



# Knowledge Transfer and Implementation of Evidence-Based Practices in Children's Mental Health

EXECUTIVE SUMMARY

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Santé Mentale pour Enfants Ontario

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## Children's Mental Health Ontario Santé mentale pour enfants Ontario

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Dear Colleagues,

The emergent trend toward the use of evidence-based practices in children's mental health services has been steadily gaining recognition and importance in Ontario. Children's Mental Health Ontario has worked to promote the use of evidence-based practices and to bring relevant, up-to-date information to the field. However, making the right information available is only one piece of the puzzle. The process of transferring knowledge about evidence-based practices and implementing these in our day-to-day work with children, youth, and families is highly complex. We believe the study of this process is every bit as important as the study of the evidence-based practices themselves.

Children's Mental Health Ontario is very pleased to take this important first step toward understanding the barriers and facilitators that come into play in the implementation of evidence-based practices in children's mental health centres in Ontario. This collaborative effort with the Community Health Systems Resource Group at the Hospital for Sick Children and the National Implementation Research Network/Louis de la Parte Florida Mental Health Institute at the University of South Florida has allowed us to begin our journey.

We would like to express our sincere thanks to the experts who contributed their time and knowledge to the project, and to the executive directors, clinical managers, and program staff who completed the surveys and helped us begin to understand the topic in a more meaningful, practical way.

Finally, we thank our colleagues Melanie Barwick, Katherine Boydell, Elaine Stasiulis, and Bruce Ferguson from the Hospital for Sick Children, and Dean Fixen and Karen Blase from Louis de la Parte Florida Mental Health Institute for their expertise, knowledge, and guidance. In particular, we thank Melanie Barwick for her project leadership.

Sincerely,

A handwritten signature in black ink that reads "Nada Martel". The signature is written in a cursive, flowing style.

Nada Martel  
President, Board of Directors



## Acknowledgements

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Several national and international experts took time to speak with us about their practical and research-based experiences in implementing and providing evidence-based practices. Their knowledge in the areas of transferring evidence-based practices to the field is vast, and we are grateful to them for sharing it with our audience.

Leena Augimeri – Director Program Development & Centre for Children Committing Offences, Child Development Institute

Jayne Barker – Provincial Director, Mental Health and Youth Services for British Columbia

Gary Bernfeld – Coordinator and Professor, School of Human Studies and Applied Arts, St. Lawrence College

Charles Cunningham – Professor Department of Psychiatry and Behavioural Neurosciences, Jack Laidlaw Chair in Patient-Centred Care, McMaster University

Ann Garland – Associate Director Child and Adolescent Services Research Centre, University of California

Kimberly Hoagwood – Director Research on Child/Adolescent Mental Health Services, Columbia University

Alan Leschied – Associate Professor Faculty of Education, University of Western Ontario

Alison Niccols – Clinical Director Infant Parent Program, McMaster Children's Hospital

Ray Peters – Research Director Department of Psychology, Queens University

Barbara Plested – Research Scientist Tri-Ethnic Center for Prevention Research, Colorado State University

Dee Roth – Chief Office of Program Evaluation and Research, Ohio Department of Mental Health

Sonja Schoenwald – Associate Director/Professor Family Services Research Center, Medical University of South Carolina

Lastly, we would like to acknowledge the collaboration of CMHO's Evidence-Based Practices Committee, in particular those individuals\* who worked most closely with the project team and provided valuable input.

Karen Engel (Chair) – Executive Director, Yorktown Child and Family Centre, Toronto

Claire Fainer – Executive Director, East Metro Youth Services, Toronto

\*Dick Meen – Clinical Director, Kinark Child and Family Services, Markham/Whitby/  
Barrie/Oakville/ Newmarket/Coburg/Peterborough

\*Doug Brown – Clinical Director, Peel Children's Centre, Mississauga

\*Mark Totten – Director of Research, Youth Services Bureau of Ottawa

Fred Schmidt – Psychologist, Lakehead Regional Family Centre, Thunder Bay

Jeff Carter – Psychologist, Madame Vanier Children's Services, London

\*Yvonne Bohr – York University (Psychology Dept) and Aisling Discoveries Child & Family  
Centre, Toronto

Sally Wills – Executive Director, Child and Youth Wellness Centre, Brockville

Greg Lubimiv – Executive Director, The Phoenix Centre for Children and Families, Pembroke

A very special 'thank you' to Joanne Johnston, Manager of Accreditation & Special Projects for CMHO, for her tireless efforts in coordinating the project from the CMHO side. The project benefited greatly from the input of all of these individuals at all stages of the project, truly exemplifying best practice in knowledge transfer.



