Research Article

Actor-Networking European Union Mental Health Governance, 1999-2018

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Abstract

Over the past three decades, a system of European-Union mental health governance (EUMHG) has emerged that incorporates a wide variety of stakeholders and consists of soft law instruments like Green Papers, Joint Actions, and Frameworks for Action. This paper applies actor-network theory (ANT) to EUMHG as it operated between 1999-2018, to understand its operation and significance. ANT is a process of identifying the moments of 'translation'—the means and processes that integrate disparate actors—into networks. Such moments in EUMHG include the problematisation of mental health, the enrolment of actors and actants in EU-level governance processes, and the use of obligatory passage points through which actors must mediate their actions and views to join a network. This analysis shows that three distinct though sometimes concurrent actor-networks have operated within EUMHG from 1999-2018, distinguishable by their core problematisations of mental ill health and its role in European societies: a public health actor-network, a disease-burden actor network, and a de-institutionalisation and Community Mental Health actor-network. This analysis shows that the Commission of the European Union has acted as actor-network builder in the former and last networks, but not the middle, where international health organisations have played that role. In each network, different actors are the recognized experts. The paper therefore indicates that because mental health and mental ill health have not been stable scientific concepts, a specific 'epistemic community', e.g., of psychiatrists or psychologists, has not held a definitive role in EUMHG. Indeed, it shows that EUMHG has produced varying constellations of actors, actions, and expertise at any given time, and that they may contradict each other's purposes. These findings contribute to scholarly understanding of changes in EU governance from the early 2000s, specifically in terms of the Commission's role as an executive body, its engagement of scientific expertise, and its relations to civil society and international organizations.

Keywords

Mental health policy; European Union; EU governance; Actor-network theory (ANT), European Commission

INTRODUCTION

Over the past three decades, a system of mental health governance has emerged at the European Union level, consisting of soft law instruments such as the Green Paper on Mental Health (2005), the Framework for Mental Health (2008), the Joint Action on Mental Health and Wellbeing (2013-2016), and the European Framework for Action on Mental Health and Wellbeing (2016-2018). Through these instruments, EU mental health governance (EUMHG) has incorporated policymakers, mental healthcare providers, academic and policy experts, non-governmental organisations, and persons suffering from mental health problems and their families in governance processes across Europe. These processes have encouraged a broad range of activities and projects, such as 'peer support networks' and 'service-user expertise' projects in Utrecht, the Netherlands (Samen Sterk Zonder   Stigma 2018) and in Zagreb, Croatia (Ročić-Petak 2018). Under the auspices of EUMHG, analysts have published research reports, state health ministries have shared policy advice, and mental health professionals have shared insights and strategies across borders and administrative levels.

How can we understand this process? This paper argues that actor-network theory (ANT) offers a useful analytic model. It adopts this approach because ANT's analytical concepts are well suited to understanding patterns of international interaction in knowledge-intensive fields and around crucial concepts (Bueger and Bethke 2014). ANT provides tools that are useful for 'studying the transformation of scientific and political practice occurring in shorter time spans' such as the two-decade life of EU mental health governance. Over the years 1999-2018, crucial concepts such as 'disease-burden' measurement, de-institutionalisation (DI), and Community Mental Health (CMH) have shaped knowledge and practitioners' views of mental (ill) health. Guided by the ANT approach, particularly as developed for international relations by Bueger and Bethke (2014), the paper describes the 'translation' or quality of integration of actors involved, and notes instances where the Commission has attempted to act as network builder, for example by establishing 'obligatory passage points.'

Other approaches to understanding the role of the Commission in EU regulation governance provide interesting insights but cannot capture key elements of EUMHG. Principal-agent, functionalist, and 'orchestrator' models rightly emphasise the informal means through which the Commission exercises (or shares) its authority (Blauberger and Rittberger 2015). Yet, they assume the actors with whom the Commission governs have fixed policy goals. This assumption runs contrary to the analysis of EUMHG, which illustrates that the goals of the actors working with the Commission were shaped and reshaped by the often-changing knowledge about their issue area.

In fact, because ANT defines a network by its knowledge content rather than a presumably fixed identity of the network actors or non-human *actants*, including technologies, my application of it identifies three different mental health actor-networks operating within EUMHG over time. The three different networks are distinguishable by their core problematisations of mental ill health and its role in European societies. Those networks included many of the same actors, including scientists and non-governmental organisations, but the actors played different roles and indeed held different identities because of the different problematisations of mental (ill) health that shaped the networks' translation processes. The paper's application of ANT to EUMHG also finds that the most recent actor-network has been the longest-lived of the three, but its future is highly uncertain given the 2019 non-renewal of EU mental health governance programmes. Indeed, the new technologies and processes that have emerged in mental health care across Europe since the onset of the Covid-19 pandemic in March 2020 indicate that while a renewed Community Mental Health network (the last EUMHG actor-network identified in this paper) may have been envisioned, it will look quite different and involve actors and new actants in slightly different problematisations of mental ill health in Europe. If such a new actor-network emerges, the Commission likely would be the network builder as it was in the first three networks. The paper also finds that the way in which mental (ill) health was problematised entailed the emergence of different kinds of actors as mental health experts.

