser extent on the exchange of information (Rowe & Frewer, 2005). To adequately assess, therefore, whether and how public perspectives informed policies, and whether the process was open, transparent and inclusive, it is critical to have a paper trail regarding how these decisions were made and how the public was consulted. Whether the goal of public engagement is information provision or inviting public deliberation to prioritise policy options, it is generally accepted in democratic societies that citizens need to be fully informed about both the decisions that affect them and the way in which those decisions were made (Rowe & Frewer, 2000). The International Association for Public Participation (IAP2, 2007) has put forward a set of core values that underscore public participation. These are listed in Table 1. Implicit in these values is the assumption that public involvement in, for example, policy decisions, can only be fully realised if participants have access both to the decision-making process and to the decisions made during those processes. This implies that transparency is central to public participation and, *ipso facto*, that the processes through which policies are developed and consulted on are documented in clear and accessible records.

Table 1: IAP2 Core Values of Participation (IAP2, 2007)

1. The public should have a say in decisions about actions that could affect their lives.
2. Public participation includes the promise that the public's contribution will influence the decision.
3. Public participation promotes sustainable decisions by recognizing and communicating the needs and interests of all participants, including decision-makers.
4. Public participation seeks out and facilitates the involvement of those potentially affected by or interested in a decision.
5. Public participation seeks input from participants in designing how they participate.
6. Public participation provides participants with the information they need to participate in a meaningful way.
7. Public participation communicates to participants how their input affected the decision.

South Africa is a representative democracy that also espouses in its Constitution (Republic of South Africa 1996) the principles of participatory democracy – the right of citizens to influence government decisions. Parliament and the nine provincial legislatures are constitutionally mandated to elicit public participation in decision-making and policy processes (Buccus & Hicks, 2011). The South African government has thus explicitly recognised public participation as critical at all levels of government (Nyalunga, 2006). The National Policy Framework for Public Participation (Department of Provincial and Local Government, South Africa, 2007) broadly outlines the rationale for public participation and provides guidance specifically for local government (wards and municipalities) to involve communities in decision making. This Framework draws on the White Paper on Local Government (Republic of South Africa, 1998), which is based on *Batho Pele* (People First) principles, including making local government more accessible and accountable to communities, and providing meaningful and relevant information to the public on a continuous basis (Arends, 2011). Indeed, a publication produced by Parliament regarding public participation emphasises that "ready access to and the appropriate distribution of information is critical…The credibility of information is also critical. This issue relates closely to the question of legitimacy" (Parliament of South Africa, n.d.).

And yet, the PAIA grounds for refusing requests to access information about public consultation seem to contradict the values of public participation espoused in the Constitution and other legislation. Perhaps this is because *the public* has not been clearly defined when speaking about public participation (Florin & Dixon, 2004), or perhaps it is because the definitions of and rationale behind public *participation* are not clearly articulated (Conklin, Morris & Nolte, 2012). While public participation is taken up as a value goal, its realisation in practice – such as through accessing information about policies and policy consultation processes – does not seem to be followed through. Consultation should not stop at consultation *events:* citizens should be able to comment on policy drafts that consolidate the input from such forums so that consultation moves from once-off event to ongoing process of engagement (Cook, 2002). But, in South Africa at least, there seem to be no policies or guidelines for public officials organising these consultation processes regarding how the consultation should be recorded, what form these records need to take and how they should be stored, and how access to such records should be managed.

Ultimately, records management and access to information is critical for government transparency, which in turn is central to the realisation of good governance. In the case of South Africa, the operationalisation of transparency through enabling access to information has had limited success. Furthermore, while public participation in policy making is promoted in South Africa at all levels of government; legislation regarding the transparency of the policy consultation process appears contradictory. What follows is a case report documenting efforts to obtain records regarding a policy consultation process. It demonstrates, among other things, a lack of consistency in how government departments are giving effect to the principles of transparency and public participation.

Background to request for records on policy consultation

South Africa's first mental health policy was promulgated in October 2013 (Department of Health, 2013), following a lengthy policy development process. Early in 2012, the Department of Health (DoH) asked each of the nine provinces to hold provincial mental health summits to get stakeholder input on the draft mental health policy document. These discussions would feed into a national mental health summit, which would ultimately inform whether any substantive changes should be made to the draft policy. The consultation process culminated, in April 2012, in the national mental health summit, where delegates gathered over two days to discuss the draft policy and make recommendations. At the end of the national mental health summit, a declaration was issued which contained the recommendations from the two-day discussions, following which a task team was established to work on finalising the mental health policy and eight point strategic plan that were adopted in October 2013.

In May 2013, as part of a study that set out to show what lines of evidence were taken up into policy via the consultation process, we sent requests for the records, minutes or transcripts from each of the provincial mental health summits held in 2012. They were addressed to the relevant DoH managers in each province. We also requested the transcripts or records of the national mental health summit from the National Department of Health. Notably, one of the authors who sent the requests had been a key role player in a provincial mental health summit and had a history of engagement with the National DoH on mental health policy; it was anticipated that this 'insider connection' might facilitate a positive response to the requests.

Findings: A case study of requesting policy consultation records

As public consultations, both the provincial and national summit proceedings could be considered public record. It would therefore seem a reasonable expectation that the reports or transcripts from these summits to be available to a member of the public upon request. However, when requesting these records from the nine provincial Departments of Health, we found that there was a large degree of variability in terms of how willing provinces were to share this data, as well as the format in which this data was presented. While none of the provinces explicitly refused to release their summit records, we were unable to directly obtain summit reports or transcripts from five of the nine provinces. Among these five provinces, responses ranged from silence or non-responsiveness, to wariness about what we were going to do with the data, ultimately resulting in no records being released. In addition, the inconsistencies in record keeping across provinces, as evidenced by those provinces that did send summit records, can be considered a potential limitation to access to information and transparency.

Of the nine provinces, four (Province A, Province B, Province C and Province D) provided some form of record of their provincial mental health summit. Provinces A, B, and C sent these records upon request, with no questions about how the data would be used beyond what was explained in the request for information. One province, Province D, responded initially that "*The Department agrees to make copies available of the recordings or transcripts ….However; classified information cannot at this stage be made available for the research*." No copies of the recordings or transcripts were sent along with this response. We responded to ask for clarification about the issue of classified information, stating that, as far as we were aware, the summit proceedings were in the public record. We were then referred to the relevant directorate, who sent Province D's provincial summit record in the form of a summarised written report, but did not send any direct record of the proceedings.

The *ways* in which the summit proceedings had been recorded also differed from one government department to the next. Provinces A and D submitted full written reports of the summit, while Province A also sent some presentation slides and published papers which appeared to have formed part of the breakaway group discussions at the summit. Province C sent presentation slides, which seem to have accompanied an oral report-back of the summit. Province B sent seven compact discs on which the audio recordings of the whole provincial summit were saved, as well as written declaration that resulted from Province B's summit. The National Department of Health escalated our request through relevant official levels and the entire audio recordings of the two-day national mental health summit were sent to us on an external storage device. Notably, in the cases where full audio recordings of the summits were received, the requester had either been instrumentally involved in the organisation of the relevant summit or had pre-existing collegial relationships with those to whom the requests were sent.

The remaining five provinces had varying responses to our requests for summit records. Two – Province H and Province I – were completely unresponsive (non-response by silence, or mute refusal), despite multiple attempts to make contact with the DoH managers. Province F sent a written response at first, informing us that "*the report is in its initial draft stage as it is being considered and engaged upon by the Executive Management of the department. Once that process is concluded, it will be released for your consumption*." This was despite the fact that the requests for summit records were made more than a year after both the provincial and national summits had been held. Despite further attempts to request the report from Province F, no further responses were forthcoming. The two remaining provinces, Province E and Province G, seemed somewhat protective of the data we had requested. At first, Province E acknowledged receipt of our request in writing. Then they wrote asking for "*a copy of the student's research proposal. We are trying to facilitate this process through the research unit within our Department and we need to submit all relevant documents to them*." Although this could be considered a reasonable request, it is unclear why this would be necessary if the summit records were part of public record and any member of the public would have access to them under the Promotion of Access to Information Act. Despite submitting the requested research proposal and attempting to make further contact, we did not receive any summit records from Province E. The response from Province G was similar. They telephonically requested the research proposal. After sending the proposal, further attempts to obtain the summit records were met with no response. Table 1 below shows the variation in responses to the request for summit records across provinces, as well as variations in the format of the five records that were submitted.

Table 2. Provincial responses to requests for summit records in the present study

Province	Initial response	Final response	Summit record sent
Province A	Sent the summit record.		Y
Province B	Sent the summit record.		Y
Province C	Sent the summit record.		Y
Province D	Agreed but would not release "classified information."	Referred to relevant directorate, which sent the summit record.	Y
Province E	Acknowledged receipt.	Requested research proposal. No further response.	N
Province F	Responded that report was still in draft stages.	No further response.	N
Province G	Acknowledged receipt.	Requested research proposal. No further response.	N
Province H	No response.	No response.	N
Province I	No response.	No response.	N

Discussion

The case study above demonstrates that access to information seems to be variably applied across different government departments in South Africa. Responses ranged from complete transparency through full disclosure, to absence of transparency through silence, with wariness or suspicion occupying the middle ground. It is possible that the level of access granted was at least partly influenced by the degree of 'insider connection' we had with those in positions of power, who could grant or refuse our requests. Further, the contrast between the accesses we were granted at national level compared with that of many provincial departments suggests that it is not the case that we were unable to obtain consultation records due either to not explicitly invoking PAIA or due to the clause in PAIA allowing for refusal of requests for such records. Our experience is consistent with a number of issues identified by previous research in implementing PAIA, including lack of access due to poor capacity to comply and lack of access due to ambivalent willingness to comply. In our case, for example, non-response through silence (mute refusal) could be interpreted in at least two ways. One is that some government departments do not have the administrative infrastructure for dealing with requests for information in terms of having dedicated contact persons and systems for dealing with such requests. Lack of response

may, in this instance, simply have been a case of our requests falling through the cracks. The second possibility is that an unwillingness to share information is cloaked in failures of administrative process through non-response. As the requesters of information, it is not possible to know which of the reasons behind non-response were in operation. Given the veiled references to information being protected or classified, however, it is not unfeasible to imagine that non-response was an act of obfuscation. The implications of lack of capacity-related non-response and of deliberate non-response are briefly dealt with below.

Challenges with respect to administrative capacity in relation to granting access to information have been well documented (Darch & Underwood, 2005; Dick, 2005; ODAC, 2003; Peekhaus, 2003). In relation to non-response due to (inferred) lack of capacity, if a response to request for information is not received within a certain time period, the (non) response is nonetheless classified as a refusal to said request (Section 27, PAIA). According to McKinley (2003, p. 4), "this allows holders of information the option of simply ignoring certain requests and gives lie to one of the main objects of PAIA which is 'to promote transparency, accountability and effective governance of all public and private bodies'." In addition, the nature of received records themselves was inconsistent in this case, showing lack of uniformity in how public consultation proceedings are documented. This suggests that administrative processes that should facilitate access to information may actually serve to hinder transparency. Keeping good records and good record keeping practices, for example, are as important to access to information as is the granting of access to information itself. "Given that PAIA only covers information that is recorded, the realisation of the right of access to that information requires that people know what records are in the custody of public and private bodies, that the records are properly kept and that they are readily available. On all three fronts, there is a long way to go" (McKinley, 2003, p. 13).

The records requested in this case were of a public consultation process regarding a draft mental health policy that had been circulated in the public domain. It is difficult to see how such records could be considered sensitive or classified information, particularly given the full access granted at national level, which technically should have included report backs from each provincial mental health summit. And yet, in some departments there seemed to be a perception that the public is not to be trusted, and that government information – or perhaps government processes – might be scrutinised and potentially criticised, demonstrating that transparency is being confounded with accountability. This confirms other reports that "public officials by their very nature are loathe to disclose information, so if that person is uncertain whether he may disclose the information, he would look for loopholes not to disclose the information" (Geldenhuys & Crooks, 2003 in McKinley, 2003, p. 21).

This is in stark contrast to the willingness of the National Department of Health and some provincial departments to provide full disclosure of information. The hesitation on the part of other provincial departments, or unwillingness by non-response if these are read as obfuscation, is therefore puzzling at best, and concerning at worst. It raises questions regarding whether the holder of information about an ostensibly public and transparent decision-making process should be able to withhold such information and, by extension, to withhold such information on the basis of what it will be used for. PAIA is very clear that the right of access to information should not be influenced by any reasons the requester gives for requesting access or by the beliefs of the government official dealing with the request regarding what the requester's reasons are (McKinley, 2003). This raises further questions regarding whether transparency should be dependent on what the information is going to be used for, and, *ipso facto*, on the requester being required to justify the need to have access to public information. It also begs the

question of what kind of use would be considered a justifiable cause for withholding information. In our view, it is controversial to suggest that the condition that it is a record from a public consultation as grounds for refusal can be applied in this case, particularly in the context of the South Africa's commitment to public participation at all levels of government decision making.

In practice, then, transparency through access to information neither lives up to democratic ideals nor matches government rhetoric. As South Africa "moves towards a more conscious model of democratic information transparency…the roles played in the coming decade by public requesters and agency implementers will determine whether the PAIA becomes a paper tiger or a genuine mechanism for citizen engagement" (Wallace, 2004, p. 202). Inasmuch as public participation in policy making depends on citizens being informed about decisions taken within and about the policy process, the ideals of citizen engagement, in this case at least, have been inconsistently realised. If holding public forums to consult the public about government decisions is one way of operationalising transparency in policy making, then not being transparent about what happens *at* those public forums seems to contradict at least one objective of such engagement. If government is committed to engaging with its citizens in this way, it is at least necessary to create an enabling environment for the public to access relevant information about decisions that goes beyond legislative mechanisms. Without adequately involving the public in a democratic and transparent way in the formulation of policies, the implementation of such policies is likely to be compromised.

Conclusion

This paper has considered how a lack of transparency through inadequate access to information can be at odds with the rationale for public participation. One follow-through from policy consultation is that it should be part of the public record, and the public should have access to it. If not, it simply becomes a discussion behind closed doors: if you were not present, you remain unaware and uninformed unless and until the final outcome of that discussion – the policy itself – is released. Because the process is lost from public record, there is no trail between policy consultation and policy promulgation, and therefore no way to assess whether the consultation process and the decisions resulting from it were fair, or to what extent the consultations informed policy. In our view, this renders the consultation process incomplete. At the very least, guidelines need to be established regarding systemic procedures for taking and keeping records on public consultations, in addition to existing guidance on how to engage the public in those consultations. Transparency is a critical element here, and access to information is one step towards realising this pillar of democracy.

The issues considered in this paper are part of a broader question about what public participation is and does in the context of democratic policy making. We acknowledge that public consultation is more than merely a rational process of information exchange or access, and that transparency is only one factor that might be used to evaluate the success or failure of such a process. Impact on policy is certainly another, as is the intrinsic value for those participating in such a process. Although the inconsistent nature of and access to records generated from the consultation process is certainly problematic, this by no means implies that the policy that came into effect following these consultations is in any way sub-optimal, nor that the government departments responsible for implementing the policy are not committed to the task. Once again, transparency is separated here from accountability – the absence of one does not automatically negate the other. The lack of transparency in this instance does make it difficult, however, to assess the degree to which the policy consultations across the nine provinces were

truly participatory or merely a form of rubber-stamping on a policy that had already been finalised. It seems reasonable to conclude, then, that for public participation to be a mechanism for government transparency, the public participation process should itself be transparent. As South Africa continues to face challenges in transforming into a healthy democracy, public participation processes have an important role to play in demonstrating government's commitment to building public trust, through engaging openly and transparently with its citizens regarding decisions that affect them.

References

Abelson, J., & Gauvin, F.P. (2004). *Transparency, trust and citizen engagement: What Canadians are saying about accountability*. CPRN Research Report P|05 Public Involvement Network. Ottawa: Canadian Policy Research Networks.

Abelson, J., & Gauvin, F. (2006). *Assessing the impacts of public participation: Concepts, evidence and policy implications.* CPRN Research Report P|06 Public Involvement Network. Ottawa: Canadian Policy Research Networks.

Arends, D. (2011). *An assessment of the effectiveness of public consultation: The case study of selected ward committees in the Northern Areas, Nelson Mandela Bay Municipality.* Thesis submitted in partial fulfilment of the requirements for the degree of Masters in Public Administration in the Faculty of Arts, Nelson Mandela Metropolitan University.

Buccus, I., & Hicks, J. (2011). Civil society and participatory policy making in South Africa: gaps and opportunities. In: J. Daniel, P. Naidoo, D. Pillay & R. Southall (Eds.), *New South African review 2: New paths, old compromises* (pp. 100 – 118). Johannesburg: Wits University Press.

Carothers, T., & Brechenmacher, S. (2014). *Accountability, transparency, participation and inclusion: a new development consensus?* Washington: Carnegie Endowment for International Peace. Available from http://carnegieendowment.org/2014/10/20/accountability-transparency-participation-and-inclusion-new-development-consensus (Accessed 12 July 2015).

Cloete, F., & Auriacombe, C.J. (2007). Governance and transparency in South Africa. *Politeia, 26,* 192-206.

Cloete, F., & Auriacombe, C.J. (2008). Counter-productive impact of freedom of access to information-related legislation on good governance outcomes in South Africa. *Journal of South African Law, 3*, 449-463.

Coleman, S., & Gøtze, J. (2001). *Bowling together: Online public engagement in policy deliberation*. London: Hansard Society.

Conklin, A., Morris, Z., & Nolte, E. (2012). What is the evidence base for public involvement in health-care policy?: results of a systematic scoping review. *Health Expectations, 18,* 153–165.

Cook, D. (2002). Consultation, for a change? Engaging users and communities in the policy process. *Social Policy and Administration, 36,* 516-531.

Darch, C., & Underwood, P. (2005). Freedom of information legislation, state compliance and the discourse of knowledge: The South African experience. *International Information & Library Review, 37,* 77–86.

Department of Health (2013). *National Mental Health Policy Framework and Strategic Plan.* Pretoria: Department of Health. Available from http://www.health-e.org.za/wp-content/uploads/2014/10/National-Mental-Health-Policy-Framework-and-Strategic-Plan-2013-2020.pdf (Accessed 4 February 2014).

Department of Local and Provincial Government, South Africa (2007). *National Policy Framework for Public Participation*. Pretoria: Department of Local and Provincial Government.

De Villiers, S. (2001). *A people's government: The people's voice – a review of public participation in the law and policy making process in South Africa*. Cape Town: Parliamentary Support Programme. Available from http://www.parliament.gov.za/live/content.php?Item_ID=285.

Dick, A.L. (2005). Power is information: South Africa's Promotion of Access to Information Act in Context. In F. Crestani & I. Ruthven (Eds.), *Information context: Nature, impact, and role: 5th International Conference on Conceptions of Library and Information Sciences*, CoLIS 2005, Glasgow, UK, June 4-8, 2005, Proceedings, pp. 212-225. Springer.

Florin, D., & Dixon, J. (2004). Public involvement in health care. *British Medical Journal, 328,* 159-161.

Grimmelikhuijsen, S. (2012). Linking transparency, knowledge and citizen trust in government: an experiment. *International Review of Administrative Sciences, 78*, 50–73.

Harris, V. (2004). Using the Promotion of Access to Information Act: The case of the South African History Archive. In C. Lange & J. Wessels (Eds.), *The right to know: South Africa's Promotion of Administrative Justice and Access to Information Acts* (pp. 180-191). Cape Town: Siber Ink.

Head, B.W. (2010). Editorial: Reconsidering evidence-based policy: Key issues and challenges. *Policy & Society, 29*, 77–94.

IAP2 (2007). *IAP2 core values of public participation.* Louisville: International Association of Public Participation.

Kennedy, C. (2015). *PAIA Civil Society Network shadow report 2014*. Johannesburg: PAIA Civil Society Network.

McKinley, D.T. (2003). *The state of access to information in South Africa*. Research report prepared for the Centre for the Study of Violence and Reconciliation, July 2003. Available from http://www.csvr.org.za/docs/trc/stateofaccess.pdf (Accessed 20 July 2015).

Mutula, S., & Wamukoya, J.M. (2009). Public sector information management in east and southern Africa: Implications for FOI, democracy and integrity in government. *International Journal of Information Management, 29*, 333-341.

Netswera, F.G., & Kgalane, T.S. (2014). The underlying factors behind violent municipal service delivery protests in South Africa. *Journal of Public Administration, 49*, 261-273.

Nyalunga, D. (2006). An enabling environment for public participation in local government. *International NGO Journal*, *1*. Available from http://ddp.org.za/information-material/articles/An%20enabling%20environment%20for%20public%20participation%20in%20local%20government.pdf (Accessed 13 August 2015).

OECD (2010). *Better regulation in Europe*. Paris: Organisation for Economic Cooperation and Development.

Open Democracy Advice Centre (ODAC). (2003). *The challenge of implementation: The state of access to information in South Africa.* Cape Town: Open Democracy Advice Centre. Available from http://www.opendemocracy.org.za/documents/results_SA_OSJI_study.doc (Accessed 24 July 2015).

Open Society Justice Initiative (2006). *Transparency and silence: A survey of access to information laws and practices in fourteen countries*. New York: Open Society Institute.

Parliament of South Africa (n.d.). *Public participation in other parts of the world*. Accessed 1 September 2015 from http://www.parliament.gov.za/live/content.php?Item_ID=311 (Accessed 1 September 2015).

Peekhaus, W. (2011). Biowatch South Africa and the challenges in enforcing its

constitutional right to access to information. *Government Information Quarterly, 28*, 542-552.

Republic of South Africa (1996). *Constitution of the Republic of South Africa.* As adopted on 8 May 1996 and amended on 11 October 1996 by the Constitutional Assembly. Pretoria: Parliament of South Africa, Republic of South Africa. Available from http://www.justice.gov.za/legislation/constitution/SAConstitution-web-eng.pdf.

Republic of South Africa (1998). *White Paper on Local Government, 9 March 1998*. Pretoria: Parliament of the Republic of South Africa, South Africa Available from http://mfma.treasury.gov.za/MFMA/Guidelines/whitepaper.pdf.

Republic of South Africa (2000). *Promotion of Access to Information Act 2 of 2000.* Pretoria: Parliament of South Africa, Republic of South Africa. Available from http://www.dfa.gov.za/department/accessinfo_act.pdf.

Rowe, G., & Frewer, L.J. (2000). Public participation methods: A framework for evaluation. *Science, Technology, & Human Values, 25*, 3-29.

Rowe, G., & Frewer, L. J. (2005) A typology of public engagement mechanisms. *Science, Technology and Human Values, 30*, 251-290.

Shipley, R., & Utz, S. (2012). Making it count: a review of the value and techniques for public consultation. *Journal of Planning Literature, 00*, 1-21.

Siddiqi, S., Masud, T.I., Nishtar, S., Peters, D.H., Sabri, B., Bile, K.M., & Jama, M.A. (2009). Framework for assessing governance of the health system in developing countries: gateway to good governance. *Health Policy, 90,* 13-25.

South African Human Rights Commission (SAHRC). (2003). PAIA annual report to Parliament. In: *SAHRC 7th annual report April 2002–March 2003*, pp. 57–73. Houghton: South African Human Rights Commission.

South African Human Rights Commission (SAHRC) (2009). *Annual report 2008/2009*. Houghton: South African Human Rights Commission.

Wallace, D.A. (2004). Thirty-five years of freedom of information in the United States. In C. Lange & J. Wessels (Eds.), *The right to know: South Africa's Promotion of Administrative Justice and Access to Information Acts* (pp. 192-202). Cape Town: Siber Ink.

Wamukoya, J.M. (2012). The role of record keeping and open government data initiatives in fostering a critical development of open government policies and public services in sub-Saharan Africa. *Mousaion 30,* 117—127.

Wang, X., & Van Wart, M. (2007). When public participation in administration leads to trust: An empirical assessment of managers' perceptions. *Public Administration Review, 67*, 265-278.