# Main Messages

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## In General

- ✎ Failure to use available science is costly and harmful. A sustained collaborative effort is required to bring evidence-based practice to children's mental health care.
- ✎ It is not sufficient to transfer evidence-based practices to the field in the absence of understanding what is needed to prepare organizations and practitioners to receive and implement this new knowledge.

## From the Literature

- ✎ The transfer of research-based information to practitioners requires attention to four critical elements: the source, the content, the method, and the audience.
- ✎ The transfer of new knowledge is more successful when there is active collaboration and partnership with all stakeholders from the beginning.
- ✎ Knowledge is transferred best when done face-to-face, allowing for the communication of tacit knowledge.
- ✎ Passive dissemination of information is not as effective in creating practice change or knowledge uptake as are active strategies.
- ✎ Transferring knowledge is part of a larger context of innovation and change.
- ✎ Leadership, power, and authority must be addressed in the knowledge transfer process.
- ✎ Organizations can foster environments that are conducive to change.
- ✎ Resistance to change—from the system, the leaders, and the practitioners—needs to be recognized and addressed.
- ✎ Change requires “buy-in” and engagement from a critical mass of people; the challenge is to create a “tipping point”—the dramatic moment when something unique becomes common.
- ✎ Change is complex and requires planning and strategizing.
- ✎ Assessing readiness for change is integral to the success of knowledge implementation and adoption of new knowledge or practices.
- ✎ Providing children's mental health services that are supported by research evidence is an important priority.
- ✎ Exactly how to implement evidence-based practice into a variety of contexts catering to multiple client groups is a burgeoning science that requires further study.
- ✎ Distilling research knowledge into practice guidelines and making these available is not sufficient for creating practice change.
- ✎ The implementation of evidence-based practices in any jurisdiction has to be a collaborative effort; it is the responsibility of organized systems of care (the province or state), the service provider organizations, the practitioners, and consumers.
- ✎ Successful implementation of evidence into practice requires strategizing at multiple levels—the practitioners, the organization, the system, the nature of the evidence, and the methods of transfer and implementation.
- ✎ A better understanding of practitioners' attitudes toward evidence-based practice is needed to address skepticism, distrust, and resistance.

- ☞ Practitioners need better access to the research base (library resources) as well as venues at which they can share their tacit knowledge with others, including scientists and decision-makers.
- ☞ The move toward the greater use of evidence-based practice in children's mental health system will require practitioners to develop the capacity for life-long learning and reflective practice.
- ☞ The implementation of evidence-based practices will require striking a balance between treatment fidelity and re-invention of the practice environment.

## From the Survey

### Respondent Characteristics

- ☞ 72.5% of the 85 executive directors surveyed responded. They predominantly had backgrounds in social work, had over 16 years of clinical and managerial experience, and represented organizations providing a wide range of clinical services.
- ☞ Among an estimated population of 3,951 clinical staff, 12.2% responded. The majority had backgrounds in social work, had over 16 years experience, and were affiliated with a range of clinical services located mainly in the Toronto (18.3%), South West (18.1%), and Central East regions (16.8%). 65.7% of respondents were clinical staff, 16% were clinical managers also providing service, and 18.3% were clinical managers not providing service.
- ☞ Survey participation of executive directors relative to the number of CMHO centres in each region indicated the highest participation among member centres in the Hamilton-Niagara (85.7%), Northern (83.3%), and Central East (71%) regions.
- ☞ 50% of responding centres had annual budgets in the \$1 to \$5 million range.

