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### **The sustainability of knowledge brokerage of the mental health improvement outcomes framework in Scotland**

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## Introduction

This article contributes to the debates about whether knowledge brokerage initiated at a national level is sustained in local contexts over time. The academic literature is now fairly well developed when it comes to identifying the issues, lessons and challenges of knowledge brokerage (see for example Ward et al. 2009; 2010; Partidario and Sheate, 2013; Petman et al. 2016; Davies et al. 2017; Powell et al. 2017); but there is a dearth of literature that evaluates knowledge brokerage activities previously undertaken by national evidence-producing agencies. Such a focus also calls into question aspects of national value-producing leadership (Hartley et al, 2015; Bryson et al, 2017; Van Wart, 2017). It is, therefore the knowledge into action literature that serves to provide the conceptual direction for this study. The assessment of the levels of maintenance of brokerage activity over time also highlights the need for researchers to reorient their evaluative foci in that local implementation contexts are not the only important units of analyses when it comes to establishing whether knowledge brokerage has been sustained (i.e. the role of national agencies is also important). We define sustainability in this context as the maintenance of the use of evidence underpinning the Mental Health Improvement Outcomes Framework (MHIOF) in shaping local programmes and initiatives affecting mental health improvement over time.

It is within this context that the article presents a follow-up study to Reid et al. (2017) published in *Evidence and Policy* (Volume 13, No 1). Reid et al. (2017) examined the barriers and facilitators of getting evidence into policy using a knowledge brokering approach undertaken by NHS Health Scotland (Scotland's national public health agency). The previous research drew on Ward et al.'s, 2009 framework in order to examine the barriers and facilitators of getting knowledge into action – with the MHIOF in Scotland being the vehicle or methodology for knowledge brokerage. In many senses this article is borne out of curiosity with regards to the sustainability of knowledge brokering activity via the case of the

MHIOF i.e. what happened next? In other words, to what extent has the MHIOF been used to shape local programmes and initiatives affecting mental health improvement over time? This question represents the dominant investigative focus of the study.

It is important to point out that although the previous study was published in the journal edition in early 2017 (and online in 2016), the initial research was concerned with the early stages of knowledge brokering activity by NHS Health Scotland in 2012-13. In this respect, the present research addresses the matter of the sustainability of knowledge brokering after five years of the implementation of the MHIOF. Although there were barriers to knowledge into action highlighted in Reid et al. (2017), questions remain about whether these barriers abated or remain pertinent. At the same time, there are questions with regards to whether the facilitators reported in the previous study have proven to stand the test of time. Although the current research concerns the MHIOF, there are inevitably opportunities for drawing general lessons about the longer-term implementation of outcome frameworks and the sustainability of knowledge. Indeed, the literature on the sustainability of outcome frameworks, as tools for knowledge brokerage, are scarce. The article presents learning from follow-up interviews with the areas from the previous study but also reports on the changing context of public sector reform in Scotland (e.g. the integration of health and social care and community empowerment legislation), which presents both challenges and opportunities for the sustainability of outcome frameworks.

### **Knowledge brokerage and the MHIOF in the context of Reid et al (2017)**

The previous study by Reid et al. (2017) was concerned with examining national knowledge brokerage in the context of the often troubled relationship between evidence and policy processes - with policy processes being defined, in this case, as the strategic decisions and actions made by actors operating at senior levels in NHS Health Boards and Local Authorities who are responsible for shaping local planning across the cross-organisational

and sectoral area of mental health improvement. The decision to take a knowledge brokering approach by NHS Health Scotland (a national agency), as a knowledge broker, was largely as a result of a recognition of the fact that any assumptions that healthcare professionals access, appraise and adopt new knowledge as it becomes available is not always realistic (Nilsson et al., 1998; McNeill, 2006; Meyer, 2010). Therefore, a process of capacity building is required in order to increase the chances of the translation and adoption of evidence. Reid et al. (2017) highlighted that the MHIOF had a galvanising effect from a knowledge brokering point of view in that those operating at local levels had a useful mechanism for channelling knowledge into policy processes and this was positive in terms of building strong relationships between the ‘knowledge producer’ (in his case NHS Health Scotland) and local areas. However, the extent of the initial use of the framework was very much dependent on there being a local champion to advocate the use of the framework. At the same time, there were barriers and impediments to the use of evidence including the lack of cultural readiness at an organisational level to adopt meaningful outcome-based approaches and the persistence of output-focussed, rather than outcome-based, management cultures. This became most evident by the lack of priority-setting for outcomes-based approaches by local managers as well as understanding which activities partners are undertaking. This impeded the development of meaningful action around monitoring and evaluation. Ironically, implementing an outcomes-based approach that allows for the mapping of partnership contributions to programme outcomes requires pragmatic conversations to be had about who takes responsibility for monitoring and measuring outcomes (Connolly et al., 2015; Connolly, 2016). Reid et al. (2017) situated their study in the context of the knowledge brokerage literature on the basis that knowledge brokers aim to undertake strategies that draw together ‘evidence producers’ and ‘evidence users’ in order to maximise the opportunities for enabling synergies between knowledge and practice. This is essentially about creating an organisational environment ‘in which there is support for gaining access to

and integrating evidence as part of dynamic processes' (Ward et al. 2009, p.271). The brokering process focusses on 'identifying and bringing together people interested in an issue, people who can help each other develop evidence-based solutions... and encouraging connections that ease knowledge transfer' (Clark and Kelly, 2005, p.7). In this respect, the knowledge broker is a significant role in terms of stimulating the environment upon which communication, facilitation and capacity building on the use of evidence can take place. This means that there is a great deal of onus on the knowledge broker to lead the process of evidence translation and this includes having a crucial role in terms of maintaining the sustainability of the use of knowledge through ongoing support, relationship management, and updating evidence when it comes to light.

