



## **CMHO Evidence-Based Practices Consultation Paper: Addendum**

### **Interim Report on the Consultations**

**May 8, 2008**

Province wide consultations were held with Children's Mental Health Ontario (CMHO) member agencies and key stakeholders to inform and discuss our future role in assisting service providers to implement evidence-based practices (EBPs) in child and youth mental health organizations. CMHO proposed the development of a Technical Assistance Center (TA Centre) to assist these service providers with the process. The consultations provided participants with the opportunity to discuss whether the proposed centre would support their needs, and to help establish priority areas and recommend next steps. Stakeholders were also able to provide feedback electronically by completing a questionnaire on SurveyMonkey.

The following is a summary of the feedback received from the consultations to date, including the survey responses. Comments are grouped according to themes and topics stemming from discussions, all information presented is anonymous.

#### **Consultation Process:**

A total of 141 participants attended sessions in the following 11 locations:

- Thunder Bay (teleconference)
- Kenora (on-site and via videoconference)
- Sudbury (on-site and via videoconference)
- Toronto (east & west sessions)
- Ottawa
- London
- Windsor
- Hamilton
- Markham
- Kingston

Consultations were also held with:

- Ministry of Children and Youth Services (MCYS) Children at Risk branch staff (Marian Mlakar, Director & Mary Mannella, Manager)
- Ian Manion, Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (CoE)

Consumer Stakeholder consultations were held with:

- Youth, New Mentality Leaders (12 participants)
- Parents/Carers, Parents for Children's Mental Health (PCMH) members (22 participants)

Upcoming consultations include:

- community partners - to be scheduled
  - an additional consultation is under consideration for members that were unable to attend previously scheduled sessions.
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## **Overall Reactions:**

- In general, the paper was extremely well received by member centres; participants attending the sessions agreed with the overall vision and direction of the paper.
- Member centres expressed great value in potentially having a body to help guide the coordination and implementation of EBPs across the sector.
- The proposed TA Centre was welcomed as a 'one-stop shopping' resource offering a variety of much needed services such as: proposal writing; program evaluation; data analysis, and the identification and selection of evidence-based programs to name but a few.
- While all participants understood and supported the need to develop a broad based long-term plan, the scale and size of the project received mixed reviews.
- Some participants felt that the project requires clearer definition, and some expressed concern that the initiative was overly ambitious, raising questions about feasibility.

The single most common response was that the working name, "Technical Assistance Centre" is not a good descriptor for the proposed service.

A number of **potential alternatives** were suggested for "TA Centre", these include:

- 'Evidence-Based Resource and Support Centre'
  - 'Evidence-Based Practice Support Centre'
  - 'Evidence-Based Implementation Centre'
  - 'Evidence-Based Practice Implementation Network'
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## **Key Messages from Service Providers:**

The following are **key messages** that emerged from the consultations:

### **1. Many member centres feel they lack the capacity to implement EBPs**

- Resources necessary to successfully implement and sustain EBPs were considered to be well beyond the capacity of most centres.
- MCYS support through the allocation of additional resources for EBPs was viewed as critical to sector-wide uptake of EBPs.
- Human capital was repeatedly identified as a barrier. Most agencies lack the staffing to adequately fulfill the requirements of some of these interventions (e.g., at a clinical level lack of access to masters of social work, psychiatrists, psychologists, and other clinical staff; at a systems level lack of access to evaluators, researchers, data analysts).
- A great deal of time and training resources are necessary to properly educate staff to carry out these interventions.
- Hidden and ancillary costs associated with evidence-based programs need to be made explicit (e.g., on-going training for certification/re-certification, staff turn-over; management training; fees for licenses, workbooks, forms etc.).

- Implementation must be well managed and planned, requires intensive practical hands on support.
- Need systems level and day-to-day practical support.

## **2. Ministry conceptual understanding, support and funding is needed for successful EBP implementation**

- Ministry recognition that EBP is worthwhile and dedicated investment is critical.
- CMHO is well positioned to strongly advocate for increased funding on behalf of sector to ensure initiative is properly resourced.
- Advocacy includes raising awareness and creating the necessary shift in thinking about EBPs with all ministry reps, from the most senior staff down to regional reps, and across sectors (e.g. young offenders, education, health etc.).
- Develop system-wide infrastructure to successfully implement and sustain EBPs.
- Recognition from the Ministry that an initial and sustained investment in funding and resources is required.
- There is grave concern among members that, without this investment, the move to EBPs will be another "added expectation" and will break the back of the system.

## **3. Ministry service targets need to be adjusted as agencies implement EBP**

- Ministry needs to look not only at numbers, but at service outcomes also.
- EBP interventions are more structured, may require more direct client contact and staff time to learn new practices and to prepare to deliver them; initial reduction in the number of clients and/or direct service time is expected.
- Centres have grave concerns that quality is being compromised in order to respond to pressure from the Ministry to meet ambitious service targets.
- If the system is to become evidence-based, these service targets will need to be adjusted in order to allow service providers to implement new evidence-based programs correctly.
- Ministry needs to understand that EBPs will require an initial and on-going investment, which over time will result in better outcomes.