This analysis reveals that the Commission of the European Union engaged in network-building activities throughout the twenty-year period. It also illustrates how the translation process of the Commission's network-building around specific concepts of mental (ill) health also constructed specific actors as experts and created European Agencies or technologies as obligatory passage points. Thus, like the 'orchestration' view of the Commission's role, this paper emphasises the mutual dependence between the Commission and the non-state actors with which it works in governance processes (Abbott, Genschel, Snidal and Zangl 2015; Blauberger and Rittberger 2015). An ANT approach, like the orchestration approach, is able to capture the non-hierarchical, mutually dependent and necessarily cooperative relationship between the network-builder (in our case, the Commission) and other network actors. Yet while the orchestration framework presumes that actors in a network hold corresponding goals (Blauberger and Rittberger 2015: 369), ANT does not presume that the network builder has preconceived goals. Instead, goals are constructed through the process of translation—the key dynamic within a network.

ANALYTIC APPROACH: ACTOR-NETWORK THEORY AND TRANSLATION MOMENTS

This paper proposes adopting actor-network theory (ANT) as an approach to understand European Union mental health governance processes, and specifically the Commission's role in them. ANT provides useful analytical tools for examining how scientific and political practice transform over shorter time spans (Bueger and Bethke 2014) as in the life of EU mental health governance. ANT is a 'heterogeneous conglomerate of studies' and thus 'should not be understood as an established 'research programme', 'paradigm' or 'theory'', but instead as 'a toolkit for telling interesting stories about, and interfering in, those relations' (Bueger and Bethke 2014: 35, citing Law 2009: 147). This paper applies ANT in this spirit. Resembling the application of ANT by Bueger and Bethke (2014), this paper highlights the ways in which EU mental health governance contributed to transnational knowledge politics and policy across Europe, and to the legitimisation and perpetuation of specific concepts in the policy area of mental health.

ANT is useful in this analysis because a quick glance at EUMHG over time reveals that mental health and mental ill health have not been stable concepts, and thus the potential of a specific 'epistemic community', e.g., of psychiatrists or psychologists, has not held a definitive role to play. In addition, the EU's legal authorities in the issue area have only recently been etched in EU law and Commission creativity. Thus, an epistemic community approach would gloss over important actor- networks being built via EU actions and would miss the key roles played not only by the scientists enrolled in the networks, but the network-building done by the Commission and the importance of technologies, such as databases, in enrolling more actors into the networks. The broader social relations could not come into relief as clearly. As Bueger and Bethke (2014: 33) observe, 'it is weak in showing how the relevant knowledge and its respective communities are actually formed'.

ANT also is useful because it ties knowledge to non-human *actants*. While this paper cannot specify with great detail the ways in which technologies enrolled actors into EUMHG networks, its use of ANT does allow us to identify the role those technologies play and their relations to other actors in the networks. Given the incorporation of technologies into mental healthcare provision (Oudshoorn 2011), including their increasing uptake during the pandemic, this element of ANT will prove even more useful in future analysis of EUMHG, to the extent it persists.

Finally, the ANT approach is useful for its non-linear conception of capacities and abilities in networks: unlike rationalist conceptualisations of actors' capacities, an ANT approach can illustrate how erstwhile incapacitated actors, such as sufferers of mental ill health, can be empowered and even rendered expert through their enrolment in an EU mental health actor-network. As Higgins and Kitto (2004: 1402) observe, rationalist approaches may assume that some actors 'have the capacities to think and act as ostensibly "active" agents, but how this occurs is a matter of empirical investigation' that rationalist approaches only assume. By

contrast, ANT encourages such investigation— something that is, I argue, decidedly necessary for understanding the dynamics of EUMHG over time.

Accordingly, this paper's investigation focuses on ANT processes of 'translation,' or the definition of actors' roles and identities in a network. It applies ANT to the brief history of EU mental health governance by reading the history as a process of *translation*. Translation is 'a general process (…) during which the identity of actors, the possibility of interaction and the margins of manoeuvre are negotiated and delimited' (Callon 1986: 203). The insight that actors' identities are not fixed but are shaped by participation on networks is an important distinction between ANT and other network theories, which assume actors' identities are stable (Bueger and Bethke 2014, p. 39). Translation gives the network its order and form and its actors' specific identities and roles: 'translation is what makes the activity of governing possible; it enables loose and flexible linkages to be established ``between those who are separated spatially and temporally, and between events in spheres that remain formally distinct and autonomous"' (Higgins and Kitto 2004: 1403, citing Rose 1999).