### Linking to the Internet

- ☞ Among both executive directors and clinical staff, over 65% thought it was "likely" their colleagues would turn to the Internet as a resource.

### Linking to Research Information via Academia

- ☞ 67% of clinical staff and 77% of executive directors link in some way with a college or university.
- ☞ Fewer than 40% of CMHCs have organizational access to a university or college library.

### Use of Research Information

- ☞ Both executive directors and clinical staff rate their organizations' ability to access, assess, adapt, and adopt research information as "somewhat well." This finding provides a useful benchmark for future comparison, and suggests there is possibility for improvement.

### Organizational Readiness for Change

- ☞ **Motivation for Change:** Unless motivation for change is "activated," individuals are unlikely to initiate change. In the three areas of importance for motivational readiness,
  - Executive directors perceive a significantly higher need for *program improvements* (i.e., tracking client improvement over time, obtaining evidence of program effectiveness, selecting new treatments, generating clinical and data outcome reports), while clinical staff perceive significantly greater *pressure for change* (from staff, supervisors, and ministry).
  - For clinical staff, pressure for change comes from supervisors/managers (62.5%), other staff (52.6%), ministry/other funders (39%), and board members (28.9%). Executive directors perceive pressure for change from supervisors/managers (51%), ministry and other funders (49%), and clinical staff (42.9%). Fewer than one-third of the respondents

from both groups perceive pressure for change from consumers, and fewer than one-quarter of executive directors perceive pressure for change from their board of directors.

- Groups do not differ with respect to the strength of their perceived need for *training support*, but they desire training in different areas. Clinical practitioners see a need for training to improve client engagement with treatment, while executive directors see a need for training in monitoring client progress.

☞ **Adequacy of Resources:** Facilities, staffing patterns and training, and equipment are also important considerations in organizational readiness for change.

- The majority of clinical staff and executive directors favourably view the adequacy of *office space* for individual and group treatment, although 44% of clinical staff view offices as inadequate for group treatment; this may have implications for future implementation of group-based EBTs.
- Both groups agree there are too few clinical staff to meet client needs.
- Staff turnover is not a worrisome issue for the most part, and there is little perceived need for additional support staff.
- The majority of executive directors and clinical staff agree their organizations value continuing education and provide opportunities for learning both in-house and at external venues.
- Both groups highly perceive the adequacy and use of *computers*.
- Both groups are split with respect to whether client assessments are conducted using a computer, an intriguing finding given the mandate for using computer-based intake and outcome assessment tools.
- More than 95% of executive directors and clinical staff report having a computer in their personal workspace. This is another intriguing finding, given the frequent anecdotal reports of low computer access as a barrier to using the mandated outcome tool. Further analysis indicated this was not a bias due to the web-based survey method.
- Both groups felt access to *e-communications*—Internet and email—is more than adequate.

☞ **Staff Attributes:** Several individual level characteristics are noted as key to ensuring readiness for organizational change.

- Generally, the extent to which both groups value and perceive opportunities for personal growth is relatively low. The majority of clinical staff do not read about new techniques each month, nor do they have enough opportunities to keep up their clinical skills (although half feel they are up on the published journal literature). Executive directors fair somewhat better.
- Upwards of 60% from both groups have confidence in their clinical efficacy and willingness and ability to influence their co-workers, two characteristics that bode well for change.
- Less encouraging is their perceived ability to adapt in a changing environment. More than 65% of both groups feel they try new ideas and adapt quickly, yet half acknowledged they were sometimes too slow or cautious to make changes—curiously contradictory.

☞ **Organizational Climate:** several organizational dimensions are identified as key to organizational change.

- Upwards of 60% of clinical staff and executive directors are aware of the organization's *mission* and goals.
- Over 50% of both groups perceive management as receptive to suggestions from staff and feel the information networks and channels are conducive to the *communication* flow.
- *Staff cohesion*—trust and cooperativeness—is high among both groups, as is the impression of *autonomy* or the decision latitude clinical staff perceive in working with their clients.