Appendix 4: Coding frameworks

Codes for mental health issues ("content" codes)

Theme	Coding rule / definition
Prevention & promotion	All references to the promotion of mental health and prevention of mental illness, including risks, early detection and screening, and a developmental approach to mental health
Monitoring & evaluation	All references to the monitoring and evaluation of mental health care services, including information systems and mental health indicators, as well as surveillance and monitoring of mental health conditions
Mental health systems	Reference to the broader mental health system, including any elements relating to primary health care reengineering, community-based care, and integration of mental health into primary health care. This code did *not* include tertiary-level, hospital-based services, which were instead coded under infrastructure or Mental Health Care Act implementation, due to the extensive reference to regulations and conditions for hospital-based services in the Act
Human resources	All references to staffing and human resources, whether specialist or generalist, including capacity, training, supervision, and task shifting
Infrastructure	All references pertaining to mental health infrastructure, including community-based facilities, but particularly tertiary-level hospital services, as well as building and infrastructural requirements for adequate provision of mental health care
Research	All references to mental health research, including research priorities, research funding, human resources or capacity for research, evidence and data on mental health resulting from research
Advocacy & user participation	All references to advocacy relating to mental health, and with and for mental health care users, promoting self-help and user representation, participation and advocacy, as well as implementing a recovery approach. References to stigma and increasing mental health literacy and awareness raising were also included in this code
Culture & mental health	All references to culture, cultural or cross-cultural perspectives, including traditional and indigenous healing, and language issues
Mental Health Care Act implementation	All references pertaining to the implementation of regulations laid out in the Mental Health Care Act. This primarily included reference to hospital-based services, 72-hour and involuntary admission, as well as responsibilities of various sectors in implementing the Act
Mental Health Review Boards	Relating to, but coded separately from, the Mental Health Care Act implementation, this code included all references to the establishment and functioning of Mental Health Review Boards
Suicide prevention	All references to suicide and suicide prevention, including incidence, prevalence and definitions, risks, stigma, advocacy, and prevention efforts
Medicines, equipment & protocols	All references to psychotropic medication (including availability, supply chains, and essential medicines list), psychological equipment, and protocols for the screening and identification of mental disorders and provision of mental health care
Governance	All references to governance of mental health at national and local levels, as well as issues relating to coordination, managerial capacity and resources for policy development and implementation
Intersectoral collaboration	All references to the intersectoral involvement and collaboration around mental health, including (but not limited to) the Department of Education, Department of Social Development, Department of Justice, and South African Police Services
Funding	All references to the financing of mental health services, including budgeting and provision of mental health funding at global, national and local levels

Quality assurance	All references to quality assurance and oversight approaches and requirements in mental health care services, with particular emphasis on human rights principles
Child & adolescent mental health	All references to child and adolescent mental health, including approaches to promotion, prevention, and treatment, and requisite service, infrastructural and human resource requirements relating specifically to provision of child and adolescent mental health care
Mental health & other conditions	All references to comorbidities of mental health with other conditions, including HIV and other infectious diseases, as well as chronic conditions, associated risks and consequences of such comorbidities, and requisite service requirements that could address co-occurring conditions within primary health care contexts

Codes for changes between draft and final policy documents (section 4.2)

Code	Coding rule / definition
Change in wording of draft policy content	The phrase or concept appears in both the draft and final policy documents, but the content of the final policy represents an amended version of the wording of the draft policy content
Addition to draft policy content	An additional phrase or concept that appears in the final policy document that did not appear in the draft policy document
Deletion of draft policy content	Content that appears in the draft policy that has subsequently been removed from the final policy document

Process codes for interviews (section 4.3)

Main theme	Sub-theme	Coding rule / definition
Knowledge about or involvement in broader policy development process	Pre-summit policy development	All references to participants' knowledge of or involvement in mental health policy development process up until the consultation summits
	Post-summit policy development	All references to participants' knowledge of or involvement in development or finalisation of the mental health policy following the consultation summits
Information & consultation transparency about the policy consultation	Pre-summit consultation & information	All references to access that participants had to information about decisions around the organisation of the consultation summits, and consultation about these decisions
	Post-summit consultation & information	All references to access to information that participants had to information or the extent to which they were consulted about the process followed and decisions made after the consultation summits
Provincial follow-through to national summit	-	All references to links between provincial and national summits, specifically regarding how provincial summit feedback was followed through to the national summit
Impact of consultation summit	Signalled priority	All references to the impact – or lack thereof – of the national summit in terms of signalling the prioritisation of mental health
	Influenced policy	All references to the impact – or lack of thereof – of the national summit in terms of influencing policy (similar terms: follow-through, uptake)
Perspectives on final policy	General perspectives about the final policy	All references to participants' perspectives / opinions about the final policy document
	Perspectives about the	All references to participants' perspectives /

	implementation of the policy	opinions about the implementation of the policy
Opportunities for service user input	-	All references to the involvement of service users in the consultation summits, including representativeness, support available, preparation time, type of participation enabled

Types of knowledge claims (section 4.4, subsection 4.4.1)

Code	Coding rule / definition
Evidence-based knowledge	All references to studies, research, data, literature/theories or international 'best practice' guidelines, regarding what is shown to be effective (e.g. interventions) or problematic (e.g. risks, treatment gap etc.)
Experiential knowledge	All references to first or third person accounts or observations of on-the-ground experiences of problematic issues/challenges or effective/ineffective approaches in practice
Other	All other references in talk that do not fit into either of the two coding rules above (e.g. clarifications, introductions, procedural comments etc.)

What knowledge claims were being used to do (section 4.4, subsection 4.4.2.1)

Main theme	Sub-theme	Coding rule / definition
Illustrate current situation	Illustrate a challenge	All knowledge claims making reference to a current "on-the-ground" situation, whether experienced in first or third person, or to evidence, to illustrate a challenge that needed addressing
	Illustrate a solution / best practice	All knowledge claims making reference to a current "on-the-ground" situation, whether experienced in first or third person, or to evidence, to illustrate a solution or demonstrate a best practice that was currently working
Highlight implications of a proposal	Highlight benefits of or motivate for a proposal	All knowledge claims making reference to a first or third person experience, or to evidence, in order to explicitly link to and demonstrate how a proposal being discussed would work or be of benefit in this situation
	Highlight disadvantages or argue against a proposal	All knowledge claims making reference to a first or third person experience, or to evidence, in order to explicitly link to and demonstrate how a proposal being discussed would not work or be disadvantageous in this situation
Engage	Support a previous point made	All knowledge claims – whether in reference to experience or to evidence – that were explicitly aimed at engaging with and supporting or building on a previous point made
	Counter a previous point made	All knowledge claims – whether in reference to experience or to evidence – that were explicitly aimed at countering a previous point made

Responses to knowledge claims (section 4.4, subsection 4.4.2.2)

Code	Coding rule / definition
Responded to (overall)	Any knowledge claim made during the group discussions that was verbally responded to in some way, acknowledging the point made (code further divided below)
Responded to and engaged with	All knowledge claims to which there was a verbal response and follow on or engagement with the point made within that knowledge claim (such as reframing, summarising, building on, countering)
Responded to but not engaged with	All knowledge claims to which there was a verbal response of acknowledgement but with which there was no further engagement in terms of following through on content (e.g. thank you, yes)
Not responded to	All knowledge claims that were made during discussions that received no verbal response from group Chair or other group participants (discussion moved onto other points or participants)
Inaudible	All knowledge claims within discussions that could be identified but for which the subsequent talk was not sufficiently audible to determine type of response / non-response

Reflection / inscription of knowledge claims in group recommendations (section 4.4, subsection 4.4.3)

Code	Coding rule / definition
Reflected or inscribed	Group recommendation reflects a comprehensive direct or summarised version of knowledge claim made
Partially reflected or inscribed	Group recommendation partially reflects the content of a knowledge claim, with some detail lost in the inscription
Not reflected or inscribed	Group recommendation does not reflect the content of knowledge claim in any way

Group process themes (section 4.5)

Code	Coding rule / definition
Awareness of time constraints	All references made by Chairs, rapporteurs or group participants relating to time and timing in group sessions, including concern about limited time, time available for presentations, discussions and formulation of recommendations within group sessions, and timing of breaks etc.
Microphone management	All references relating to the use of / facilitation by microphone within the group sessions, whether explicitly (direct reference to passing around microphone) or indirectly (indicating raising of hands, moving around room, turn taking etc.)
General process/procedural comments	Any general references by Chairs, rapporteurs, or group members to process or procedural issues relating to the group sessions / consultation process, particularly pertaining to interaction
Engagement with draft documents	All explicit references to reviewing or engaging with the draft policy or draft summit declaration during group discussions
Awareness of needing to formulate recommendations	All references made during group sessions indicating explicit awareness of needing to formulate and/or capture specific recommendations for feedback
Processes for formulating recommendations	All references relating to processes for formulating proposals or recommendations made during group sessions

Reflection of group discussions in group recommendations (section 4.6, subsection 4.6.2.1)

Code	Coding rule / definition
Comprehensively reflected or aligned	Group recommendations reflect a comprehensive summary of points raised during group discussions
Partially or broadly reflected or aligned	Group recommendations partially reflect group discussions in broad ways, with some detail lost in summarisation
Not reflected or aligned	Group recommendations do not reflect the substantive content of the group discussions

Reflection of group recommendations in summit recommendations (section 4.6, subsection 4.6.2.1)

Code	Coding rule / definition
Comprehensively reflected or aligned	Summit recommendations reflect a comprehensive summary of group recommendations
Partially reflected or aligned	Summit recommendations partially reflect group recommendations in broad ways, with some detail lost in summarisation
Not reflected or aligned	Summit recommendations do not reflect the substantive content of the group recommendations

Reflection of group recommendations in policy changes (section 4.6, subsection 4.6.2.2)

Code	Coding rule / definition
Directly reflected or aligned	Group recommendations can be directly linked to the group recommendations
Partially reflected or aligned	Group recommendations relate to the same issue as policy change, or is consistent with direction/nature of the change
Not reflected or aligned	Group recommendations not reflected in policy changes
Contrary	Policy change seems contrary to or contradicts group recommendations

Reflection of group recommendations in draft policy (section 4.6, subsection 4.6.2.3)

Code	Coding rule / definition
Broadly reflected or aligned	Group recommendations broadly reflected in the policy content
Requiring change to existing content	Group recommendations relate to the same issue as policy content, but requires change to or deviates from existing content around that issue
Not reflected or aligned	Group recommendations not reflected in policy content and would require additional content to be added

Reflection of group recommendations in implementation plan (section 4.6, subsection 4.6.2.4)

Code	Coding rule / definition
Correspondence with implementation priority	Group recommendation/s and implementation priority concern the same issue/s
Reflected in key activity on implementation plan	Group recommendations are reflected in detail of key activity

Reflection of group recommendations in both implementation-appendices (section 4.6, subsection 4.6.2.4)

Code	Coding rule / definition
Reflected in both key activity on implementation plan and Terms of Reference action	Group recommendations reflected in detail of both key activity on implementation plan as well as in Terms of Reference action
Reflected in either key activity on implementation plan and Terms of Reference action	Group recommendations reflected in detail either in key activity on implementation plan or in Terms of Reference action
Reflected in neither key activity on implementation plan or Terms of Reference action	Group recommendations not reflected in either key activity on implementation plan or Terms of Reference action

Reflection of group recommendations in Terms of Reference actions (section 4.6, subsection 4.6.2.5)

Code	Coding rule / definition
Reflected in action relating to Terms of Reference structure	Group recommendations are reflected in detail of action relating to Terms of Reference structure

Note: All references to summit recommendations below refer only to those recommendations that were added to the summit declaration at the end of the summit – i.e. post-summit recommendations

Reflection of summit recommendations in policy changes (section 4.6, subsection 4.6.3.1)

Code	Coding rule / definition
Reflected in detail in policy changes	Summit recommendations reflected in detail in the policy changes
Broadly reflected in policy changes	Summit recommendations broadly relate to the same issue as policy change
Not reflected in policy changes	Summit recommendations not reflected in policy changes in any way

Reflection of summit recommendations in draft policy (section 4.6, subsection 4.6.3.2)

Code	Coding rule / definition
Broadly reflected or aligned	Summit recommendations broadly reflected in the policy content
Requiring change to existing content	Summit recommendations relate to the same issue as policy content, but requires change to or deviates from existing content around that issue

Reflection of summit recommendations in implementation plan (section 4.6, subsection 4.6.3.3)

Code	Coding rule / definition
Correspondence with implementation priority	Summit recommendation/s and implementation priority concern the same issue/s
Reflected in key activity on implementation plan	Summit recommendations are reflected broadly in key activity

Reflection of summit recommendations in Terms of Reference actions (section 4.6, subsection 4.6.3.4)

Code	Coding rule / definition
Reflected in action relating to Terms of Reference structure	Summit recommendations are reflected broadly in action relating to Terms of Reference structure

Reflection of summit recommendations in both implementation-appendices (section 4.6, subsection 4.6.3.4)

Code	Coding rule / definition
Reflected in both key activity on implementation plan and Terms of Reference action	Summit recommendations reflected broadly in both key activity on implementation plan as well as in Terms of Reference action
Reflected in either key activity on implementation plan and Terms of Reference action	Summit recommendations reflected broadly in either in key activity on implementation plan or in Terms of Reference action
Reflected in neither key activity on implementation plan or Terms of Reference action	Summit recommendations not reflected in either key activity on implementation plan or Terms of Reference action

Appendix 5: Changes from draft to final policy

{ } indicates a change of wording from the original text < > indicates an addition ------ indicates deletion. Note: Page references refer to pages of policy document Word version available in October 2013, not the final policy pdf version on available on the Department of Health website.

Draft	Final	Section
Health Establishments: {Institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and include facilities such as community health and rehabilitation centres, clinics, hospitals, and psychiatric hospitals.}	**Health Establishments:** {The whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment}, diagnostic or therapeutic interventions,{ nursing, rehabilitative, palliative, convalescent, preventative} or other health services. This includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals.	**Glossary of terms** **(Infrastructure)**
Health Promotion: {The process of enabling people to increase control over, and to improve their health}	**Health Promotion**: {Actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy lives and those that create living conditions and environments that support health}	**Glossary of terms** **(Promotion & prevention)**
Involuntary Care, Treatment and Rehabilitation: The provision of health interventions to people who are deemed incapable of making informed decisions due to their mental health status and who refuse health interventions but require such services for their own protection or for the protection of others.	**Involuntary Care, Treatment and Rehabilitation**: The provision of health interventions <for the period during which> people are deemed incapable of making informed decisions due to their mental health status and who refuse health interventions but require such services for their own protection or for the protection of others.	**Glossary of terms** **(MH Care Act)**
Primary Health Care: ~~The first level of contact for individuals seeking health care~~. Essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable (Alma Ata Declaration, 1978). This approach is organised to reduce exclusion and social disparities in health, is people-centred, intersectoral, collaborative, and promotes the participation of all stakeholders.	**Primary Health Care:** Essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable (Alma Ata Declaration, 1978). This approach is organised to reduce exclusion and social disparities in health, is people-centred, intersectoral, collaborative, and promotes the participation of all stakeholders.	**Glossary of terms** **(Mental health systems)**
See Primary Health Care above – that sentence moved to new term in final document	<**Primary Level Services**: The first level of contact for individuals seeking health care>	**Glossary of terms** **(Mental health systems)**

Psychosocial rehabilitation: Definition to come	**Psychosocial rehabilitation:** <Mental health services that bring together approaches from the rehabilitation and the mental health fields, combining pharmacological treatment, skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities.>	**Glossary of terms** **(Mental health systems)**
Recovery model: Definition to come	**Recovery model:** <An approach to mental health care and rehabilitation which holds that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.>	**Glossary of terms** **(Mental health systems)** **(Advocacy)**
~~**Rehabilitation**: a process that facilitates an individual attaining an optimal level of independent functioning~~	Deleted from final version	**Glossary of terms** **(Mental health systems)**
Task shifting: Definition to come	**Task shifting:** <The use of specialist mental health staff in training and supervisory roles to non-specialist health workers, as a mechanism for more efficient and effective care.>	**Glossary of terms** **(Human resources)**
Tertiary Care: Specialist care that is rendered at {academic health institutions}	**Tertiary Care:** Specialist care that is rendered at {central hospitals}	**Glossary of terms** **(Infrastructure)**
This section on scope and the two sub sections were not included in the draft document	**<Scope** **1. Substance abuse** Historically, in South Africa substance abuse treatment services have been provided by both the Department of Social Development and the Department of Health. The policy and legislative framework for this area is set out in the Prevention and Treatment of Substance Abuse Act (2008) and the National Drug Master Plan (2006). There are important issues of co-morbidity between substance use and mental disorders, and hence a need to coordinate services. Substance use disorders are to be covered by this policy insofar as there is co-morbidity with mental disorders. The Department of Health committed itself during	Part of **Introduction** section, p. 11 **(Other conditions)**

	Parliamentary debate of the Prevention and Treatment of Substance Abuse Act (2008) to provide care, treatment and rehabilitation for those users that present with co-morbid substance use and mental disorders in designated psychiatric hospitals, rather than referring them to the substance abuse treatment centres run by the Department of Social Development. This decision is reflected explicitly in this Mental Health Policy. **2. Intellectual Disability** The Mental Health Care Act (2002) provides for care and rehabilitation services for mental health care users. The responsibility of the Department of Health is to provide developmentally appropriate healthcare for those with severe and profound intellectual disabilities, many of whom will also have physical disabilities. The vocationally related service needs of people with mild and moderate intellectual disability range are the responsibility of the Department of Education and later the Department of Labour, while housing and community service needs are currently provided in some provinces by the department of Social Development. Where co-morbidity exists between intellectual disability and mental disorders, the treatment and care of the person suffering from these disorders is the responsibility of the Department of Health.>	
Not included in the Context section in the draft version	<In South Africa these patterns are exacerbated by the history of violence, exclusion and racial discrimination under apartheid and colonialism. The trauma and abuses meted out during the apartheid era have been well documented in the findings of the Truth and Reconciliation Commission (TRC) (Truth and Reconciliation Commission, 2000), as have the effects of these acts on the mental health of victims. Ongoing realities of violence and crime also exact their toll on the mental health of South Africans, chiefly through the trauma experienced by victims. South Africa also has major challenges regarding substance abuse (including alcohol, tobacco and illicit drugs). South Africa has the highest incidence of alcohol abuse in the world, after the Ukraine. Until recently areas of the Western Cape had some of the highest rates of foetal alcohol syndrome	Section 2: **Context**, p. 14 **(Other conditions)**

	(FAS) in the world, but have now been surpassed by the Northern Cape. In the Western Cape there is a growing methamphetamine (tik) epidemic. Cannabis is the most common illicit drug in the country, with particularly high use among the youth. The consequences of these patterns of substance abuse include increased risk for mental disorders, crime and violence and motor vehicle injuries.>	
9. A few consumer and family associations have been established in some provinces, often with the support of NGOs, such as the SA Federation for Mental Health	9. A few consumer and family associations have been established in some provinces, often with the support of NGOs, such as the SA Federation for Mental Health. <There are a few locally based, user run self-help associations >	Section 2.5. of Context, entitled **Current Service Provision**, p. 16 **(Advocacy)**
10. Some important steps have been taken towards inter-sectoral collaboration, particularly at the national level. However, at the district level, and in many provinces, such inter-sectoral collaborations are the exception rather than the rule.	10. Some important steps have been taken towards inter-sectoral collaboration, particularly at the national level. However, at the district level, and in many provinces, such inter-sectoral collaborations are the exception rather than the rule. <This situation is improving with the legal requirement that districts should produce Integrated Development Plans (IDPs)>	Section 2.5. of Context, entitled **Current Service Provision**, p. 16 **(Governance)**
Not included as a point in the draft version	<12. Deinstitutionalisation has progressed at a rapid rate in South Africa, without the necessary development of community–based services. This has led to a high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns of care>	Section 2.5. of Context, entitled **Current Service Provision**, p. 17 **(Mental health systems)**
These policies were not mentioned in this section in draft version	This mental health policy is based on and consistent with a number of existing policy and legislation mandates in South Africa. These include: ……< ❑ School Health Policy and Implementation Guidelines, 2003; ❑ Child Justice Act, Act 75 of 2008; ❑ Sexual Offences Act, Act 37 of 2007; ❑ Older Persons Act, Act 13 of 2006; and ❑ Criminal Procedure Amendment Act, Act 65 of 2008.>	Section 2.7 of Context, entitled **Policy and legislation mandates**, p. 19 **(Governance)**
Vision: No health without mental health in South Africa	Vision: {Improved mental health for all in South Africa by 2020}	Section 3: **Vision** **(Not specific)**

In the draft version, this was the order of the sections following section 3, Vision: 4. Mission 5. Values and Principles 6. Objectives	In the final version, the order of the sections changed as follows: (i.e. objectives moved up) {4. Mission 5. Objectives 6. Values and Principles}	Order of sections, page 20 **(Not specific)**
In Values and Principles section, the draft had this in under Accessibility and equity: ~~Wherever possible, users should be treated in their communities or near to their homes and families~~	This did not appear in the final draft	Section 5**: Values and Principles**, page 17 of draft **(Mental health systems)**
In Values and Principles section, the draft had this under Participation: {Mutual aid} and advocacy groups should be encouraged	In the final draft under Participation, this changed slightly to: {Self-help} and advocacy groups should be encouraged	Section 5: **Values and Principles**, page 22 of final **(Advocacy)**
The section 7.1. Organisation of services in the draft version started immediately with numbered points	In section 7: Areas for action, under 7.1. Organisation of services, before starting with the numbered points as in the draft, there was an addition of this text, and of the diagram at end of document: In line with the World Health Organisation recommendations regarding organisation of mental health services, the mental health systems will include an array of settings and levels that include primary care, community based settings, general hospitals and specialised psychiatric hospitals.	Section 7: Areas for action, 7.1 **Organisation of services** p. 23 **(Mental health systems)**
Section 7.1. Organisation of services, under subsection on the district mental health system: b. Mental health training programmes for general health staff will be conducted at PHC level	Section 7.1. Organisation of services, under subsection on the district mental health system: b. Mental health training programmes for general health staff will be conducted at PHC level and district and regional hospitals.	Section 7: Areas for action, 7.1. **Organisation of services**, sub section on the district mental health system, p. 24 **(Human resources)**
Section 7.1. Organisation of services, under subsection on the district mental	Section 7.1. Organisation of services, under	Section 7: Areas for action, 7.1.

health system: h. ~~No new psychiatric hospitals will be built~~. {Where inpatient units are needed, these will be developed in district and regional hospitals.}	subsection on the district mental health system: h. {Inpatient units will be built in district and regional hospitals.}	**Organisation of services**, sub section on the district mental health system, p. 25 **(Infrastructure)**
This section was not in the draft version under section 7.1. Organisation of services	**3. <Psychiatric services in general hospitals** a. Inpatient units will be provided in general hospitals to improve access for voluntary admission, assisted care, emergency mental health services, 72-hour assessment of involuntary mental health care users, further care, treatment and rehabilitation. b. Voluntary mental health care users that require admission will be admitted in terms of general health legislation. c. The psychiatric wards that are attached to general hospitals must be designated in terms of the Mental Health Care Act where they meet the criteria. d. The general hospitals that provide 72-hour assessment for involuntary mental health care must be listed as prescribed in the general regulations of the Mental Health Act no.17 0f 2002. e. Information regarding health establishments that provide 72-hour assessment for involuntary mental health care must be compiled and provided to relevant stakeholders to facilitate referral and access to services.>	Section 7: Areas for action, 7.1. **Organisation of services**, p. 25 **(Mental Health Care Act) (Infrastructure)**
This section was not in the draft version under section 7.1. Organisation of services	**4. <Specialised psychiatric hospitals** a. Further care, treatment and rehabilitation of mental health care users will be provided in specialised psychiatric hospitals. b. Provision of inpatient and limited outpatient mental health services. c. Functioning as centres of excellence that provide ongoing routine training, supervision and support to secondary and primary health care services. d. Provision of sub-specialist services, such as forensic psychiatry and child and adolescent services. e. Forensic facilities will fulfil their role as set out in the Criminal Procedure Act No. 51 of 1977 as amended, with regards to	Section 7: Areas for action, 7.1. **Organisation of services**, p. 25 **(Mental Health Care Act) (Infrastructure)**

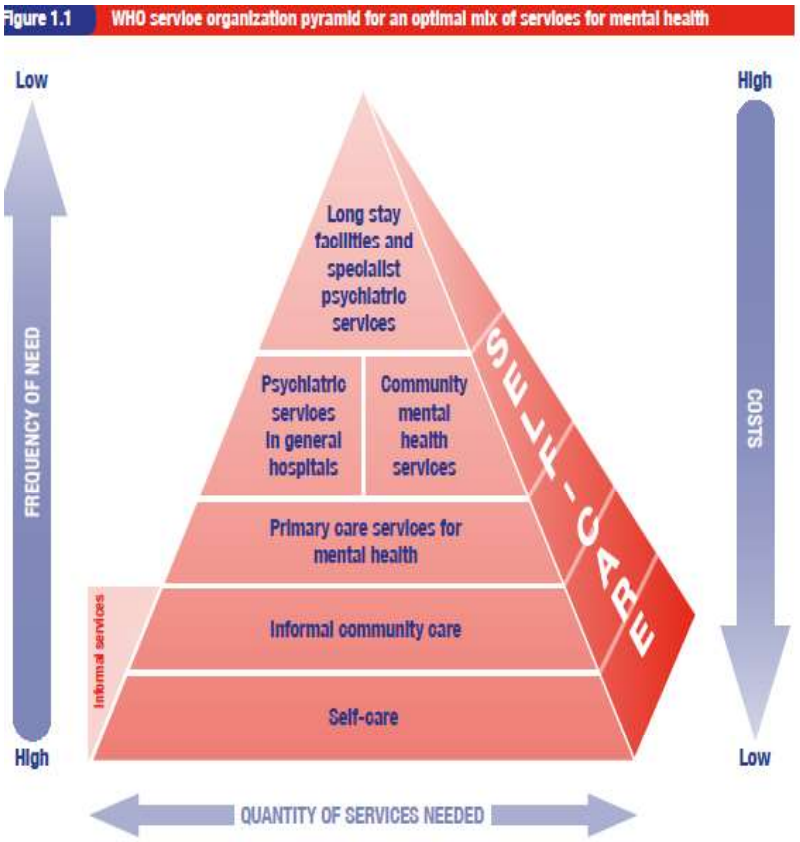
	forensic psychiatric observations. Section 41 and 49 of the Mental Health Care Act provides for designation of health establishments and procedures with regards to State patients and mentally ill prisoners.>	
Section 7.2, Financing, this point changed in the final version: 5. At national level, budget will be allocated to ensure that regular discussions are held with provinces to discuss strategies for implementation. At provincial level, mental health budgets will be reviewed annually to align mental health with national priorities, for each of the areas of action	Section 7.2, Financing, this point changed in the final version: 5. At national level, budget will be allocated <to meet targets set for the implementation of areas of action within the> policy and regular discussions will be held with provinces to discuss strategies and <monitor progress> with implementation. At provincial level, mental health budgets will be reviewed annually to align mental health with national priorities, for each of the areas for action <in 2011 and annually thereafter>.	Section 7.2: **Financing**, p. 26 **(Funding) (M&E)**
Under section 7.4 Intersectoral collaboration, one of the points in the draft read as: 1. The Department of Health will engage non-health sectors (such as Education, Social Development, Labour, Criminal Justice, South African Police Service, Housing, Agriculture and NPOs), to ensure that an inter-sectoral approach to mental health is followed in planning and service development.	Under section 7.4 Intersectoral collaboration, one of the points in the draft read as: 1. The Department of Health will engage non-health sectors (such as Education, Social Development, Labour, Criminal Justice, South African Police Service, Housing, Agriculture and NPOs), <as well as for-profit organisations>, to ensure that an inter-sectoral approach to mental health is followed in planning and service development.	Section 7.4. **Intersectoral collaboration**, p. 27 **(Intersectoral collaboration)**
This point was not included in the draft version	In section 7.5. Advocacy, this point was added: <5. The Mental Health Review Boards in each province will, as stipulated in the Mental Health Care Act, play a key role in advocating for the needs of mental health service users, and upholding and protecting their human rights.>	Section 7.5. **Advocacy**, p. 28 **(Mental Health Care Act Mental Health Review Boards)**
In section 7.6. Human rights, the second point in the draft version read as: 2. The UN Convention on the Rights of Persons with Disabilities (2007) will be actively implemented by South Africa, as a signatory to the Convention	In section 7.6. Human rights, the second point changed in final version: {2. The Department of Health will work closely with the Ministry for Women, Children and Persons with Disability to ensure that provisions of the UN Convention on the Rights of Persons with Disabilities (2007) are actively implemented for persons with mental disability in South Africa.}	Section 7.6. **Human rights** **(Advocacy)**
This point appeared under roles and responsibilities of Minister of Health in	This point was deleted from the roles and responsibilities of the Minister of Health in the final	Section 8 **Roles and responsibilities, 8.1. Minister of**

draft version: ~~Developing national strategic plans for mental health, in collaboration with provincial health services, and in consultation with a range of stakeholders~~	version	**Health**, p. 31 **(Governance)**
This point did not appear in draft version	Under roles and responsibilities of Minister of Health, this point was added to final version: <Liaise with the Ministry of Women, Children and Disabilities to support inclusion of persons with mental disability in disability related policies and programme>	Section 8 **Roles and responsibilities, 8.1. Minister of Health**, p. 31 **(Governance)**
In roles & responsibilities of Minister of Health, this point read as follows in draft version: Identifying and driving the implementation of key priority areas, namely: Detection and management of depression and anxiety disorders at PHC level	In roles & responsibilities of Minister of Health, this point was changed in final version as follows: Identifying and driving the implementation of key priority areas, namely: Detection and management of {common mental disorders (e.g. depression and anxiety disorders)} at PHC level	Section 8 **Roles and responsibilities, 8.1. Minister of Health**, p. 31 **(Mental health systems)** **(Prevention & promotion)**
The point that was deleted from the roles and responsibilities of the Minister of Health above was moved to Director General's responsibilities in final version, where it did not appear before	In roles & responsibilities of Director-General, this point was moved down from the Minister of Heath's responsibilities: <Developing national strategic plans for mental health, in collaboration with provincial health services, and in consultation with a range of stakeholders>	Section 8 **Roles and responsibilities, 8.2. Director General**, p. 31 **(Governance)**
This point did not appear under the roles & responsibilities of the provincial departments of health in the draft version	Under roles & responsibilities of Provincial Departments of Health, this was added: <Establishment of a Mental Health Directorate in each province, with responsibility for both community and hospital based mental health services>	Section 8 **Roles and responsibilities, 8.3. Provincial Departments of Health**, p. 32 **(Governance)**