The paper traces the emergence of EUMHG over time with an eye to specific 'moments' in the translation process, including *problematisation*, *enrolment*, and attempts at establishing *obligatory passage points*. Problematisation occurs when an actor or group defines an issue as problematic, determines a set of actors and establishes their identities 'in such a way as to establish themselves as an obligatory passage point' (Callon 1986: 204). Enrolment is the process of defining a set of interrelated roles and rules of engagement for network participants, and their acceptance of those roles and rules (Callon 1986: 211; Higgins and Kitto 2004); enrolment gives the network order and form (Bueger and Bethke 2014). Finally, the paper identifies attempts to identify moments of establishing obligatory passage points in EUMHG. Obligatory passage points are groups, processes, or institutions 'that others must pass through to meet their own interests as well as the interests of the network builder' (Higgins and Kitto 2004: 1406). Such passage points therefore involve attempts to define and homogenise the meaning of core concepts that shape a network (Bueger and Bethke 2014) or repeated attempts to demonstrate to relevant actors that they must pass through that point to meet their interests (Callon 1986: 205). Translation is not always a neat and linear process: 'Translation work is often an ongoing struggle in which some actors enrol, others resist, and counterstrategies and -compromises are made, leading to more fragile textures and less orderly webs' (Bueger and Bethke 2014: 40).

ANT's analytical concepts are well suited to understanding patterns of international interaction in knowledge-intensive fields and around crucial concepts (Bueger and Bethke 2014). Mental health is one such issue area. Scientific discourses have contributed to ideas of mental health and mental illness in Europe for over 150 years (see for example studies of the French, Italian, and UK cases by Babini 2014; Coldefy and Curtis 2010; Jones 2000; Jones 2001; Ventriglio 2016). Over this time, psychiatry has emerged as a distinct scientific discipline, first advancing a *psychosocial* model of mental pathology (especially severe mental illness) that 'emphasised factors such as parental and intrapsychic influences'; it then turned to the current *biopsychosocial* model that emphasises the 'interplay between biological and psychosocial factors' (Drake, Green, Mueser and Goldman 2003: 428). It is therefore not surprising to see shifts in EUMHG networks that reflect shifts in scientific debates about mental health.

To trace the history of EUMHG with an eye to moments of problematisation, enrolment, and the establishment of obligatory passage points, the paper uses methods of discourse analysis and participant observation. These methods enable examination of micro-level interactions within policy processes. While these methods are not necessarily 'the natural choices' for applying ANT, the spirit of ANT as a 'toolbox' encourages analysis that enriches and 'betray[s]' conventional methodological choices (Bueger and Bethke 2014: 41, citing Mol 2010: 247). Indeed, a key point of ANT is that micro-level interactions can be simultaneously part of global-level policy: the global/local binary becomes analytically unnecessary (Bozorgmehr 2010).

While ANT's analytical concepts are well suited to understanding patterns of international interaction in knowledge-intensive fields and around crucial concepts (Bueger and Bethke 2014), ANT has nonetheless been relatively rarely used in studies of EU governance. It has been used to explain the rise and fall of policy concepts such as the 'failed state' (Bueger and Bethke 2014) and has been highlighted as an approach that captures the observed relations between otherwise local and global actors while also avoiding the positive normative connotations of 'global health' analysis. (Bozorgmehr 2010). ANT also has been applied to global public health policy for several decades, where it has highlighted how 'ideas, technologies, or institutions (…) emerge and become stable parts of public life' (Szlezák 2012: 5).

THE COMMISSION: EU MENTAL HEALTH GOVERNANCE NETWORK-BUILDER

In promoting European level mental health governance, the Commission continually has linked its work to EU law. The Commission has adopted this technique other policy areas, including health policy, over time (Greer 2008: 223-224). By the late 1990s, the Commission was citing Article 152 of the Treaty of the European Community to advance mental health as a concern. The Article stipulated that 'a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities' (Commission of the European Communities 2005: 5). This language enabled the Commission to emphasise 'the importance of mental health for general health and well-being' in a 199 Framework paper (Lahtinen, Lehtinen, Riikonen and Ahonen 1999: 6).

Indeed, by the late 1990s the Commission was advancing mental health as an EU-level concern. For example, an April 1998 Commission communication said mental health should be 'taken into account in the future Community action in the field of public health', and cited 'new health threats, the increasing pressures on health systems, the enlargement of the Community and the new provisions of the Treaty of Amsterdam' as motivations for its recommendations (Commission of the European Union 1998).[1] The Council passed a mental health resolution the following year (Council resolution of 18 November 1999 on the promotion of mental health, OJ C 86, 24.3.2000, p. 1).

PROBLEMATISATION PHASE I: 'NO HEALTH WITHOUT MENTAL HEALTH' AND 'DISEASE BURDEN'

As these events were occurring in the late 1990s, the Commission contributed to the problematisation of mental health via its management of EU-level project grants. In this process, it began to establish itself as an *obligatory passage point* for network participation – a move that is well within Commission powers on a regular basis, because it is allowed and enabled by the institutional structures of the EU. For example, the Commission granted EU Community Action Funds (for health promotion, information, education, and training) to a joint project of the Finnish government and the European Network on Mental Health Policy (ENMHPO), a pan-European non- governmental organisation (NGO). The project advanced the issue of mental health through a high- level (EU Presidency) European Conference on Promotion of Mental Health and Social Inclusion, in Tampere, Finland, in October 1999 (Finland held the EU Presidency during the last half of 1999). The project also produced a report by the Finnish Ministry of Health and ENMHPO entitled, 'Public Health Approach on Mental Health in Europe.' This report echoed Commission discourse by stating, 'mental health must be regarded as an indivisible part of public health' (Lahtinen, Lehtinen, Riikonen and Ahonen 1999). This Conference can be considered moments of enrolment – of conference participants – and of the creation of experts in EUMHG's first actor-network, the public health actor-network (see Table 1).