The manner in which knowledge brokering is approached and managed must, however, be carefully considered. The volume of literature collating, analysing, proposing and testing models for approaching knowledge transfer and composite elements demonstrates that there is no single approach appropriate for all healthcare/public health contexts. However, it highlights that a mechanism for drawing together organisational interests through collaborative approaches to policy design can maximise programme success - ranging from the basic understanding of language of outcome frameworks to translating the complexities of evidence which underpin outcome frameworks for local contexts (Pertuck and Bassendowski, 2006; Dobbins et al., 2009; Ward et al., 2010; Cairney, 2015). Yet, the importance of the wider political architectural environment and contexts within which knowledge transfer is being undertaken should not be underestimated. Although the positive impact of a supportive institutional or governance context is rarely analysed in great depth, it is clear that the absence of, or change in, senior management support for a project can impede change processes (Reid et al., 2017). The benefits of a positive policy and governance environment are also clearly evidenced in the work undertaken by Nutley et al. (2010). Yet, the recurring obstacles encountered by those seeking to foster better links

between research and practice are, chiefly, the absence of practice implications in published research, poor readability and inadequate explanation of relevance for practice (see Funk et al., 1995; Nilsson et al., 1998). In short, it is clear that the process of knowledge brokering and the knowledge broker's skills-set are both manifold and context-driven, but the accessibility and practical application of the mechanisms of knowledge brokering - in this case the MHIOF – is of paramount importance and may have implications for the sustainability of implementation.

The MHIOF is made up of a number of evidence tools including Outcome Triangles and Multiple Results chains (see Appendix 1). On the Health Scotland Outcome Frameworks website (Health Scotland, 2017a) there are a range of logic models and evidence tools from different topic areas (examples include tobacco, healthy weight, tobacco, drug use, and parenting). Taken together, the range of evidence tools are described as 'Outcome Frameworks' that serve to summarise systematic review-level evidence of interventions which are likely to achieve these outcomes. The purposes of Outcomes Frameworks are:

- To support local planners and partnerships to move to an outcomes approach;
- To facilitate knowledge into action (that is, changes in policy and practice);
- To improve collaboration between partners in order to implement evidence-based programmes, interventions and processes; and
- To aid decision-making processes in terms of prioritising activities in complex contexts (i.e. where there is a crowded policy landscape and actor contestation over the adoption of the best course of action.

(Reid et al. 2017: 2)

The MHIOF Outcome Framework is made up of evidence dissemination tools (as noted above) but also includes 'nested' logic models grouped around the intermediate outcomes within an overall strategic logic model, which provide evidence regarding the strength of

activities interventions and outcomes. The nested model themes of the strategic model are: 1. Promoting Healthy Behaviours; 2. Sustaining Inner Resources; 3. Increasing Social Connectedness; 4. Increasing Social Inclusion; 5. Increasing Financial Security and Mentally Healthy Environments; and 6. Promoting a Safe and Supportive Environment (Health Scotland, 2017b). The success of the use of the evidence contained within the Outcome Framework relies significantly on stakeholder engagement processes and the activities to translate evidence into practice via knowledge brokerage. Olejniczak et al. (2016) argue that the process of brokering is crucial if credible and rigorous evidence is to be successfully taken up by decision makers and integrated into policy frameworks. The potential for knowledge brokering processes to enhance the transition of knowledge into usage-orientated contexts is clear (as demonstrated by Reid et al., 2017). However, arguably the greatest obstacle to successful brokering is a lack of knowledge regarding ‘what contextual factors influence it and its effectiveness’ (Ward et al., 2010, p.6). In this respect, evaluating the sustained use of the mechanisms to aid knowledge brokering in the longer-term is important and merits more attention within the literature (Ward et al, 2009; Meyer, 2010; Olejniczak et al, 2016).

The remainder of the article draws out the findings of the follow-up study in the context of the challenges and interpretations of sustainability based on the semi-structured interview after detailing the methodology of the study.

## **Methods**

The study was informed by the following research objectives:

1. Whether the framework is still being used.
2. What barriers and facilitators remain when it comes to using the framework.

3. Which factors have implications for the use of the framework (this includes the wider political and public policy context as well as local circumstances).
4. What lessons can be drawn for NHS Health Scotland and other knowledge brokers on the best strategies for sustaining outcome frameworks.