This point was not included in the draft version	Under 8.4 roles & responsibilities of District health services: <3. Providing emergency care (24 hour) and 72 hour observation services in designated District and Regional Hospital Inpatient settings, as set out in the Mental Health Care Act (2002).>	Section 8 **Roles & responsibilities, 8.4. District health services**, p. 32 **(MHC Act) (Infrastructure)**
Under 8.4 roles & responsibilities of District health services, this point was included in draft version: ~~Establishing and maintaining Assertive Community Treatment (ACT) teams in all districts~~	This point was excluded from the final version	Section 8 **Roles & responsibilities, 8.4. District health services**, p. 32 **(Mental health systems)**
This section in the draft policy was called "Specialist psychiatric hospitals" and appeared above "District health services"	In the final version, the title of this section changed to {Designated Psychiatric Hospitals, Care and Rehabilitation Centres} and it appeared below the section "District health services"	Section 8 **Roles & responsibilities, 8.5. Designated psychiatric hospitals, care and rehabilitation centres**, p. 33 **(Infrastructure)**
In section 8.5. on roles & responsibilities of psychiatric hospitals, this point in the draft version read as: Provision of ~~specialist~~ inpatient and outpatient mental health services	In section 8.5. on roles & responsibilities of psychiatric hospitals, this point in the final version read as: Provision of inpatient and <limited> outpatient mental health services	Section 8 **Roles & responsibilities, 8.5. Designated psychiatric hospitals, care and rehabilitation centres**, p. 33 **(Mental health systems) (Infrastructure)**
This point did not appear in the draft version of the policy under roles & responsibilities of psychiatric hospitals	Under roles & responsibilities of psychiatric hospitals, this point was added to final version: <4. Forensic facilities will fulfil their role as set out in the Criminal Procedure Act No 51 of 1977 as amended, with regards to forensic psychiatric observations. Section 41 and 49 of the Mental Health Care Act provides for designation of health establishments and procedures with regards to	Section 8 **Roles & responsibilities, 8.5. Designated psychiatric hospitals, care and rehabilitation centres**, p. 33

	State patients and mentally ill prisoners, which need to be included in the mental health policy.>	**(MHC Act)**
Section 8.7. roles & responsibilities of non-governmental organisations: 1. The Department of Health will licence and regulate the provision of community-based mental health services by NGOs, such as community residential care, day care services, and halfway houses, ~~programmes addressing violence in communities (targeting both victims and perpetrators).~~	Section 8.7. roles & responsibilities of non-governmental organisations: 1. The <Provincial> Departments of Health will licence and regulate the provision of community-based mental health services by NGOs <and for-profit organisations>, such as community residential care, day care services, and halfway houses.<This is in keeping with section 43 of the regulations of the Mental Health Care Act.>	Section 8 **Roles & responsibilities, 8.7. Non-governmental organisations**, p. 33 **(MHC Act- but not the deletion) (Mental health systems)**
Appendix: Intersectoral Roles & Responsibilities, section on Police Services: Early identification and referral of youth offenders	Appendix: Intersectoral Roles & Responsibilities, section on Police Services: Early identification and referral of {mental health care users in terms of section 40 of the Mental Health Care Act, 2002}	**New Appendix: Intersectoral Roles & Responsibilities, Police Services**, p. 48 **(MHC Act)**

New diagram in final policy in section 7.1. Organisation of services, p. 23:



Appendix 6: Detailed analysis: Embodied knowledge enacted

6.1 Types of knowledge claims

The percentages of talk drawing on experiential, evidence-based, and *Other* knowledge claims in the breakaway group presentations and discussions are shown in Table A6.1 below. The talk that did not draw explicitly on either evidence-based or experiential knowledge claims – i.e. *Other* – comprised the bulk of group presentations and discussions across all ten groups. This seemed to particularly be the casein group 8 on culture and mental health (96.23%), and in group 2 on research, monitoring & surveillance (89.45%), and but less so for group 6 on the Mental Health Care Act (66.09%). Of the total 95 experiential knowledge claims made, 59 (62%) were made during the discussions, and 36 (38%) during the presentations. Of the 130 evidence-based knowledge claims, 32 (25%) were made during the discussions, and 98 (75%) during the presentations.

In seven of the ten groups, evidence-based knowledge claims were referenced more frequently than experiential knowledge claims, as shown in Table A6.1. Experiential knowledge claims constituted the majority of explicit knowledge claims in group 3 (mental health care systems; 12.47%), group 9 (suicide prevention; 13.73%), and group 10 (advocacy; 8.04%). It is worth noting that in group 9 (suicide prevention), the first presenter focused almost exclusively on presenting evidence around suicide prevention, while the second presentation was based on the experiences of the director of an NGO in running a suicide helpline. This could explain the higher frequency of experiential-knowledge claims than evidence-based knowledge claims in group 9, particularly during the presentations (10.04%).

Group 10 (advocacy) reflects what might be expected in more formal presentations versus informal discussions, with evidence-based knowledge claims featuring exclusively in the formal “expert” presentations, and experiential knowledge claims only occurring during the group discussions. Only in group 3, however, did total experiential knowledge claims outnumber total evidence-based knowledge claims by more than five percent. The discussion in this group was quite strongly focused on the integration of mental health care into primary health care, and specifically on whether mental health services in primary health care should be specialised or generalised. Participants drew on experience on the ground to motivate for the need for district specialist mental health teams, as well as to justify why having a dedicated health professional providing mental health services in primary care facilities would or would not work.

Table A6.1: Knowledge claims in group presentations and group discussions

Group	Experiential			Evidence-based			Other
	Presentations	Discussions	Subtotal	Presentations	Discussions	Subtotal	
1: Prevention & promotion	0%	10.27%	**10.27%**	10.99%	6.71%	**17.70%**	**72.03%**
2. Research & surveillance	0%	0%	**0%**	9.71%	0.84%	**10.55%**	**89.45%**
3. Mental health systems	0.50%	11.97%	**12.47%**	5.72%	1.15%	**6.87%**	**80.66%**
4. Human resources & infrastructure	0%	0%	**0%**	22.15%	0.86%	**23.01%**	**76.99%**
5. Other conditions	0%	7.72%	**7.72%**	13.59%	5.27%	**18.86%**	**73.42%**
6. Mental Health Care Act	10.28%	6.26%	**16.54%**	17.37%	0%	**17.37%**	**66.09%**
7. Child & adolescent mental health	0.57%	4.31%	**4.88%**	9.62%	0.85%	**10.47%**	**84.65%**
8. Culture & mental health	N/A*	1.72%	**1.72%**	N/A*	2.05%	**2.05%**	**96.23%**
9. Suicide prevention	10.04%	3.69%	**13.73%**	3.50%	6.99%	**10.49%**	**75.78%**
10. Advocacy & user participation	0%	8.04%	**8.04%**	6.27%	0%	**6.27%**	**85.69%**

* Note: There was no audio for the presentations in this group

It is interesting to note the absence of experiential knowledge claims in group 2 (research, monitoring and surveillance) and group 4 (human resources and infrastructure). While this is perhaps not surprising for group 2, where the discussions were dominated by reference to research and to indicators and targets, it is somewhat surprising that the discussions in group 4, where presumably participants would have a substantial amount of first-hand experience of issues encountered around these two issues (human resources and infrastructure). The presentations in both groups were strongly evidence-based; however, neither evidence-based nor experiential knowledge appeared to be explicitly drawn on during the discussions in either of these two groups.

In the seven groups in which evidence-based knowledge claims were referenced more frequently than experiential knowledge claims, this difference was greater than five percent in all but two of the groups: group 6 (Mental Health Care Act), and group 8 (culture and mental health). A limitation here is that the audio of the presentations on culture and mental health was not available for analysis. Nonetheless, it seems notable that participants in this group appeared to draw on neither evidence-based nor experiential knowledge during the discussions. In group 6, experiential knowledge claims were more frequently drawn on during presentations (10.28%) than during the discussions (6.26%). This is likely because one of the two presentations given in this group was entirely dedicated to drawing on the "on the ground" experience of setting up an effective Mental Health Review Board.

It does, appear, then, that evidence-based knowledge was drawn on more frequently than experiential knowledge. However, as can be seen in Table A6.1 above, much of this evidence-based knowledge was contained in the formal presentations. In all but two of the groups, the largest proportion of evidence-based knowledge claims was identified in the formal presentations, with less reference to evidence-based knowledge during the group discussions. The exceptions were group 8 (culture and mental health), for which there was no audio of the presentations, and group 9 (suicide prevention), where more evidence-based knowledge claims were made during discussions than in presentations. The fact that more of the evidence-based knowledge claims were identified during the discussions than in the presentations in group 9 could at least partly be because the presenter of the more explicitly evidence-based presentation was very vocal during the group discussions. In two groups – group 6 (Mental Health Care Act) and group 10 (advocacy) – no reference to evidence-based knowledge was made during the group discussions.

6.2 Enactment of knowledge claims

6.2.1 Functions of knowledge claims – what were they being used to do?

The enacted uses of knowledge claims are presented in Table A6.2. Only those uses for which there were sufficient instances to warrant discussion are included in this table. In one or two instances, knowledge claims appeared to be drawn on to make a particular appeal, or to claim legitimacy or authority as a speaker. These were not included in the final analysis. In Table A6.2, the percentage of knowledge claims per sub-theme are shown. For example, 37 references to experiential knowledge claims were made to illustrate a current challenge. This comprised 67% of the total cases where knowledge claims were used to illustrate a current challenge. Note that many of the knowledge claims were employed for more than one purpose and were coded accordingly. Thus, the number of references

for experiential and evidence-based knowledge claims shown in columns 3 and 5 do not always add up to the total number of experiential or evidence-based references shown in the first row of Table A6.2.

The findings presented in Table A6.2 suggest that both experiential and evidence-based knowledge claims were explicitly drawn on to illustrate the current situation in relation to a particular issue, more frequently than to perform any of the other functions identified. Of the 78 instances identified where knowledge claims were used to illustrate a current situation, the majority of these were experiential knowledge claims – either illustrating a challenge (67%) or a solution/best practice (87%). Similarly, where knowledge claims were used to highlight the implications of a particular proposal, the majority of these were also experiential knowledge claims – either to highlight the benefits of or motivate for a proposal (59%), or to highlight the disadvantages or argue against a proposal (70%).

Conversely, evidence-based knowledge claims seemed to be used more frequently than experiential knowledge claims to engage with previous points made – both to support (56%) as well as to counter (57%) these points. Finally, in the 38 cases where knowledge claims were made to illustrate a current situation in order to highlight the implications of a proposal (composite code), participants most frequently (n=23) described challenges experienced in order to highlight the benefits of – and need for – a particular policy proposal. Experiential knowledge claims (65%) were drawn on more frequently than evidence-based knowledge claims (35%) to do so. Participants were less likely to make explicit knowledge claims to describe challenges in order to highlight disadvantages of – or argue against – a proposal, and even less to describe solutions currently being employed to highlight the benefits. Where they did, however, they were more likely to draw on experiential than evidence-based knowledge.

Table A6.2: The enacted uses of experiential and evidence-based knowledge claims

		Experiential (N = 59)		**Evidence-based** (N = 32)	
Theme	Sub-theme	n	% of subtheme	n	% of subtheme
Illustrate current situation (N = 78)	**Challenge** (n = 55)	37	67%	18	33%
	Solution (n = 23)	20	87%	3	13%
Highlight implications of a proposal (N = 51)	**Highlight benefits or motivate for a proposal** (n = 41)	24	59%	17	41%
	Highlight disadvantages or argue against a proposal (n =10)	7	70%	3	30%
Engage (N = 16)	**Support previous point** (n = 9)	4	44%	5	56%
	Counter previous point (n = 7)	3	43%	4	57%
Illustrate current situation to directly highlight implications (N = 38)	**Describe challenge to highlight benefits** (n = 23)	15	65%	8	35%
	Describe challenge to highlight disadvantages (n = 7)	6	86%	1	14%
	Describe solution to highlight benefits (n = 8)	7	88%	1	12%

6.2.2 Responses to knowledge claims – were they being responded to?

This subsection presents findings showing whether and how experiential and evidence-based knowledge claims were responded to or not. As shown in Table A6.3, both experiential (n=37, 63%) and evidence-based (n=19, 59%) knowledge claims were more frequently responded to than not. There did not seem to be a substantial difference, however, between experiential and evidence-based knowledge claims: both seemed equally likely to elicit some form of response or acknowledgement. This pattern is similar when looking at the extent to which different knowledge claims seemed to be engaged with, as shown in Table A6.4. While those knowledge claims that were responded to were more likely to be engaged with more substantively than merely acknowledged, neither experiential nor evidence-based knowledge claims were more likely than the other to result in such engagement. The lack of substantive differences between likelihood of responsiveness in relation to evidence-based knowledge claims and experiential knowledge claims seems to suggest that contributions to such discussions that drew on either of these two knowledge types were equally likely to be attended to. The question that is explored in the next

subsection is whether this pattern continued in the extent to which different knowledge claims appeared to be captured or followed through into group recommendations.

Table A6.3: Responses to evidence-based and experiential knowledge claims within discussions

	Experiential		**Evidence-based**	
	References	%	References	%
Responded to	37	63%	19	59%
Not responded to	18	31%	12	38%
Inaudible	4	6%	1	3%
Totals	59	100%	32	100%

Table A6.4: Breakdown of responsiveness to knowledge claims

	Experiential		**Evidence-based**	
	References	%	References	%
Responded to but not engaged with	10	27%	7	37%
Responded to and engaged with*	27	73%	12	63%
Total responded to	37	100%	19	100%

Responded to defined as some form of acknowledgement
Engaged with defined as taking up and engaging with the points made in continuing discussion

6.3 Inscription of knowledge claims

Table A6.5 below shows what proportion of evidence-based knowledge claims and experiential knowledge claims were reflected, partially reflected or not reflected in the group recommendations. The total percentages of experiential and evidence-based knowledge claims per group are shown as totals in each group row. The proportions of these totals that were either reflected, partially reflected or not reflected in group recommendations are shown for the two knowledge claim types (experiential and evidence-based). For example, for the total 10.27% of experiential knowledge claims that referred to prevention and promotion (group 1), the majority of these clams (5.27%) seemed to be reflected in group recommendations – although only slightly more than those that were not reflected (4.19%).

Table A6.5: Reflection of experiential and evidence-based knowledge claims in recommendations

Groups	Experiential				Evidence-based			
	Reflected	**Partially reflected**	**Not reflected**	**Subtotal**	**Reflected**	**Partially reflected**	**Not reflected**	**Subtotal**
1	7.36%	0.36%	2.55%	**10.27%**	8.73%	1.57%	7.40%	**17.70%**
2	0	0	0	**0**	1.70%	0	8.85%	**10.55%**
3	3.27%	2.03%	7.17%	**12.47%**	0	4.30%	2.57%	**6.87%**
4	0	0	0	**0**	0.89%	8.51%	13.61%	**23.01%**
5	1.70%	2.58%	3.44%	**7.72%**	10.25%	0.56%	8.05%	**18.86%**
6	2.98%	0.79%	12.77%	**16.54%**	1.44%	2.82%	13.11%	**17.37%**
7	0.44%	0	4.44%	**4.88%**	1.14%	3.80%	5.54%	**10.48%**
8	0	0	1.72%	**1.72%**	0	0	2.05%	**2.05%**
9	2.18%	4.80%	6.75%	**13.73%**	1.28%	2.28%	6.93%	**10.49%**
10	1.42%	0.83%	5.79%	**8.04%**	0.37%	5.09%	0.81%	**6.27%**

Group number key: 1. Prevention & promotion; 2. Research & surveillance; 3. Mental health systems; 4. Human resources & infrastructure; 5. Mental health & other conditions; 6. Mental Health Care Act; 7. Child & adolescent mental health; 8. Culture & mental health; 9. Suicide prevention; 10. Advocacy & user participation

As shown in Table A6.5 group 1 (prevention and promotion) was the only group in which the majority of both evidence-based (8.73%) and experiential knowledge (7.36%) claims seemed to be reflected in the group's recommendations put forward in the plenary session. Group recommendations also seemed to reflect the largest proportion of evidence-based knowledge claims made in group 5 (mental health & other conditions; 10.25%), while in group 3 (mental health systems; 4.30%) and group 10 (advocacy; 5.09%), most of the evidence-based knowledge claims were only partially reflected. However, in the remaining six groups, the majority of evidence-based knowledge claims did not seem to be reflected in group recommendations. Similarly, of the eight groups in which experiential knowledge claims were made, these were predominantly not reflected in the group recommendations for seven of these groups. These findings suggest that making reference to neither evidence-based knowledge nor experiential knowledge increased the likelihood that such inputs would be followed through into recommendations.

The next level of analysis focused on finer distinctions in terms of whether evidence-based and experiential knowledge claims seemed more likely to be reflected if they were made during group presentations versus group discussions. Table A6.6 shows the percentages of experiential knowledge

claims made in the group presentations and the group discussions that were considered to be reflected, partially reflected, or not reflected in the respective group's recommendations. Columns 5 and 9 show the total percentage of experiential knowledge claims made within the presentations and the total percentage made during the discussions, respectively. Within each of these categories (presentations and discussions), the total percentages are broken down into the percentage of claims reflected, partially reflected, or not reflected. For example, 10.27% of the talk during the discussions in group 1 (prevention and promotion) were experiential knowledge claims; of these, 7.36% were reflected in group recommendations, 0.36% were partially reflected, and 2.55% were not reflected. No experiential knowledge claims were made during the presentations in group 1.

Of the four groups in which experiential knowledge was referenced during presentations (mental health systems; Mental Health Care Act, suicide prevention, and culture and mental health), the majority of this did not appear to be reflected in the group recommendations. In the eight groups in which participants drew explicitly on experiential knowledge during the discussions, in only two instances were the majority of these reflected or partially reflected: in group 1 (promotion and prevention; 7.36%) and in group 9 (suicide prevention; 1.65%).

Table A6.6: Reflection of experiential knowledge from presentations and from discussions

	Experiential knowledge							
Groups	**Presentations**				**Discussions**			
	Reflected	**Partially reflected**	**Not reflected**	**Subtotal**	**Reflected**	**Partially reflected**	**Not reflected**	**Subtotal**
1	0	0	0	**0**	7.36%	0.36%	2.55%	**10.27%**
2	0	0	0	**0**	0	0	0	**0**
3	0	0	0.50%	**0.5%**	3.27%	2.03%	6.67%	**11.97%**
4	0	0	0	**0**	0	0	0	**0**
5	0	0	0	**0**	1.70%	2.58%	3.44%	**7.72%**
6	0	0.79%	9.49%	**10.28%**	2.98%	0	3.28%	**6.26%**
7	0	0	0.57%	**0.57%**	0.44%	0	3.87%	**4.31%**
8	-	-	-	**-**	0	0	1.72%	**1.72%**
9	0.90%	3.15%	5.99%	**10.04%**	1.28%	1.65%	0.76%	**3.69%**
10	0	0	0	**0**	1.42%	0.83%	5.79%	**8.04%**

Group number key: 1. Prevention & promotion; 2. Research & surveillance; 3. Mental health systems; 4. Human resources & infrastructure; 5. Mental health & other conditions; 6. Mental Health Care Act; 7. Child & adolescent mental health; 8. Culture & mental health; 9. Suicide prevention; 10. Advocacy & user participation

Along similar lines to the experiential knowledge analysis above, the next level of analysis was also applied to evidence-based knowledge, comparing the percentages of evidence-based knowledge from the group presentations that seemed to be reflected in group recommendations, with the percentages of evidence-based knowledge claims reflected from the group discussions. In Table A6.7 below, evidence-based knowledge claims are differentiated between those made during formal presentations and those made during group discussions.

In Table A6.7, the total percentages shown in columns 5 and 9 reflect total evidence-based knowledge claims as a percentage of the overall presentations and group discussions, respectively. This total percentage is then divided according to the percentage of evidence-based knowledge claims that that were considered to be reflected, partially reflected or not reflected within the presentations and within the discussions. In group 1, for example, evidence-based knowledge claims made up 6.47% of the total talk within the group discussions. Of this, 3.96% seemed to be reflected in the group recommendations, 1.57% was partially reflected, and 0.94% was not reflected.

Consistent with the finding above that the majority of evidence-based knowledge claims seemed to be reflected in group recommendations for groups 1 and 5, these reflected knowledge claims seemed to stem largely from the formal presentations in both groups (group 1: 4.77%; group 5: 9.33%). It should be noted, however, that of the evidence-based knowledge claims made in the presentations of group 1, the majority (6.46%) of these within-presentation claims were not reflected in the recommendations. The majority of the evidence-based knowledge claims made during the presentations in group 3 (mental health care systems; 3.62%) and group 10 (advocacy; 5.09%) were partially reflected in group recommendations. For the remaining six groups, whether references to evidence-based knowledge were made during formal presentations or during group discussions did not seem to change the overall finding that evidence-based knowledge claims were not more likely than experiential knowledge claims to be followed through into group recommendations.