Commission network-building centred on different discourses, or problematisations, of mental (ill) health and governance. The Commission began its mental health activities by taking up the concept of 'no health without mental health' (WHO 1999: 9) This

problematisation emerged during the joint World Health Organization/European Commission meeting, '[b]alancing mental health promotion and mental health care' held in Brussels from 22 to 24 April 1999. World Health Organization documents trace this phrase back to the WHO original Director-General, Dr. Brock Chisholm, who 'shepherded the notion that mental and physical health were intimately linked' (Kolappa, Henderson and Kishore 2013), but the phrase was used officially in this 1999 conference report. The phrase was later adopted at the 2005 WHO Ministerial Conference (WHO 2005).

The problematisation did not fundamentally alter the emerging EUMHG network: there is little contradiction between concepts of mental health as a public health problem and mental health as a requisite element of general health. Until 2011, the Commission maintained the public- health/no health without mental health views. But health experts at the World Bank also had taken up another discourse by 1999. This was the 'disease burden' concept.

Disease-burden epidemiology is a policy approach developed at the World Bank in the 1970s that promoted measurements and monitoring techniques as a means of managing mental health (Wahlberg and Rose 2015). Disease-burden discourse encourages quantifying 'the experience of living with mental disease' and in terms of monetary individual, familial, and societal costs of mental disorders, with a special emphasis on depression (Wahlberg and Rose 2015: 78-81). It involves new techniques of measurement, including the quality-adjusted life year (QALY) which encourages policy-makers to ask, 'how much health do I get in return for a given intervention or treatment?' and the disability-adjusted life year (DALY), which prioritises diseases according to return on investment (Wahlberg and Rose 2015: 73) The Commission's 1999 paper appears to have been early to adopt disease-burden discourse on mental health. The WHO did not adopt it until its 2001 paper, 'Mental health: New understanding, new hope' (Wahlberg and Rose, 2015).

Disease-burden discourse thus seems to entail a very different problematisation of mental (ill) health than no health without mental health. Nonetheless, all three concepts – no health without mental health, mental health as a public health issue, and disease burden—appeared in the 1999 Finnish-ENMHPO report. In addition to linking mental health to public health and to general health, it also argued that 'Mental health problems (…) add significantly to general health expenditure and contribute to disability, mortality, loss of economic productivity, poverty and low quality of life…. [They] impose a heavy burden not only on the individuals but on society as a whole.' (Lavikainen, Lahtinen and Lehtinen 2000: 17) Indeed, the report observes that '[e]ight of the ten leading causes of the global burden of disease are related to mental health. Depression alone accounts for 5% of the total years of life lived with a disability in Europe.' (Lavikainen, Lahtinen and Lehtinen 2000: 17). We can therefore say that in 1999, the EUMHG actor-network had not yet stabilised the identities of its enrolees, actors, or actants: the only salient technologies (actants) – DALYS and QALYS—contributed only to the disease-burden problematisation of mental ill health, and not to the public-health or 'no health without mental health' problematisations.

The 'no health without mental health' problematisation did not survive long, perhaps because it lacked any technologies to which it could be linked. By contrast, the other two problematisations—community mental health and disease burden—survived throughout the history of EUMHG, though the latter was not as robust. Thus, by the beginning of the twenty-first century, EU mental health governance included two separate problematisations and thus actor-networks: a European public health network that viewed mental health as a general and public health problem, and a global disease-burden network that viewed mental health as a cost burden on societies. The two networks are different in that they engage different actors and technologies, though there is some overlap (see Table 1).

Table 1: European-Level Actor-Networks in the Area of Mental Health, Ca. 1999-2005

ACTOR-NETWORK PROBLEMATISATION (APPROX. YEARS)	PUBLIC HEALTH ACTOR-NETWORK (1998-2005)	DISEASE BURDEN ACTOR-NETWORK (1998-2018)
PROBLEMATISATION/ KEY CONCEPTS	No health without mental health	Disease burden' epidemiology
	Mental health as part of public health 'enable the Community to meet its key responsibility to contribute towards a high level of health protection' improving health information tackling health determinants.	Mental health problems as 'heavy and increasing burden that contributes high costs to our societies'
NETWORK BUILDER	European Commission	World Bank, WHO, (European Commission?)
ENROLLEES	EU member states as responsible members	Mental health clinics (submitting data to network-builders or obligatory passage pts.
	NGOs (reporters of data) Experts: Health administrators at (sub-) state level	Experts: States as risk-managers Epidemiologists Demographers Health administrators at state level (as risk management professionals)
OBLIGATORY PASSAGE POINTS:	WHO, EU Public Health Executive Agency (later called Chafea)	WHO, World Bank, European Commission?