To explore these objectives the current study adopted a qualitative design made up of semi-structured interviews underpinned by social constructivist epistemological stance (e.g. Burr, 2015; Harrison et al., 2001). This approach is useful in exploring themes in more depth, clarify content with the participants and provides richer, more detailed narratives from participants (e.g., Barriball & While, 1994; Braun & Clarke, 2006, Burr 2015) - investigating the latter was particularly important for the present research. This approach has also been noted in the knowledge into action literature as an appropriate methodological approach for studies that are quasi-evaluations of a policy experiment and/or for understanding the issues and effectiveness of implementation (see Boaz and Nutley, 2009). Whilst a quantitative approach allows researchers to generalise information to a wider population, and has been reported to be beneficial in maintaining researcher objectivity (Krefting, 1991), this approach would not have been suitable in the current study as the team was specifically interested in how and why participants believed the MHIOF had, or had not been, successful over time (including understanding the impact of contextual factors that can only be teased out using qualitative methods).

The interviewees for the study were drawn from the areas that were involved in the original research into the use of the MHIOF sampled by Reid et al. (2017). The data was analysed by a research team (JC and MK) using a deductive team approach to thematic analysis (Braun & Clarke, 2006; Crabtree & Miller, 1999). Teamwork in qualitative research is increasing in popularity and can help broaden conceptual understanding of the research question (Milford et al., 2017). It has also been noted that health settings may provide ideal contexts in which



researchers from different epistemological backgrounds and disciplines can collaborate on research projects (Ulin et al., 2012 as cited in Milford et al. 2017). Consequently, this collaborative team approach was adopted for the current study. The research team consisted of university researchers from Politics and Psychology, who carried out the data collection and analysis, and senior managers from the NHS and local government. As noted earlier in the article, a social constructivist epistemological stance was taken, in which reality is based on human subjectivity (Burr, 2015), and where both the interviewer and the interviewee are active agents in the knowledge construction process (Harrison et al., 2001).

Given that the current study was primarily intended as a follow-up to Reid et al.'s (2017) research, this project involved purposeful recruitment of the same participants that took part in the original study. Invitation for interviews were sent out via email to the original interviewees. In four cases, the research team interviewed the same individuals from the areas that were included in the previous research (areas: Lothian, Ayrshire and Arran, Dundee and Lanarkshire). Two of the original participants did not take part in the interviews. One individual indicated that they were not in a position to take part in a re-interview due to the lack of recollection of being part of the original research, and, in another case, an individual had retired. In these cases, the research team were advised by the project team (GR, SW and WH) with regards to potential interviewees that were of a similar seniority level within local areas including those who have a remit for mental health improvement within their area and are part of the same policy network. Overall, eight interviews were completed and six of the interviewees had participated within the NHS Health Scotland-led working group that led to the development of the MHIOF and had been involved in capacity building activity on the framework within their local networks. In this respect, interviewees can be described as key 'catalytic' leaders (Luke, 1998) given they are change agents who, or at least attempt to, galvanise silos and span boundaries. Williams (2012, p.103) maintain that such individuals are not in abundance (and this is certainly the

case in Scotland, which has a relatively small policy network), but are, importantly for network-building, responsible for multilateral brokerage, coordination and integration who ‘manage within interorganizational theatres’. This means that, for this qualitative empirical study, the quality and type of interviews outweighs the need for quantity. In line with the previous research, the local areas and research participants are anonymised within this paper. Table 1 provides an overview of the sample frame.

**Table 1: Sample frame for the follow-up study**

INSERT TABLE 1

The interview schedule comprised seven parts. The first two parts related to a) the introduction of the project and reiteration of ethical concerns, and b) the clarification of the role of the interviewee in mental health provision and any changes in their roles since the original research was carried out. The next four sections of the interview schedule consisted of questions related to a) the strategic focus on the uses of the outcomes framework over time, b) the look, feel and accessibility of the framework documents, c) capacity building and how this relates to sustainability, and d) the wider context of the framework (i.e. public sector reform and whether this facilitates or hinders sustainability). The last section of the

interview schedule offered the interviewees a brief summary of the interview and provided them with the opportunity to ask question. The interview questions themselves were similar to those used by Reid et al. (2017). However, given the focus of the research aims in terms of the sustainability of the MHIOF, the interview schedule incorporated questions with a 'sustainability focus'. For instance, participants were asked about the extent to which such barriers and facilitators reported in the previous research were still relevant, acute or whether they had taken on a different form due to changing programme and organisational contexts (both in an internal and external sense). The interview questions were semi-structured to provide a common framework for the interviewers to explore the different themes related to the MHIOF. However, semi-structured interviews also allow researchers to adapt questions to suit the interview situation, ask for clarification of content and explore the opinions of participants in relationship to complex issues (e.g., .Barriball & While, 1994), which was an important aspect of the current research. The interview schedule was agreed with NHS Health Scotland before the interviews were conducted but NHS Health Scotland did not substantively change the focus of the content suggested by JC and MK as the field researchers (the changes were mainly in terms of providing narrative context to interview questions, particularly regarding public sector reform in Scotland). The NHS Health Scotland members of the project team (GR, SW, and WH) were project advisors who helped to ensure that any access issues were overcome in terms of reaching the original interviewees and in relation to understanding the contextual issues surrounding the research project. Ethical approval for the study was granted by the University Ethics committee of the University of the West of Scotland.

