CREATIVE PROFESSIONAL ACTIVITY DOSSIER

MELANIE BARWICK PhD CPsych

2009 -2017

TABLE OF CONTENTS

Table of Contents

Overview 1

Professional Innovation and Creative Excellence 2

- Professional Development Courses 2
- Scientist Knowledge Translation Training (SKTT)™ 2
- The Knowledge Translation Professional Certificate™ 6
- Tools and Educational Resources 9
- Knowledge Translation Planning Template (KTPT) 9
- The KT Game 11
- Implementation Science e-Learning Curriculum 12
- KT and KTPT e-Learning modules 13
- KTPC Casebook 14
- KT Stories 14
- cpa related to research studies 15
- Pain Assessment and Pain Management (PI B. Stevens) 15
- #ItDoesntHaveToHurt (PI C. Chambers) 16
- Muskoka Initiative – Global Child Health 20
- Emerging Team in Knowledge Translation and Child and Youth Mental Health 21

Exemplary Professional Practice 23

- Leadership in the profession 23
- REporting guidelines 23
- ADMINISTRATIVE ACTIVITIES 24
- International 24
- National 24
- Provincial / Regional 25
- Local 26

TABLE OF CONTENTS

Recognition of Expertise _____ 27

Appendices _____ 28

SKTT Infographic Overview _____ 29

SKTT Client List (2011-2017) _____ 30

SKTT Australia Infographic Overview _____ 31

Knowledge Translation Professional Certificate Infographic Overview _____ 32

Knowledge Translation Planning Template _____ 33

Stories from the Floor Monograph _____ 34

#itdoesn'thavetohurt Social Media Postings _____ 36

Muskoka Initiative Study (Global Health) _____ 39

Muskoka Initiative Study – Knowledge Snapshots _____ 41

Child and Youth MEntal HEalth Outcome Initiative – CAFAS _____ 42

General accolades FOR CPA _____

letters of Recognition and Colleague Testimonials _____

OVERVIEW

Overview

My CPA has focused on building capacity in knowledge translation and implementation science in several areas within the general categories of *Professional Innovation and Creative Excellence*, including: (1) through the development of KT skills and knowledge among health researchers (Scientist Knowledge Translation Training course / SKTT); (2) through the development of KT skills and knowledge among knowledge translation practitioners and building KT capacity within the organizations in which they work (Knowledge Translation Professional Certificate / KTPC); (3) development of tools and educational resources to leverage this work (KT Game, Knowledge Translation Planning Template / KTPT, Implementation Science e-Learning Curriculum, KT and KTPT e-Learning modules, videos); (4) other KT deliverables related to individual projects and research; and Leadership in the Professional Practice of KT through (5) the advancement of CPA in academic promotion; (6) leadership in KT and implementation on boards, committees, working groups; and (7) the CAFAS outcome measurement initiative. In addition, (8) I have contributed to academic service within the university.

The following sections describe the nature of these activities and associated impacts, and provide examples and/or links to work located on the Internet.

Professional Innovation and Creative Excellence

PROFESSIONAL DEVELOPMENT COURSES

Scientist Knowledge Translation Training (SKTT)™

In 2004 I received funding from the *Canadian Health Services Research Foundation* (CHSRF) for an innovative funding opportunity seeking to explore the role of knowledge brokering in a variety of health organizations. This grant supported the first ever knowledge translation professional at The Hospital for Sick Children (SickKids), and the development and evaluation of the Scientist Knowledge Translation Training course (SKTT). My idea for this course emerged from a growing focus among research funders for researchers to produce KT plans and intended research impacts alongside the science of their research proposals. KT had begun to gain prominence within CIHR in and around 2000, having been previously championed and highlighted by the *Canadian Health Services Research Foundation* and its leader in the day, Dr. Jonathan Lomas. In my view, the time was right for professional development that could inform and guide scientists in this activity and help them to integrate KT efforts within their research programs. Other Canadian funders soon followed the growing emphasis on KT, including the *Michael Smith Foundation for Health Research*, *Alberta Innovates Health Solutions*, and *Nova Scotia Health Research Foundation*.

The idea for the course originated with me, and the Canadian research context was ripe for its actualization. My boss at the time, Dr. Bruce Ferguson, provided the scope and latitude that allowed me to develop this idea into a professional development opportunity, in light of the funded research, and together with the teams knowledge broker, we offered 4 initial training workshops within the Research Institute at SickKids (2004-2007). In 2009 I received my first invitation to teach the course outside of SickKids, from the *Alberta Heritage Research Foundation* (now AIHS), and soon after, by the *Michael Smith Foundation for Health Research* in BC. Clearly, there was burgeoning national demand for KT capacity building in the academic and health sectors. Around this time, SickKids launched a third pillar, the Learning Institute, which serendipitously provided a foundation from which the SKTT program could grow.