- There is division within both groups as to whether job pressures impede effectiveness.
- High levels of *stress* and the negative impact of a heavy workload on program effectiveness is perceived by both groups, albeit more so by clinical staff.
- Interests in keeping up with the demands of change vary across groups: two-thirds of executive directors feel procedures change quickly to meet new conditions, while only 30% of clinical staff share this view.
- There appears to be a positive attitude toward and encouragement for trying new techniques among both groups, and this is encouraging.

### **Use of Evidence-Based Treatments**

- ☞ The 10 most commonly used EBTs are: Cognitive Behaviour Therapy (65%); COPE (42.7%); wraparound (42.5%); behavioural parent training (41.2%); brief strategic family therapy (39.2%); narrative therapy (38.8%); “The Incredible Years” (36.4%); Multisystemic Therapy (35.9%); “Stop Now and Plan” (32.4%); and “Right from the Start” (29.3%).
- ☞ A range of other treatment approaches are reportedly in use (e.g., Modified Interactional Guidance, brief solution focused therapy, “Watch, Wait & Wonder”). While not all have met rigorous evaluation criteria, many have undergone some level of empirical study to support their use.
- ☞ Among executive directors, half perceive their services and programs to be “somewhat” supported by research evidence, while the majority of clinical staff are more optimistic (40% said “pretty much”). This information provides a useful benchmark against which to measure improvement

### **From the Expert Interviews**

- ☞ Developing “buy-in” for the implementation of evidence-based practices is necessary at all levels in the system—practitioners, leaders, and policy makers. It primarily involves identifying the relative advantage of the practice (what are the benefits for me and my client, and how does it make my job easier?) and demonstrating the availability of the resources, training, and leadership required to effect the change.
- ☞ Skepticism among practitioners presents a significant barrier to the implementation of evidence-based practices. Continued professional education and specific training is integral to counteracting misconceptions, fear, and skepticism.
- ☞ Identifying “champions” for evidence-based practice is important at all levels in the system—the champion can be anybody, but it has to be somebody!
- ☞ Resistance to change occurs at the level of the individual practitioner and collectively within the organization. Leaders need to create organizational cultures that foster change by promoting professional growth, innovation, and decision latitude.
- ☞ Change takes time and requires a sustained effort and plan for long-term maintenance. Beginning with a vision and realistic plan, consideration must be given to facilitators and barriers at all levels of the system, as well as to the unique characteristics of the practice being implemented and the individuals adopting it.
- ☞ Implementation requires creating and maintaining a “culture of adherence” or a system of quality management and evaluation to ensure that outcomes are acceptable, and that contributes to an overall culture of evidence-based practice. Implementing new treatments is meaningless if they are not effective.

- ☞ A more equitable balance must be struck between contending with long wait lists for clinical service and the time and energy required for innovation and professional development. Both increased funding and a strategic shift are needed to help us get off the treadmill and develop a culture where this is accepted. That there are too few practitioners to provide service to too many children and their families is not the service providers' burden to bear alone—it is a systemic issue that requires increased funding and innovative solutions at all levels.
- ☞ Implementation of evidence-based practices will be slow if service providers are expected to go this route alone in a one-off fashion. We need to consider system-wide implementation initiatives similar to those used for screening and outcome management in Ontario (e.g., CAFAS and BCFPI).
- ☞ Consumers need to be informed of the evidence-based treatment options as they become more widely available so they might make the most informed choices regarding the care of their children, and so they may create pressure to ensure they are delivered. All children's mental health stakeholders have a duty in this regard.
- ☞ Partnership between funders, providers, and researchers can go a long way to creating opportunities for effectiveness and implementation research, and for the evaluation of field-based interventions that have promise. This, in turn, will contribute to our knowledge of what treatments work, for whom, in what contexts, and how best to support their implementation and adoption in the field. Such partnerships will also serve an educational purpose by demystifying research and improving practitioners' competencies in determining which treatments are worthwhile and to what extent they may be "reinvented" to serve distinct client populations.