All interviews were carried out in the occupational premises of the participants. Interviews took an average of an hour. They were transcribed verbatim by a transcription service as soon as possible after the interviews had taken place. The final written transcripts were checked by the interviewers for accuracy before the final analysis was carried out. For the

analysis, a deductive approach was chosen as the research aim was to explore the existing themes identified in Reid et al.'s (2017) research in more detail. The first part of the analysis comprised careful reading and re-reading of the transcripts (e.g., Rice & Ezzy, 1999) to identify and label appropriate utterances in the transcripts. The next part of the analysis consisted of combining these labels into relevant themes (e.g., Braun & Clarke, 2006). After the initial analysis was carried out by two members of the research team (JC and MK) independently, a team approach was taken and the analyses were reviewed and rigorously checked in a collaborative effort before the final write-up of the data.

The subsequent sections of this article will highlight the key learning from the interviews. However, before this is presented, it is important to revisit and highlight key points from the literature regarding knowledge brokering as a mechanism for change in order to prime the subsequent discussion.

### **The mental health improvement outcomes framework: The sustainability of knowledge brokerage**

- *Local use of the MHIOF for strategic planning*
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Respondents were asked about the extent of local use of the MHIOF in shaping strategic planning at local levels. The qualitative research interviews found that the sustained local use of the framework was variable in many respects. It was clear that some areas used the framework extensively and translated it into their own contexts within local mental health strategies and wider engagement activities. For example, respondent A from local area B noted that they had 'emotionally invested' in the use of the framework (given their involvement in its development) and even indicated that their *entire* local mental health

planning had been based on the MHIOF. When asked about their knowledge about the longer-term local use of the framework, the respondent indicated the following:

Any evidence? I have in front of me our Mental Health and Well-being Strategy for the whole of [local area B] and it is based entirely on the outcomes framework. (Interviewee A, 2017)

The strategy quoted within the interview extract above is a 10-year strategy and respondent B within the same area was responsible for integrating local mental health indicators within the strategy and these indicators were formulated based on the evidence contained within the MHIOF. The respondent from local area E also indicated that they had used the MHIOF since its inception and have continued to champion its sustainability locally. However, this was not consistent across all areas. The dominant reasons given for a lack of its use included a lack of national targeting and accountability mechanisms to ensure its use (Areas A and D) and local areas not being at the same implementation stage as others in relation to planning for mental health and wellbeing (Areas F and G). However, similar to local area B, the respondent in local area C highlighted that the MHIOF has been sustained locally and the MHIOF, and the methodology behind its development, has had positive implications for local change processes. The MHIOF, with support from Health Scotland, helped to steer local work and stimulate network-building on mental health through the implementation of training:

We developed local health and wellbeing networks which kind of steered the work, developed various tests of change, and built up evidence at every stage of our results chain, which stood us in good stead when we then had strategic discussions about how to mainstream this work, and it was mainstreamed in 2014. So where we have been over the past couple of years is, ... building on that work, if you like, making sure it's embedded strategically, that there's activity happening locally. And then our mental health literacy programme has actually grown and grown so that there's a training programme that sits

alongside our local activity which is about raising awareness of health inequalities and poverty sensitive practice, and mental health inequalities ... Embedded through all this really has been the evidence that sits behind what we're doing. So there's been a process of really hooking people in, saying this is why it's important, what you're doing matters.

(Interviewee C, 2017)

The local areas reported that change processes were dependent on capacity building activities in local areas. Capacity building in this context refers to the local training of partners and a general theme to emerge across the interviews was that sustainability of the MHIOF depends considerably on there being a local champion, network manager or discipline lead to galvanise support for its use. However, identifying the *key* network lead for taking responsibility for capacity building is becoming ever more challenging in the densely partnership-based environment stimulated by developments in contemporary public sector reform in Scotland (see later in this paper). Both respondents in area B highlighted that they have felt confident in facilitating meetings and workshops around the MHIOF and its associated tools. Area C undertook extensive capacity building and the respondent cited implementing 'training for trainer' sessions to sustain the use of outcomes planning and evaluation. In this respect, area C used the MHIOF to develop staff and partners on the methodology and tools of the framework behind it. Accordingly, there is evidence of local translation of the main themes or 'spirit' of the framework in Area C:

...it's fair to say we don't hold up the outcomes framework and say look at this and, you know, this is your Bible, but it's threaded through.

(Interviewee C, 2017)

Area A, on the other hand, noted that capacity building was reserved for discussing how the MHIOF might help design 'sense of belonging' interventions, but that there were no local capacity building workshops *per se*. Area D did not have a local champion for the use of the

MHIOF and indicated lack of ongoing local training/capacity building activity in relation to the framework. There were also skills-deficits at a local level in terms of understanding *how* to build local capacity on the MHIOF and that ongoing national support (in terms of the delivery of training) would be useful (Area D). Having said that, all of the respondents were in agreement that the MHIOF itself was very useful and accessible. The general view was that certain tools were more user-friendly and more suited to capacity building in partnership contexts than others, namely the Outcome Triangle and the Multiple Results Chain, due to their visual power (see Appendix 1). Respondent B from area B, who has a more evaluation research role in the Health Board, highlighted that the strategic and nested models of the MHIOF were very useful in terms of accessing references to evidence, but also noted that the evidence links were seen as rather complex, which is likely to impact (negatively) on the extent and simplicity of ongoing local dissemination. Respondent A from area B considered that the value of the MHIOF is to ensure that there is familiarity in terms of understanding of the process behind developing frameworks ‘rather than sitting down at a computer and clicking through/using links etc.’. This relates to the point noted earlier by the respondent within local area C who indicated that the reality is that local areas will be more comfortable when it comes to discussing the spirit and general themes of the MHIOF. Indeed, and related to this theme, local area E also noted that even those with experience of public health and health improvement would have struggled to understand much of the thinking behind, and the content of, the MHIOF without the initial support that was given by NHS Health Scotland as a knowledge broker. At a conceptual level, local area C felt that the key challenge around the local use of the interactive model would be the challenges of clarifying the definitions of concepts of the framework. Yet, at the same time, the respondent from local area A was clear that, at an intrinsic level, there is value in the existence of the framework given that it promotes mental health and wellbeing (i.e. that this is useful in itself). There was also recognition, and positive feedback, regarding the amount