This two-day course was grounded in the knowledge that a well-developed knowledge translation (KT) plan is often a proposal requirement for health research funding agencies in Canada and abroad. In addition, various sectors are demonstrating greater attention to the utilization and impact of research. The SKTT course was developed on the premise that scientists, and increasingly, other practitioners and educators, are agents of change in creating research impact, promoting research utilization and ensuring that research findings reach the appropriate audiences. This course was designed to teach the unique skill set that surrounds KT practice.

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

All of my work within the KT Program is subsumed by my role as senior scientist within the Research Institute; although working as a Senior Scientist with a primary role in research, I have deployed my own initiative to make this work part of my role. An overview of the KT Program can be viewed here: http://www.sickkids.ca/Learning/AbouttheInstitute/Programs/Knowledge-Translation/index.html and here http://www.sickkids.ca/Learning/Stories/Knowledge-Translation/Knowledge-Translation-Stories.html. Together, the KT team provides KT consultation to clinician educators and researchers internally, provides professional development through training and e-learning to internal audiences, and develops tools and resources to support effective KT; see http://www.sickkids.ca/Learning/AbouttheInstitute/Programs/Knowledge-Translation/Resources/Resources.html.

I am responsible for providing SKTT training to external organizations, as permitted by the consulting policy of the Research Institute, which permits up to 200 hours of consultation per year. There has been great and steady demand for this course across Canada and beyond, and I typically provide between 8-12 workshops annually. Please see the Appendix for a list of clients.

Course Overview

A well-developed knowledge translation (KT) plan is often a proposal requirement for health research funding agencies in Canada and abroad. In addition, various sectors are demonstrating greater attention to the utilization and impact of research. This training course was developed on the premise that scientists, and increasingly, other practitioners and educators, are agents of change in creating research impact, promoting research utilization and ensuring that research findings reach the appropriate audiences. This course was designed to teach the unique skill set that surrounds KT practice.

Initially developed to help SickKids scientists build their KT skills, the course is equally suited to KT professionals, clinicians, clinician-scientists, educators and decision makers. The material is universally applicable across sectors, job roles and geographic location.

This is a very practice-oriented course that covers:

1. The utility of KT, for researchers, educators, clinician-scientists and others
2. KT strategies and their evidence base
3. Developing a KT plan (practical, hands-on approach using tools)
4. Plain language communication
5. Communicating with different audiences

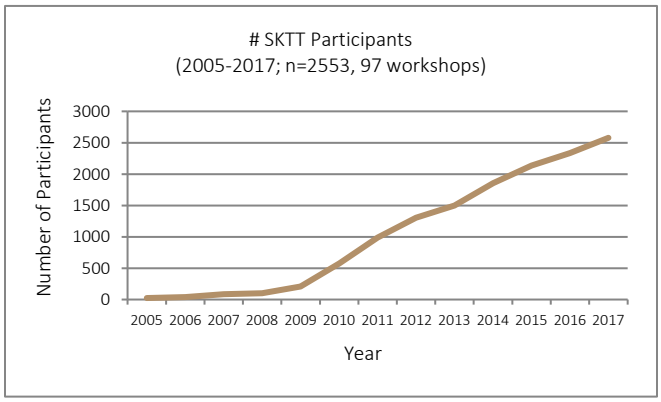
Learning Objectives: Upon completing this course, participants will be able to:

- Define KT and related terms
- Describe the role and importance of KT in our current social, political and research contexts
- Use KT planning tools and resources to begin developing a KT plan
- Identify communication strategies for reaching multiple audiences

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

- Outline and apply strategies for working with the media and engaging policy and decision-makers