Table A6.7: Reflection of evidence-based knowledge from presentations and from discussions

	Evidence-based knowledge							
Groups	**Presentations**				**Discussions**			
	Reflected	**Partially reflected**	**Not reflected**	**Subtotal**	**Reflected**	**Partially reflected**	**Not reflected**	**Subtotal**
1	4.77%	0	6.46%	**11.23%**	3.96%	1.57%	0.94%	**6.47%**
2	1.70%	0	8.01%	**9.71%**	0	0	0.84%	**0.84%**
3	0	3.62%	1.67%	**5.29%**	0	0.68%	0.90%	**1.58%**
4	0.51%	8.51%	13.13%	**22.15%**	0.38%	0	0.48%	**0.86%**
5	9.33%	0.56%	3.69%	**13.58%**	0.92%	0	4.36%	**5.28%**
6	1.44%	2.82%	13.11%	**17.37%**	0	0	0	**0**
7	0	4.08%	5.54%	**9.62%**	0.85%	0	0	**0.85%**
8	-	-	-	**-**	0	0	2.05%	**2.05%**
9	0	0.96%	2.54%	**3.50%**	1.28%	1.32%	4.39%	**6.99%**
10	0.37%	5.09%	0.81%	**6.27%**	0	0	0	**0**

Group number key: 1. Prevention & promotion; 2. Research & surveillance; 3. Mental health care systems; 4. Human resources & infrastructure; 5. Mental health & other conditions; 6. Mental Health Care Act; 7. Child & adolescent mental health; 8. Culture & mental health; 9. Suicide prevention; 10. Advocacy & user participation

Appendix 7: Examples of *Other* talk in national summit breakaway group discussions

***Other* Talk Theme**	**Examples**
Introductions and greetings	So, welcome back, those of you who were here yesterday afternoon. All we did yesterday afternoon was to meet, and greet, and arrange to be here this morning. So, I think perhaps before we start the presentations, what would be quite useful, seeing that we are a small group, is to get a sense of who is here. So maybe we can just quickly go around and introduce ourselves (Speaker 2, Group 5) I think we would be missing a critical point if we don't, maybe use this opportunity to recognise contributions that these group of participants will be able to make, and I know, and I can see in our midst here, that it is not only the mental health practitioners in the hospitals and so on, but I also see traditional health practitioners, and other mental health care users and so on, so I think it's going to be important that maybe each one of us can just spend a minute to introduce themselves (Speaker 1, Group 8)
Instructions and logistical information	So, and just to recap then, in terms of what we're required to come up with as a product of this meeting, is for us to endorse, add, and really comment on the existing policy on mental health promotion and prevention, that is in the draft policy framework for mental health. And everyone hopefully has had been able to actually have a look at that. And then we're also required to make some comment on the declaration. What we're also hoping to do is just move a step beyond just policy statements to actually also look at the feasibility of actually implementing some of those things and to come up with a list of priority areas (Speaker 1, Group 1) After a shortish tea break we'll come back and spend the last hour or so just talking about what we would like to put forward, in terms of the declaration. Okay? Specific recommendation, perhaps 1 paragraph, we need to word it nicely… (organiser name) just said to us yesterday that please when we come with those proposals they must be reasonable, ((*laughs*)) they must be achievable, ((*laughs*)) it mustn't be, I think, completely bizarre. So, we need to bear that in mind as well (Speaker 1, Group 9)
Within presentations: theoretical background and descriptions or explanations with no explicit reference to evidence or experience	Okay, if we look at the human convention on the rights of persons with disabilities, I'm just going to focus on a few of the principles that we are failing to comply with, which is non-discrimination, full and effective participation and inclusion in society, respect for difference, and acceptance of persons with disabilities as part of human diversity and humanity, and equality of opportunity (Speaker 2, Group 10) Now if we look at our history, or the history of our country, [in] 1994 we saw the end of apartheid and the world hailed and lauded South Africa for this very peaceful dismantling of apartheid which was based on discrimination along the lines of race. And it took 10 years before the mental health care act was promulgated. And for me, this represented the department of health's attempt to start dismantling the apartheid that exists within the health system (Speaker 2, Group 6)
Comments on presentations and presenter responses to questions or comments	I think he took what, 10 questions in one go. I think if you don't mind I'll just comment immediately yes absolutely I appreciate all the comments and I think the task shifting's a really critical on (Speaker 1, Group 4) Okay. Thank you very much. Ja, I'm sitting here, I've listened to both presentations that were made. They are very nice in their

	own way. But I'm challenged by the 2 issues here, the legislation and the politics that evolved around this. I assume the presentation that we had is from a psychologist and from a psychiatrist. And that informed setting the scene for the discussion. But we had no presentation from the faith-based practitioners and the indigenous health practitioners. So now I feel put in a box to participate here, you know, because even the recommended way forward is within that context (Speaker 2, Group 8)
Suggestions for changes to words, phrases or content on one or other of the documents being reviewed	Sorry maybe I'm jumping, but, middle-adulthood, it says strengthening family programmes for at-risk children. Now I think the concept must come across, it's important to have good families. And then we will have less risk. So, I don't think we should word it in this way. Family strengthening programmes full stop because that's the right thing to do (Speaker 4, Group 1) Just one of the comments that I had from ((*clears throat*)) pardon me, late yesterday afternoon was that there is no definition in the in the proposed the first draft of psychosocial rehabilitation of psycho-social illnesses so, I think that that needs to be very carefully worded and looked at (Speaker 33, Group 10)
Requests for clarification / provision of clarification of terminology and concepts	I just want to ask for my own clarity because I've never worked for the department of health. When a policy like this gets accepted, is there a specific team appointed to do the monitoring and evaluation of implementation or not? Who monitors the implementation of such a policy? (Speaker 2, Group 3) When you speak of prevention- I mean the gentleman was talking about what I think was primary, secondary and tertiary prevention. And in primary prevention you don't actually screen, do you? You just prevent at a population level. And so, the screening would need to occur at the secondary level, ja, so one would need to integrate it that way (Speaker 3, Group 5)
Reframing or summarising previous points made, primarily by the Chairs	Thank you, I think that is an extremely important point and a generic point, because it's a point in relation to any chronic disease. The relationship with a health provider is actually a very significant component of the care. And in so many of our settings that just doesn't happen, and it's one of the things that we really have tried to fight for in mental health, because that relationship is so important (Speaker 2, Group 5) Okay. So, the proposal would be that the public service introduce formal mentoring and coaching programmes, as well as training programmes structured around the mental health care act specifically (Speaker 3, Group 6)
Attempts (also mostly by Chairs) at refocusing discussions and/or requests for more feasible proposals	So maybe, we could have some discussion just to say in the ideal world and you know we would all promote it, that we have a dedicated person to do the counselling but, quite honestly, trying to be pragmatic and realistic about it and in discussion with (organiser name) yesterday, that ain't happening. So, you know I mean I think we need to try and look at what's feasible within the re-engineered primary health care system as it stands (Speaker 1, Group 1) Just before we carry on, because we seem to be jumping between all these different areas, and I think we need to be systematic about it, can we agree that these are sort of like 6 major areas, and then focus on them systematically and then we're gonna maybe have to choose or maybe we'll find that 1 gets subsumed under another (Speaker 2, Group 5) That's why I want to be clear about what our job is, because if we have to give recommendations to the government, I think we need to be clear about recommending things that can be measured, that they can tick off and that we can say this has been done or not (Speaker 26, Group 7)

Adding to, reiterating or countering statements made by others	I just want to add something there because it's very crucial. I think she said at risk women for counselling on site, if you can just put the word on site there, because the minute you say you refer them to another area they will not go there (Speaker 27, Group 1) Alright, I'm a psychiatrist and it was interesting to hear the last 2 comments, and it's very clear to me that, just like there are prejudices about practices of traditional healing and faith healing on the allopathic side, there are clearly prejudices on the other side as well (Speaker 3, Group 8)
Providing information, descriptions or explanations phrased in the abstract, without specific reference to evidence-based knowledge or experiential knowledge	In relation to the psychologists' assistant. I remember that the previous minister, I think Manto Tshabalala or something you know when she met us at some point you see she was proposing that we establish a category of something like psychology or mental health assistant. We refused because it was going to be too expensive in fact it was going to be cumbersome for us as institutions so I'm sure the documents still retain that assistant but I know it does not exist. Instead we have something called registered counsellors, the B Psych ones (you see), you know (Speaker 11, Group 4) Let's just give a little bit of an experience in the HIV and AIDS. You know when we did the AIDS city campaign in 2010, the minister said we're going to test 50 million people. At that time, there were only 290 nurses who were actually trained to initiate treatment. 290. And there were only 490 health facilities which were actually able to initiate treatment. So, we had this huge number in order to do that…. By the end of the period, there were 3 thousand health facilities, which were able now to actually do that. So that's the kind of things that makes changes (Speaker 52, Group 5)
Generic observations or opinions, proposals or appeals. These were mostly used in reference to *what is currently happening* and/or to *what needs to happen*, without explicit reference to either evidence-based or experiential knowledge from within a specific (personal) instance	I'm going to put it very bluntly. We've got a big problem with boredom. Boredom leads to irresponsible sexual activities, boredom leads to substance abuse. We have a lot of adults, especially young adults, who aren't employed and they have nothing else to do. It lowers their self -esteem. So apart from social development, we need to start getting things like clubs going, maybe chess clubs or ballroom dancing. This does not have to be expensive (Speaker 37, Group 1) I'd just like to comment on the psychiatrist at district hospitals. I'm sure in the Free State that won't be possible. I don't know if we have that many psychiatrists. I think we can say either a psychiatrist or a doctor, taking responsibility for psychiatry, it's a major problem, at the moment the primary nurses sit with the patients and then there's no in between. Doctors at secondary level or at district levels often refuse to see patients with mental illnesses. It's unbelievable (Speaker 31, Group 3)
Formulating and prioritising recommendations	Thank you very much. That's a difficult one to capture as a resolution. And I wonder if somebody can help me capture that as a resolution? What we talking about here – the rights of users on the one hand, the rights of the health care professionals dealing with users on the other hand. Now are those not covered in common law or in other laws, I'm not sure. Can I get some help? (Speaker 3, Group 6). Okay let's call it programme, that sounds quite broad. Okay. So, we need a national suicide prevention programme, alright. Let's think of key words that need to be part of the way we describe that. We said, for instance, I'm trying to remember now, it needs to target all levels. And that was primary, secondary, tertiary. How do we- because remember, we've been talking about vulnerable groups over here as well, like specifically adolescents, young people, police, defence force (Speaker 1, Group 9)

Feedback to the group from the rapporteur/s	I'll just run through the points quickly, I'm afraid I didn't manage to summarise everything, but by the end of today, hopefully I will have all our points. But from the points I've included here are from the presentations, as well as the discussion that we had. And obviously it's my version of it, so we need to edit it so that the group here can feel they happy with it (Speaker 27, Group 10) Colleagues I have tried to summarise the issues on human resources. I think you realise that it was a complicated highly informed presentation so it was a very difficult task to do that so please I'm opening up for input as I go along so that we can check if we have covered everything and the recommendations. Okay (Speaker 22, Group 4)

Appendix 8: Detailed analysis of Phase 2: Group recommendations in policy outputs

8.1 Reflection of group recommendations in policy changes: Detailed analysis

This subsection includes a detailed analysis of the reflection of breakaway group recommendations in policy changes. For the purposes of this and other analyses going forward, the recommendations made by the groups at the national summit were re-categorised according to the themes they most corresponded to, as opposed to the theme of the specific breakaway group in which they were made. This allowed for a more accurate comparison of group recommendations made at the summit and the changes made to the policy after the summit. In some cases, group recommendations pertained to more than one theme and were counted in both. Thus, the total number of recommendations increased from the actual (N=125) to the thematically categorised (N=136).

Those groups that did engage directly with the policy only reviewed the *Areas for Action* section relating to their theme, while others engaged with the draft summit declaration with the goal of adding recommendations for actions. As such, only those policy changes made to the *Areas for Action* and the *Role and Responsibilities* sections of the policy document were included in this comparative analysis. In addition, none of the summit or group recommendations related to changing or adding definitions to the *Glossary* section. Notably, as shown in section 4.2 (Chapter 4), this is one of two sections in which there were the most changes in the post-consultation policy.

As shown in Table A8.1 below, the reflection of group recommendations in policy changes was coded along four possibilities: i) directly reflects – a change or addition to policy document that can be linked to the group recommendation/s; ii) partially reflects – group recommendation/s relates to the same issue or theme or is consistent with the direction / nature of the change; iii) group recommendation/s are not reflected in any way – unrelated in content to the policy change; iv) contrary – the policy change seems contrary to or contradicts what was recommended. In terms of the direct reflection code, even where wording and nature of the group recommendation seemed to have a direct association with the policy change, this finding has limited interpretation in terms of attribution of causality, as discussed above. Table A8.1 has been structured such that those issues with recommendations most reflected (directly and/or partially) in policy changes appear at the top, with decreasing proportions of reflection moving down the table. Thereafter, the rows are listed in ascending order according to the number of *recommendations* made (and therefore not reflected), to demonstrate the extent to which issues were not reflected in relation to the number of recommendations made about them.

The majority (n=115; 84%) of group recommendations (N=136) did not seem to be reflected in any way in the changes made to the draft policy following the national summit. There were a handful of instances (11%) where the group recommendation seemed to relate to the same issue or theme as the policy change, or was consistent with the general spirit of the change. Some group recommendations relating to funding, infrastructure, monitoring and evaluation, mental health systems, governance, prevention and promotion, and human resources were either directly or partially reflected in policy changes. These are listed in detail in Appendix 14.

It is notable that although many of the group recommendations pertaining to infrastructure did seem to be aligned with additions to the policy following the summit, this was also the one theme for which a policy change directly *contradicted* the group recommendations. The summit groups recommended that no new stand-alone psychiatric hospitals should be built. However, one of the changes to the policy, under *Organisation of Services*, was the *deletion* of the statement, "no new stand-alone hospitals will be built." As will be seen in later analyses, this group recommendation was also in direct contrast with one of the activities associated with the implementation priorities, to build a new psychiatric hospital in Mpumalanga. No other policy changes seemed to be contrary to what was proposed by the groups at the national summit.

For the majority of group recommendations, therefore, there appeared to be no corresponding changes made to policy following the summit. Although it could be the case that the group recommendations were simply aligned with *existing* policy content, the lack of correspondence between the changes that were made to the draft policy following the summit and the recommendations put forward at the summit, is interesting. If, as will be explored in the next section, the group recommendations were not aligned with the draft policy, this suggests that inputs made at the consultation summits differed from policy content but were nonetheless not used to inform the policy – at least not in any direct way. A detailed description of the policy changes and group recommendations that did not seem to correspond is provided in Appendix 14.

Table A8.1: Reflection of group recommendations in post-consultation policy changes

Theme	Total group recommendations	Total policy changes (by theme)*	Number of group recommend-ations directly reflected in policy changes	Number of group recommend-ations partially reflected in policy changes	Number of group recommend-ations not reflected in policy changes	Number of group recommend-ations contrary to policy changes[#]
Funding	2	1	1 (50%)	1 (50%)	0	0
Infrastructure	11	8	3 (27%)	4 (36%)	**3** (27%)	1 (0.9%)
Monitoring & evaluation	7	1	1 (14%)	2 (29%)	**4** (57%)	0
Mental health systems	9	8	0	3 (33%)	**6** (67%)	0
Governance	5	4	0	1 (20%)	**4** (80%)	0
Prevention & promotion	14	1	0	**2** (14%)	**12** (86%)	0
Human resources	22	1	0	2 (9%)	**20** (91%)	0
Medicines, equipment & protocols	1	0	0	0	**1** (100%)	0
Quality assurance	1	0	0	0	**1** (100%)	0
Mental health & other conditions	1	0	0	0	**1** (100%)	0
Mental Health Care Act	2	8	0	0	**2** (100%)	0
Mental Health Review Boards	3	1	0	0	**3** (100%)	0
Intersectoral collaboration	3	1	0	0	**3** (100%)	0
Suicide prevention	5	0	0	0	**5** (100%)	0
Research	7	0	0	0	**7** (100%)	0
Culture & mental health	10	0	0	0	**10** (100%)	0
Child & adolescent mental health	13	0	0	0	**13** (100%)	0
Advocacy & user participation	20	1	0	0	**20** (100%)	0
Totals	**136**	**35**	**5** (4%)	**15** (11%)	**115** (84%)	**1** (1%)

* Only policy changes in the *Areas for Action* and *Roles and Responsibilities* sections were included in this analysis

8.2 Reflection of group recommendations in draft policy: Detailed analysis

As previously noted, the breakaway group recommendations were re-categorised according to most relevant theme for the purposes of the analysis. These were then compared with the corresponding sections in the draft policy that was available at the summit. In Table A8.2 below, themes are depicted as being addressed in the draft policy as a stand-alone section, as content within sections, or not at all (third column). As discussed above, the recommendations were only compared with the *Areas for Action* and *Roles and Responsibilities* sections in the pre-consultation draft of the policy.

Group recommendations were determined to be reflected in the draft policy when the areas for action identified in both the recommendations and the policy were broadly aligned. This is shown in the fourth column of Table A8.2 below. The issues are ordered in decreasing order, with the themes for which the most group recommendations were broadly reflected in draft policy appearing at the top of the table. Those themes for which a recommendation was determined to correspond with content in the draft policy, but which required a change to that content, are shown in the fifth column in Table A8.2. The final column in Table A8.2 shows those group recommendations which were considered not to be reflected in the draft policy. Coding definitions can be found in the coding framework in Appendix 4.

Just over a third (37%) of the 136 group recommendations put forward at the national summit seemed to be reflected in the draft policy. The only two recommendations made by summit groups regarding medicines, equipment and protocols, and regarding quality assurance were captured in existing policy content. The majority of recommendations regarding governance (80%), prevention and promotion (71%), intersectoral collaboration (67%) and mental health systems (56%) seemed to be broadly reflected in the draft policy. Interestingly, only two of these areas – prevention and promotion, and mental health systems – were identified as key topics for discussion in the national summit breakaway groups.

It is also worth noting that the content of the presentation given in the prevention and promotion breakaway group at the summit – notably, by the Chair of this group session – was identified as having been deliberately structured around the format and content of the existing policy draft. This may explain why so many of the recommendations put forward around this theme were reflected in the draft policy, and why there were no explicit recommendations for changes to existing content.

Table A8.2: Reflection of group recommendations in draft policy

Theme	**Total group recommendations**	**Reflected in policy** (as own section, within other sections, or not at all)	**Number of group recommendations broadly reflected in draft policy**	**Number of group recommendations requiring policy change**	**Number of group recommendations not reflected in draft policy**
Medicines, equipment & protocols	1	Section (medication)	1 (100%)	0	0
Quality assurance	1	Section	1 (100%)	0	0
Governance	5	Content within sections	4 (80%)	1 (20%)	0
Prevention & promotion	14	Section	10 (71%)	0	4 (29%)
Intersectoral collaboration	3	Section	2 (67%)	0	1 (33%)
Mental health systems	9	Section (org of services)	5 (56%)	0	4 (44%)
Advocacy & user participation	20	Section	8 (40%)	1 (5%)	11 (55%)
Human resources	22	Section	8 (36%)	5 (23%)	9 (41%)
Infrastructure	11	Content within sections	4 (36%)	4 (36%)	3 (27%)
Research	7	Section	2 (29%)	0	5 (71%)
Monitoring & evaluation	7	Section	2 (29%)	2 (29%)	3 (42%)
Child & adolescent mental health	13	Content within sections	2 (15%)	0	11 (85%)
Culture & mental health	10	Content within sections	1 (10%)	0	9 (90%)
Mental Health Care Act	2	Content within sections	0	0	2 (100%)
Mental Health Review Boards	3	Content within sections	0	0	3 (100%)
Suicide prevention	5	None	0	0	5 (100%)
Funding	2	Section	0	2 (100%)	0
Mental health & other conditions	1	Content within sections	0	1 (100%)	0
Totals	136		**50 (37%)**	**16 (12%)**	**70 (51%)**

Just over half (51%) of the 136 group recommendations put forward at the national summit were determined to *not* be reflected in the draft policy content in any way. The majority of recommendations regarding suicide prevention (100%), Mental Health Review Boards (100%), Mental Health Care Act implementation (100%), culture and mental health (90%), child and adolescent mental health (85%), research (71%), and advocacy and user participation (55%). A brief description of the remaining group

recommendations which had either required changes to, or had not been reflected in, the draft policy is included in Appendix 14.

8.3 Reflection of group recommendations in implementation plan: Detailed analysis

Findings from the comparative analysis of the group recommendations with the eight-point Strategic Plan (implementation plan) are presented in this section. Note that although there were eight priorities for implementation on the Strategic Plan, some of these reflected a combination of more than one theme. Hence the greater number of implementation priorities reflected in the analysis going forward, than were included on the Strategic Plan in the policy document.

Limitations about the inferences that can be drawn about numerical comparisons across summit outputs and implementation activities are acknowledged. The number of recommendations associated with a particular theme is not necessarily an indication that the corresponding theme was a more pressing or priority issue. Other explanations include that the theme lent itself to more tangible action outputs, or that a particular group was more detailed in their recommendations. This was not necessarily a good thing in terms of policy consultation: policy proposals lend themselves to a particular kind of format, which is, by definition, broad. In addition, there were those groups that pulled together their recommendations into only one or two clear recommendations, which are subsequently reflected in the implementation priorities and/or activities. Therefore, only so much can be concluded from a numerical analysis. However, it does give an indication of where emphasis might have been placed, particularly in the case of group recommendations and key activities on the implementation plan, as these allowed for more detail to be captured.

Findings from the comparative analysis of group recommendations with implementation priorities and key activities are shown in Table A8.3. In columns 2, 3, and 4, the total numbers of group recommendations, implementation priorities, and key activities that correspond to each theme are included. For ease of reference, the fifth column explicitly states where a particular theme was reflected in one of the eight priorities identified for inclusion on the implementation plan. In the final column, the number of group recommendations that were considered to be reflected in the key activities for each theme is shown in descending order (see Appendix 4 for coding definitions). Note that in some instances key activities were included on the implementation plan that could be coded according to a particular theme – such as Mental Health Review Boards – but where there was no explicit implementation priority associated with that same theme.

Table A8.3: Reflection of group recommendations in implementation priorities and key activities

	Total number of group recommendations, implementation priorities and key activities			Reflection of group recommendations in implementation plan	
Theme	**Total group recommendations** (by theme)	**Total implementation priorities** (by theme)	**Total key activities (KA)** (by theme)	**Corresponding implementation priority for this issue? (Y/N)**	**Number of group recommendations reflected in key activities**
Governance	5	1	2	Y	5 (100%)
Infrastructure	11	1	5	Y	10 (91%)
Mental Health Review Boards	3	0	1	N	2 (67%)
Suicide prevention	5	0	1	N	2 (40%)
Human resources	22	1	4	Y	8 (36%)
Advocacy & user participation	20	1	1	Y	7 (35%)
Intersectoral collaboration	3	1	1	Y	1 (33%)
Mental health systems	9	1	1	Y	3 (33%)
Monitoring & evaluation	7	1	2	Y	1 (14%)
Culture & mental health	10	0	1	N	1 (10%)
Prevention & promotion	14	1	1	Y	1 (7%)
Research	7	1	1	Y	0
Medicines, equipment & protocols	1	1	3	Y	0
Mental Health Care Act	2	0	1	N	0
Funding	2	0	0	N	0
Quality assurance	1	0	0	N	0
Child & adolescent mental health	13	0	0	N	0
Mental health & other conditions	1	0	0	N	0
Totals	**136**	**10** (by theme)	**25** (by theme)	**Y = 10** **N = 8**	**41** **(30%)**

As shown in Table A8.3, the themes that seemed to be the focus of the most attention in the group-generated summit recommendations, merely in terms of the number of recommendations by theme, were: human resources (n=22), advocacy and user participation (n=20), prevention and promotion

(n=14), child and adolescent mental health (n=13), infrastructure (n=11), and culture and mental health (n=10). This apparent prioritisation was reflected in the priorities identified for implementation for all but two of these themes: no corresponding priorities were included in the implementation plan for child and adolescent mental health, and culture and mental health. For child and adolescent mental health, there was also no key activity on the implementation plan, while one key activity partially reflected the culture and mental health group recommendations.

Conversely, fewer group recommendations were put forward for the themes relating to governance (n=5), intersectoral collaboration (n=3), and medicines, equipment and protocols (n=1) at the national summit, a priority for implementation was included in the eight implementation priorities listed on the implementation plan. Notably, these three themes had also not been included as specific topics for discussion in the summit breakaway groups, but were nonetheless prioritised for implementation, while other summit-related topics and corresponding recommendations were not.

Of the 136 recommendations by theme put forward by the summit group commissions, 41 (30%) of these were reflected in some way in the key activities included on the implementation plan. Governance was the only theme for which there was a specific implementation priority *and* for which *all* of the recommendations (n=5) were reflected in the key activities. However, these group recommendations were very broadly or abstractly phrased (e.g. build political will to prioritise mental health), such that they were easily coded as reflected in the key activities, which represented a more detailed operationalisation of these broad recommendations.

Interestingly, 10 of the 11 group recommendations (91%) regarding infrastructure were reflected in some way in the key activities. One possible reason for this is that recommendations regarding infrastructure might be more concrete and therefore easily taken up as actions for implementation. However, for the one remaining recommendation around infrastructure that was not reflected – that no new psychiatric hospitals should be built – the implementation priority was in direct opposition: for a new psychiatric hospital to be built in Mpumalanga.

There were neither implementation priorities nor key activities that corresponded to the following four themes: Mental Health Care Act implementation, funding, quality assurance, and child and adolescent mental health. This is perhaps most striking for child and adolescent mental health, which had specifically been identified as a key topic for discussion at the national summit, and for which 13 recommendations had been made. Although there were implementation priorities for mental health research, and for medicines, equipment and protocols, the key activities listed under these priorities did not reflect the group recommendations put forward for these themes. It is possible that these

recommendations may have been reflected in the one other substantive addition to the final policy following the national summit: the Terms of Reference for key structures. This is explored next in subsection 8.4. Those group recommendations that were reflected in neither of these two appendices are also identified in the analysis that follows.

8.4 Reflection of group recommendations in Terms of Reference: Detailed analysis

Table A8.4 shows the number of group recommendations reflected in the Terms of Reference (ToR) actions (see Appendix 4 for coding definitions). These are presented in descending order.

Table A8.4: Reflection of group recommendations in Terms of Reference actions

Theme	**Total group recommendations** (by theme)	**Number of group recommendations reflected in ToR actions**
Quality assurance	1	1 (100%)
Mental Health Review Boards	3	2 (67%)
Human resources	22	10 (45%)
Prevention & promotion	14	6 (43%)
Research	7	3 (43%)
Mental health systems	9	3 (33%)
Monitoring & evaluation	7	2 (29%)
Suicide prevention	5	1 (20%)
Culture & mental health	10	1 (10%)
Infrastructure	11	1 (9%)
Advocacy & user participation	20	1 (5%)
Medicines, equipment & protocols	1	0
Mental health & other conditions	1	0
Mental Health Care Act	2	0
Funding	2	0
Intersectoral collaboration	3	0
Governance	5	0
Child & adolescent mental health	13	0
Totals	**136**	**31 (23%)**

Results show that a total of 31 (23%) of the 136 group recommendations, by theme, that had been put forward at the national summit were reflected in actions included in the ToR appendix to the policy. The only recommendation that was made regarding quality assurance seems to have been reflected in the ToR actions. The only other theme for which the majority of group recommendations (67%) were reflected in ToR actions was Mental Health Review Boards.

In a second level of analysis, analysis was conducted to determine how many of the group recommendations were reflected in *at least one of* the implementation-related appendices added to the policy, as well as how many group recommendations may have been reflected in *both* of these appendices. Of particular interest, however, was the third level of analysis done here: identifying the number of group recommendations per theme that had *not been reflected* in any way in either of these implementation-related appendices. Results are presented in Table A8.5 below. For all coding definitions relating to this analysis, see Appendix 4.

In the second column of Table A8.5, the number of group recommendations that were reflected in both the implementation plan key activities and the ToR actions are presented. The numbers of group recommendations reflected in at least one of these documents are included, in descending order. The final column shows the number of group recommendations that were found to not be reflected in either the implementation plan or the ToR.

Over half (55%) of the total group recommendations made at the national summit were not reflected in any way in either of the two implementation-related appendices. The themes of those group recommendations that were reflected in neither the implementation priorities and key activities nor the ToR actions were: child and adolescent mental health (n=13), funding (n=2), Mental Health Care Act implementation (n=2), medicines, equipment and protocols (n=1), and mental health and other conditions (n=1).

In total, 61 (45%) of the 136 group recommendations made at the summit – just under half – were reflected in either the implementation key activities or the ToR actions in some way. Given the detailed nature – and amount – of these group recommendations, this is potentially a substantial proportion. Again, however, causal inferences cannot be made regarding a linear association between consultation inputs and policy outputs. Eleven group recommendations (8%) were reflected in both the implementation key activities and the ToR actions. These recommendations corresponded to the themes relating to human resources (n=7), Mental Health Review Boards (n=2), infrastructure (n=1), and suicide prevention (n=1). This could suggest that these group recommendations were particularly

attended to, or relevant for implementation, in terms of their inclusion in both the substantive additions to the final policy following the national summit. All of the group recommendations made in relation to governance and quality assurance were reflected in at least one of these appendices, while more than half the group recommendations were captured for infrastructure (91%), Mental Health Review Boards (67%), and mental health systems (67%).