## **4. Differentiate CMHO and Centre of Excellence roles**

- CMHO needs to position itself for activities that complement rather than duplicate CoE activities; identify CMHO's added value/contributions.
- Member centres viewed CoE as providing some services e.g. program evaluation; however redundancy is a concern.
- CMHO should work collaboratively with the CoE, to identify gaps and leverage resources to benefit the field.
- CMHO should collaborate with CoE, so that support to the field is more 'applied' and hands-on.

## **5. TA Centre funding models**

- Fee-for-Service was uniformly identified as the least palatable method for sustaining the TA Centre.
- The smallest agencies could not afford to pay fees for the proposed services; some larger agencies already have the capacity/resources, therefore will not need the same type of assistance.

- Access to and use of the TA Centre will be largely dependent on its services being fully funded by Ministry and/or a corporate sponsor.
- CMHO must explore a range of funding models (e.g., partnerships, corporate sponsors, MYCS, graduated fee for service, informal barter economy).

**6. Support a balance between evidence-based practice (EBP) and practice-based evidence (PBE):**

- The TA Centre must support the development and evaluation of in-house programs, in addition to established EBPs.
- Evaluation and rigidity of EBPs can be a barrier to accessibility and innovation.
- The skills and expertise of clinicians needs to be recognized and valued.
- Empirically-supported interventions are not replicable with all populations (e.g., francophone, First Nations). Populations with culturally, geographically and linguistically diverse needs require additional supports to assist with program adaptations, translation, fidelity checks, etc.
- Clinical services are often reduced in order to re-allocate funds to program evaluation.
- Support practice-based evidence in areas where empirically supported treatments do not currently exist or are not typically examined (e.g. treatment of special populations).
- Investigate clinical role of hope, empathy, and rapport; examine common mechanisms of effective clinical practice and support training regarding their development.
- Identify common level of clinical expertise required by graduates to respond to workplace needs.
- Capture Canadian knowledge; develop expertise in quantifying how to manualize in-house programs for Canadian dissemination.
- Create benchmarks for comparing program/service efficacy.
- Some participants concerned that paper is not focusing sufficiently on the positive results that are being achieved in the field.
- Lobby/advocate for support and valuing of practice-based research activities.

## **Voice of Consumers:**

### **Parents/Carers**

- Some parents support the direction of a more evidence-based system.
- Some parents concerned about supporting anything that could divert funding away from direct client services, lengthen wait times or could create another layer of bureaucracy.
- Needs of families are immediate e.g., better access to services (professional and non-professional); seamless transition between MCYS services, hospital, community care, and child protection, etc.
- More attention paid to prevention, social determinants of health; system needs to be proactive vs. reactionary.
- Some parents had experience of an EBP being recommended, but unavailable due to centre not having staff trained in the intervention.
- A more consistent level of service is needed across the system.

- Parents want to have a voice in planning and decision making; current stress of dealing with their situation makes it challenging to participate.
- Parents want access to child and youth mental health information; want to know what treatments are most effective.

## **Youth**

- Overall support for the system to become more evidence-based.
- Everyone wants to know about effective treatments (not limited to service providers).
- Education is needed for all professionals who work with youth (e.g. police, teachers, addictions workers).
- Mental health information needs to be accessible (electronic, web-based preferred), relevant, brief, understandable.
- Youth should be involved in creating and disseminating educational material on effective treatments.
- Create networking opportunities to find out more about EBP.
- Service providers must involve youth in new ways, e.g. "youth advocates" at centres especially residential programs, much like "patient advocates" in health system.
- Active involvement in specific projects-including sufficient training for meaningful participation.
- Recruit 'youth delegates' from member agencies to sit at TA Centre planning meetings to ensure work is grounded in the needs of the consumer and specific sub-cultures e.g., gender, cultural, etc.
- Parent advisory committee to TA Centre and to local agencies (focus groups, satisfaction surveys, pre/post tests).
- CMHO should look at what other countries are doing to provide TA to service providers.
- Youth presence at professional conferences is needed.

## **Possible starting points recommended by members:**

### Clearinghouse for Mental Health Information & Research

- Create a depository of information containing interesting research (RBP and PBR), program evaluation, best practices, best tools, training costs, etc, equipped with contact information that centres could access to connect with others who provide similar services and might serve as resources.
- Access to literature, and how to apply knowledge.
- Conduct a scan and/or make use of Ministry's mapping data to generate & maintain a database of EBPs in use in sector.
- Create consortium of best practices with Canadian/Ontario focus, keep it active and alive (it should identify promising, innovative, and model programs).
- Develop the evidence for interventions not currently studied, how to strategize to do that, be evidence informed (e.g., residential and day treatment - what is evidence base, who is implementing what).
- Research available interventions/programs, compare/rate them using levels of criteria to rank EBPs endorsed by CMHO/TA Centre (similar to Blueprints Colorado conference).
- Identify core elements of EBPs.