Impacts Metrics and Evaluation



- Since its development, I have trained 2,578 individuals in 93 workshop offerings in 4 countries (see Appendix for SKTT Infographic).
- The KT program at SickKids is now a team of 5 funded positions, complemented by my role as Course Founder and Director.
- The SKTT course has been emulated and 're-imagined' by several other organizations, including St. Mikes KT program, the Institute for Knowledge Mobilization, and Guelph University, to name but a few of which I am aware. With one exception, SKTT was the first KT training opportunity for researchers in Canada – the exception being a short course developed by Dr. Paula Goering and Dale Butterill (CAMH/U Toronto) through an MOHLTC funded research grant and provided to local participants for a short time.
- The SKTT course is continually evaluated, and improvements made as findings and recommendations emerge. Evaluation data are presently being written up for publication. Briefly, our post workshop evaluation for a sample of 268 participants from 7 seven centres across North America shows that the SKTT course elicited a significant change in knowledge from baseline to post-training across all variables: relevance of KT to their work ($U = 2773$, $p < .001$); KT strategies ($U = 1708$, $p < .001$); key components of a KT plan ($U = 621$, $p < .001$); working with the media ($U = 6317$, $p < .001$); plain language communication ($U = 3175$, $p < .001$); and developing successful partnerships/collaborations with non-academic users ($U = 2873$, $p < .001$). Overall, participants' knowledge of KT increased from baseline to post-training across all variables.
- Table 1. Participants' perceived impact of taking the SKTT course is summarized in the following table:

Variable, *n* (%)	Post-training (*n* = 178)
Knowledge of KT increased	
Not at all	1 (0.6)
A little	17 (9.6)
Somewhat	36 (20.2)
Very much so	112 (62.9)
Will recommend course to colleagues	
Not at all	7 (3.9)
A little	10 (5.6)

Somewhat	38 (21.3)
Very much so	112 (62.9)
Course was worth the time	
Not at all	4 (2.2)
A little	12 (6.7)
Somewhat	32 (18.0)
Very much so	118 (66.3)
Interested in using the KT Game with group/colleagues/team	
Not at all	4 (2.2)
A little	10 (5.6)
Somewhat	49 (27.5)
Very much so	103 (57.9)
Will advocate for the recognition of KT activities as "scholarly" and deserved of professional recognition	
Not at all	5 (2.8)
A little	21 (11.8)
Somewhat	55 (30.9)
Very much so	85 (47.8)
KT skills have improved	
Not at all	3 (1.7)
A little	17 (9.6)
Somewhat	59 (33.1)
Very much so	87 (48.9)
Have a sense of how to better promote the value of KT activities	
Not at all	6 (3.4)
A little	21 (11.8)
Somewhat	74 (41.6)
Very much so	66 (37.1)

- An *Impact Evaluation Survey* was also administered to former participants to assess the effectiveness of SKTT in influencing knowledge translation learning, activities and knowledge sharing (*N* = 102) With respect to Knowledge Sharing, the majority of respondents indicated that the SKTT course influenced how they share research/project findings (*yes*: 39.3%, *somewhat*: 47.1%). Respondents shared their learning from the SKTT course by talking to their colleagues (41.2%); referring someone to the SKTT course (16.9%); embedding their learning into a course or educational activity that was delivered (11.9%); and sharing information with network contacts outside of the organization (9.0%). In terms of the application of knowledge learned in the SKTT course, most respondents tried a KT strategy they had not used before (26.9%); developed a KT plan (21.9%) and implemented a KT plan (17.5%). Of the KT tools introduced in the course, the KT Planning Template was the most utilized (35.7%), followed by the Plain Language Writing Checklist (25.2%).

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

- In September and October of 2016, I launched SKTT Australia™, in partnership with KT Australia, providing KT training to researchers in Australia and New Zealand under license by SickKids Hospital.
- The SKTT curriculum was integrated into two CIHR STIHR grants – the *Canadian Child Health Clinician Scientist Program* and the *Social Aetiology of Mental Illness* (see Research Funding in CV).
- SKTT has recently been adopted as the KT training model for the *Western Australia Health Translation Network* recognized by NHMRC, and by Murdoch Children's Research Institute, in the development of their KT program (*see Letter from Dr. John Challis*).
- Net revenue for the course to date is $97,000 CAD, which is reinvested into the SickKids KT Program.

The Knowledge Translation Professional Certificate™

I began developing the *Knowledge Translation Professional Certificate* (KTPC) in 2010, based on my observations of who was taking the SKTT training. While the SKTT was attracting researchers – the intended audience – it was also engaging a large number of KT professionals (KTPs) who were laying the foundation for a new profession in a range of organizations (academic, government, NGO, community based). Given that KTPs were embedded in the KT role 24/7, their needs for skills and knowledge were both deeper and broader than the average scientist. These observations lead me to develop a national survey of KTPs that informed development of the KTPC (Barwick et al., 2010; manuscript under prep).