We can discern some important distinctions between these actor-networks (see Table 1). NGOs arguably have little role to play in the disease-burden actor-network as they are not the official entities that would have access or the authority to interpret state-level disease data necessary for epidemiologists to produce data for QALYs or DALYs calculations. Additionally, the scientific expertise needed for the two actor-networks is quite different: the public health actor- network would require sociological or public health authorities' knowledge of European-level and state-level institutional settings, while the disease burden actor-network would involve actuarial work of calculating population numbers and disease likelihood. An important observation for our analysis is that the European Commission has a much smaller role to play in the disease-burden actor-network, because the network largely already has been built via World Bank and WHO initiatives. Any possible Commission expertise in the area of epidemiology was likely not going to be as relevant as its more immediate expertise in European Union institutional dynamics. Given this last challenge, it is perhaps not surprising that even though a 'global movement' on mental health may have emerged around the question of disease burden (Wahlberg and Rose 2015), EUMHG as networked by the Commission largely has taken a different form that involves a broader array of actors, under the problematisation of community mental health.

PHASE II: DE-INSTITUTIONALISATION AND COMMUNITY MENTAL HEALTH

The Commission's 2005 Green Paper on Mental Health is a significant event in the history of EUMHG, because it problematised mental (ill) health in yet a different way and thus enrolled different actors. Although the Green Paper still referred to the disease burden question and highlighted the rights of EU citizens as reasons for pursuing mental health governance at European level, its central focus shifted to questions of de-institutionalisation and pursuing community mental health in member states. This new problematisation therefore represented different roles for some participants such as state governments and NGOs, a de-emphasis on some kinds of expertise and therefore experts (such as epidemiologists). It also arguably put the Commission firmly in the role of network builder, whereas the Commission's network-building role was less well-defined in the public mental health network, where it was secondary to state-level authorities, as well as in the disease-burden network, where the World Bank held a more prominent role. In this sense, the Green Paper was an attempt to establish a new actor-network of EUMHG. I label this actor-network the CMH network (see Table 2).

The CMH problematisation emerged within psychiatry in the 1950s and 1960s amid a push for the de-institutionalisation (DI) of care. At this time, the rise of new pharmaceutical treatments, including psychotropic drugs, made it possible to treat people's mental ill health outside the hospital setting, and public and psychiatric opinions about appropriate forms of treatment shifted (Fioritti 2018). These medicines therefore constitute actors – or in ANT terminology, non-human *actants* within the network. Post-war anti-institutional views in the US reflected DI and inspired federal legislation in the US in 1963 which was supposed to subsidise the construction of community mental health centres (CMHCs). CMHCs were viewed as the antithesis of the hospital and were intended as the 'cornerstone' of CMH. The vision was that symptoms would be identified early, treatment would be preventive, and care by centres would be integrated and continuous. CMH and its institutions therefore represented a radical change in mental healthcare that 'would render traditional mental hospitals obsolete' (Grob 1995: 52). In the US, this reality never materialised because federal funding was cut and the CMH model was not fully implemented. Meanwhile, in Italy in the 1970s, DI became a social and political movement to 'reformulate relations between individuals and the society, balancing power relationships in favour of the vulnerable subject' (Fioritti 2018: 4).

The CMH concept itself has shifted in meaning over time, from a focus on symptom control (in the 1970s), to rehabilitation (1980s), to recovery (1990s) (Drake, Green, Mueser and Goldman 2003). The recent theme of recovery is related to larger trends in medicine that focus on 'patient-centred care' and shared decision-making (Drake, Green, Mueser and Goldman 2003: 429, citing Edwards and Elwyn 2001). As a 2018 Position Paper funded within the third EU Health Programme observes, 'the recovery movement and its associated principles have become central to mental health practice and policy in most Western settings. Traditional conceptualisations of clinical recovery, specifically symptom remission and a return to pre-morbid levels of functioning, are now typically complemented by an emphasis on personal recovery' (Killaspy, McPherson, Samele, Keet and Caldas de Almeida 2018: 13). The most recent studies on Community Mental Health emphasises both recovery and 'resilience' (Harper and Speed 2012) though EU problematisation does not often refer to resilience.

The 2005 Green Paper problematised mental ill health as a public concern that needed response via Community Mental Health. According to the Paper, CMH 'signals a change of paradigm, in line with human rights. But with a move away from institutional care, there is (…) a need to develop proactive community services and to ensure that money follows the patient' (Commission of the European Communities 2005: 10). The Paper argued that EUMHG was necessary for the EU to promote social inclusion and protect the rights of people suffering from mental ill health (Commission of the European Communities 2005: 9, 10). EUMHG would focus on promoting CMH and the rights of persons with mental ill health; at the EU level, assistance would come by mapping member states' legal frameworks on human

rights and defining 'rights, obligations, and structures' (Commission of the European Communities 2005: 11).