of work that NHS Health Scotland invested in developing the framework. Respondent A from local area B recognised the ‘massive amount of work’ that went into it which, they said, would be the equivalent amount of work required for a PhD. However, this respondent also acknowledged that the framework’s utility, in the longer-term, will only be possible ‘as long as they keep on keeping it up-to-date then it’s there in perpetuity and there’s no reason why it can’t be used’.

Furthermore, the general message across all of the interviews was that currency and sustainability of the MHIOF are inextricably linked. The respondent from area A indicated refreshment should be a priority because they had actually ‘forgotten about the framework’. This chimes with the general view across the interviews. Indeed, the respondent from local area C, who emerges from this research as one of the key local champions for the sustainability of the MHIOF, was complimentary about the evidence within the framework but noted that it has lost its momentum and that it is ‘time to refresh or re-promote it’. Respondent B from local area B noted that some of the evidence contained in the MHIOF is now perceived as dated. In terms of evidence-gaps within the existing framework, the respondent from local area D felt that the framework could draw on more qualitative research and respondent A from area B would like to see more evidence included on ‘social isolation’ as a factor which impacts on mental health and wellbeing. There was, however, enthusiasm shown across the interviews that actors would support NHS Health Scotland in refreshing the framework and that this type of work programme would enhance its sustainability through the interaction of ideas and interests between knowledge producers and users. This point can be considered in the wider context of knowledge brokerage at a national level and how national level direction is a dominant driver to enable sustainability. This also relates to leadership at a methodological level.



*The need of national messages to be clearer regarding the levels of congruence between methods for supporting public sector reform*

Respondents were asked about the wider policy context and how this, in their view, has had implications for the sustainability of the use of the MHIOF. This is an area which is yet to be considered to any great extent within the academic literature i.e. how the national policy context impacts on the use of outcome frameworks over time. A key issue to emerge from the interviews was the implications of multiple methodologies promoted nationally for aiding public sector reform and the lack of clarity regarding their levels of congruence. National agencies, including the Scottish Government, have been advocates for the use of both improvement science approaches to change practice *and* outcome (theory)-based evaluation approaches (also known as contribution analysis). Yet less emphasis has been given to reconciling how, and in what circumstances, they should be applied (Scottish Government, 2011a; Connolly, 2016; NHS Health Scotland, 2017a; National Improvement Service, 2017). There was a sense in the interviews that sustainability requires direction with regards to the best use of standards and approaches for stimulating change within partnership contexts. However, respondent E noted that the local areas have interpreted the level of congruity between improvement approaches and outcome-based evaluation approaches in a ‘pragmatic way’ i.e. a renewed focus around the relationship between undertaking activities/interventions flexibly in order to achieve outcomes in the context of resource limitations (in the absence of national guidance):

...I think [improvement science and outcomes-based approaches] are compatible because the outcomes are your big picture, the end point you want to get to, but improvement science is how we get there and what changes we can make without having to wait for a mega evaluation to report. And none of us have capacity or resource to do that anymore. (Interviewee E, 2017)

The issue of trying to wrestle with different methodological approaches speaks to wider complexities – namely shifting national level priorities within a fast-paced and changing public health environment. The respondents were clear that the initial support provided by NHS Health Scotland was extremely valuable. However, they also highlighted that key opportunities now exist to continue to promote how evidence from the MHIOF is important as part of local strategic planning and, as part of the health and social care integration agenda, to recalibrate relations with local areas. A suggestion from the interviews was that knowledge brokers at a national level could build on the previous successes of having specialist mental health improvement network group meetings that bring together key individuals from NHS Health Boards and local authorities in Scotland. This previous network (which helped to produce the MHIOF) enabled coordination, knowledge dissemination and lesson-drawing across areas. These points indicate that the nurturing of national and local relations are important for maintaining the sustainability of the MHIOF.

- *The challenge for sustaining knowledge brokerage: Structural reform agendas*

Interviewees were also asked about the public sector reform agenda in Scotland and how this has affected knowledge brokerage in the longer-term. It was noted earlier in this article that an obstacle to successful brokering is a lack of knowledge regarding how brokering works and ‘what contextual factors influence it and its effectiveness’ (Ward et al., 2010, p.6). A major theme to emerge from the interviews is that barriers to the sustainability of the use of evidence via the mechanism of outcome frameworks are as a result of the multiple pressures and drivers for public sector reform in Scotland. Equally, there are also key opportunities for knowledge brokerage in order to temper or align with the trends of reform. With this in mind, it is important to provide a brief overview of the recent developments in public sector reform.