The KTPC™ course was developed in 2010 by me in collaboration with KT Program staff in the Learning Institute, Sarah Bovaird and Kelly McMillen, and a KTPC Advisory Committee. The KTPC™ is a five-day professional initiative taught by a core faculty of 9 instructors. The curriculum, presented as a composite of didactic and interactive teaching, focuses on the core competencies of KT work in Canada, as identified by a survey of knowledge translation practitioners (Barwick et al., 2010). KTPC™ is hosted three times a year, at SickKids. Each session is open to a maximum of seventeen participants. This one-of-a-kind opportunity for professional development and networking.

My role as Course Director involves overseeing selection of applicants, review of curricula, teaching of 8 modules (see sample agenda from June 2017 below), reviewing daily and course evaluation feedback, and all scholarship related to the course.

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

Knowledge Translation Professional Certificate (KTPC™) June 2017 Agenda

Time	Monday, June 5th
8:00 am - 8:30 am	Breakfast & Networking
8:30 am - 9:15 am	**Welcome and Orientation** **Melanie Barwick and Kelly Warmington** *(686 Bay Street, Room 2a/b)*
9:15 am - 10:15 am	**KT in Practice** Instructor: **Melanie Barwick**
Break	
10:30 am - 11:30 am	**KT in Practice cont'd** Instructor: **Melanie Barwick**
11:30 am - 12:30 pm	**KT Models and Frameworks** Instructor: **Desre Kramer**
Lunch	
1:15 pm - 2:15 pm	**KT Models and Frameworks cont'd** Instructor: **Desre Kramer**
2:15 pm - 3:15 pm	**Invited Speaker** *Janet Parsons* *St. Michael's Hospital*
Break	
3:30 pm - 5:30pm	**Plain Language and KT** Instructor: **Clodagh McCarthy**

Time	Tuesday, June 6th	Wednesday, June 7th	Thursday, June 8th	Friday, June 9th
8:00 am - 8:30am	Breakfast & Networking	Breakfast & Networking	Breakfast & Networking	Breakfast & Networking
8:30-8:40	Debrief & Quiz	Debrief & Quiz	Debrief & Quiz	*Optional Supervisor Attendance
8:40 am - 10:30 am	**KT Strategies** Instructor: **Melanie Barwick**	**KT and the Policy Community** Instructor: **Ron Saunders**	**Working with the Media and Other Audiences** Instructor: **Suzanne Gold and Matet Nebres**	**Panel: Becoming a KT Friendly Organization*** **KTPC Alumni**
Break				
10:45 am - 12:45 pm	**KT Planning and The KT Game©** Instructor: **Melanie Barwick**	**KT Evaluation Part II** Instructor: **Kathryn Parker**	**KT Impact and Implementation** Instructor: **Melanie Barwick**	**PRESENTATION OF KT PLANS*** Instructor: **KTPC Faculty**
Lunch				
1:45 pm - 3:45 pm	**Partnerships and Networks** Instructor: **Heather Bullock**	**Faculty Consultations** **Work on KT Plan**	**Faculty Consultations** **Work on KT Plan**	**PRESENTATION OF KT PLANS*** Instructor: **KTPC Faculty**
Break				
4:00 pm - 6:00 pm	**KT Evaluation Part 1** Instructor: **Kathryn Parker**	**Commercialization and Technology Transfer** Instructor: **David Phipps**	**Work on KT Plan**	**Wrap Up, Course Evaluation and Reflections**
6:00 pm		**Faculty and participant dinner @ Adega**		

Course Overview

The Knowledge Translation Professional Certificate™ (KTPC) is a five day professional initiative. The curriculum, presented as a composite of didactic and interactive teaching, focuses on the core competencies of KT work in Canada, as identified by a survey of knowledge translation practitioners (Barwick et al., 2010). Developed in The Learning Institute, KTPC™ is hosted three times a year. Each session is open to a maximum of fifteen participants. This one-of-a-kind opportunity for professional development and networking is fully accredited by the University of Toronto's Continuing Professional Development Office.

The KTPC™ course is aimed at developing the competencies of KT practitioners working across all disciplines such as health, education, prevention/promotion, agriculture and others. However you identify yourself professionally, this course is for you if you serve an intermediary role between science and practice. We invite active participation of your employer to help build organizational culture for KT.