Table A8.5: Reflection of group recommendations in implementation-related appendices

Theme	**Total group recommendations** (by theme)	**Number of group recommendations reflected in *both* ToR and key activities**	**Number of group recommendations reflected in *either* ToR or key activities**	**Number of group recommendations reflected in *neither* ToR or key activities**
Governance	5	0	5 (100%)	0
Quality assurance	1	0	1 (100%)	0
Infrastructure	11	1	10 (91%)	1 (9%)
Mental Health Review Boards	3	2	2 (67%)	1 (33%)
Mental health systems	9	0	6 (67%)	3 (33%)
Prevention & promotion	14	0	7 (50%)	7 (50%)
Human resources	22	7	11 (50%)	11 (50%)
Monitoring & evaluation	7	0	3 (43%)	4 (57%)
Research	7	0	3 (43%)	4 (57%)
Suicide prevention	5	1	2 (40%)	3 (60%)
Advocacy & user participation	20	0	8 (40%)	12 (60%)
Intersectoral collaboration	3	0	1 (33%)	2 (67%)
Culture & mental health	10	0	2 (20%)	8 (80%)
Mental health & other conditions	1	0	0	1 (100%)
Medicines, equipment & protocols	1	0	0	1 (100%)
Mental Health Care Act	2	0	0	2 (100%)
Funding	2	0	0	2 (100%)
Child & adolescent mental health	13	0	0	13 (100%)
Totals	**136**	**11 (8%)**	**61 (45%)**	**75 (55%)**

Appendix 9: Detailed analysis of Phase 3: Summit recommendations in policy outputs

9.1 Reflection of summit recommendations in policy changes: Detailed analysis

The findings of the analysis of the reflection of summit recommendations in policy changes are presented in Table A9.1. In the second and third columns of Table A9.1 below, the total number of post-summit recommendations and the total number of policy changes are reflected, respectively. The fourth column fourth column shows the number of post-summit recommendations that were determined to be broadly reflected in detail in the policy changes, while the fifth column shows the number of post-summit recommendations broadly reflected in policy changes. The number of post-summit recommendations per theme which were not reflected in any policy changes is shown the final column. For ease of reference going forward, post-summit recommendations will be referred to as summit recommendations, unless otherwise stipulated.

None of the summit recommendations were reflected in detail in the policy changes, as shown in column 4. Just over half (58%) of the summit recommendations seemed to be broadly reflected in changes made to the policy following the summit (column 5). Given the broad scope of these recommendations, however, and the specific micro-detail of policy changes associated with that theme, it seems unlikely that the change was made to the policy directly as a result of the summit recommendations. Nonetheless, each one of the recommendations made in relation to the following themes were determined to be reflected – in broad terms – in the policy changes: prevention and promotion, monitoring and evaluation, mental health systems, infrastructure, Mental Health Review Boards, and funding.

Summit recommendations were made regarding culture and mental health, suicide prevention, quality assurance, and medicines, equipment and protocols. However, no changes were made to content of the policy relating to these issues (column 6). For the remainder of the themes shown in Table A9.1, no post-summit recommendations were made, negating comparison with policy changes around these themes. The actual summit declaration recommendations that were considered to not be reflected in changes made to the policy following the national summit are listed, by theme, in Appendix 14.

Table A9.1: Reflection of post-summit recommendations in post-consultation policy changes

Theme	**Total post-summit recommend. added to declaration**	**Total policy changes** (by theme)	**Number of post-summit recommend. reflected in detail in policy changes**	**Number of post-summit recommend. broadly reflected in policy changes**	**Number of post-summit recommend. not reflected in policy changes**
Prevention & promotion	1	1	0	1 (100%)	0
Monitoring & evaluation	1	1	0	1 (100%)	0
Mental health systems	1	8	0	1 (100%)	0
Infrastructure	1	8	0	1 (100%)	0
Mental Health Review Boards	1	1	0	1 (100%)	0
Funding	1	1	0	1 (100%)	0
Human resources	2	1	0	1 (50%)	1 (50%)
Culture & mental health	1	0	0	0	1 (100%)
Suicide prevention	1	0	0	0	1 (100%)
Medicines, equipment & protocols	1	0	0	0	1 (100%)
Quality assurance	1	0	0	0	1 (100%)
Advocacy & user participation	0	1	-	-	-
Mental Health Care Act	0	8	-	-	-
Governance	0	4	-	-	-
Intersectoral collaboration	0	1	-	-	-
Research	0	0	-	-	-
Child & adolescent mental health	0	0	-	-	-
Mental health & other conditions	0	0	-	-	-
Totals	**12**	**35**	**0**	**7 (58%)**	**5 (42%)**

9.2 Reflection of summit recommendations in draft policy: Detailed analysis

Table A9.2 shows which summit recommendations were broadly reflected in draft policy content (fourth column), which recommendations represented a change or addition to be made to the policy (fifth column), and whether this change was made (sixth column). Where the issue was reflected in the draft policy – as a stand-alone section or as content within sections – is shown in the third column of the table. Coding definitions are included in Appendix 4.

As seen in Table A9.2, the majority (75%) of post-summit recommendations seemed to be broadly reflected in the draft policy content that was available for discussion at the national summit. It is again important to note that the summit declaration recommendations were very broadly stated, such that they could be said to be reflected in more detailed policy content around a particular area, regardless of whether there was intentional alignment or not. It is notable, however, that three (25%) summit recommendations were considered to require a change to existing policy content, but none of these changes were made following the summit. These related to suicide prevention, Mental Health Review Boards, and medicines, equipment and protocols.

The summit recommendation pertaining to suicide prevention – establishing a national suicide prevention programme – represented an addition that could be included in the final policy, where no such content existed before. This addition, however, was not made. Conversely, a statement regarding Mental Health Review Boards was added to the final policy following the summit, regarding their role in advocating for the needs and human rights of mental health service users. However, this addition does not correspond to the summit recommendation that Mental Health Review Boards be better capacitated. Finally, a summit recommendation was made to "implement with vigour the Health Sector Mini Drug Master Plan." This represented an addition to be made to existing policy content; the addition also did not appear, however, in the final policy.

Table A9.2: Reflection of post-summit recommendations in draft policy

Theme	**Total post-summit recommendations added to declaration**	**Issue addressed in draft policy*** (as own section, within other sections, or not at all)	**Number of post-summit recommendations broadly reflected in draft policy**	**Number of post-summit recommendations requiring policy change**	**Was this policy change made?**
Human resources	2	Section	2 (100%)	0	_
Prevention & promotion	1	Section	1 (100%)	0	_
Monitoring & evaluation	1	Section	1 (100%)	0	_
Mental health systems	1	Section (org of services)	1 (100%)	0	_
Funding	1	Section	1 (100%)	0	_
Quality assurance	1	Section	1 (100%)	0	_
Infrastructure	1	Content within sections	1 (100%)	0	_
Culture & mental health	1	Content within sections	1 (100%)	0	_
Medicines, equipment & protocols	1	Section (medication)	0	1 (100%)	No
Mental Health Review Boards	1	No content	0	1 (100%)	No
Suicide prevention	1	No content	0	1 (100%)	No
Research	0	Section	_	_	_
Advocacy & user participation	0	Section	_	_	_
Intersectoral collaboration	0	Section	_	_	_
Mental Health Care Act	0	Content within sections	_	_	_
Governance	0	Content within sections	_	_	_
Child & adolescent	0	Content within sections	_	_	_
Mental health & other conditions	0	Content within sections	_	_	_
Totals	**12**		**9 (75%)**	**3 (25%)**	

9.3 Reflection of summit recommendations in implementation plan: Detailed analysis

Table A9.3 presents findings from the analysis of the reflection of summit declaration recommendations in the implementation plan. In Table A9.3, the total number of post-summit recommendations, implementation priorities, and key activities, by theme, are presented in columns two, three and four respectively. The fifth column shows whether a priority was included on the implementation plan for each theme. The final column includes the number of post-summit recommendations that were determined to be broadly reflected in the key activities associated with each implementation priority. In general, where key activities on the implementation plan corresponded to summit declaration recommendations, the former were usually more detailed than the latter, and represented the operationalisation of the summit declaration recommendations.

The eleven recommendations included on the summit declaration as a result of summit discussions roughly reflected the topics chosen for discussion at the national summit – with the exception of child and adolescent mental health, advocacy and user participation, and research. However, advocacy and user participation and research nonetheless seemed to be identified as priorities for inclusion on the implementation plan. The only issue that did not seem to get prioritised in either the summit outputs or policy appendices, then, was child and adolescent mental health. Other issues that had been put forward as one of the eleven recommendations on the summit declaration but which were not included as implementation priorities were Mental Health Review Boards, suicide prevention, quality assurance, culture and mental health, and funding.

The majority (75%) of the post-summit recommendations were broadly reflected in the more detailed key activities on the implementation plan that were associated with particular implementation priorities. As noted earlier in this subsection, no strong causal inferences can be made in this regard, in the sense that these themes are commonly identified as particularly pertinent in terms of mental health. Thus, the fact that these themes are reflected through summit recommendations into key implementation activities may not have been a direct follow-through from summit to final policy outputs. It is somewhat more conclusive to make inferences about what was left out of the implementation priorities and key activities, despite featuring as key issues in summit recommendations – particularly those recommendations that were added to the declaration at the end of the summit.

Table A9.3: Reflection of post-summit recommendations in implementation priorities & key activities

	Total number of summit recommendations, implementation priorities and key activities			Correspondence between summit recommendations & implementation priorities and key activities	
Theme	**Total post-summit recommendations** (by theme)	**Total implementation priorities** (by theme)	**Total key activities** (by theme)	**Is there a corresponding implementation priority for this issue? (Y/N)**	**Number of post-summit recommendations reflected in key activities**
Human resources	2	1	4	Y	2 (100%)
Prevention & promotion	1	1	1	Y	1 (100%)
Monitoring & evaluation	1	1	2	Y	1 (100%)
Mental health systems	1	1	1	Y	1 (100%)
Infrastructure	1	1	5	Y	1 (100%)
Medicines, equipment & protocols	1	1	3	Y	1 (100%)
Mental Health Review Boards	1	0	1	N	1 (100%)
Suicide prevention	1	0	1	N	1 (100%)
Quality assurance	1	0	0	N	0
Culture & mental health	1	0	1	N	0
Funding	1	0	0	N	0
Research	0	1	1	Y	-
Advocacy & user participation	0	1	1	Y	-
Governance	0	1	2	Y	-
Intersectoral collaboration	0	1	1	Y	-
Mental Health Care Act	0	0	1	N	-
Child & adolescent mental health	0	0	0	N	-
Mental health & other conditions	0	0	0	N	-
Totals	**12** (by theme)	**10** (by theme)	**25**	**Y = 10** **N = 8**	**9** **(75%)**

Only three summit recommendations were considered to not be reflected in key activities, for each of the following themes: quality assurance, culture and mental health, and funding. While there is a key

activity relating to culture and mental health, this pertains to indigenous language competency of mental health care professionals. Since the post-summit recommendation referred instead to strengthening links with traditional healers, this is shown as not reflected in the implementation plan. The remaining summit recommendations that were not followed through or reflected in the implementation plan are detailed in Appendix 14.

9.4 Reflection of summit recommendations in Terms of Reference: Detailed analysis

Table A9.4 shows the number of Terms of Reference (ToR) actions relating to particular themes (n=32), and the number of post-summit recommendations per theme that were determined to be reflected in these ToR actions (see Appendix 4 for coding definitions). In general, there were more ToR actions per theme than there were summit recommendations. Again, determination of alignment was based on a broad matching of general topic areas, given the more broadly stated recommendations and the more detailed ToR actions.

The majority (83%) of post-summit recommendations were reflected in ToR actions. There were only two recommendations that did not correspond to content in the ToR in some way: infrastructure, and medicines, equipment and protocols. The post-summit recommendations around medicines, equipment and protocols related to implementing the Health Sector Mini Drug Master plan, while the recommendation concerning infrastructure was to "develop a fit for purpose plan for mental health infrastructure at all levels." Notably, both of these issues were covered somewhat extensively in the Strategic Plan, as discussed earlier.

There were also instances where key activities on the ToR addressed issues that had been discussed at the national summit, but which had not been included as post-summit recommendations on the summit declaration. This was the case for research, advocacy and user participation, Mental Health Care Act implementation, governance, child and adolescent mental health, and mental health and other conditions.

Table A9.4: Reflection of post-summit declaration recommendations in Terms of Reference actions

Theme	**Total post-summit declaration recommendations** (by theme)	**Total Terms of Reference actions** (by theme)	**Number of post-summit recommendations reflected in Terms of Reference actions**
Human resources	2	5	2 (100%)
Prevention & promotion	1	3	1 (100%)
Monitoring & evaluation	1	2	1 (100%)
Mental health systems	1	6	1 (100%)
Culture & mental health	1	1	1 (100%)
Mental Health Review Boards	1	3	1 (100%)
Suicide prevention	1	1	1 (100%)
Funding	1	2	1 (100%)
Quality assurance	1	1	1 (100%)
Infrastructure	1	1	0
Medicines, equipment & protocols	1	0	0
Research	0	1	N/A
Advocacy & user participation	0	2	N/A
Mental Health Care Act	0	1	N/A
Governance	0	1	N/A
Intersectoral collaboration	0	0	N/A
Child & adolescent mental health	0	1	N/A
Mental health & other conditions	0	1	N/A
Totals	**12**	**32**	**10** **(83%)**

The second part of the analysis considered whether post-summit recommendations were reflected in either the implementation plan priorities and key activities or the ToR actions – thereby suggesting that the summit recommendations may have informed, or at least were aligned with, the new additions made to the mental health policy following the national summit. Of particular interest in this analysis was to identify any summit recommendations that were reflected in neither the implementation plan nor the Terms of Reference. These findings are presented in Table A9.5.

In Table A9.5, a comparison of summit recommendations with implementation plan key activities and ToR actions is shown according to three categories: i) number of recommendations reflected in both implementation plan and ToR (third column); ii) number of recommendations reflected in either the implementation plan or the ToR (fourth column); and iii) number of summit recommendations reflected in neither the implementation plan nor the ToR. Themes are listed in descending order according to the number of summit recommendations that were included in at least one of the two appendices.

All of the post-summit recommendations were reflected in at least one of the new implementation-related appendices added to the policy following the consultation summit. More than half of these (58%) were broadly reflected in *both* the implementation plan key activities and ToR actions. Arguably, where recommendations were reflected in both of the additions to the final policy following the summit, this suggests that these were considered important for implementation. Those issues for which summit recommendations were reflected in only one of these documents were culture and mental health, funding, quality assurance, infrastructure, and medicines, equipment and protocols.

The purpose of this analysis was to trace knowledge inputs across summit inputs and outputs to determine whether and how the policy consultation informed policy. Limitations with respect to assuming causal, linear links between summit content and policy content have been highlighted. However, there were instances where issues were *not* included in recommendations put forward from the national summit but were nonetheless added to the policy in some way following the summit. This could suggest a disconnect between consultation priorities and what was ultimately prioritised in the policy. For example, no post-summit recommendations were included for research, advocacy and user participation, Mental Health Care Act implementation, governance, intersectoral collaboration, child and adolescent mental health, and mental health and other conditions. However, each of these issues were reflected in one or both of the implementation plan and ToR appendices added to the policy following the summit.

Another interpretation of these findings is that it reflects the tension between the necessity of capturing a great deal of detailed input in broad summit recommendations, and the level of detail required in implementation plans and activities. The follow-through of issues from their identification as key topics for discussion at the national summit through to summit declaration recommendations, through to policy content and implementation-related activities is explored in the next subsection.

Table A9.5: Reflection of post-summit recommendations in Terms of Reference actions and implementation key activities

Theme	Total post-summit recommendations added to declaration	Number of post-summit recommendations reflected in both ToR and key activities	Number of post-summit recommendations reflected in either ToR or key activities	Number of summit recommendations reflected in *neither* ToR or key activities
Human resources	2	2 (100%)	2 (100%)	0
Prevention & promotion	1	1 (100%)	1 (100%)	0
Monitoring & evaluation	1	1 (100%)	1 (100%)	0
Mental health systems	1	1 (100%)	1 (100%)	0
Mental Health Review Boards	1	1 (100%)	1 (100%)	0
Suicide prevention	1	1 (100%)	1 (100%)	0
Culture & mental health	1	0	1 (100%)	0
Funding	1	0	1 (100%)	0
Quality assurance	1	0	1 (100%)	0
Infrastructure	1	0	1 (100%)	0
Medicines, equipment & protocols	1	0	1 (100%)	0
Research	0	N/A	N/A	N/A
Advocacy & user participation	0	N/A	N/A	N/A
Mental Health Care Act	0	N/A	N/A	N/A
Governance	0	N/A	N/A	N/A
Intersectoral collaboration	0	N/A	N/A	N/A
Child & adolescent mental health	0	N/A	N/A	N/A
Mental health & other conditions	0	N/A	N/A	N/A
Totals	**12**	**7 (58%)**	**12** (100%)	**0**

9.5 Reflection of mental health issues across all summit inputs and policy outputs

Table A9.6 shows the prioritisation of issues across the summit breakaway groups, summit declaration recommendations, policy content, policy changes, implementation priorities and key activities, and Terms of Reference actions. In this analysis, an issue was coded as reflected simply by virtue of its appearance in content relating to that issue – as opposed to reflecting the actual content of group or

summit recommendation made in relation to this issue. Table A9.6 is colour coded to show reflection or lack thereof of issues across documents. Blue coding indicates all instances where any content related to a particular was included in a document; grey indicates where an issue is not reflected in any content within a particular document.

Eighteen themes were identified in this analysis. Of these, 13 were chosen as themes for discussion in the summit breakaway group commissions (with some being combined in one group commission) and had a number of associated group recommendations. Interestingly, four issues that had not been predetermined as themes for discussion in the summit groups had nonetheless been flagged as priority issues in the draft summit declaration that was available at the start of the summit. This may be precisely because they had already been included on the pre-drafted summit output. As shown in the third column of Table A9.6, these were medicines, equipment and protocols, governance, intersectoral collaboration, and funding.

As shown in the fourth column of Table A9.6, a number of breakaway group topics did not get taken up in the recommendations added to the summit declaration at the end of the summit, despite a number of group recommendations being made in relation to these themes. This was particularly the case for advocacy and user participation, research, and child and adolescent mental health. (Note: although there appears to be no post-summit recommendation for Mental Health Care Act implementation, there was a corresponding recommendation relating to Mental Health Review Boards, which was considered to represent the operationalisation of this topic. In addition, no specific post-summit recommendation reflects for mental health and other conditions. However, the group recommendations made from this breakaway group topic were largely related to prevention and promotion and to human resources, and were thus considered to be reflected elsewhere. This is the case across the remainder of this analysis).

There were five issues that were consistently reflected across all the summit group commissions, the pre-summit declaration text, the post-summit declaration recommendations, as a priority on the implementation plan, and in the implementation key activities. These were prevention and promotion, monitoring and evaluation, human resources, mental health systems, and infrastructure. With the exception of those themes already discussed above, the remaining issues were all addressed in some way in one or the other pre- or post-summit recommendations, policy outputs and appendices.

Table A9.6: Themes reflected across all summit and policy outputs

	Summit group	Summit declaration recommendations		Policy		Implementation plan		Terms of Reference
Theme	**Group topic at summit**	**Pre-summit**	**Post-summit**	**Policy changes**	**Content in draft policy**	**Implementation priority**	**Implementation key activities**	**Terms of Reference actions**
Prevention & promotion					Section			
Monitoring & evaluation					Section			
Human resources					Section			
Mental health systems					Section			
Infrastructure					Within section			
Advocacy & user participation					Section			
Research					Section			
Culture & mental health					Within section			
Mental Health Care Act					Within section			
Mental Health Review Boards					None			
Suicide prevention					None			
Medicines, equip & protocols					Section (meds)			
Governance					Within section			
Intersectoral collaboration					Section			
Funding					Section			
Quality assurance					Section			
Child & adol. mental health					Within section			
Other conditions					Within section			

Key: **Reflected** **Not reflected**

Appendix 10: Provincial summit recommendations

Free State: summit report

(PowerPoint presentation with bullet point recommendations per breakaway group)

Prevention and promotion

- No specific recommendations.

Research and monitoring and evaluation

- Avail funding for tertiary institutions to do research in mental health.
- Dissemination of research findings at all levels – provincial research database on mental health.
- Strengthening monitoring and evaluation in mental health.

Mental health systems (primary health care re-engineering)

- Make mental health care an integral part of primary health care reengineering (school health and family health teams).
- Integrate mental health into other programmes such as maternal and child health services, communicable and non-communicable diseases, HIB/AIDS and TB.
- Strengthen implementation of community-based mental health services, including group homes, boarding houses, support groups, sheltered employment and independent living.
- Designate care and rehabilitation for persons with intellectual disabilities.
- Prioritise funding for rehabilitation services in health care establishments.

Infrastructure

- Do not build another tertiary psychiatric hospital as this is a more expensive option.
- Decentralise services to the districts and maintain the Free State Psychiatry Complex as the only tertiary institution.
- Designate more regional hospitals to provide services for adults and children.
- All regional hospitals must benefit from the revitalisation grant and be upgraded as designated mental health care units.
- 72-hour facilities must have acute observation rooms which are properly modified for the purpose.
- Utilise the revitalisation grant to fund the upgrading of all 72 hour services to improve compliance and security.
- National Department of Health to speed up the process on completion of norms and standards on mental health care services.

Human resources

- Free State University Faculty of Health Sciences to provide courses on specialised psychiatric services.
- The Free State Psychiatry Complex to re-open its nursing school to provide training for Advanced Psychiatric programme, as well as child psychiatry.
- Every health establishment must have a mental health coordinator.
- All health practitioners/providers need to be trained on mental health care issues.
- National together with provinces should review practitioner/provider-patient norms for the development of staff establishments.
- Security officers' posts to be graded to ensure appropriately qualified personnel for mental health care facilities.
- Consider paying danger allowance for those staff employed in mental health facilities.
- Create the Provincial Mental Health Directorate.
- Develop policies to enable employer-initiated, preventative support service against mental illness.
- Appoint psychiatrists at provincial level for districts using National Tertiary Services grant.

Mental health and other conditions

- No recommendations.

Mental Health Care Act

- Protect the independence of the Mental Health Review Boards.
- Centralise the administration of Mental Health Review Boards in the Mental Health Directorate at provincial level.
- The Mental Health Care Act and regulations must empower Mental Health Review Boards to enforce implementation thereof.
- Necessary amendments to address gaps identified to be effected, like silence of the administration of oaths and child and mental health services.
- Standardise remuneration for Mental Health Care Review Boards countrywide.
- Empower and strengthen the relationship with the South African Police Services.

Child and adolescent mental health services

- Decentralise in and out patient child and adolescent mental health services to the regional and district hospitals.
- Child and adolescent mental health services should be integrated into primary health care re-engineering.
- Train educators to identify early behavioural, emotional and psychosocial symptoms of mental illness.

- Prioritise training in child psychiatry as a discipline in the Department.
- Vigorous marketing of child and adolescent mental health services.

Culture

- No recommendations.

Suicide prevention

- No recommendations.

Advocacy (subsumed in report under prevention and promotion)

- Improve community awareness through all forms of media.
- Establishment of support groups for users and family members.

Intersectoral collaboration

- Strengthen intersectoral collaboration.

Gauteng: oral feedback at national summit; no report received

Commissions (9)

1. Promotion and prevention, advocacy, social mobilisation, user and community participation.
2. Culture & indigenous mental health practices.
3. Suicide prevention.
4. Mental health research, innovation & surveillance.
5. Mental health systems, including primary health care, community-based mental health, information, finance and referral systems.
6. Mental Health Care Act.
7. Infrastructure, human resources, equipment and psychosocial rehabilitation.
8. Mental health and other conditions.
9. Child and adolescent mental health and forensic services.

Prevention and promotion

- There should be a promotion of mental well-being and prevention of mental illness, by way of cross-sectoral collaboration between government departments in partnership with all stakeholders.
- We should strengthen and implement measures to reduce the preventable causes of mental health problems, such as comorbidity, suicide prevention and causes of harmful stress, violence, depression, anxiety, alcohol abuse, and other substance abuse disorders through a multi-pronged communication strategy, early detection and screening.
- We should also improve financial support and reporting of NGO's providing services in the field of mental health.

Research and monitoring and evaluation

- Commission and support appropriate metal health research through funding and training of all health professionals.
- We should also coordinate all research by the establishment of district research committees which include all our stakeholders.

Mental health systems

- There should be an integration of mental health in the reengineering of the primary health care.
- We want to see implementation of the mini drug master plan in a comprehensive and integrated manner.
- The initial services should include mental health and psychiatry at all levels of care.
- We also said we should create and support centres of excellence in specialised psychiatric units, dealing with neuro-psychiatry, HIV and mental illness, addiction psychiatry, child and adolescent psychiatry and forensic psychiatry.
- We should also improve referral procedures by ensuring that all facilities provide clearly defined services package, which the public is familiar with. Leading to this is a referral system from within and from outside that is known and acceptable.
- The implementation of mini-drug master plan in a comprehensive and integrated manner, but also the reinventing of the budget for the mental health care services so it's not used for other things you know like us, in Gauteng, we can end up paying suppliers instead of doing these things.

Infrastructure

- We should also improve infrastructure at all existing and planned mental health facilities, in accordance with the infrastructure standards for effective care, treatment and rehabilitation.
- We should increase the number of beds in maximum secure units for forensic services, for adults and adolescents, but also establish at least one secure child and adolescent service in the province. We said a specialised psychiatric hospitals should be reclassified as tertiary hospitals with appropriate staff establishment and should report to the chief director hospital services, as part of an integrated health services.

Human resources

- We should improve human resource management, design recruitment, retention, education and training programmes, to create sufficient and competent multi-disciplinary work force by including mental health in the curricular of all health

professionals training, compulsory continuous professional education, and training programmes for the mental health work force.
- We should also increase specialised mental health professional staff establishment in accordance with revised norms and standards guidelines and service demands.
- Primary care providers must be supported and trained to improve access.
- We should include psychiatric services in the national tertiary services grant. I know that this is against policy but it's something that we want to drive, as a result in other capacities. We also want to influence that this should be looked into thoroughly.
- We must engage with the department of correctional services, to ensure that their hospital staff are trained, have skills to manage those patients with basic mental health conditions, and state patients who are waiting for beds at designated hospitals.

Mental health and other conditions
- No specific recommendations.

Mental Health Care Act
- With regard to the mental health care act number seventeen and other pieces of legislation, we said mental health policies and guidelines, in accordance with legislation which sets standards for mental health services, and uphold human rights, must be further formulated, disseminated, and implemented.
- Specialist mental health professionals and other relevant stakeholders, must be involved in a review of the norms and standards and the plan that must be integrated and should be holistic.
- The incorporation of the international rights of children, adolescents and of all the persons into mental health legislation.
- Other people with mental health problems, effective and comprehensive care and treatment in a range of settings and in a manner which respects their healthcare needs and protects them from neglect and abuse.