### Tools/measures

- Provide database of standardized tools, preferably listed by topic. Agencies need to be able to consult with someone about measures for assistance in selecting the appropriate measures to evaluate programs and to measure constructs, etc.
- Common tools are necessary but field needs to go beyond BCFPI and CAFAS to measure outcomes/publish findings.

### Link to experts

- Create database of experts in the field to allow agencies to link up with each other to share information/resources, learn from colleagues, and discuss progress/challenges.
- Create Communities of Practice in various EBPs.

### Researchers/learning institutions

- Link centres with researchers or develop partnerships with universities who are conducting research in the field, centre could provide population and researcher could provide evaluation expertise. Database needs to go beyond listing contact information currently available on CoE researcher directory.
- Linkages should support centres on 'how to do it', with hands-on, on-site help from evaluators/researchers.

### Data Analysis

- Data analysis assistance.
- Facilitate bulk purchases of data programs, or identify capable agencies that could assist other centres with data analysis.
- Demonstrate clinical utility of BCFPI/CAFAS tools; reports need to be interpreted/analyzed so they are helpful to clinician and agency planning.
- Get different database systems speaking to each other.
- Need interpretation/synthesis of data that is easily understood and usable.
- Integrate service with research, select what data is important e.g., service hours, outcomes. etc.

### Support

- Northern communities need more technical support to bridge requirements of program with realities of community, need more hands-on tech assistance to move this type of training into remote areas; ensure that agencies have technology to deliver services.
- Present training model to educate board members, staff etc. about EBPs.

### Consultation (in person/on-site and remotely)

- Centres would like on-site consultation about centre specific process for implementing EBP (discuss ideas, logistics); initially consultant should be physically present and later provide follow-up by phone.

- In person and on-line access to research to determine if program is appropriate with clinical skills, population, presenting problems of centre clients; need to know barriers and advantages of program before deciding to implement in order to make an informed decision; hook-up with individual/agency already providing intervention to shadow program to see if it is a good fit.
- Members would like more support when selecting interventions. View developers of manualized program as more concerned with selling product versus providing full information about intervention (e.g., are results based on full implementation or partial).

#### Proposal writing

- Offer support and/or training in grant proposal writing. This activity is time consuming and is currently added to staff workload.

#### Evaluation/fidelity

- Fidelity requires evaluation and supervision to remain true to model.
- Need to know when adaptations can be made.
- Need experts to consult with, and to do evaluation of adapted model.
- Identify essential elements, how to make adaptations, then do research.
- Develop internal capacity to evaluate programs, especially for Aboriginal or French populations where evidence base is very small.
- Evaluation support, assistance measuring outcomes.
- Assistance with research plans/identification of priorities for research.

## **CMHO Evidence-Based Practices Committee Recommendations:**

1. Work with Ministry to ensure implementation of EBPs is fully understood, funded, supported and sustained. Effective uptake from Ministry requires a broader understanding of EBPs and a recognition of needed change in current practices (e.g., dedicated budget/resources for 'training line' and a recognition that evaluation is important).
2. Develop a business plan for sustainable funding for the TA Centre, and establish achievable short and long-term goals & objectives. Explore variety of funding options to secure additional resources (corporate and private).
3. Collaborate with Centre of Excellence to determine roles/activities, and best use of resources for the greatest system impact.
4. Provide coordinated training opportunities, broker training costs, provide web interfaces to host CoPs.
5. Create formal linkages with academic institutes (universities/colleges) to ensure that clinicians are graduating with the necessary skill set (e.g. work with York University to develop post-graduate training such as an Implementation Management Certificate).

6. Scope of TA Centre activities need to be clearly defined, costed and properly resourced.
7. Make a decision regarding the working paradigm of the TA Centre. Address the dichotomy - CMHO and the TA Centre as the centre of expertise vs. CMHO facilitating a grassroots TA Network of emergent knowledge and expertise. Develop a new name that reflects this positioning.

Outcomes of these discussions will help to determine whether CMHO has a role to:

- Create a depository of EBP/make use of MCYS mapping data.
  - Create a database of experts in the CMH field, so that members can tap into resources within local community.
  - Create networking opportunities (web-based interface and repository).
  - Develop Communities of Practice regarding specific empirically supported interventions, as well as more general EBPs (e.g., evidence-based parenting intervention skills, evidence informed process for adapting interventions).
  - Develop Community of Practice regarding EBP implementation, adaptation, clinical supervision, evaluation, etc.
  - Develop web-based information/networking forums.
8. Provide training models that illustrate how to educate agencies including board members on EBPs. Highlight successful models that focus on change processes.
  9. Demonstrate clinical utility of tools (BCFPI and CAFAS), provide reports that are helpful to clinicians and are at a program level.
  10. Engage in further consultation with stakeholders on next steps & implementation plan for the TA Centre.