KTPC™ supports participants to achieve the following learning objectives:

- Improve their confidence and ability to carry out knowledge translation activities (e.g., networking, building partnerships, selecting KT strategies, creating knowledge products, advocating for KT, etc.)
- Acquire and apply new knowledge and skills for KT planning
- Develop and present a completed KT plan based on their current work
- Establish short-term, post-course KT goals and develop a plan to achieve them

Impacts Metrics and Evaluation

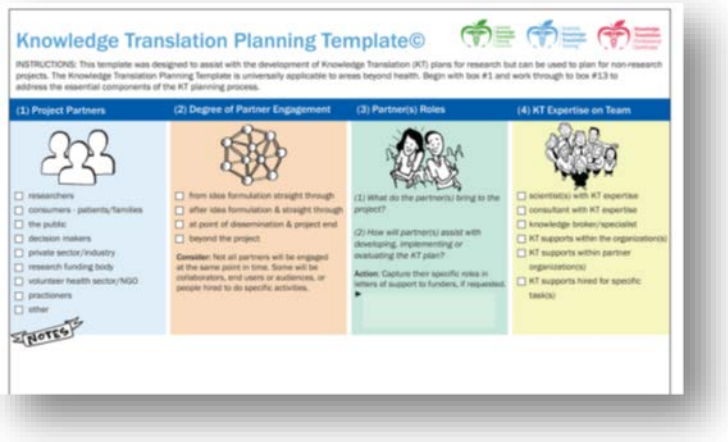
- This October 2017 will see the 19th KTPC cohort since 2010. All told, the course has trained 272 graduates since 2010 (see appendices for KTPC infographic). KTPC is the only course of ITS kind anywhere in the world and regularly attracts participants from Australia, with an alumni from 10 countries including Brazil, Spain, Australia, Ireland, England, Canada, Germany, USA, Trinidad and Tobago, and United Arab Emirates. Net revenue to date is $350,000 CAD.
- The course has been recognized as a Leading Practice by *Accreditation Canada*.
- The KTPC is fully accredited by the *University of Toronto's Continuing Professional Development Office.*
- We are rigorously evaluating the KTPC on an ongoing basis. We are preparing a manuscript for publication on the post workshop evaluations of 87 individuals (from 175 potential respondents; 49.7% response rate), from 11 cohorts. Prior to participating in KTPC, participants were asked to identify three changes they intended to implement following completion of the course. Of the potential respondents, 71.21% stated that they were able to either partially or completely implement these changes. The vast majority (86.9%) of respondents indicated that the KTPC course helped to improve their skills required to implement these changes. The top three aspects of the course that respondents found the most helpful in implementing each of these changes included the KT template tool, the KT impact and implementation module, and the KT evaluation module. Of the factors that helped participants implement these changes, most respondents cited support of supervisor/director, the KT planning template, and the KTPC course itself as the most helpful.

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

TOOLS AND EDUCATIONAL RESOURCES

I have developed several tools to improve KT skills, learning, and knowledge, each of which is briefly described alongside impact indicators.

Knowledge Translation Planning Template (KTPT)



The growing attention to knowledge translation in research and practice created a need for both researchers and practitioners to develop new skills and competencies in knowledge translation practice, related to their research, academic, or to organizational activities. It is in this context that the Knowledge Translation Planning Template was developed to support knowledge translation planning. There is increasing expectation globally that researchers will be able to demonstrate the "real world" impact of their research, requiring them to think strategically about their work and how it can be applied in practice. The first step in achieving this aim is to consciously plan their knowledge translation activities. Few studies have explored the knowledge translation activities of researchers and no other tools focused on supporting this important activity other than several that have been based on the Knowledge Translation Planning Template.

The Knowledge Translation Planning Template is available as a downloadable static or fillable worksheet (see Appendix for a copy), and it is organized as 13 core planning steps/components:

1. Identifying the project partners
2. Degree of partner engagement
3. Partner roles in the knowledge translation planning
4. Knowledge translation expertise on team
5. Targeted knowledge users
6. Research findings presented as main messages
7. Knowledge translation goals, such as building awareness or interest, informing research or policy, or changing practice
8. Knowledge translation strategies to be used to meet the knowledge translation goals
9. Knowledge translation process, such as integrated or end of grant activities
10. Indicators of knowledge translation impact and evaluation metrics
11. Resources needed to actualize the plan
12. Related budget items to include in funding proposals

13. Details of how the knowledge translation strategies will be implemented

The tool is available for free on the web - http://www.melaniebarwick.com/training.php.

Impact Metrics and Evaluation

- A publication describing the development of the tool was published in 2016:

  Barwick, M. (SRA) (2016). Building Scientist Capacity in Knowledge Translation: Development of the Knowledge Translation Planning Template. *Technology Innovation Management Review*, 6(9): 9-15. *Impact*: GoogleAnalytics (14 Mar 2017): viewed 186 times; 23 tweets.

- *Reach* is a measure of impact insofar as it identifies connection with one's potential audience. Reach metrics indicate how far content is disseminated and to how big an audience. Simply put, knowledge users cannot benefit from empirical knowledge they cannot access and/or cannot understand.