Child and adolescent mental health care
- We also said we should create and support centres of excellence in specialised psychiatric units, dealing with neuro-psychiatry, HIV and mental illness, addiction psychiatry, child and adolescent psychiatry and forensic psychiatry.

Culture
- No specific recommendations.

Suicide prevention
- No specific recommendations.

Advocacy
- Mental reviewing of the publishing as a whole must be promoted by measures which aim to create a wellness and positive change for individuals and families, communities and civil society, educational and working environment, and all sphere of government by using all forms of media.
- We should also eliminate stigma and discrimination and enhance inclusion by increasing public awareness and empowering people at risk, to participate fully and equally in society.
- To this end public and private institutions must be made responsible for protecting and upholding the rights of mental health care users.

KwaZulu-Natal: summit report

(3-page document with bullet point resolutions)
Unknown number of commissions based on summit report

Prevention and promotion
- No specific recommendations.

Research and monitoring and evaluation
- Request for the review of the mental health information systems within district health information systems (DHIS) and its implementation supported.
- Encourages the creation of a formal mental health research platform for the province.

Mental health systems
- Require the inclusion of mental health services within clinical governance at all levels of care.
- Urge for the integration of mental health services across all levels of care from the re-engineered Primary Health Care (PHC) system to the quaternary (central) hospital level.
- Call for the review and implementation of a comprehensive and multi-disciplinary post establishment for mental health
- Call for the development and implementation of decentralised regional mental health services in order to improve access to general and specialised mental health programmes such as child & adolescent, forensic, and substance abuse services to all citizens.

- Request for improved access to tertiary level of care by developing tertiary psychiatric services in the three health areas supported by appropriate funding and resource allocation.
- Ask for the establishment and implementation of appropriate referral pathways for mental health which facilitate the provision of a continuum of care that include prevention, promotion, early detection, treatment, rehabilitation, and aftercare services.

Infrastructure

- Call for the development and implementation of updated, evidence-based protocols and treatment guidelines on the following areas: acute & chronic psychiatric care, detoxification, child and adolescent mental health services, forensic services and dual diagnosis with defined packages of services for each level of care.
- Request for the review of the Essential Drug List (EDL) taking into consideration prescriber levels, access, availability, safety, and cost at all levels of care.

Human resources

- Request for on-going training and development programme for mental health at all levels of care and across all disciplines, linking it to the human resource (HR) strategy with appropriate costing and supporting a task-shifting approach.
- Call for the development of infrastructure plan for mental health across all levels of care in line with the Service Transformation Plan (STP) and the implementation of the National Health Insurance.
- Stress the need to establish multi-disciplinary community mental health teams as well as specialised mental health outreach programmes to support primary and secondary levels of mental health care.

Mental health and other conditions

- No specific recommendations.

Mental Health Care Act

- Call for the review of the composition, functioning and remuneration of and control measures for Mental Health Review Boards (MHRBs).
- Call for the full implementation and enforcement of the legislative requirements of the Mental Health Care Act No. 17 of 2002 by 2014.

Child and adolescent mental health care

- Call for the development and implementation of decentralised regional mental health services in order to improve access to general and specialised mental health programmes such as child & adolescent, forensic, and substance abuse services to all citizens.

Culture

- No specific recommendations.

Suicide prevention

- No specific recommendations.

Advocacy

- Support the improvement of mental health literacy both at public and professional levels.
- Urge for the building of a strong advocacy movement for mental health which is driven by users in order to combat stigma and discrimination and to ensure that the human rights of all mental health care users (MHCUs) are upheld.

Intersectoral collaboration

- Encourage for formal and official integration of mental health within existing frameworks to ensure inter-sectoral collaboration for the implementation of mental health services.

Governance

- Call on the Department of Health to recognize Mental Health and Substance Abuse as a priority programme both at provincial and national levels.
- Call for the finalization of the National Mental Health Policy to guide the development of the Provincial Mental Health Policy.
- Stress the need to develop and implement a Provincial Strategic and Implementation Plan for mental health service delivery.

Limpopo: oral feedback at national summit; no report received

Commissions (5)

1. Forensic mental health services including Mental Health Care Act and Criminal Procedures Act.
2. Advocacy & social mobilisation, including suicide prevention and governance structures.
3. Community-based mental health services, including culture and faith-based practices.
4. Integration with other programmes.
5. Resourcing of mental health services.

Prevention and promotion

- No specific recommendations.

Research and monitoring and evaluation

- Lack indicators in our APP's in the provinces, is of critical importance. In our province, we are looking at 2013/2014 financial year, our DHP' and our APP shall have the indicators on mental health services.

Mental health systems

- Our services have been centralised, but now our plan now is to decentralise it even at the level of primary health care.
- We also need to start looking at the role of one stop centres, which many a times our people don't understand when we are say we need to establish one stop centres, what do we mean.
- Community mental health services: We need to start having halfway house.
- In our province, we are currently reviewing our referral policy, which we shall include mental health services, to make sure that our patients are being referred appropriately.

Infrastructure

- One of the challenges is that even those hospitals which are designated, our patients are still mixed, you find male and female patients still mixed in one ward and this we are urgently addressing.
- We need to also start standardising those facilities.
- And the technology part, the equipment which is needed there need to be standardised.

Human resources

- We have also found that the health care workers are also victims; many a times we forget ourselves. We forget about some of the colleagues who were here in the morning. We need to start looking at you know, taking care of the carers.
- Every health practitioner, should be able to can assess mentally, a thing which is currently not happening.

Mental health and other conditions

- No specific recommendations.

Mental Health Care Act

- We actually agree that definitely there's no intersectoral collaboration; as such our resolution, we are saying we need to start actually immediately working together with SAPS and justice and other departments like education.
- We are aware that in many of our facilities, in Limpopo we do have designated hospitals for seventy-two hours observation, except for the specialised hospitals which are three.
- Governance structures: We have launched our Review Boards.
- Almost all our facilities don't really comply appropriately with the Act, and we shall make sure that we comply.

Child and adolescent mental health care

- We need to have a special unit for child mental health services in the province, which we haven't been having for quite some time.

Culture

- Culture, faith, and then the role of traditional leaders: It's known that Limpopo is notoriously known about you know witchcraft, and we shall not, we shall not ignore such kind of very important belief amongst our people. As such as the department we are actually starting to talk to our traditional leaders, and the traditional health practitioners to make sure that we also understand.
- By the way it's not one way, many a times we make a mistake, that we keep on saying we are educating and training traditional health practitioners, they need to also teach us, you know what they're believing in.
- And then faith mental health services: There are many churches which are believing in trying their luck on mental health services. We can't ignore that. We know these are people who are easily accessible, you know in terms of a- of need. And as such, we are suggesting that we need, even in the next level of summit, we need to start actually letting these people participate fully. That is, traditional health practitioners, faith healers, and even our traditional leaders.
- Also, further, our traditional leaders in the communities, are taking part in making sure that when it's mental health day celebration, the kings do take part. An example is in Vhembe where every year, King Tshivase celebrate that.

Suicide prevention

- Suicide prevention: We have found that the forms which are being used are not user friendly, therefore we are requesting that the forms should be standardised and also be relevant for the programme.

Advocacy

- Victim empowerment: We do have a victim empowerment but unfortunately you know many a times it's just hollow. We need to urgently make sure that they are user friendly and they are well equipped, not just, you know, one room and a table there, for you know discussion with a patient.
- We are talking about job creation in general in this country, but many a times, we tend to forget those who are currently recuperating, who are recovering from mental illness. We need to make sure that we have got sheltered employments within this country.

Mpumalanga: oral feedback at national summit; no report received

Commissions (6)

1. Promotion & prevention, advocacy, social mobilisation, user and community participation.
2. Mental health systems.
3. Infrastructure and resources.
4. Child and adolescent mental health.
5. Culture & indigenous practices.
6. Suicide prevention.

Prevention and promotion

- That a clear mental health care strategy be developed for strengthening community based health promotive and preventive interventions to ensure the improvement of the health status of communities, and develop clear policies on community based organisations and NGO's involvement.

Research and monitoring and evaluation

- We must also have integration of mental health care indicators into the district health information system, and other systems. So, let's capture mental health into our information systems that we have.

Mental health systems

- We must integrate mental health care into the three streams of primary health care reengineering.
- So, we want to make sure that even as we address our NHI programmes, mental health care must not be left behind. So we want to integrate nicely into the NHI.
- All relevant stakeholders should participate in the development of programmes, to address social economic determinants of ill health by inputting into the mental health care programme.
- That communities and managers should be empowered to actively participate in the primary healthcare and school health outreach teams, with specific focus on mental health.
- That a clear mental health care strategy be developed for strengthening community based health promotive and preventive interventions to ensure the improvement of the health status of communities, and develop clear policies on community based organisations and NGO's involvement.
- We must ensure adequate allocation of resources, or finances.
- We must establish a community based mental health service.

Infrastructure

- We must revitalise and custom build the three designated psychiatric units that we have in the province.
- Involvement of mental health care practitioners in planning and decision making on infrastructure planning. We currently are sitting with a situation in Ermelo hospital where a psychiatric unit was built in the hospital and it doesn't conform with the norms and standards. So, the involvement in the planning of infrastructure is very crucial.
- We must make sure that there're enough drugs and there's no breakage in the drug supply.

Human resources

- We must train and appoint mental health practitioners.
- The death of that programme that we had in psychiatric nursing, actually has compromised us, so we need to actually get more into the province.
- Appointment of mental health programme manager, district and sub district programme coordinators.
- We must intensify training of all healthcare providers on management of mental health care users, both at hospital and primary health care facilities such as clinics, and community health centres.

Mental health and other conditions

- We felt that we must integrate mental health into the existing HIV and AIDS forums. We have the Mpumalanga AIDS council. We feel that they must focus not only on HIV, but also on mental health.

Mental Health Care Act

- We must decentralise Mental Health Review Boards from provincial into all districts.
- If we can have only one such a hospital in the province, I know that they were saying that in every district, but we're advocating for just one psychiatric hospital that will actually alleviate the challenge that we have regarding forensics, concerning our awaiting trial prisoners.
- And then establishment of 72-hour assessment services in all district hospitals.
- We must have capacity building of managers and practitioners on Mental Health Care Act.

Child and adolescent mental health care

- We need more personnel to be trained in rendering this service.
- We must have a formal cluster in the province to work on children and adolescent issues, involving other stakeholders.
- The psychiatric facility must be built. The one that we are talking about, it must accommodate children and adolescent mental health.

- We thought that the province must actually do some benchmarking on child and adolescent mental health with provinces that have the best practice.
- And then we must also have a 24-hour forensic service for children and adolescents. They must not wait longer than that.
- And then we must improve communication between different departments and disciplines regarding child and adolescent mental health care.

Culture

- Training of indigenous and western practitioners on alternative ways of treating mental health care users. We felt that it's important, especially if we have to bring in our traditional healers and our faith healers.
- Strengthening the provincial, traditional medicine programme, by appointing district and sub-district coordinators.

Suicide prevention

- We must educate our children in schools on how to identify symptoms of suicide.
- We must incorporate the suicidal screening tool at all our schools.
- We must extend youth friendly clinics to the suicidal children.
- We must strengthen the support group outreach services.
- And strengthen the intersectoral collaboration.

Advocacy

- No specific recommendations.

North West: summit report

(30-page document with summarised paragraph recommendations and appendices tabling detailed recommendations per breakaway group)

Commissions (8)

1. Destigmatisation, mobilisation & advocacy.
2. Community-based services.
3. Funding of mental health services – grants, etc.
4. Mental Health Care Act, 2002 & related legislation.
5. Suicide & suicide intentions.
6. Other conditions with mental health implications.
7. Culture & traditional healers.
8. Child and adolescent mental health care services.

The commission recommendations were included in table form as appendices, depicting the current status, challenges or constraint, and remedial actions – i.e. recommendations. These were then summarised in the narrative body of the report as the recommendations coming from this summit.

Prevention and promotion

- No specific recommendations.

Research and monitoring and evaluation

- The Department should invest in research in mental health.
- Monitoring of mental health services and support groups needs attention.
- The establishment of Mental Health Forums in communities with relevant stakeholders will assist the department with the monitoring of services.

Mental health systems

- Community-based resources, e.g. halfway houses and day care centres are needed.
- There should be a budget available for the empowerment of community health care workers.
- Peer/social support groups should be established at community level and be strengthened.
- Prioritise the mental health programme through equal distribution of financial resources.
- Submit budgets in a timely manner to relevant managers for inclusion in the provincial and sub-district budgets.
- Lobby for national grants to cover community-based services.
- Fund NGOs to assist the Department with the mental health programme and strengthen community participation and development.
- Financial management and resource mobilisation for sustainability of NGOs is another aspect that needs attention.
- The quality of mental health services should be strengthened.
- The strengthening of school services and deinstitutionalisation were also identified as important.
- Reviewing users' condition and treatment regularly is one of the many challenges to be addressed.

Infrastructure

- Formulation of policies in infrastructure and uniformity in the mental health service in the country is needed and adherence and implementation of policies, guidelines and protocols need to be strengthened at all levels of cares.

- The security of patients and staff in all service points, particularly community health centre and clinic level, also needs urgent attention to ensure the safety of staff and patients.

Human resources

- Mental health staff recruitment and retention should be a priority.
- Recruitment of scarce professionals, e.g. child psychiatrists, needs attention in terms of revisiting the package the Department offers.
- The department should avail a dedicated budget for super specialists.
- Training of staff in special fields, e.g. occupational therapy, social work and psychology, is needed to ensure the holistic multi-disciplinary teams at all levels.
- Opportunities for psychiatric nurses to do advanced psychiatry should be created because there is a need for at least each community health centre to have a psychiatric nurse with advanced psychiatry qualification.
- The criteria of the payment of occupations specific dispensation should be revisited at national and provincial level as a matter of urgency.
- Danger allowance for all professionals who render mental health services should be considered.
- Joint appointment of registrars with universities should be prioritised to attract specialists in the North West province.
- Thorough training of mental health coordinators on the mental health conditions to be able to take care of users in the absence of medical officers should be considered.
- Bursaries should be made available to mental health providers in order to retain them in the province.
- Training opportunities for psychiatry staff in primary health care facilities should be created.
- Continuous training for health workers including medical practitioners must be established.

Mental health and other conditions

- No specific recommendations.

Mental Health Care Act

- Orientation and training of police officers on implementation of the Act.
- Corrections and amendment of the Act on some areas is necessary.
- Implementation of the Act should be re-addressed by means of orientation sessions and workshops with staff in facilities.
- Amendment of either the Mental Health Care Act or the Children's Act, or both, is needed to agree on the age of children.
- An increase in the number of designated mental health establishments is an urgent matter, as well as the designation of special courts for mental health issues in other countries.

Child and adolescent mental health care

- Separate child and adolescent in-patient units and investing in resources were identified as areas of concern.

Culture

- Traditional health practitioners' practice must be specified by national legislation, policies and criteria.
- Involve traditional healers with the multi-disciplinary team so their knowledge can be included in the treatment plan, share information and identify research areas.
- Training materials should be developed for the purpose of educating traditional healers.

Suicide prevention

- No specific recommendations.

Advocacy

- Awareness raising through workshops for teachers, parents and at nursery schools.
- Involve other stakeholders, e.g. SAPS, in awareness raising activities.
- Make IEC material available on mental health in all languages.

Intersectoral collaboration

- Relationships with other departments, health programmes and other role players, e.g. traditional health practitioners, should be strengthened.
- The mental health programme should work in close collaboration with others and share resources where possible.
- Role clarification among all the stakeholders should be done.

Western Cape: summit report

(23-page document with narrative recommendations per breakaway group)

Commissions (5)

1. Patient led recovery approaches / person-centred recovery.
2. Prevention and promotion: upstream issues.
3. Integration with chronic disease management.
4. Legislative frameworks.
5. Research.

Prevention and promotion

- Improve detection of common mental disorders including substance abuse, through:
    - Screening of high risk patients (including children and adolescents) for common mental disorders including substance abuse.
    - Improving mental health literacy.
- Planning for screening and expansion services.

Research and monitoring and evaluation

- Improve availability, quality and usage of mental health data, through:
    - Establish a mental health information system.
    - Inclusion of mental health indicators in annual performance plans.
- Prioritise research as part of clinical care, evidence-based research that is culturally appropriate.
- Build partnerships with other disciplines, NPOs, universities.
- Prioritise funding.

Mental health systems

- Strengthening of primary level and community-based mental health services to improve prevention, rehabilitation and restoration of social roles.
- Expand availability of mental health services for common mental disorders, child and adolescent services and substance abuse, through:
    - Expansion of child and adolescent mental health services.
    - Provision of brief interventions for clients screening positive for substance abuse.
    - Expansion of adult mental health services and programmed addressing common mental disorders.
- Strengthen community-based mental health services for severe mental illness.
- Expand on best practice models (e.g. using SAMISS to screen for mental illness).
- Strengthen the link between the nurse and community care workers.
- Provide treatment adherence support as for HIV and TB – i.e. a DOTS strategy for mental health.
- Expand Specialist Assertive Community Teams for referral of more complex cases.
- Find a balance between integration and specialist referral to maintain optimal quality.
- Introduce appointment system at PHC for follow up to prevent long wait and clinic congestion.

Infrastructure

- Improve physical infrastructure and provide support to professionals providing mental health care service at primary health care.

Human resources

- No specific recommendations.

Mental health and other conditions

- No specific recommendations.

Mental Health Care Act

- Improve the rights of state patients and prisoners undergoing observation.
- Improve access to legal services through the establishment of a legal resource centre for mental health care users.
- Review consistency of the Mental Health Care Act and other Acts, and clarify relevance of other Acts to the Mental Health Care Act.
- Improve compliance with the Act by providing training and accreditation for all health care facilities providing 72-hour assessments.
- Revise the regulations and section 19 of the Act and strengthen the powers of Mental Health Review Boards.
- Clarify whether private facilities are authorised to provide mental health care services for assisted and involuntary users.

Child and adolescent mental health care

- Expand availability of mental health services for common mental disorders, child and adolescent services and substance abuse, through:
    - Expansion of child and adolescent mental health services.

Culture

- No specific recommendations.

Suicide prevention

- No specific recommendations.

Advocacy

- Promotion of recovery awareness.
- Active measures against discrimination.
- Consumer involvement in service feedback, planning and delivery.
- Measures to improve accessibility to the wide range of treatment and support services that are required for recovery.

Appendix 11: Detailed summit breakaway group recommendations

Group 1: Mental health promotion and prevention of mental disorders
(Time: 6m22s)

First and foremost was **increasing the human resource to include training of all stakeholders in all sectors**, because we find there's a lot of discourse. You train people within the department of health and then people within the department of education or labour do not understand what we're trying to achieve and within the NGO's perspective I think we actually get very confused.

We felt that the two issues that were very prominent is **foetal-alcohol syndrome** as well as **maternal depression.**

Within the **foetal-alcohol syndrome** the proposal is that programmatic interventions to address alcohol and substance abuse during and after pregnancy and screening brief interventions at antenatal and postnatal clinics.

With regard to **maternal depression** we looked at interventions to treat maternal depression and promote attachment and stimulation. Within the prevention and promotion package we recommend that we train antenatal and postnatal service providers in mental health. We look at ongoing screening of all pregnant women for mental disorders, pre- and postnatal, and then the home visitation programme delivered by community care-givers, but also to utilise your social workers who are involved in ongoing care and services to persons with mental illness.

With regard to your middle childhood, we looked at **family strengthening** which is a core component in terms of prevention and promotion. We looked at **strengthening collaboration** between the department of health, department of social development, as well as the department of education. While we've identified these three departments, we thought if there's other relevant stakeholders, if there's other relevant departments involved in terms of family strengthening they should also be called into this training.

In terms of school health teams, we want to **link with the community care givers who link with family champions**,

We want to **include mental health into life skills curriculum at school level**

We also want to look at **teacher education and support**.

In terms of adolescence, this was a huge discussion because I think most of our problems in terms of identification come out in terms of adolescent behaviour. **School retention and out of school programmes** are vital, **intersectoral collaborations** at all levels are essential and then we're looking at **school health teams** as part of your re-engineered public health system to **assist with screening for mental illness and referral.**

In terms of your adult and older persons, we've combined the two to look **at linking psycho-social support programmes and group activities with income generating projects** and here we've looked at **whose responsibility** would this be and very prominently our department of social development was absent or is absent and that is a primary responsibility within **department of social development** and we also want to rope in **department of labour** and the recommendation would be for **health to reach out the these departments** to bring them in to provide services to adults and older persons.

Work based interventions to promote employee wellness.

Dementia is a huge issue in terms of older persons in terms of prevention, **community caregivers to educate and support family members and assist with medication**. And, a recommendation is for **dementia units to be at all provincial level**.

There were various cross-cutting issues in our discussions of vital importance in the relevant sectors. **Department of**

social development and the department of basic education need to include policy on mental health, promotion and prevention in their programmes.

Monitoring and evaluation of policy should be managed nationally, provincially and locally.

Group 2: Mental health research and innovation, and surveillance
(Time: 6m4s)

Firstly, is that the DOH **drive regular collaborative that's nationwide, multisite, population based surveys to establish the evidence for mental health service planning.** This will be every five to ten years, for example **as part of other ongoing national population based survey**s so that mental health is not separate but it's included and it's part of ongoing or research or surveys that's already ongoing.

The second one was to **ensure that planning and provision of mental health services is evidence based**. We felt strongly that evidence based should be incorporated or it can even include the KPAs of the hospitals, the general hospitals so that it can be monitored and seen where is this evidence based, is it realising? And then it can include, ag it can involve policy makers in planning and conduction of mental health research and it can also involve research in the development and evaluation of policy.

The third one is to **establish an integrated national surveillance system and appropriate monitoring and evaluation systems for mental health care, relevant to all tiers of health systems**. This thing includes the minimum mental health data set and that's case definitions based on the ICD 10 codes and also the **development of baseline mental health indicators** to be included in the NSDA and routine monitoring of outcomes.

Then there's others that I can list, **electronic medical records, national mental health clinical registry, data relevant to cost effectiveness** because we also felt that cost effectiveness is very important within research and in, for us as the research group.

Then to **increase resources and for us that included human as well as technical resources** and that's specifically for the mental health research training skills as well we also brought in the evidence based practice again. So **to invest in ongoing research training**, that can be at Universities but also it can be at/on an advanced level but it can also include health workers and managers at all different levels.

Then we also recommended that there should be **appropriate mental health service and research funding from government** in line with the NSDA and the WHO recommendations. The NSDA's and the national service delivery agreements and for this collaborative funding initiatives of research is needed. That can include local and international institutions, DOH and Universities, research fellowships, research programmes in key areas and then the public-private partnership as well.

Then the **establishment of statutory bodies to incorporate and have specific indicators on mental health**, and examples there can be the national health research committee should incorporate specific priorities for research in mental health and medicines control councils should provide information on the number of trials conducted in mental health and it can also include, these bodies can also include the MRC, the HSRC, and the NRF as well.

Then the last one is that we felt c**onsideration should be given to new approaches and technology** as well and this can include tele-psychiatry, pharmaceutical, tele-education, clinical consultations and clinical and research supervision, task shifting

Group 3: Mental health systems
(Time: 4m36s)

The first one we looked at was mental health to be taken as a priority programme. We said that the **Department of Health should recognise mental health as one of the top five priority programmes**, both at national and local levels,

with clear financial planning budgeting and also to have indicators and then you do monitoring and evaluation.

The second point is on district mental health care teams. What we are saying here is that we need to **establish a specialist district mental health care team in each district and** a team should include a psychiatrist and also a medical officer, preferable with, additional training, post-graduate training, to include a social worker, a clinical psychologist, a specialist mental health care nurse, and also an occupational therapist. And we also added that the team must have a vehicle and other resources and in terms of the time frames, we said that we must identify districts which have been identified as pilot projects for the national health insurance and we start from there and then we will increase by twenty-five percent every two years.

Now, the third point of discussion looks at integration of mental health into primary health care. Here we are saying that we must **call for the integration of mental health services across all levels of care** from the reengineered primary health care model and to include the me/the mental health care workers, the PAC clinics, the school health, the district health teams, the NGO's, also needs to be brought on board and also, we must look at the referrals upwards and downwards.

The next one is on referral pathways. Here we ask for the **establishment of appropriate referral pathways for mental health which will facilitate the implementation of a continuum of care in a public health approach** that will provide for prevention, treatment and rehabilitation services.

The next one looks at funding. There was a discussion between whether we look at funding in terms of the burden of disease or we have a dedicated budget which is referenced for mental health and we ended up agreeing that we should be smart in this one **and call for improved monitoring system where we monitor mental health activities and thus, indirectly, we will monitor the budget which is allocated to the programme**. That is the end of our discussion, thank you.

Group 4: Mental health infrastructure and human resources
(Time: 12m38s)

The ten forensic psychiatric units in this country need to be revitalised because they are not fit for purpose, all of them.

Infrastructure must not do harm to mental health care users and it must be fit for purpose across all levels of care and be based on clinical needs and service package including academic institutions.

We need to **decentralise mental services down to original district, primary and community levels** and definitely make sure that we treat mental health care users nearer their homes as a key principle.

We need to provide for, the group here wanted to refer to gender, I mean **gender groups, not population groups**, so **we must provide for children, adolescents and older persons**

We need to **build facilities according to mental health requirements from the start** with proper maintenance plans because it's recommended that it's cost effective to do so unlike having to go back and renovate and correct mistakes.

Also, as part of the principles, that mental health **infrastructure must uphold and reflect human rights of mental healthcare users** and it should **promote a therapeutic environment** and we must **make sure that the safety of mental healthcare users arranged**, is in short in the infrastructure that we build.

So as a way forward the group recommended that there should be no **new stand-alone psychiatric hospitals that must be built**, we need to **accelerate revitalisation of existing psychiatric hospitals** with proper reconfiguration of bed requirements and therefore provincial, comprehensive strategies on revitalisation of psychiatric hospitals needs to be drawn.

All newly built hospitals must provide for mental services, that's another recommendation, ((applause)) thank you.

Clear clinical policy guidelines and with operational narratives on mental health infrastructure should be developed. This should include all psychiatric hospitals, facilities that render seventy-two hours and also on community based mental health facilities, so we need clear guidelines on this.

All district hospitals to render 72-hour assessment services and the number and size and **infrastructure design needs to be aligned to the mental health needs of the population.** We need to go away from that old notion of building big psychiatric hospitals and locating them outside communities where families cannot reach and visit their significant others.