The macro-level policy direction of the Scottish Government post-2007 (under the Scottish National Party) have included specific initiatives highlighting inter-agency collaborations, joint service delivery, integrated public services, joined-up approaches and partnership working under the auspices of the National Performance Framework (Dickie, 2015; Thomson et al., 2015). The task for the public sector was to maximise the coordination of the work of agencies and partnerships (and to link them with the private and not-for-profit sectors) in order to enhance service delivery. In 2011, the Christie Commission, which had been established to examine the future delivery of public services in Scotland, devoted a section of its report to matters relating to ‘inter-agency training to reduce silo mentalities, drive forward service integration and build a common public service ethos’. The Scottish Government’s formal response to this report proposed a reform agenda framed around the key principles and themes of ‘prevention’, ‘partnership’, ‘workforce development’, and ‘performance’ (Christie Commission, 2011; Scottish Government, 2011b). Within these approaches were located matters of important detail including outcome agreements with public service providers, efficiency savings targets, and the greater use of shared services (in response to one of the recommendations of the Christie Commission Report). By 2017, the key policy instruments driving the public services reform agenda in Scotland were the National Performance Framework (NPF), the Community Empowerment (Scotland) Act, and the integration agenda for health and social care via the Public Bodies (Joint Working) (Scotland) Act. The NPF, introduced in 2007 as an element of the spending review, was a 10-year vision. The Community Empowerment (Scotland) Act 2015 refers to the NPF by placing a duty on Scottish Ministers to publish a set of national outcomes for Scotland and report on progress towards these, and renew them at least every 5 years. Additionally, this Act legally constitutes community planning structures, with the effect of requiring services to be planned, delivered and monitored across partnerships (including the health service, local authorities, the police services, community groups and the third sector). These policy

developments highlight the increasing devolution of policy responsibility (i.e. an empowerment model) when it comes to the implementation of evidence-based reform within the public sector.

All of the interviewees indicated that their roles within their local areas have been affected by contemporary public sector reform agendas in Scotland since the development of the MHIOF. The main theme to emerge from the interviews was that there have been a number of national and local drivers for reform that have impacted on local mental health improvement strategies. The narrative from the interviews is that reform agendas have been inextricably linked to the extent to which the MHIOF will be translated and sustained within partnership contexts (e.g. Community Planning Partnership structures and ever-increasing inter-organisational arrangements). Indeed, the terms ‘partnerships’ and ‘networks’ are highly relevant to the challenges cited in the interviews in relation to public sector reform. The interviewees all noted the challenges of accommodating the post-Christie Commission agenda around sharing services and adopting joined-up approaches to service planning and delivery. This has been evident in terms of the health and social care agenda and working within Community Planning Partnerships to address multi-faceted societal issues (e.g. mental health and wellbeing), including the development of Local Outcome Improvement Plans (LOIPS) in order to take forward community planning (Improvement Science, 2017). For local authorities and local communities there has also been the empowerment agenda (as a result of the Community Empowerment Act 2015) but, at the same time, local partnerships need to work within the context of the national outcomes contained within the NPF. Yet all of this needs to be seen in the context of austerity, which, as the respondent in local area C noted, does not serve to facilitate joined-up working in that partners can resort to silo-working and protectionist behaviours ‘cause they’re starved of resources’. It is within this context that the challenges and opportunities of public sector reform, in terms of the sustainability of the MHIOF, are considered.

Public sector reform in Scotland has led to a complex network landscape that is challenging to navigate. The respondent in local area G noted that ‘it’s just quite a messy picture out there in terms of who’s doing what, where and how do you feed in’. Respondent A from local area B had similar sentiments and noted that ‘oh ... I don’t know that any of us are actually managing to navigate our way through it. I think it’s very, very challenging’. The respondent from local area C reflected that ‘it’s difficult, but you can’t do everything all at once so you have to eat an elephant in bite size chunks, I guess’. The respondent cites the integration of health and social care and refers to this as an ‘enormous’ challenge and that it leads to the feeling that they ‘don’t know where to start’, particularly in terms of the difficulties of ensuring coherence across partnerships. A typical perspective on the matter of multiple reform drivers and the daily challenges of this were cited by the respondent in local area F:

...we’ve done some, the health and equalities planning that I mentioned, we’ve got a kind of sense of three broad priorities in the [area F]. But then the health and social care locality groups are looking at, well, what are the issues for us. And they’re not particularly coming up with the things that are set as these higher level priorities. So we have to join up the top down and the bottom up. And it, it’s quite sensitive stuff. It’s quite difficult to do and everyone’s very time pressured and, you know, you need a lot of time to work that through and discuss it and arrive at some agreed definition of what it is that we’re all about in this.