    - The *Knowledge Translation Planning Template* has been disseminated and taught to over 2,578 *Scientist Knowledge Translation Workshop* participants since its development in 2008, and to 286 *Knowledge Translation Practitioner Certificate* participants since 2010 (metrics as of 20 July 2017).

    - It has been viewed by 27,708 unique visitors who have visited my website (http://www.melaniebarwick.com) from 165 countries since 2010; this represents exposure in 85% of the worlds' countries.

    - From the perspective of engagement, it has been downloaded over 12,846 times between January 2014 and July 20th 2017.

- Since its development, several organizations and authors have emulated the KTPT to develop similar tools and resources to assist in knowledge translation planning and activities, and many more have adopted the Knowledge Translation Planning Template in its original format (e.g., *Canadian Centre for Substance Abuse; Parachute; Michael Smith Foundation for Health Research; EENet; York University Knowledge Mobilization Unit; Health Care Programs and Policy Directorate at Health Canada; Ontario Agency for Health Protection and Promotion*). Others have, with permission provided earlier on in its developmental history, adapted the Knowledge Translation Planning Template for their own purpose (e.g., *Institut national de santé public Québec; Health Care Programs and Policy Directorate at Health Canada*). Adaptations are no longer encouraged or permitted to protect against violation of intellectual property.

- The tool is currently undergoing a translation to French.

- An extension version is under development by the *Center on Knowledge Translation for Technology Transfer* at the University of Buffalo to capture knowledge translation activities in the commercialization realm: http://sphhp.buffalo.edu/cat/knowledge translation4tt/projects/development-projects/technology-transfer-planning-template.html

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

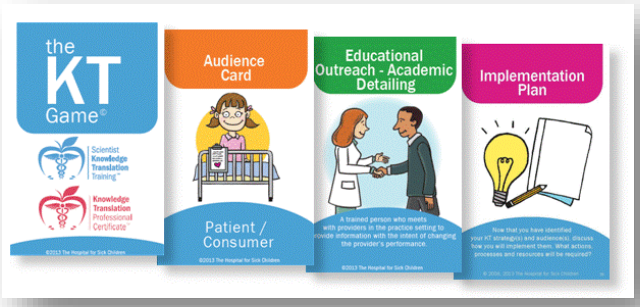
- A survey evaluation of its impact is still in data collection, but preliminary data for 210 individuals (35% scientists; 4% students; 8% clinicians; 12% educators; 19% knowledge translation professionals; 4% consultants) who had downloaded the template and consented to be contacted for purpose of evaluation indicate the following:

Use and Relevance

- 69% have used the tool upon having downloading it
- 42% found it *very relevant* and 37% found it *relevant*
- When asked how they used it, 30% used it to plan for the KT practice work, 37% used it to plan KT for a research proposal, 35% used it to plan for their research at some point in the work, and 48% used it to teach others about KT planning
- With respect to how the tool benefited them, 52% reported it improved their KT knowledge, 26% said it improved their overall research approach, 38% reported it improved their KT practice work, 29% said it helped them to demonstrate their KT and research impacts
- 55% shared the tool with others, extending its reach
- In terms of the benefits of the tool, 54% said the tool expanded their KT knowledge, 49% said it taught them the key components of knowledge translation, 64% said it helped them to develop a KT plan and 48% said it motivated them to think about KT, 32% said it helped them to identify knowledge users they hadn't previously considered, 45% set KT goals and 40% identified KT strategies.

A peer reviewed publication is planned for the results of the survey in 2017.

The KT Game



The KT Game™ (Barwick, 2009) is a card game that incorporates the core elements of knowledge translation planning, as defined by the Knowledge Translation Planning Template, and it is useful for active learning of the knowledge translation planning process. Knowledge Translation Game cards identify the process, knowledge translation strategies, and knowledge translation user audiences that are integral to a knowledge translation plan for a scenario depicted on knowledge translation scenario cards or for a project or research endeavour of the users' own choosing. The Knowledge Translation Game is available for purchase from Cvent for a cost of $49, with funds reinvested into the SickKids KT Program (http://www.cvent.com/d/44qs3m).