## Taking Action

- ☞ CMHCs are by and large disconnected from the evidence base. Fewer than 40% of executive directors and clinical staff have access to a university or college library. CMHO can play an important role in brokering a connection between children's mental health centres and university library systems.
- ☞ Executive directors and clinical staff view opportunities for professional growth as relatively few. CMHO can play a part in encouraging the emergence of continuous professional development as a core activity in children's mental health centres. Opportunities for dialogue and knowledge sharing need to be viewed as an important investment.
- ☞ Innovation is often taxing on financial and human resources. When we upset the status quo we cause upset in operational procedures, practitioner time is taken away from direct service, and financial resources are reorganized. Change is a long process and it can be challenging to maintain morale over the long haul. There is a need for government and organizations such as CMHO to develop incentives for change, and to provide opportunities through which innovators and early adopters can showcase their accomplishments and through which others can learn first hand of their approaches, struggles, and solutions.
- ☞ Encourage the adoption of Berwick's seven rules for disseminating innovations in children's mental health care: find sound innovations, find and support innovators, invest in early adopters, make early adopter activity observable, trust and enable reinvention, create slack for change, and lead by example.
- ☞ The successful implementation of evidence-based practices requires a level of awareness and knowledge among clinical practitioners and their leadership. More work is needed to raise awareness and knowledge and to evaluate and document shifts in these areas. CMHO is

encouraged to commission research to explore the level of awareness, knowledge, and support of evidence-based practices among Ontario service providers.

- ☞ Acquisition of training for evidence-based practices and treatments requires support from both the provincial and organizational leadership. Leaders need to recognize the value of training—release time away from service delivery brings returns in the form of more knowledgeable and happier practitioners—and that resources need to be set aside for such activities. CMHO can play a role in facilitating EBT training for their members.
- ☞ Evidence that executive directors do not perceive pressure for change from their boards is intriguing and leads to questions about the efficacy of this governance system. CMHO could commission research to explore the dynamics of board governance among children's mental health centres.
- ☞ CMHO is ideally positioned to represent the interests of member organizations regarding the education of new graduates in children's services programs. As such, CMHO could develop linkages with educators and professional colleges in social work and psychology to ensure that new graduates entering the work force are armed with knowledge about evidence-based practices and outcome management.
- ☞ Lab-based treatment interventions are but one end of an important service spectrum. Many promising treatments are being developed on the front lines, often with the distinct advantage of being culturally and developmentally sensitive. Since the knowledge and resources needed to evaluate the effectiveness of these promising treatments often evade service providers, CMHO could develop an infrastructure that would help children's mental health centres in this regard.



## Executive Summary

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Evidence-based practice is an emerging concept that reflects a burgeoning effort to build quality and accountability in mental health service delivery. Though not yet formally recognized on the Canadian health care agenda, the concept conveys a fundamental belief that children with emotional and behavioural disorders should be able to count on receiving care that meets their needs and is based on the best scientific evidence available. Moreover, the fundamental concern is that for many of these children, the care that is delivered is not effective care (Huang, Hepburn, & Espiritu, 2003). Most children and youth who receive an empirically supported treatment get significantly better and do so more quickly than with other treatments or no treatment (Brestan & Eyberg, 1998; Chambliss & Ollendick, 2001; JCCP, 1998; Spirito, 1999). Bringing evidence-based treatment to Ontario requires a dual effort: provide the financial resources and public agenda that sees children receive services on the basis of need not availability, and ensure the services provided are of the highest quality and most scientifically sound. While the government must address the financial aspects of this course, the children's mental health sector is challenged to move forward on the accountability and quality front.

If Ontario's children's mental health system is going to tackle the implementation of evidence-based practices, then what do we need to know to get the job done? This question provides the main focus of the work undertaken here. Initially challenged by Children's Mental Health Ontario to review the literature in knowledge translation to determine what could be applied to the transfer of evidence-based practices in Ontario, we counter-challenged with the notion that even transferring knowledge well would be insufficient to achieve change. A mutual understanding was achieved, and we set out to review knowledge transfer, readiness for change, and implementation science—hoping to arrive at a more comprehensive approach that would guide Children's Mental Health Ontario in leading the sector on this important and inevitable journey.