(Interviewee F, 2017)

Respondent F also noted the challenges of ensuring coherence and noted the prevalence of ‘complex systems and lots of ideas and juggling lots of agendas’. These pressures clearly challenge the opportunity for using systemic evidence to influence policy given the multitude of interests at play. Nevertheless, the interview findings suggest that an alternative view of this situation is that complexity provides opportunities for national knowledge brokers to

accelerate reaffirmations of importance of the MHIOF as a vehicle for change. In other words, the challenges of contemporary public sector reform will have implications for the translation of the MHIOF but there are now windows of opportunity for enhanced knowledge brokerage in order to shape the mental health agenda. This activity would help to build on the success of MHIOF in terms of the contribution it has made to elevate the importance of outcomes-based monitoring and evaluation in shaping public management norms. Indeed, a typical ongoing benefit of the knowledge brokerage activities are highlighted by the respondents in areas F and G who both highlighted the role that the MHIOF has plays in this regard:

[The] outcomes framework could help drive you towards putting things together better because you can sort of show these interventions together would have an impact on. And if it is mental health and wellbeing, you know, how we get to that co-ordinated work...and a common understanding of what we mean by mental health outcomes. (Interviewee F, 2017)

So the whole language of outcome focused planning is much, is much, is used much more frequently. People are more in tune with that. So I think there's an opportunity, a really key opportunity at the moment to make sure that mental health is part of that outcomes focused discussion, both in terms of...you know, locality planning but also in terms of individual, planning with individual or with a group of individuals.

(Interviewee G, 2017)

In terms of future developments, the sustainability of the integration agenda has potential from a programme of activity to refresh the MHIOF:

Setting the next framework in the context of health and social integration provides a fantastic opportunity because within integration you would argue that in principle we should be in a much stronger position to

address those wider determinants of health and wellbeing that the framework sets out to achieve. So we should be in a stronger position. Part of the challenge will be that quite often a lot of the people who were previously involved or had previously been champions will now have new roles. And maybe...or there's two sides, so through integration perhaps new people have emerged that have a specific focus on interests from mental health improvement. Or the other side of that could be that people have moved, they've been asked to take on different roles and we've lost a bit a' leadership around mental health improvement.

(Interviewee G, 2017)

The respondent from local area C noted that there was leadership required for the MHIOF to sustain but also to use it to influence national government policy in the context of a revised national mental health strategy, and also in the development of LOIPS, to direct the contours of community planning.

There's the draft national mental health strategy around just now, but in the meantime we're trying to develop a logic model for mental health and we don't know what the national priorities are. So there's that kind of it feels like a bit of a disconnect, and timescales don't maybe match-up between what's being expected for community planning partnerships for producing their LOIP and some of the national strategies that would help direct that.

(Interviewee C, 2017)

In short, in terms of the sustainability of knowledge brokerage, it is clear from this follow-up research from Reid et al (2017) that the structural changes within the Scottish public sector provide opportunities for refreshing the MHIOF and that the framework could support knowledge users navigate through the complexities of reform.

## Conclusions

This article presents follow-up research to Reid et al. (2017) to address the simple question of ‘what happened?’ since the previous study which considered the barriers and facilitators to getting knowledge into action by adopting a knowledge brokering approach via the mechanism of the MHIOF. The issue of sustainability is at the forefront of this analysis and there is some positive evidence to emerge from the follow-up interviews in certain areas as to how the framework has been used for local planning and evaluation within partnership contexts for public health. This activity has also made a contribution to shaping the narratives of outcomes planning and evaluation as a norm for public management in Scotland. For the national knowledge broker, in this case NHS Health Scotland, this gives a sense that the amount of time and work that went into developing the framework was ‘worth it’. However, the worth of this knowledge brokering activity will be challenged if local and national relations are not maintained over time and this is likely to be exacerbated if there are shifts in the national policy agenda. At the same time, this research presents evidence to suggest that a refreshed MHIOF will be useful for national decision-making on mental health policy and for local planning. The involvement of local areas in the further development of the MHIOF may improve its future utilisation as a result of enhanced co-productive practices.

In broader terms, this article offers insights into the complexities of the patchwork surrounding the relationship between knowledge production, dissemination and practice within partnership environments whereby actors have relative autonomy to translate evidence tools to their own contexts. The realities of the public sector, not just in Scotland but in Europe (Torres, 2004; Kazepov, 2010; Ruano and Profiroiu, 2017), has been to adopt empowerment principles and this is to be expected given that in multi-level policy systems the conditions of local populations must be respected. Nonetheless, empowerment approaches can present challenges when it comes to the maintenance of national and local



relations as part of knowledge brokerage processes. What this points to is the need for more research that considers knowledge brokerage and how this is challenged or otherwise by changing multi-actor policy relationships and how these relationships relate to styles of governance.

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**Appendix 1: MHIOF Tools: Multiple Results Chain and Outcomes Triangle**

**Figure 1: Outcomes Triangle**

Source: [http://www.healthscotland.com/ofhi/MentalHealth/content/results\\_chain.html](http://www.healthscotland.com/ofhi/MentalHealth/content/results_chain.html)