Thus, the Paper envisioned a broad network that would enrol different actors, or the same actors in different roles/identities, than the disease-burden problematisation. These included participants from 'health and non-health policy sectors and stakeholders whose decisions impact on the mental health of the population' as well as patient organisations and civil society (Commission of the European Communities 2005: 5). Non-state actors engaged in community mental health were identified as experts—in contrast to the disease-burden network, whose experts were state and World Bank analysts. State health administrators would play different roles, encouraging community mental health systems rather than (or in addition to) calculating risk. The 2005 paper encouraged a broad focus on prevention, stigma-reduction, and public education on mental ill health (Wahlbeck 2011).

Subsequent initiatives by the Commission maintained the CMH problematisation and enrolled more actors in the CMH actor-network. But by 2008, the anticipated EU strategy on mental health did not appear, and the Commission shifted focus from broad public mental health to specific mental disorders (Wahlbeck 2011). Instead of a strategy, its 2008 EU-level conference launched a Pact for Mental Health and Well-Being that identified five priority areas for EU action: promotion of mental health in schools, promoting action against depression and suicide and implementation of e- health approaches, and developing community-based and socially inclusive mental health care for people with severe mental disorders. The Pact did not emphasise that '[t]here is no health without mental health' and as Wahlbeck (2011) observes, its focus on specific mental disorders abandoned the public health problematisation of mental ill health as a concern for everyone.

While the focus on specific mental disorders was new, the Pact nonetheless (re-)built the CMH model, for example by encouraging 'health services which are well integrated in the society', as well as 'active inclusion of people with mental health problems in society, including improvement of their access to appropriate employment, training and educational opportunities' (WHO Europe 2008). The Pact was careful to recognise the pre-eminence of member state law relative to EU legal instruments regarding mental health, but it made a case for EU leadership in mental health and positioned the EU as the central institution in a network that 'brings together European institutions, member states, stakeholders from relevant sectors, including people at risk of exclusion for mental health reasons, and the research community' in a 'longer-term process of exchange, cooperation and coordination on key challenges' (WHO Europe 2008: 6).

By shifting away from a public health in problematisation to a CMH problematisation that linked EUMHG to states' mental healthcare systems, the CMH network may have undermined EUMHG legitimacy in the eyes of member states (Wahlbeck 2011). It is true that such network activity requires engagement of NGOs and sub-state mental healthcare providers and renders national-level health administrators' roles and identities as equal to those of NGOs: they are both experts. Moreover, caregivers and local stakeholders such as family members and community care administrators, not Ministers of Health, are natural enrolees in the network.

The Commission maintained its network-builder role in this CMH actor-network via standard EU policy tools such as the 2013 Joint Action on Mental Health and Wellbeing (signed by 25 EU member states plus Norway), and the European Framework for Action on Mental Health and Wellbeing (2016-2018). The Joint Action included the same five focus areas identified in the 2008 Pact, and both the Joint Action and the Framework for Action maintained the CMH problematisation of mental (ill) health. The obligatory passage points within these networks included the requests for project proposals released and reviewed by the Consumers, Health, Agriculture and Food Executive Agency (Chafea). Chafea's roles included fielding recommendations for the Joint Action from member states, commissioning tenders for projects, and releasing calls for expression of interest by experts whom it then screens for membership in EU expert panels and other proceedings.

While space does not allow a full discussion of Chafea's many roles or powers, the ANT concept of obligatory passage point succeeds in capturing the potentially powerful and somewhat obscure nature of Chafea and other such agencies operating within EU governance. Aside from Chafea, a specific and particularly interesting obligatory passage point was the EU Compass for Action on Mental Health and Wellbeing. EU Compass was established with the 2013 Joint Action. It was a 'web-based mechanism used to collect, exchange and analyse information on policy and stakeholder activities in mental health' that also communicated information on the European Framework for Action on Mental Health and Well-Being. Thus, it was a tool to 'monitor the mental health and wellbeing policies and activities' within participant states and the EU generally (European Commission, DG Health and Food Safety 2019). The technology of EU Compass was therefore obligatory in the sense that any NGO or state organisation with a project on mental health would want to enlist in the technology so that their programmes and projects, and the 'best practices' and insights gleaned from them, could be shared with interested parties of all sorts. The act of sharing on the EU Compass became a means of enrolling or being enrolled in the network.

A related technique, EU Compass Forums, also served as obligatory passage points. The Forums were a series of 'multi-sectoral awareness raising workshops with a focus on investing in Europe's mental capital' in every member state. They communicated Joint Action priorities to member states and included three annual transnational conferences (EU Compass Consortium 2018). The Forums therefore brought together health ministries at EU member states, trans- European and state-level medical and psychiatric organisations like the European Psychiatric Association, the European Union of Medical Specialists, and the Federal Chamber of Psychotherapists in Germany, as well as non-governmental organisations like the European Federation of National Organisations Working with the Homeless, among many others. Similar to the EU Compass technology, the Forums provided incentives and rewards for multiple actors at all levels of government, and in many different areas of European society, to enrol in EUMHG.