In the area of knowledge transfer, we learned of the importance of active strategies, collaboration, leadership, and the power of sharing tacit knowledge face-to-face. The organizational change literature spoke of the importance of assessing readiness for change, planning, and strategizing at all levels in a participatory fashion that gives all stakeholders a voice and a hand in the change process. Give people a chance to observe the innovators, incentives, and slack time to try things out, and reward them for trying and when they do well. We learned that change is both complex and lengthy, and requires buy-in from all of the players. The science of implementation tells a similar story: plan well, include all stakeholders, address barriers unique to the situation, assess the important motivators, resources, and change factors, take a deep breath, and jump in. This is a messy process, in particular because it is only beginning to be studied and understood.

But this is the literature, not the real world. What do the experts have to say? Well, we asked them, and again, the same tune was sung: "buy-in" is built best with a carrot not a stick, and needs to happen at all levels of service provision; practitioners are skeptical so expect their resistance—train them and develop organizations that will reward their risk taking; pick the best people, give them the latitude to do their job, listen to them respectfully, and let them mingle with others—other practitioners, researchers, consumers; and let them get off the treadmill of service provision now and again. When you do start something new, have a vision and a plan for its sustainability. We know enough to

anticipate the barriers that will be encountered, so settle in for a long and rough ride and enjoy the sense of accomplishment and pride that will encompass your staff when you have done something scary and new and have succeeded! Don't be afraid to tinker, but be certain to evaluate your efforts: access to mental health service is nothing if it's not effective. Develop partnerships with researchers—let them test out how best to implement their lab-based treatments while they in turn help you to evaluate the promising approaches you are developing in the field. Have faith and know that, together, we can do this.

But what of the practitioners and their world? We asked them, too. They told us they were doing pretty well in their ability to use research knowledge, but there is room for improvement, and so we should come back and ask them again in a few years time when they have had more support for these kinds of changes. We learned that clinical staff and their executive directors share many attitudes and perceptions about their readiness to deal with organizational change. There were two exceptions: clinical staff perceive higher pressure for change and executive directors sense greater need for program improvements. Curiously, pressure for change is not perceived as coming from agency boards or consumers, and such pressures need to increase to a point where it will be sufficient to motivate change. As for the resources that often underlie change efforts, they told us their offices are adequate but perhaps less so for conducting group interventions. This will need to be addressed, since many evidence-based treatments are group based. Training opportunities, computer access, and electronic communications are all perceived as adequate—findings that do not fully hold their own against years of anecdotal evidence to the contrary. They told us there are not enough clinical staff to do the job that is required—a lament that does strike a familiar chord. Perceptions of opportunities for professional growth are not overly high, although both groups perceive a high sense of efficacy, influence, and ability to adapt to a changing environment. Ask again about clinicians' ability to change procedures in face of new conditions though, and fifty percent will tell you they don't do this well. So, we can conclude there is some discomfort with change. Lastly, we learned that while clinical staff feel connected, cohesive, and in touch with one another, they experience high levels of job related stress.

The seemingly simple task of transferring a number of evidence-based practices to the field is anything but simple. It requires involvement from all stakeholders, good planning and resourcing, and a system that can develop a culture of evidence-based practice delivery and accountability. This will not be a quick and easy journey. Changing practice is a formidable task that occurs at a painstakingly slow pace, often requiring changes in practice behaviour, program restructuring, and reallocation of resources. This is especially difficult in an environment of tight budgets and competing priorities. It will require: engaging policy and decision-makers, leaders, and practitioners; educating and supporting the absorption of new knowledge and ways of doing things; planning and patience. There will be opportunities, and the challenge will be to find them and take them up. Who are the champions, what are the incentives for change, how can we balance the importance of professional development with the onslaught of service need?

In the face of this daunting task, take baby steps—each one moving us closer to our goal. The full range of possible actions is best explored in a participatory forum, but we suggest a few that came to mind as we undertook this work:

- connect children's mental health centres to the evidence base;
- reintroduce professional development as a core activity;
- develop incentives for the implementation of evidence-based practices
- bring practitioners and researchers together face-to-face to share their knowledge and do this often;

- implement Berwick's seven rules for disseminating innovations using Ontario-centric solutions;
- identify practitioners' knowledge and attitudes about evidence-based practices; and
- make it easier for practitioners to acquire training and skills.