At least one child and adolescent mental service per province and **also units for co-morbid disorder,** so I don't know what's happening with this thing, eh, so it's recommend that **this unit should be built in ratio to the population needs** and then **each province to have a forensic psychiatric unit** that provides for forensic services for observations and mentally ill prisoners and state patients.

Strengthening community based mental services, the draft policy must articulate to that and then also to say that we must **scale up rehabilitation services in mental health including substance abuse**, **and all academic hospitals to include mental health services.**

So, in terms of human resources, the group reported that **mental health is not fully developed in PHC's three streams on re-engineering strategy** and that mental health is not included in the total package of services according to the policy on hospitals and the new definitions.

There is **no database for mental health professionals**, their utilisation and the current supply and retention in the department.

Also, that **mental services are not included in the tertiary service grant**, there is no information on competencies required for mental health in line with the WHO pyramid for mental services, you remember that pyramid by WHO on organisation of mental services, to say that it needs to be clarified what competencies are required according to all those levels up.

And then, also that there is a need to **expand the field of psychology**. It reported that currently, what is kept charting this persal system for this group, they are grouped together with vocational counsellors and this is not clear, you know what vocational counsellors and psychologists are. So it's recommended that **psychologists be included also in the definition of health sciences** and that, the fact that they **also do not receive clinical training grant, or health professions training and development grant allocations.**

There is absence of social workers in the HR strategy and **social workers and OT's are very critical in psycho-social rehabilitation programmes in mental health** and also limited support for NGO's in mental health.

So, what is recommended is that the **PHC re-engineering policy document should include mental health professionals** So, there is lack of **data on professional training and CPD after qualification** in provincial departments

The **policies on hospital management, classification of hospitals and service packages must also include mental health** at all levels and all mental health multi-disciplinary workforce should be included in the departmental HR strategy.

We need to have a **database on mental health professionals** which is linked to the developing NGOH database as specified in the new HR strategy.

It's recommended that we have **a systematic needs-based approach to be adopted to establish a needs,** I mean, **needs for mental health professionals** so as to inform target setting and planning. This should include the norms and guidelines for staffing.

And the group then recommended that **a task-team be developed by mental health stake holders and NGOH to develop a work force plan and a training plan for mental health professionals**.

Mental health also be included in the national tertiary service grant and **the field of psychology be revisited** and be defined together in/as a health sciences programme.

Also issues around resourcing, creation of posts, be aligned to the training in this field and **also the training of psychology be included in the clinical training grant for health professionals**, training and development grant. We were informed that clinical psychology's the only profession that's not included in this grant, all other programmes in the health programme are included.

Social workers and OT's be part of the mental health requirements in the HR strategy. Lastly the post for OT's and social workers be created and we need to benchmark from HIV and AIDS and TB on the dot programme, maybe we should develop a mental health dot strategy.

We need to review norms based on mental health needs and support **for psychiatric nurses in terms of the OSD** and **incentives and posts need to be revised**, **standardised training for mental health** and lastly, we **need a policy to facilitate accreditation of nursing colleges as higher education institutions in collaboration with the department of education**.

Group 5: Mental health and other health conditions
(Time: 9m36s)

The discussion was mainly focused at mental health and HIV specifically, but it was recognised that it was an area that was not adequately addressed.

One is looking at human resources; the other is looking at the whole area of mentorship and support, screening and prevention interventions, integration and coordination of services, health promotion in general, both for mental health and other chronic illnesses.

So, looking at human resources which we have **added employee wellness plan for mental health and other chronic illnesses management**.

The whole area of task-shifting and training, that **within mental health there also has to be an area where we also look at task-shifting of some responsibilities** and some functions to the lay workers, which in particular, looking at the lay counsellors who are already in the health system, and patient advocates, but looking at what other areas of skills that they need to be given to strengthen their function, to take on the work of mental health as well.

And looking also on the area of **increasing some skills for all professionals and screening and identification of mental disorders,** and that this needs to be a coordinated area within the human resource plan, which will include NGO's who are in this area of chronic illnesses but also who- in mental health, social development and health, so it's not just a health area to be addressing. **Everyone else who's also providing psycho-social support to be also included in how they can also support in screening and identification of mental disorders.**

The other area under human resource plan is the area of **training and task-shifting of all staff who are working on HIV and other chronic illnesses** because as we know, that currently it's not happening as the picture was painted that it- we're working in different specific diseases, there's no in-there's very limited integration and going forward, if we want to integrate, there has to be training, a **training element that capacitates all health care workers who are working in chronic illnesses and mental health to also embrace mental health,** but also, they need to be trained on mental health.

And that we also **tap into the piloted districts on the national health insurance in how the human resource planning for mental health and other chronic illnesses is going to be integrated** and that we take lessons from that and how it

can be rolled out in other, in other districts as well, beyond the piloted districts.

On the area of mentoring and support, we also recommend **that part of the role of the mental health professionals should be training, and training others in outreach,** since we acknowledge that we don't have enough human resource capacity, how about the ones that are already in the system train others but also support outreach programmes in areas where there is no professional or healthcare worker that specialises in mental health? And that we also **monitor this training in terms of outcomes**, so it's not just training for the sake of training but also with specific targeted outcomes that we want to get out after the training. And this doesn't necessarily have to be physical support or mentorship support that is physical at the facility, it could be **done by using existing models like the tele-psychiatry**, in making sure that we reach out in areas where there is limited support and mentorship for other health workers. But also, **strengthening supervision and mentorship of counsellors, specifically lay counsellors** who are already working on the area of counselling for other chronic diseases.

On the issue of screening and prevention, we thought that maybe as a start, **we need to be targeting screening and detection of chronic illnesses and mental health illnesses rather than saying it will be done routinely. Where are the entry points** that are-((*inaudible*)) obvious that we are missing out in screening. For example, mention was made around testing when people are coming for testing for chronic illnesses, another was made on when people are starting ART, or maybe when they are diagnosed with HIV, those are some of the clear entry points that we are missing, but they are not limited to that, we didn't want to mention which ones, but it could be broadened to what are the obvious entry points that we could tap into.

Also, to **identify appropriate instruments for screening**. There is already existing screening for the other chronic diseases and mental health, how can we integrate those screening tools so that we screen comprehensively rather than screening for specific diseases as we are going towards integration.

Also, to look at **what would be the appropriate referral pathways that we could look at, that we would be looking at all the other chronic illnesses, not just mental health**.

And **also identify key targets that we need to be meeting**, so that we're not just meeting here and defining policy, but also operationally, what are the key services that we want to get out, scaling up services, especially on mental health who are already not adequately received by the population, what are the key targets that we need to be putting forward so that we can measure ourselves against.

And also, we are saying that **adherence monitoring and interventions also needs to be**- it underlines all of the outcomes in terms of screening so that we don't only identify people when they are already defaulting.

And then the other area on integration of services, that there has to **be coordination of these services**, we can't assume that everyone will embrace mental health, or embrace this comprehensive move towards integration of chronic illnesses and mental health, that various administrations from national to local, that everyone embraces coordination of these services so that there's also this systemic work comprehensive way that we work in all administration.

And that at each point of service, there has to be **clear referral from when a person comes into the health system**, and how do people get into other services so that they are not lost in between the cracks.

Also, integration of services within chronic illnesses themselves, so that there are people who have multiple chronic illnesses that sometimes there's also lack of integration within the services that already supposed to be integrated. That also, **integration of services needs a lot of political leadership and will, within health and social development** to coordinate within their own departments but also amongst themselves as it was noted by other groups that the absence of social development in the summit needs to be addressed so that also we're not talking about social development in absence of social development, it needs to be part of the coordination discussion.

And also looking at the **whole issue of health promotion**, that we can't just address this issue at the service level point of care, we also **need to be addressing communities around where people are accessing services**, that there has to be

primary and secondary tertiary prevention of chronic illnesses and early interventions of mental health disorder, so that we don't wait until the problem is big, that we actually ongoingly promoting healthy living amongst people with chronic illnesses and mental disorders.

Also, to also promote healthy, prevention in communities and **mobilise communities around the whole issue, around stigma** on all the chronic illnesses and mental health issues, so that it's not just an issue that is dealt within the health system.

Group 6: Mental Health Care Act of 2002 – lessons learned from implementation
(Time: 1m54s)

We identified eleven challenges and we came up with fifteen proposals.

Those are the challenges. We identified infrastructure and human resource problems, budgetary constraints and also discussed the Mental Health Care Act and other relevant acts, as well as policy, problems with policy.

The fifteen proposals, very briefly, focuses on **the implementation of the Mental Health Care Act that are limited by language barriers** for example, by **cumbersome forms that are being revised**, but we also recognise **the central role of the Mental Health Review Boards** and that many of the Mental Health Review boards are not fully functional due to budgetary problems, and we urge the Minister to pay particular attention to the revitalisation of the Mental Health Review Boards. Thank you.

Group 7: Child and adolescent mental health
(Time: 5m16s)

The first one is that the **National Mental Health Care Policy must make adequate provision for child and adolescent healthcare**.

Child and adolescent psychiatry should be reclassified as a major speciality akin to paediatrics, such as psychiatry is akin to internal medicine.

There is a **need for a child and adolescent psychiatrist to take responsibility for child and adolescent mental health services in every province and nationally**, and to work with the provincial and national departments in the delivery of child and adolescent Mental Health Services.

We **need a child and adolescent mental health professional within the provincial directorates of health programmes to drive prevention and health promotion.**

The **government should implement the national standard, norms and standards.**

Infrastructure should be provided in all provinces and should be adequate and developmentally appropriate.

Human resources should be fit for purpose, not based on generic medical estimates. Adequate staffing is vital.

Child and adolescent Mental Health Services should be part of the NTSG Grant.

All disciplines should receive remuneration commensurate with their level of expertise.

Sufficient numbers of child and adolescent specialists in all disciplines to be trained. Two specialist registrar training posts per medical school.

The resuscitation of Psychiatric Nursing Training specifically in the area of Child Psychiatry.

Child and adolescent Mental Health training should be **included in the training of all health and child professionals**.

Packages of care and appropriate outreach should be implemented according to current policy and legislation across all levels of care.

Appropriate standard treatment protocols and guidelines should be made available and monitoring should be implemented.

Intersectoral responsibility, and this has been discussed a lot in the course of the last couple of days, specifically applying to other departments on whom Child Psychiatry is particularly dependent, this responsibility **needs to be made explicit in relevant legislation or policy.**

Child and adolescent substance abuse in particular needs to be coordinated and evidence based, and take account of the need for parallel programmes for dual-diagnosis patients.

Finally, the group wished to continue this consultation, the decision was that this really could not be the end of this story, that there is a **need for an appropriate, ongoing forum of this nature, perhaps coordinated and funded by the National Department of Health**.

Group 8: Culture, faith-based practices and indigenous mental health practices
(Time: 4m50s)

We felt that, **going through the declaration, there was not enough mentioned of cultural and faith based practices in Mental Health.**

We therefore recommended that **the very first sentence, which defines health, should also include a statement that says there is no Mental Health without the fulfilment of cultural and spiritual needs of an individual**.

In the same document, we also felt that Mental Health Services delivery should also take into account that there is currently **no two-way system of education between allopathic, traditional and faith-based healers** and this needs to be addressed.

Again, sticking to the declaration, we also felt there **should be a statement included regarding the significant amount of South Africans who consult traditional and faith based healers** and by so doing, one can then decide what to do in order to encompass these aspects of the patient when treating them.

We also felt that, on page three of the declaration, **there should be an inclusion regarding the traditional and faith based healing practices within the universal treatment of Mental Health Disorders**.

And then the last, very last page of the declaration leaves space for what we are then saying, we're going to focus on in addressing Mental Health Issues and the recommendations are that we should first of all **accept the right of users and carers to consult healers other than allopathic healers.**

We should **include cultural issues in the curriculum of the school and training of all mental health practitioners.**

We should also **increase the number of Mental Health Practitioners who are well trained to deal with cultural needs of the users** they serve and this training should be delivered by the healers themselves where possible.

Recommendation number four looks at **ethical practices**, and we feel these need to be **central to the management of users and carers** and the protection of their human rights in all the treatment systems, whether allopathic or traditional or faith-based, with **ways of redress made available to users in case of unethical practice**.

We also felt that there should be **an encouragement in collaborative research and funding from both streams** to

contribute to a unified body of knowledge which can then be accessed to better fulfil the needs, whether cultural, faith-based of users and carers.

Group 9: Suicide prevention
(Time: 4m51s)

On the declaration, there's only **one sentence about suicide prevention**, and it was about the fact that it is increasing. And then we realised that maybe **we really need to say a little bit more** because it is increasing due to all those aspects that are in the declaration. HIV, you know, all those different conditions are risk factors.

So now we said that we should **establish a statutory South African National Suicide prevention programme** which we could call SANSPP, which comprises the following principles:

Inter-provincial variations which are contextual to each community, that is, which should be relevant according to the different religious groups as well as the different cultures.

Very few people recognise the cry for help of these suicidal individuals, then it will be important for us to **make sure that education and awareness programmes are put into place** to deal with the general and the specifics as follows:

For general at community level, to be enabling and capacitating, **reducing stigma**, because there's a lot of stigma that is attached to suicide, and decreasing unrealistic expectations.

For specific, we thought that **education and awareness programmes** should be put in place so that we are able to deal with adolescents, the patients with depression, family discord, uninformed services- uniform service providers and all other **risk groups**.

We also said that it will be important to make sure that there is **unrestricted access to all levels of care, primary, secondary and tertiary,** for all persons seeking help, **including adequate financing**, because sometimes you'll find that there is not enough money to help, resources, community support and intersectoral linkages.

We also thought there must be **an over-arching national, provincial and local monitoring and surveillance programme on the trends.**

Group 10: Advocacy, social mobilisation, user and community participation
(Time: 11m10s)

So firstly, recovery principles we feel must be **an ethos which pervades policy and practice** in South Africa overall. In the mental health policy as it stands **there's reference to recovery approach but we feel this should be strengthened**. There's a two-based focus here. Number one, the human rights focus and secondly a recovery approach to mental health in South Africa. Mental Health Service delivery is a service delivery system which would support people to build and maintain a meaningful and satisfying life regardless of whether or not they have ongoing symptoms of mental illness. So, we're wanting to **move away from the medical model of cure to a recovery approach which looks at meaning for life creation, not symptoms**. I'll leave the rest. Then, importantly a flipside to the corn of recovery, which is a personal journey of each individual who has mental health problems is the provider, the government, the policy-maker, the politician's response to this recovery, this personal journey of recovery and this **response can be framed in terms of recovery but within the health system within the service delivery approach, a treatment approach which we know is like a social rehabilitation**, and we felt psych-social rehabilitation should underpin the practices within the health department and we've listed some ways that we can do this. For example, **developing recovery centres that focus on development of strength**, **revising psycho-social programmes** which is premised on the needs and voices of people with psycho-social disabilities, **revision of health establishments visions, missions, goals to reflect recovery principles** as well as being reflected **in annual expected outcomes with annual performance reviews, inclusion of recovery modules in training programmes and in-service training programmes** and we feel that this should be a theme running throughout the whole policy and also be related to other sectors who have an impact on people with mental

health problems.

Then the second area I mentioned was **active measures are needed against stigma and discrimination**. We've heard about how people are stigmatised and some of the things we feel needs to be addressed here is in the Ottawa Charter speaks about the reorientation of health workers and we think in line with that, that **public sector departments and service providers should be supported to re-orientate their current medical relational style to a recovery orientated approach** which encourages them to share their expertise, their skills as well as decision making platforms, such as we are doing today, with users and their families. There's a need for **the development of a national mental health lobby of users and their allies**. This would be providers, users, researchers, putting our heads together in a TAC style. We felt that the TAC, the Treatment Action Campaign, really provides us with a good model how to develop such a national lobby and then thirdly, and **ongoing national public awareness campaign and we felt that government should direct resources for advocacies to mental health NGO's, DPO's and self-help organisation so that we can develop our own advocacy campaigns to overcome stigma and discrimination**. There were some specific targeted strategies that we mentioned which I won't go into right now except to say that it should be targeted at different levels. At the policy makers to harness a political will for changes in the mental health system, to government, to increase their accountability to users and of mental health services, to the media who propagate certain visions, views of mental health services, we need to engage them as partners as well as being a watch of the practices they do have and then at community level we need to support inclusion by assisting communities to de-stigmatise and include mental health users.

Then the third issue was organisation for representation of users in policy development and implementation and the basic thing here was that **there should be support from government and other agencies to develop user-lead DPO's** and there's international literature around how ministries, development agencies, NGO's, DPO's and Donor organisations can support these without imposing their own agendas on these organisations. At a local-level, we felt that **a building block for the development of self-help organisations was the establishment of support groups** because through these users can progressively become empowered either towards wellness or for those that are interested to become leaders in advocacy because as we've already said, it's important to have users of mental health services included in all advocacy programmes because it's only as they are speaking for themselves that attitudes will change. We also want to **establish closer connections with available mechanisms for representation including the human rights commission and other independent monitoring bodies**, which has been established under the constitution. There's also thought that there should be an **establishment of an independent national user-led implementation watch** within either the Human Rights Commission or the Ministry on Women, Children and persons with disability, and that this would be a formally legislated mechanism for getting user voices out there. The Mental Healthcare review boards should also have, not just the occasion to use the community representation possibly for mental health users to be represented but there should **be a category of mental healthcare user representation on the review boards** and then lastly their **ombudsman for mental health.**

Finally **improving access to medical, social and environmental supports**. These related to the **intersectoral duties** that we mentioned earlier and there are many environmental supports which can capacitate users to take their place as citizens in South Africa. This included issues related to **income generation, education and skills development**, including tertiary education, **housing and basic amenities, disability benefits** and we've spoken extensively about **treatment**. These are just some of the examples of how each department can actually do this. I think what I will just mention is that there was a very strong feeling that the **mental health directorates in the Department of Health need to be beefed up at least to a directorate level** because your access to decision making for a depends on your echelon in a department and for users and providers and other people to have a voice within government, we feel that that role should actually be at a decisional level, it should not be at a lower level where you've got to feed your views through several echelons before you can actually get to the nitty gritty.

Appendix 12: Descriptive analysis of alignment of group discussions with group recommendations and group recommendations with summit recommendations

Group 1: Mental health promotion and prevention of mental disorders

Group recommendations reflect group discussions: There was substantial alignment between the formal presentations in this group session and content of the subsequent discussions. This may have been partly because the session Chair was also one of the presenters. The group recommendations also map onto many of the issues raised in the presentations. The recommendations presented at the plenary seem to closely reflect the issues raised during the group discussions. However, recommendations around the specific phrasing in the promotion and prevention section in the policy were not taken up in either the group recommendations or the final policy document.

Summit recommendations *partially* and *broadly* reflect group recommendations: The one recommendation added to the summit declaration following the summit could be argued to broadly reflect the specific proposals made by this group: "develop and implement a mental health service delivery platform based on community and district based models to ensure that prevention, promotion, treatment and rehabilitation services meet the needs of all." However, the specific detail contained in the 12 group recommendations is abstracted out in this broad statement.

Group 2: Mental health research and innovation, and surveillance

Group recommendations *partially* group discussions: Although the two presentations focused primarily on research priorities and on telepsychiatry, the group discussions kept returning to issues around surveillance and monitoring and evaluation. The group recommendations that were presented at the plenary session broadly reflected the group discussions.

Summit recommendations *partially* and *broadly* reflect group recommendations: The recommendations on the summit declaration that emerged directly from the national summit do not address research and innovation, although this is captured in the summit text that was drafted *pre*-summit ("developing and supporting research and innovation in mental health"). One post-summit recommendation related to monitoring and evaluation; this could be argued to be an abstracted reflection of the group recommendations pertaining to this issue: "establish a national surveillance system and appropriate monitoring and evaluation systems for mental health care integrated into the National Health Information System." There were thus nine group recommendations pertaining to this topic, and one recommendation added to the final summit declaration.

Group 3: Mental health systems

Group recommendations *partially* reflect group discussions: Issues covered in the group presentations roughly aligned with the group discussions. The group recommendations made at the plenary session do seem to broadly reflect the suggestions made during group discussions, although inevitably some of the detail was lost. Concerns about lack of funding support for NGOs to deliver community-based services were not followed through into the group recommendations. Similarly, the debate regarding general versus mental-health focused staffing at primary health care facilities is not reflected in the group recommendations.

Summit recommendations reflect group recommendations: The main recommendations from this group related to the establishment of a district specialist mental health team, adequate financing of mental health, integration of mental health care into primary health care, and monitoring and evaluation. These were all relatively directly reflected in the summit recommendations added to the summit declaration following the summit. Of the five recommendations put forward by this group, the only one not reflected in the summit declaration is the establishment of appropriate referral pathways to facilitate a continuum of care.

Group 4: Mental health infrastructure and human resources

Group recommendations reflect group discussions: The group recommendations regarding human resources were quite data- and target-focused, with the result that many of the proposals seem to depend on the accurate collection of information regarding numbers of human resources for adequate planning. This may have been influenced by the statistical modelling nature of the formal presentation. Many of the group recommendations made regarding human resources seem to have been covered in the formal presentation. Although task shifting was mentioned in the group discussions, it was not reflected in the group recommendations that were fed back at the plenary session. Interestingly, the issue of district specialist mental health teams was not discussed at all in this group. Because there was no access to audio from day 1 group presentation and discussions around infrastructure, it was not possible to determine the extent to which the group recommendations reflected the discussions. The summary that the rapporteur captured from this session and that she read back to the group appeared to be accepted by the group as an accurate representation; this summary was almost identical to what was presented at the plenary. The 27 group recommendations were strongly focused on hospital infrastructure, as opposed to infrastructure for community-based or primary health care mental health services.

Summit recommendations *partially* and *broadly* reflect group recommendations: Two of the eleven post-summit recommendations on the summit declaration relate to human resources and to infrastructure. The human resources recommendation to “Embed and increase mental health human resources within the National Human Resource Plan”

could be said to broadly encapsulate the recommendations from the group; however, a great deal of the detail is lost. Similarly, the recommendation to "develop a fit for purpose plan for mental health infrastructure at all levels" roughly reflects the recommendations from this group; once again, however, it is a significant abstraction of the detailed group recommendations.

Group 5: Mental health and other conditions

Group recommendations reflect group discussions: The 16 recommendations coming out of this group were strongly focused on human resources – in particular, task shifting and the training and supervision of primary health care and lay workers to detect and refer mental disorders. There was also an emphasis on targeted screening and prevention, as well as on mental health promotion. This is consistent with the group discussions, which were framed by issues raised in the two formal presentations. The only two points from the discussion that seemed to get lost in the recommendations were the suggestion of integrating oral health or dentistry services into primary health care clinics, and employing a case manager to coordinate and support PHC staff – particularly nurses – in the detection and management of mental disorders.

Summit recommendations *partially* and *broadly* reflect group recommendations: There were no specific summit declaration recommendations addressing mental health and other chronic conditions, apart from the call – in the declaration content drafted prior to the summit – to integrate mental health into the general health service environment. The group recommendations that addressed human resource issues are roughly summarised in the recommendation added to the summit declaration following the summit, that mental health human resources should be embedded and increased within the National Human Resource Plan. However, all of the detail contained in the group recommendations gets lost in this abstraction. Similarly, the detailed group recommendations around prevention, screening and referral of mental disorders are abstracted to a broad recommendation in the summit declaration to "develop and implement a mental health service delivery platform based on community and district based models to ensure that prevention, promotion, treatment and rehabilitation services meet the needs of all."

Group 6: Mental Health Care Act of 2002 – lessons learned from implementation

Group recommendations do not reflect group discussions: The focus of the presentations and discussions in this group was on challenges encountered with the implementation of the Mental Health Care Act. As a result, the proposals that were raised related particularly to factors that would improve implementation of the Act, including a baseline audit of hospital infrastructure, consultation of mental health professionals in infrastructure planning, training and awareness raising around the Act, licensing community-based organisations and step-down facilities, better resourced Mental Health Review Boards, the protection of mental health care users' human rights, improving intersectoral collaboration,

and addressing the administrative burden of implementation, especially around forms and court processes. Although it seems likely that all fifteen proposals that the rapporteur reported capturing were taken into the closed-door meeting with the Department of Health summit organisers, only four recommendations were presented at the plenary session. These reflected some of the group recommendations, but most of the detail and other proposals was left out. The recommendations made to the plenary were to ease the administrative burden associated with the implementation of the Act, and to make forms available in other languages, and to adequately resource and finance Mental Health Review Boards.

Summit recommendations *partially* and *broadly* reflect group recommendations: The group discussions relating to infrastructure were reflected in the summit declaration content drafted prior to the summit, with the commitment to providing physical infrastructure that is conducive to the needs and human rights of people with mental disorders. They were also reflected in the recommendation added to the declaration following the summit to "develop a fit for purpose plan for mental health infrastructure at all levels." However, these were not directly linked to the four group recommendations given at the plenary session, which did not address infrastructure. The group recommendations around Mental Health Review Boards were broadly captured in the recommendation added to the summit declaration following the summit, to strengthen Mental Health Review Boards.

Group 7: Child and adolescent mental health

Group recommendations *partially* reflect group discussions: Some of the proposals that were mentioned in the formal presentations in this group were picked up in the discussions, although the presentations did not seem to have a strong influence in terms of framing the issues raised. These issues were quite diverse, ranging from early intervention and screening to treatment protocols, and from intersectoral responsibilities to human resources. The focus of the 17 group recommendations was on increasing human resources for child and adolescent mental health services, and reflected much of the group discussions around this. The detailed concerns raised during the group discussions about lack of appropriate infrastructure – such as inpatient and forensic units – for children and adolescents with mental disorders were only broadly captured in the one group recommendation to develop fit-for-purpose, developmentally-appropriate infrastructure for child and adolescent mental health. Proposals around the role of schools and teachers, and programmes for victims of child abuse do not seem to have been followed through into the group recommendations.

Summit recommendations do not reflect group recommendations: There were no direct references to child and adolescent mental health or mental health services in either the content of the summit declaration drafted prior to the summit, or the recommendations added to the declaration following the summit. Given that this issue seems to have been considered important enough to include it in the provincial and national consultation summits as one of breakaway group topics, it is notable that this does not seem to have followed through into summit recommendations.