The CMH actor-network did include some of the same actors enrolled in the public health actor-network, but their roles were different: in the public health actor-network, for example, NGOs largely provide data for the purpose of providing improved public health services, such as emergency response services; in the CMH actor-network, NGOs and other local-level institutions and actors represented the driving force of political change, in a more 'bottom-up' political dynamic (see Table 2). An advantage of an ANT approach is that it highlights how different actors become experts— namely, by dint of the way in which an issue-area is problematised. ANT reveals how a small-scale mental health clinic in Denmark, or a peer-support advocacy programme in Croatia, can hold an 'expert' role in the community mental health actor-network, just as an analyst the World Bank might do in the disease-burden network. Under an ANT lens, expertise depends on the ways in which the issue is problematised.

Table 2: European-Level Actor-Networks in the Area of Mental Health, ca. 1998-2018

ACTOR-NETWORK PROBLEMATISATION (APPROX. YEARS)	PUBLIC HEALTH ACTOR-NETWORK (1998-2005)	DISEASE BURDEN ACTOR-NETWORK (1998-2018)	DE-INSTITUTIONALISATION & COMMUNITY MENTAL HEALTH ACTOR-NETWORK (2008-2018)
PROBLEMATISATION/ KEY CONCEPTS	No health without mental health Mental health as part of public health 'enable the Community to meet its key responsibility to contribute towards a	Disease burden epidemiology Mental health problems as 'heavy and increasing burden that contributes high costs to our societies'	**De-institutionalisation Community Mental Health** awareness of the…destructive and dehumanizing effects of heavy institutional interventions and a continuous effort to minimise them', develop proactive community services and (…) ensure that money follows the patient'.

ACTOR-NETWORK PROBLEMATISATION (APPROX. YEARS)	PUBLIC HEALTH ACTOR-NETWORK (1998-2005)	DISEASE BURDEN ACTOR-NETWORK (1998-2018)	DE-INSTITUTIONALISATION & COMMUNITY MENTAL HEALTHACTOR-NETWORK (2008-2018)
	high level of health protection' improving health information tackling health determinants.		
NETWORK BUILDER	European Commission	World Bank, WHO, (European Commission?)	European Commission
ENROLLEES	EU member states as responsible members NGOs (reporters of data)	Demographers, mental health clinics (submitting data to network builders or obligatory passage points)	EU member states as DI managers
	Experts: Public Health administrators	Experts: Health administrators at state level (as risk management professionals)	Experts: NGOs, Care providers Clients/patients/survivors/families

Of course, while the CMH actor-network enjoyed relative stability of actor identities and roles during the years 2008-2018 (after the public health problematisation was largely abandoned), there were tensions within it. The tensions emerge in part between the different professional or scientific backgrounds of participants. For example, at the Third EU Compass Forum, a member of the European Psychiatrists' Organisation observed pointedly that 'community psychiatry' is different from 'community mental health care', while the President of the European Alliance against Depression resisted discussing mental health in general and emphasised, '[i]t risks stigmatisation to put all these disorders in the same basket'. As another Forum participant explained, these comments rubbed some participants the wrong way, because they emphasise (a psychiatrist's concern with) mental disorder and treatment, rather than wellbeing and recovery (Third EU Compass Forum on Mental Health and Well-Being 2018).

The 'paradox' of the CMH model – that the movement to deinstitutionalise has contributed to the need for other resources of mental healthcare (Grob 1995: 53)—also put pressure on the CMH network. EU member states exhibit a broad variety of mixes of deinstitutionalisation and CMH institutions (Killaspy, McPherson, Samele, Keet and Caldas de Almeida 2018). But they were also feeling pressure to cut resources. In the face of post-2008 financial crisis, the post-2010 European debt crisis, and subsequent austerity measures, many member states' budgets were stretched thin. Even the vaunted Italian CMH system, often held as a model of CMH implementation, was experiencing such pressures by 2018. As Fioritti (2018: 1) observes, '[m]ental health care services have been asked to do much more, in terms of care to a larger population with very diversified needs, but with [far fewer] resources, due to the financial consequences of the economic crisis.'

Yet the CMH actor-network was able to accommodate these tensions, though disagreement over the concept of recovery persisted until the end of (this first iteration of) the CMH network. As a 2018 Position Paper funded within the third EU Health Programme observed,

'due to the complex and multidimensional nature of [the recovery] concept, implementing practice guidelines to reflect the underlying philosophy, and designing appropriate empirical investigations into their effectiveness have been challenging' (Killaspy, McPherson, Samele, Keet and Caldas de Almeida 2018: 13). In other words, it was not clear which actors were experts and which techniques were the preferred techniques for measuring recovery. This tension might be seen as a failure of the Commission in its network-building role.