In addition, search beyond our borders and seek out people who have undertaken similar challenges and have them share the lessons they learned. Lastly, recognize that Ontario's children's mental health sector is breaking new ground, and soon others will come asking how we got here.



## Project Team

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### The Hospital for Sick Children

**Melanie Barwick** is a Registered Psychologist in the Community Health Systems Resource Group and Associate Scientist in Population Health Sciences at The Hospital for Sick Children. She is Associate Professor in the Departments of Psychiatry and Public Health Sciences at the University of Toronto. Melanie completed her Ph.D. in Educational Psychology from McGill University in 1992, and went on to two successive post-doctoral fellowships within the Department of Psychiatry, University of Toronto at the Hincks Institute in the areas of developmental psychopathology, language impairment, and infant attachment. Her program of research in children's mental health systems and knowledge translation focuses on the implementation of evidence-based practices. Together with Bruce Ferguson, she is the Lead for the provincial initiative for outcome measurement for Ontario.

**Katherine Boydell** is a Qualitative Sociologist and Health Systems Research Scientist in the Community Health Systems Resource Group and Scientist, Population Health Sciences at The Hospital for Sick Children. She is Associate Professor in the Departments of Psychiatry and Public Health Sciences at the University of Toronto. Katherine has a Master of Health Sciences in Epidemiology from the University of Toronto, and she received her doctorate in Sociology from York University in 1996. Her program of research in children's mental health systems and knowledge translation focuses on access to mental health care for children and youth in rural and remote communities, pathways to care for youth at ultra high risk for psychosis and youth who have experienced psychosis, and pediatric telepsychiatry. She has a special interest in innovative methods of translating research, particularly in the form of arts-based dissemination models.

**Elaine Stasiulis** works as a research coordinator on various projects at the Hospital for Sick Children. Her undergraduate degree is in Health Studies with a minor in Psychology at the University of Waterloo, and she obtained her Master of Arts in Sociology at Central European University (affiliated with Lancaster University in the UK) in Warsaw, Poland. Using qualitative methodology, her main area of research has been in mental health, working initially within the adult mental health sector. More recently, her research interest has included first episode psychosis, childhood survivors of cancer, and knowledge transfer within children's mental health in rural communities.

**Bruce Ferguson** is Director of the Community Health Systems Resource Group at The Hospital for Sick Children, and Professor of Psychology, Public Health Sciences, and Psychiatry at the University of Toronto. Dr. Ferguson received his Ph.D. in Psychology at Monash University in Australia. Dr. Ferguson has taught at Carleton University and the University of Ottawa, and has been a visiting scientist at the National Institute of Mental Health in Bethesda, Maryland. His research interests include community intervention and prevention programs, neurological basis of hyperactivity and other learning disorders in children, and the development of antisocial behaviour in children and adolescents. Currently, Dr. Ferguson is focusing his efforts on strengthening communities for children and youth to produce the best outcomes and successes.

### **Louis de la Parte Florida Mental Health Institute**

**Karen Blase** is a Research Professor at the University of South Florida and co-director of the National Implementation Research Network. She received her doctorate in Developmental and Child Psychology from the University of Kansas with a focus on school-based interventions and with research and training experiences with the Achievement Place Research Project. She has been a program developer, researcher, trainer, evaluator and published author in the human service field for over 25 years. She also led the development of a national replication and implementation program for the teaching-family model.

**Dean Fixsen** is a Research Professor at the University of South Florida and co-director of the National Implementation Research Network. Dean received his doctorate in Experimental Psychology from the University of Kansas in 1970, and has been actively involved in developing and extending the evidence base of the Teaching-Family Model and summarizing the steps involved in program development and dissemination. He has co-authored nearly 100 publications, served on numerous editorial boards, and advised local, state, and federal governments.

### **Evidence-Based Practices Committee of Children's Mental Health Ontario**

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Karen Engel (Chair) – Executive Director, Yorktown Child and Family Centre, Toronto  
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