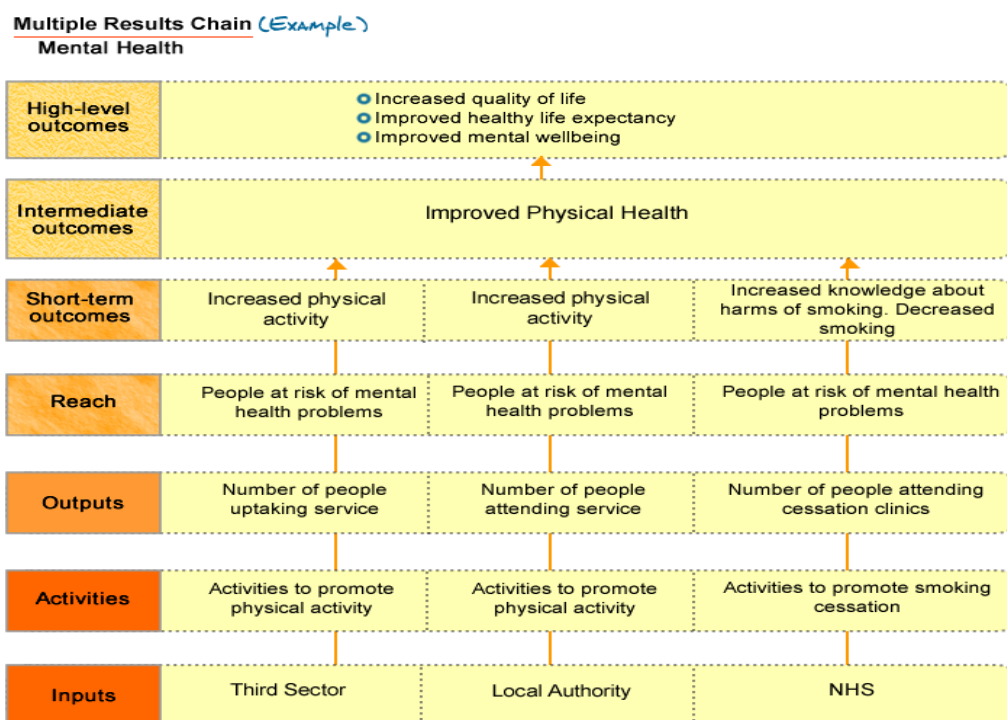
**Figure 2: Outcomes Triangle**

INSERT FIGURE 2

Source:  
[http://www.healthscotland.com/ofhi/MentalHealth/content/MHOutcomes\\_triangle.html](http://www.healthscotland.com/ofhi/MentalHealth/content/MHOutcomes_triangle.html)

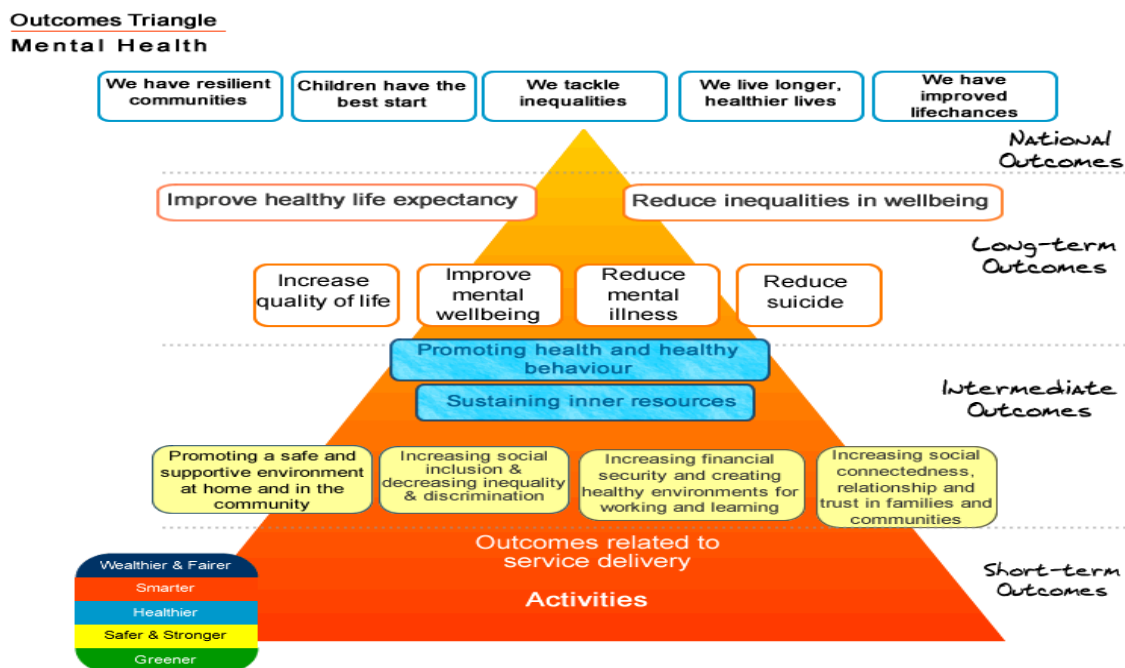
## Appendix 1: MHIOF Tools

Figure 1: Multiple Results Chain



Source: [http://www.healthscotland.com/ofhi/MentalHealth/content/results\\_chain.html](http://www.healthscotland.com/ofhi/MentalHealth/content/results_chain.html)

Figure 2: Outcomes Triangle



Source:

[http://www.healthscotland.com/ofhi/MentalHealth/content/MHOutcomes\\_triangle.html](http://www.healthscotland.com/ofhi/MentalHealth/content/MHOutcomes_triangle.html)

**Table 1: Sample frame for the follow-up study**

<b>Area</b>	<b>Role</b>	<b>Organisation</b>
A	Board-wide health improvement role (including mental health and strategic planning)	Health Board
B	Respondent A: Board-wide health improvement role (including mental health and strategic planning)	Health Board
B	Respondent B: Analytical and evaluation role covering the mental health improvement area	Health Board
C	Strategic lead for mental health	Local Authority
D	Public health lead role	Health Board
E	Mental health service management	Health Board
F	Health and health inequalities lead	Health Board
G	Partnership manager	Local Authority