Group 8: Culture, faith-based practices and indigenous mental health practices

Group recommendations *partially* reflect group discussions: As there was no audio of the two presentations for this group, it was not possible to determine how much of an influence these had on framing group discussions. The poor audibility also limited the comparison of group discussions with group recommendations. From the discussions that could be heard, a number of issues raised in the group do not seem to have been followed through into the group recommendations. Specifically, language was identified as an important focus area, but this was not addressed in the recommendations back to the plenary; similarly, suggestions to incorporate cultural issues into the diagnostic systems for mental disorders and the mental status examination, and to revisit implementation of relevant regulations regarding traditional healers, were not taken up into the recommendations. The specific suggestions relating to changes and additions to the policy document were not captured as group recommendations that were presented during the plenary.

Summit recommendations *partially* and *broadly* reflect group recommendations: This group engaged directly with the summit declaration throughout their discussions, and made specific recommendations regarding changes and additions to this document. Notably, one of the group recommendations was to change the wording of the statement in the declaration regarding there being no health without mental health to include "without the fulfilment of cultural and spiritual needs of an individual. Although this statement was not altered in the final declaration, a reference to culture was added to the body of the text drafted prior to the summit (addition italicised): "Recognising that…mental health must be achieved through increased services for mental health at all levels of the health care system, *and that culture plays a key role in mental health."* Other specific group recommendations regarding additions to the summit declaration were not incorporated. The one recommendation relating to culture that was added to the relevant recommendations on the summit declaration following the summit refers to strengthening links with traditional, complementary and faith based healers. Although this somewhat broadly captures some of the group recommendations, much of the detail is lost, while none of the remaining nine group recommendations were reflected in the summit declaration.

Group 9: Suicide prevention

Group recommendations *partially* reflect group discussions: These group discussions were framed around the more evidence-based presentation, and focused on the elements that should be incorporated into a national suicide prevention programme. The second presentation also made a number of recommendations regarding suicide prevention and interventions, such as strengthening health care workers' capacity to detect and manage suicidal risk behaviours, and improving the availability of psychotropic medication in primary care. This presentation also placed a lot of emphasis on task shifting and human resource capacity at primary care level. The detail regarding the capacity of

health care workers and the primary health care system to identify and manage suicide was extrapolated to one recommendation regarding providing unrestricted access to all levels of care. The emphasis in the group recommendations was on the components of a national suicide prevention programme, and on monitoring and surveillance of suicide trend. This reflected some of the group discussion, which focused on obtaining accurate data on suicide trends and on a national prevention campaign. However, there were other suggestions raised during the group discussions that were not followed through into group recommendations, including an emphasis on the role of culture in expressions of and responses to suicide, access to suicide methods, and increasing human resource capacity in schools and communities to play a role in detection and prevention.

Summit recommendations *partially* and *broadly* reflect group recommendations: One of the eleven recommendations added to the summit declaration following the summit was to establish a national suicide prevention programme. This captures the main focus of the group recommendations, although the detail of the components of this programme contained in the five group recommendations is lost in the summit recommendation. Notably, the one other reference to suicide made in the content of the summit declaration drafted prior to the summit – which noted that suicide rates were increasing – was removed from the final version of the declaration.

Group 10: Advocacy, social mobilisation, user and community participation

Group recommendations *partially* reflect group discussions: The first presentation was a brief account of the efforts of a service-user led advocacy organisation and is not reflected in the group recommendations; on the other hand, the rapporteur captured all of the proposals raised in the second presentation, which outlined the recovery approach. The group discussions seemed similarly to have been framed more by the recovery approach presentation than the user-led advocacy presentation. The recommendations put forward by this group were extensive – twenty-one in total. What was presented back to the plenary was a long and detailed list of recommendations; as such, it seems as though much of what was proposed by the sub-groups within this group was captured in the group recommendations. There are a few notable exceptions. The issue of inadequate and inconsistent financing for NGOs that provide mental health services, as well as those that run advocacy initiatives, was raised a number of times by both service users and NGO representatives. However, this was only broadly captured in the group recommendation that resources be re-directed to mental health NGOs and self-help organisations to enable them to develop their own advocacy campaigns.

Interestingly, some of the issues raised – sometimes more than once – by service users themselves do not seem to have been captured in the group recommendations. These included attending to the concerns of service users with respect to their treatment (such as medication side effects); an appeal for scholarships and education opportunities at tertiary level for mental health care service users; and more active creation of employment opportunities for mental health care service users. The latter two issues were broadly referenced in the group recommendation to strengthen intersectoral

responsibilities to improve access to medical, social, and environmental supports, including income generation, education and skills development.

Summit recommendations do not reflect group recommendations: Some of the group recommendations were broadly reflected in the content of the summit declaration that was drafted *prior* to the summit, such as calling for the participation of mental health care service users in planning, implementation and monitoring services, eliminating stigma and discrimination, and fostering a person-centred recovery paradigm. However, no specific recommendations regarding advocacy, user participation or recovery were added to the summit declaration following the summit. Given how extensive the recommendations made by this group were, it is surprising that this did not follow through into an emphasis on these issues in the summit recommendations. On the other hand, given how extensive and detailed these group recommendations were, it is perhaps equally not surprising that they were not followed through into summit recommendations, particularly considering the summative nature of the eleven summit declaration recommendations.

Appendix 13: Convergence coding matrix

How were participants' embodied knowledges enacted and captured (inscribed) during the consultation process? (embodied knowledge enacted)		
Summit group transcripts	**Interviews**	**Convergence**
Evidence-based knowledge claims were made more frequently during formal presentations than during discussions.		Silence (methodological, not thematic)
Most of talk during group discussions did not draw explicitly on evidence-based or experiential knowledge.	There seems to have been inadequate service user representation at the national summit. The lack of opportunities for service user involvement provide some insight into how the broader organisation of the process may have affected how participants' embodied knowledge could be enacted and inscribed during the summit.	Complementarity
Participants drew explicitly on both evidence-based knowledge and experiential knowledge to illustrate a current situation (challenge or best practice), highlight the (positive or negative) implications of a proposal, or engage with previous points raised.		Silence (methodological, not thematic)
There were no clear differences between the frequency with which either experiential or evidence-based knowledge were responded to or engaged with during group discussions.	Findings also suggested that the consultation and policy may have represented stronger (service provider) voices. In combination with the largely 'academic' the way that the summit programme and process were structured, this suggests that the consultation space may not have been enabling of knowledge inputs that deviated from the more formal or academic. However, the absence of explicit references to both experiential and evidence-based knowledge casts this finding in a different light. What service user representation there was may have been somewhat tokenistic, with the implication that even where service users' embodied knowledges were enacted, the possibility that these would be captured and transferred as inscribed knowledge may have been limited. However, the equal likelihood of experiential and evidence-based knowledge being captured – or not being captured – suggests that other factors may have been at play. The issues by interview participants regarding mental health seemed to strongly reflect their backgrounds and positions, which may be an insight into the nature of contributions that consultation summit participants made during summit group discussions. However, given the lack of explicit knowledge claims made by summit participants, the factors influencing what got responded to and captured (if not such warrants) are difficult to assess	Complementarity *and* Dissonance
Neither evidence-based nor experiential knowledge appeared more likely to be reflected (inscribed) in group recommendations across all groups. This suggests that what was reflected would have been captured as "other" in this coding, where no explicit references to knowledge claims were made.		

	Findings highlight the influence at the level of the individual on the consultation process and outcomes – through, the initiative required of individuals to ensure participation and representation at the consultation, as well as the endorsement of the process by certain key individuals.	Silence

How did the consultation process enable or constrain the movement of knowledge from enacted to inscribed forms? (enacted knowledge inscribed)		
Summit group transcripts	**Interviews**	**Convergence**
Little time available for discussion & engagement with draft policy.	{Findings conveyed the sense that some or all of the consultation outputs were predetermined, which would have acted as a significant constraint on the opportunities for enacted and inscribed knowledge to move through the process}. {This may also have made the influence of different group processes on follow-through and uptake of knowledge inputs from enacted to inscribed outputs somewhat inconsequential}.	Silence (methodological, not thematic)
All group processes were a form of 'microphone management'. Groups differed in terms of how they were Chaired.		
Group processes differed in how they engaged with draft documents (i.e. engagement of enacted with inscribed knowledge).		
Group processes differed in how they got to recommendations (i.e. went from enacted to inscribed).		

How did inscribed knowledge outputs from the consultation move through points of abstraction <u>to inform policy</u>? (inscribed knowledge transferred)		
Summit group transcripts & consultation/policy outputs	**Interviews**	**Convergence**
ABSTRACTION (first, within summit, and then with policy outputs)		
Provincial inputs went through abstraction / summarisation process to produce provincial reports. Comparison of recommendations with national recommendations suggest broad alignment. However, the more detailed and localised recommendations from provincial summits were inevitably not reflected in the broadly focused national summit recommendations.	The lack of consistency regarding whether and how provincial recommendations were used in or beyond the national indicates that alignment may have been more arbitrary or ad hoc than systematic. The findings from this analysis seem to highlight quite strongly the tension between moving from the particular or specific contextual knowledge (e.g. individual level, and provincial level) to the more abstract, inscribed knowledge of policy, with subsequent implications for policy implementation.	Complementarity
Group recommendations broadly represented group discussions in summarised form. (But) the enacted knowledge inputs during the group discussions at the national summit were substantially abstracted and summarised in the inscribed outputs.		
Summit declaration recommendations broadly represented group recommendations in summarised form.		
125 group recommendations were summarised into 11 summit recommendations. Although the 11 summit recommendations seemed to at least partially and broadly reflect the 125 group recommendations, much of the detail of the group recommendations was lost.		

How did inscribed knowledge outputs from the consultation move through points of abstraction to inform policy? cont.		
Summit group transcripts & consultation/policy outputs	**Interviews**	**Convergence**
INFLUENCE / USE / FOLLOW-THROUGH		
More alignment between group & summit recommendations and implementation appendices than the policy / policy changes suggests that kinds of inputs at consultation more amenable for uptake into this form of output, particularly in terms of the degree of detail in these recommendations.	There was general agreement that the policy is a good one, but there needed to be clearer, *more* detailed directives in terms of how the policy – and even implementation plan – should be implemented (further suggesting that consultation might be (better) utilised towards filling in these gaps?).	Complementarity
	Lack of transparency and consultation regarding how the implementation priorities were decided on and on how summit inputs may have been used towards this.	Silence
My own requests for provincial summit reports show lack of consistency / transparency regarding outputs from provincial summits and how they were used. There were inconsistences in the degree to which provincial summit recommendations were incorporated into the national summit – there was only oral feedback at the national summit from three provinces.	Lack of clarity regarding whether and how provincial summit findings transferred to national summit. Lack of clear follow-through of provincial summit inputs to national summit & policy.	Convergence
Pre-assigned issues for discussion and existence of draft summit output at start of summit suggest outcomes were somewhat predetermined. This, together with the existence of a pre-drafted summit declaration (output of the summit) suggests that the outputs of the summit were somewhat predetermined. Also, the correlation of the 11 summit recommendations with almost every one of the group topics suggests one per topic chosen (with exception of child & adolescent mental health, and advocacy).	Findings conveyed the sense that some or all of the consultation outputs were predetermined. Findings suggest that the consultation (national summit) may have been more of a rubberstamping / endorsement exercise than a genuine dialogue.	Convergence
Policy did not change substantially following consultation This suggests that, at the level of inscribed knowledge at least, there was not much follow-through of inscribed knowledge from the summits to the final policy.	Policy did not change substantially following consultation. Lack of transparency & consistency in information about/from summits. Closed door meeting to finalise summit recommendations make it hard to tell if / how group recommendations were used. The lack of information and consultation during finalisation of the policy subsequent to the summits makes it difficult to determine exactly how consultation inputs were used.	Convergence
There was little direct reflection of the summit declaration recommendations in the changes made to the policy following the summit and, due to the broad nature of the summit recommendations, limited interpretations can be made regarding alignment or lack thereof.		
The majority of group recommendations put forward at the national summit did not seem to be reflected in the changes that were made to the policy after consultation. This may be in part because few groups directly engaged with the draft policy during consultation.		

How did inscribed knowledge outputs from the consultation move through points of abstraction <u>to inform policy?</u> cont.		
Summit group transcripts & consultation/policy outputs	**Interviews**	**Convergence**
INFLUENCE / USE / FOLLOW-THROUGH cont.		
Broad summit recommendations aligned with draft policy.	As one participant intimated, many of the issues raised at the national summit may have already been reflected in the draft policy.	Convergence
Group recommendations requiring policy change built on existing draft content rather than opposed it or requiring modification that would change the nature or direction of the policy approach.		
More than half of group recommendations **not** reflected in draft policy.		Dissonance
The two substantive additions to policy following consultation were appendices relating to implementation priorities & activities.	Communication and consultation around the final policy and the priorities chosen for implementation was considered inadequate. Respondents raised concerns regarding the implementation of the policy and the potential disconnect between provincial and national levels.	Silence
Summit recommendations were largely reflected in both implementation-related appendices (but had to be generous in matching as the recommendations very broad and implementation plan actions more detailed – so in a way, was inevitable they'd match if they relate to same 'topic' as summit recommendation). While around half of the summit recommendations corresponded to the 8 priorities identified on the implementation plan, most of these recommendations were reflected in the more detailed key activities associated with these implementation priorities. The majority of summit recommendations were found to be reflected in some way in the Terms of Reference actions.		
Group recommendations were partially reflected in implementation-related appendices: Just under half of the group recommendations made at the summit seemed to be reflected in some way in one or the other of the implementation-related appendices. A third of the group recommendations were reflected in the key activities associated with the eight priorities on the Strategic Plan; less than a third of the group recommendations were reflected in the Terms of Reference actions.		

Appendix 14: Reflection of summit recommendations in policy and policy appendices

Summit declaration recommendations not reflected in post consultation policy changes

Monitoring & evaluation:

- Using the outputs from the summit to finalise the Mental Health Policy Framework 2012-2016 and to assist with its implementation and monitoring (pre-summit).

Note that for both this and for the governance theme below, this recommendation would not necessarily have reflected in the policy, as it was more of an action for the task team to follow in finalising the policy. Whether and how the summit outputs were used in finalising the policy is the question being addressed in this study.

Research:

- Developing and supporting research and innovation in mental health (pre-summit).

Advocacy and user participation:

- Promoting mental health as an important development objective (pre-summit).
- Ensuring that all users of mental health services participate in the planning, implementation, monitoring and evaluation of mental health services and programmes (pre-summit).
- Fostering person-centred recovery paradigm that respects the autonomy and dignity of all persons (pre-summit).

Human resources:

- Establish at least one specialist mental health team in each district (post-summit).

Culture and mental health:

- Developing and strengthening human capacity for prevention, detection, care treatment and rehabilitation of mental and substance use disorders and build links with traditional and complementary health practitioners (pre-summit).
- Strengthen links with traditional, complementary and faith based healers and non-governmental organisations (post-summit).

Suicide prevention:

- Establish a national suicide prevention programme (post-summit)

Note that in this instance, the summit recommendations may not have been reflected in any policy changes because there was not any policy content relating to this issue in the first place. However, given that there was a whole group commission at the summit dedicated to suicide prevention at the summit, it is surprising that this resulted in no *additions* to the policy regarding interventions in this area.

Medicines, equipment and protocols:

- Reducing costs and increase the efficiency of mental health interventions, including making medicines more affordable, in order to provide essential health services (pre-summit).
- Implement with vigour the Health Sector Mini Drug Master Plan (post-summit).

Governance:

- Using the outputs from the summit to finalise the Mental Health Policy Framework 2012-2016 and to assist with its implementation and monitoring (pre-summit)

Funding:

- Reducing costs and increase the efficiency of mental health interventions, including making medicines more affordable, in order to provide essential health services (pre-summit).

Quality assurance:

- Revise norms and standards in line with the service delivery platform (post-summit).

Reflection of group recommendations in policy changes

Funding:

Recommendations:

- Improve the **monitoring and evaluation of** mental health activities and thereby **monitor the budget** which is allocated to the programmes.
- The Department of Health should recognise mental health as one of the top five priority programmes, both at national and local levels, with **clear financial planning, budgeting and indicators linked to monitoring and evaluation.**

Policy change:

- At national level, budget will be allocated <*to meet targets set for the implementation of areas of action within the*> policy and regular discussions will be held with provinces to discuss strategies and <*monitor progress*> with implementation. At provincial level, mental health budgets will be reviewed annually to align mental health with national priorities, for each of the areas for action <*in 2011 and annually thereafter*>.

Monitoring and evaluation:

Recommendation:

- Improve the **monitoring and evaluation of** mental health activities and thereby **monitor the budget** which is allocated to the programmes.

Policy change:

- At national level, budget will be allocated <*to meet targets set for the implementation of areas of action within the*> policy and regular discussions will be held with provinces to discuss strategies and <*monitor progress*> with implementation. At provincial level, mental health budgets will be reviewed annually to align mental health with national priorities, for each of the areas for action <*in 2011 and annually thereafter*>.

Infrastructure:

Recommendations:

- Each province should establish **a forensic psychiatric unit** that provides forensic services and observations of mentally ill prisoners and state patients.
- All **newly built hospitals** must provide for **mental services**.
- All district hospitals should render **72-hour assessment** services.

Policy change:

- Specialised psychiatric hospitals: i) Provision of sub-specialist services, such as forensic psychiatry and child and adolescent services, ii) Forensic facilities will fulfil their role as set out in the Criminal Procedure Act No. 51 of 1977 as amended, with regards to forensic psychiatric observations. Section 41 and 49 of the Mental Health Care Act provides for designation of health establishments and procedures with regards to State patients and mentally ill prisoners;
- Psychiatric services in general hospitals: i) Inpatient units will be built in district and regional hospitals, ii) Inpatient units will be provided in general hospitals to improve access for voluntary admission, assisted care, emergency mental health services, 72-hour assessment of involuntary mental health care users, further care, treatment and rehabilitation.
- District health services: providing emergency care (24 hour) and 72-hour observation services in designated District and Regional Hospital Inpatient settings.

Misalignment of group recommendations and policy changes

Advocacy and user participation:
Although there was a policy change regarding advocacy ("The Department of Health will work closely with the Ministry for Women, Children and Persons with Disability to ensure that provisions of the UN Convention on the Rights of Persons with Disabilities (2007) are actively implemented for persons with mental disability in South Africa"), this did not reflect any of the group recommendations made.

Mental Health Care Act implementation:
A number of fairly substantive additions were made to the policy regarding implementation of the Mental Health Care Act. However, the group recommendations made at the plenary were limited to two, and only reflected challenges with the implementation, not direct policy proposals. The policy changes related mostly to hospital regulations and services, while the two group recommendations were around language and administrative barriers to the implementation of the Act. It must be noted that the closed-door meeting at which group Chairs reported back their recommendations may have included more recommendations from this group, as intimated by the rapporteur at the plenary.

Mental Health Review Boards:
The policy change here was the Mental Health Review Boards in each province "will, as stipulated in the Mental Health Care Act, play a key role in advocating for the needs of mental health service users, and upholding and protecting their human rights." However, this does not reflect group recommendations, which called for the revitalisation of the boards, particularly in terms of financing, and for user representation on the boards, as opposed to the role or functions of the Boards.

Intersectoral collaboration:
The intersectoral collaboration group recommendations referred to various government sectors and responsibilities of these sectors around mental health, while the policy change related to including for-profit organisations in intersectoral collaboration.

Group recommendations not reflected in draft policy

Despite many of the recommendations regarding prevention and promotion already being reflected in the policy, some of the recommendations were neither reflected in the draft policy, nor added to the final policy. These related to interventions around adults and older adults, including linking psychosocial programmes to income-generating activities, establishing dementia units for older adults, and implementing employee wellness interventions. In terms of monitoring and evaluation, the recommendations that were not reflected related to fairly specific actions, such as establishing electronic medical records, monitoring treatment protocols, and establishing a monitoring and surveillance system on suicide. Notably, two recommendations built on existing policy content by recommending that monitoring and evaluation be linked specifically to budgeting – and this was actually reflected in the changes that were made to the final policy following the summit. Many of the recommendations pertaining to mental health systems were captured in the draft policy; those that were not related to referral pathways, to access to services for persons at risk for suicide, and to building units for comorbid conditions.

The presentation given in the group commission on human resources had focused strongly on developing human resource plans based on statistical modelling and indicators. This focus was reflected in the group recommendations, which placed emphasis on establishing data on the mental health workforce, and on appropriate remuneration. Some of the group recommendations built on existing content, such as linking human resource capacity building to existing models like the national health insurance sites and primary health care re-engineering, consulting with mental health professionals in the expansion of the workforce, and using innovations such as telepsychiatry in training and supervision. These elements were not made explicit as mandates in the policy but could have been linked to existing content around building the human resource workforce for mental health. The other group recommendations were very specific and detailed, and much of this detail was not reflected in the policy. Another focus of the group recommendations was the emphasis on mental health care professionals, while much of the policy seems to be more focused on task shifting and mental health training of generalist health care professionals. Some of the group recommendations pertaining to infrastructure were already reflected in the policy. Some built on existing content, most of which specified requirements around ensuring that infrastructure was fit for purpose and that configuration and revitalisation of psychiatric facilities be effected. The recommendations that were not reflected in the draft policy related to establishing forensic facilities, and to ensuring that infrastructure was consistent with the regulations of the Mental Health Care Act; these were in fact captured as part of the substantive additions made around infrastructure to the final policy.

Group recommendations regarding research that were not reflected in the draft policy related to increasing human capacity to conduct research, and to increasing research funding. The main focus of content related to advocacy and user participation in the draft policy was human rights focused, emphasising the inclusion of mental health on the disability agenda, and as well as strategies to reduce stigma and promote mental health. The one change that could have been made to this as a result of a group recommendation was to involve the media as partners in overcoming stigma and discrimination, but this was not added to the final policy. While there was some reference in the draft policy to engaging with users around policy and service development, and a brief reference to the “recovery framework” in terms of framing psychosocial rehabilitation, the group recommendations around these issues were much more detailed. A great deal of the recommendations around recovery were neither reflected in nor added to the policy. Specific recommendations around how to promote engagement with service users around policy and service planning – such as supporting the development of user-led organisations and support groups, a user-led human rights watch, and user representation on Mental Health Review Boards – were also not captured.

Culture was only briefly mentioned in the draft (and final) policy, in “Other sectors roles and responsibilities”, regarding building links with traditional and faith-based healers (among others). The group recommendations reflected the engagement by the group with the draft text of the summit declaration, making specific reference to highlighting the importance of culture in that document. Other recommendations around increasing training in cultural issues, providing funding for collaborative research, and making provision for ethical practice and redress, were not reflected in the draft policy. Four of the five group recommendations regarding governance were already reflected in or aligned with existing policy content. Although reference was made to Mental Health Directorates in the draft policy, this pertained to building human resource capacity within these structures, as opposed to elevating the authority of the structures within the Department of Health, as recommended by the group. The one recommendation relating to intersectoral collaboration that was not reflected in the draft policy, and

that did not get added, was around intersectoral responsibilities with respect specifically to child and adolescent mental health. The majority of the draft policy content relating to child and adolescent mental health referred to prevention and management at the level of primary health care level services, as well as the broad references to the provision of specialist child and adolescent services. The group recommendations were much more specific and detailed, and focused quite strongly on specialist training and service provision, and incorporating child and adolescent psychiatry at management and policy levels, as well as specific infrastructure for child and adolescent mental health services. None of this was specifically referenced in the draft policy.

The group recommendations relating to funding did represent some of what was in the policy, but required a change to the existing content by requiring the mental health budget to be specifically linked to monitoring and evaluation. Notably, this extension of existing content was reflected in the changes made to the final policy. As previously discussed, most of the group recommendations relating to the mental health and other conditions theme were subsumed under other themes, particularly prevention and promotion and human resources. The one specific group recommendation was to build units for comorbid disorders, which was not reflected in the policy, which could be seen as an extension on existing policy content relating to infrastructure and integration of mental health into primary health care.

Pre-summit recommendations not reflected in implementation priorities & key activities by theme

Culture and mental health:

- [Developing and strengthening human capacity for prevention, detection, care treatment, and rehabilitation of mental and substance use disorders and] build links with traditional and complementary health practitioner.

Advocacy & user participation:

- Ensuring that all users of mental health services participate in the planning, implementation, monitoring & evaluation of mental health services and programmes.
- Fostering a person-centred recovery paradigm that respects the autonomy and dignity of all persons.

Funding:

- Providing equitable, cost-effective and evidence based interventions and thereby ensure that mental health is available to all who need it, including people in rural areas and from disadvantaged communities.
- Reducing costs and increase the efficiency of mental health interventions, including making medicines more affordable, in order to provide essential health services.

Post-summit recommendations not reflected in implementation priorities and key activities by theme

Culture and mental health:

- Strengthen links with traditional, complementary and faith based healers and non-governmental organisations.

Quality assurance:

- Revise norms and standards in line with the service delivery platform

Funding:

- Adequately fund mental health services as per WHO recommendations

Themes and associated group recommendations completely not reflected in either implementation key activities or Terms of Reference actions

Mental Health Care Act implementation:

- Language barriers limit the implementation of the Mental Health Care Act.
- Cumbersome forms limit the implementation of the Mental Health Care Act and need to be revised.

Medicines, equipment & protocols:

- Develop appropriate standard treatment protocols and guidelines and implement monitoring thereof.

Funding:

- The Department of Health should recognise mental health as one of the top five priority programmes, both at national and local levels, with clear financial planning, budgeting and indicators linked to monitoring and evaluation.
- Improve the monitoring and evaluation of mental health activities and thereby monitor the budget which is allocated to the programmes.

Child and adolescent mental health:

- At least one child and adolescent mental service unit should be established per province.
- The national mental health care policy must make adequate provision for child and adolescent healthcare.
- Reclassify child and adolescent psychiatry as a major speciality akin to paediatrics.
- Appoint a child and adolescent psychiatrist to work with the provincial and national departments in the delivery of child and adolescent mental health services.
- Include a child and adolescent mental health professional within the provincial directorates of health programmes to drive prevention and health promotion.
- Provide adequate, developmentally appropriate infrastructure for child and adolescent mental health in all provinces.
- Include child and adolescent mental health services in the NTSG Grant.
- Train sufficient numbers of child and adolescent specialists in all disciplines and establish two specialist registrar training posts per medical school.
- Resuscitate psychiatric nursing training, specifically in the area of child psychiatry.
- Include child and adolescent mental health training in the training of all health and child professionals.
- There is intersectoral responsibility to make child psychiatry explicit in relevant legislation or policy.
- Ensure that child and adolescent substance abuse services are coordinated and evidence based and take account of the need for parallel programmes for dual-diagnosis patients.
- Establish an appropriate, ongoing forum for child and adolescent mental health, coordinated and funded by the national Department of Health.