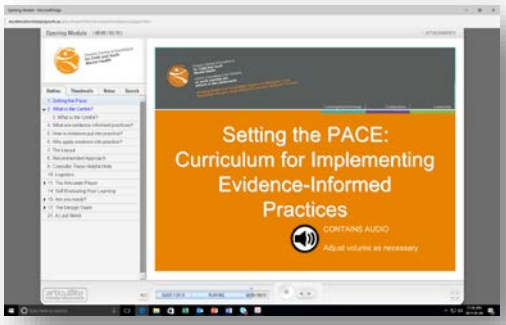
Barwick, M. The KT Game. (2009). Available from: http://www.cvent.com/d/44qs3m

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

Impacts Metrics and Evaluation

- 269 disseminated (as of 13 March 2017)
- 120 sold ($49CAD) – total revenue to date: $5,880CAD

Implementation Science e-Learning Curriculum



Barwick, M. Bennett, L. Boydell, K.M. Wotring, J. Parker, K. Van Dyke, M. Darling, J. (2012). Setting the PACE: Curriculum for implementing evidence informed practices. 2012 Jul 26. Developed in 2012 under contract for the Ontario Centre of Excellence for Child and Youth Mental Health, this e-learning curriculum has been used to build knowledge and capacity for the implementation of evidence based practices within the CYMH sector. Usage, reflected in the table below, provides an indicator of impact.

Available from: http://www.excellenceforchildandyouth.ca/training/learning-modules

Impacts Metrics and Evaluation

Reach Altmetrics (April 2017)	April 1 2015- March 31 2016	April 1 2016 – March 31 2017
Introductory module	208	251
Leading organizational change	177	258
Teamwork and collaboration	117	129
Needs assessment	116	165
Implementing evidence-informed practices	200	178
Monitoring and evaluating outcomes	119	146
Closing module	10	11

- Evaluations conducted by the *Ontario Centre of Excellence for Child and Youth Mental Health* for their PACE program (People Advancing Change Through Evidence) in support of CYMH service provider organizations provide some direct evaluation of the modules themselves, as these were embedded as a resource within that program. The following excerpts identify some of the strengths and challenge of the modules, as identified by organizations receiving the PACE supports.

  "The PACE program is a new way of proceeding to implement a change within our organization. Although the agency was eager to jump into implementation, the planning was essential as it allowed us to gain a solid understanding of the EIP and how to best prepare for implementation and sustainability. Through the completion of the training modules, assessing evidence from the literature and conducting a needs assessment, the agency learned about factors that drive and influence organizational capacity building within a context of change. Equipped with new knowledge and tools, the agency revised the target staff group of the EIP initiative to include a team that works closely with

many families receiving services from the agency. It was felt that this addition was both beneficial for the organization and for the agency as it would include representation of this team on the agency."

The in person trainings were more powerful and productive than the online modules.

Online Module challenges:

Whether this grant or the Logic Model or past capacity building grants, the ability of the Centre to match resources to the need for an individual agency was great. The only challenge during these points in time was sometimes the amount of information shared (eg Learning Modules-sometimes too much versus refined) or the inability to print off our input to inform reflection.

Although comprehensive, the modules were sometimes too detailed and repetitive, and a little confusing. Overall the training and support has made a great impact on our implementation of EIP's.

The on-line modules were not that user friendly and it would have been helpful to down load the slides for ease of future reference.

This is unfortunate as there was much helpful information on the slides but not easy to access or refer to.

KT and KTPT e-Learning modules

In 2017, the KT program set out to develop two e-learning modules to support educational objectives. One module provides a general overview of KT and the other is a companion to the Knowledge Translation Planning Template. Both are completed and ready to be launched any day now. My role in their development was to create the content and to record the video audio. Both modules are accessible for free:

www.melaniebarwick.com/training.php

http://www.sickkids.ca/Learning/AbouttheInstitute/Programs/Knowledge-Translation/Resources/Resources.html

1. Barwick M, Filipovic S, McMillen K, Metler S, Warmington K. (2017) Introduction to knowledge translation. E-learning module.
2. Barwick M, Filipovic S, McMillen K, Metler S, Warmington K. (2017) Working with the KT Planning Template. E-learning module.

Impacts Metrics and Evaluation

- The Modules were launched and disseminated via Twitter on July 19 2017. Since then, there have been 632 page views.