The Commission dropped its community mental health problematisation and failed to renew funding for Joint Actions in its 2019 budget proposal. In the meantime, mental health has been problematised in different ways in the European Union. During the early twenty-first century, there have been shifts in mental health research agendas that de-emphasise the study of psychosocial phenomena and instead support study of the brain, including neuroimaging, genetics, pharmacological mechanisms, molecular biology, and other neuroscience studies (Drake, Green, Mueser and Goldman 2003: 428). In 2019, the Commission seemed poised to emphasise 'innovation', which it largely understood in technological rather than psycho-social terms, and thus a turn to neuroscientific problematisations of mental health seemed likely. But in 2020, the emergence of the Covid-19 pandemic and the recognition of its mental-health effects appear to have spurred interest in several different problematisations. In the European Parliament, a November 2020 webinar on mental health (Ciucci 2020) engaged in a disease-burden epidemiology problematisation. But across Europe in 2020 and 2021, dramatic shifts in forms of community care especially towards online care appear to have renewed the CMH problematisation and the Commission seems to be attempting to (re-)build the CMH network: its proposed 2021 Joint Action on Mental Health would involve 21 member states in efforts to 'implement a community-based mental health system reform and a best practice aiming to prevent suicide' (Kyriakides 2021).

CONCLUSION

This paper has advanced the argument that an actor-network analysis of European Union mental health governance (EUMHG) can shed light on various elements of the short history of this policy. It finds that from 1999-2018, three actor networks of mental health governance emerged at the EU level, each of which incorporated policymakers, mental health care providers, research scientists, non-governmental organisations, and patients and families across Europe in processes of mental health governance. The three actor-networks exhibited different problematisations of mental ill health, and thus different actors, actants, and obligatory passage points: 1) a mental health as public health network that was built by the Commission of the European Union but soon fell by the wayside, 2) a disease-burden network that adopted technologies from World Health Organization research, and 3) a Community Mental Health (CMH) network. This last network was built by the Commission beginning in 2005, and in 2008 it shed many vestiges of the first network's public health problematisation. Via two separate obligatory passage points – CHAFEA and EU COMPASS – this network enrolled a broad range of actors into the network. In each of these networks, the Commission assumed the role of network-builder, though this role seemed most appropriate for it in the CMH network, where it could rely on its extensive connections with member state policy makers, non-governmental organisations, and other community/societal actors, to shape their thinking about mental (ill) health.

This analysis illustrates how the Commission's role as network-builder in two of the networks enabled it to determine expertise – who is 'authorised to speak' on the issue of mental (ill) health (Bueger and Bethke 2014: 31). The analysis also illustrates how other approaches to EU-level policy-making can over-emphasise institutional relations and thereby neglect the knowledge relations that are central to policy areas of all sorts including mental health. The paper therefore contributes to larger discussions about the relationship of the Commission to (knowledge) elites, and to theorising about the role of the Commission. Specifically, the foregoing analysis illustrates that when policy areas are problematised as dynamic science-society problems, the Commission is well-positioned to play the role of network-builder, and

despite some evidence of low participation in obligatory passage points such as the databases or best-practice tools built by the Commission (including EU Compass Forum) (Killaspy, McPherson, Samele, Keet and Caldas de Almeida 2018), the Commission can in fact play the network-builder role in EU-level governance. In this way, the Commission plays a key role in determining who or what 'counts' as (actors or actants in the position of) obligatory passage points. That is, the Commission helps determine what counts as expertise in different policy areas, including the technologies (e.g., databases like the EU Compass) people, machines, and specific choices of data that comprise them. While this paper has not expressly connected to literature on experts and expertise, its approach can contribute to it.

For example, this research can spur more-detailed analyses of specific workings of actor-networks, such as the mental health networks, in specific locations within Europe. Armed with this approach, we can examine a particular EU-sponsored community mental health project in Utrecht or Zagreb and trace its translation processes such as the enrolment of new families, clients, or patients in the network's particular understanding of community mental health and find that survivors of mental ill health fill the role of peer-support advocates—and expert role. Actor-network analysis also enables us to situate these networks in relation to global scientific debate on mental health, mental ill health, and stigma. Indeed, the ANT approach allows us to examine EU mental health projects in terms of their interaction with globally or regionally circulating technologies, medicines, and concepts of care; the unique characteristics of different project locales; the network-participation process; and the social dynamics that emerge when these are combined. (Jolivet and Heiskanen, 2010) And of course, this approach can be performed in other EU governance areas as well.

In light of the foregoing analysis, it seems likely that the anticipated 2021 Joint Action on Mental Health will take up some elements of the community mental health actor-network that was built from 2008-2018. But the new technologies developed in mental health care provision during the Covid-19 pandemic, such as telepsychiatry and e-Mental Healthcare, along with delayed visits and increased reporting of mental ill health in new reporting mechanisms at regional or state health offices, will reshape the network in new ways. It seems likely that community mental health may be redefined to include electronic connectivity as a key actant, its presence perceived as beneficial and its absence as detrimental to mental health in Europe. ANT analysis will allow us to understand how such new technologies that have reshaped social relations worldwide have also become part of our understandings of and relations to mental health in Europe. Such findings will deepen our abilities to understand how science and expertise are shaped by and help shape mental health and other policy areas at the EU level.

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ENDNOTES

[1] The Treaty of Amsterdam (1997; entered into force 1999) amended significantly the Maastricht European Community Treaty by inserting a Social Chapter to authorise legislation in the field of employment

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