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

KTPC Casebook

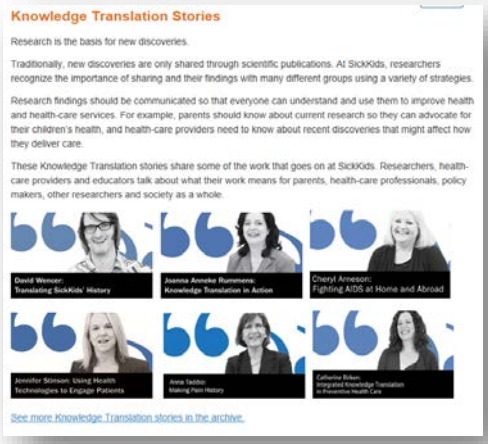
The KTPC course curriculum includes a panel discussion with KTPC alumni to discuss how they are building KT friendly organizations. These discussions have always been a rich source of knowledge and it occurred to me that we could extend their benefit by capturing these 'stories' in a casebook format. We are just now developing our first casebook volume, which will include 10 chapters written by KTPC alumni. We hope to launch this at the KMb Forum in Ottawa on May 17-18 2017, promoting it widely to the KTP/KT/KMb community. The intent is to evaluate the reach/use, usefulness, and impacts of the casebook. NOTE; the KTPC Casebook will be included in the July 31 Dossier submission). My role in this KT deliverable was developing the idea and concept, editing the chapters, and writing the preface and conclusion. Completion: September 2017

Impacts Metrics and Evaluation

Not yet available

KT Stories

KT Stories were first developed when the SKTT program was under development. A series of video vignettes, the KT stories aim to capture first person narratives of KT work in action, from a variety of individuals (researchers, educators, KTPs, community-based organizations). Since the development of the original 4 vignettes, we have adopted this format within the KT Program at SickKids and developed several more. These can be viewed at on the web, and have not been evaluated. Reach/view metrics are forthcoming.
http://www.sickkids.ca/Learning/Stories/Knowledge-Translation/Knowledge-Translation-Stories.html



PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

Impacts Metrics and Evaluation

Knowledge Translation Stories	
Views from Sickkids.ca or YouTube channel	Views
Landing page	1,526
David Wencer	686
Joanna Anneke Rummens	672
Cheryl Arneson	311
Jennifer Stinson	301
Anna Taddio	261
Catherine Birkin	224
Pamela Fuselli	169
David Jaffray	376
Rosemary Tannock	255
Kelly Warmington and Miriam Kaufman	154
Anna Taddio	2,554
Katherine Boydell	434
Stanley Zlotkin	1,118

CPA RELATED TO RESEARCH STUDIES

Pain Assessment and Pain Management (PI B. Stevens)

I am co-investigator / co-applicant on several research studies in KT and implementation in pediatric pain, under the leadership of Dr. Bonnie Stevens (SickKids/U Toronto Nursing; see CV for grants and publications). Most recently I have become involved as program expert on a CIHR Foundation Scheme grant, work that seeks to develop a toolkit for the implementation of pain evidence in hospital care). Earlier studies explored pain assessment and management in pediatric hospital across Canada, and implemented an intervention to impact pain assessment/management practices in these hospitals. Newer research grants are focused on delivering this KT methodology via a toolkit format, to support the integration of pain evidence in hospital care and to encourage appropriate and timely pain management. My role as CI/CA has shaped KT deliverables, and implementation thinking which contributed significantly to Dr. Steven's recent Foundation Scheme grant. In addition, I co-supervised the work of Dr. Kim Widger to develop a casebook of KT examples from the national CIHR study. I conceived of the

idea and collaborated with Dr. Widger who worked on it as her post-doctoral project. The final monograph is available online and has been circulate within the pediatric community (see appendix).

Impacts Metrics and Evaluation

Not evaluated

#ItDoesntHaveToHurt (PI C. Chambers)

#ItDoesntHaveToHurt is an initiative in partnership with Erica Ehm's YummyMummyClub.ca (YMC), that uses the power and reach of social media to make sure research evidence about children's pain management gets directly into the hands of parents who can use it. This work is primarily funded by the Canadian Institutes of Health Research (CIHR) through a Knowledge to Action grant. The initiative spans 12-months (we launched in September 2015) of targeted sharing and discussion of content about children's pain through blogs, videos, Twitter parties, Facebook polls, and social media images, all posted and promoted on the YMC website and social media. YMC has an online reach of over 5 million people per month. We will be covering a range of topics in children's pain, including both acute and chronic pain, from newborns to adolescents. Data are still being collected and analyzed.

Links: Initiative website itdoesnthavetohurt.ca and launch video [https://www.youtube.com/watch?v=5c1JCew]

Links to the #ItDoesntHaveToHurt content published to date are as follows:

Blogs

- Sept 7: Science Proves You're Right To Question Your Doctor by Erica Ehm (@YummyMummyClub)
- Sept 2: How Our Family Motto Became "We Can Make Anything Worse" by Jeni Marinucci (@highlyirritable)
- July 29: Life Lessons for Everyone from a Brave Girl Who Has Arthritis by Chloe Girvan (@Mom_interrupted)
- June 10: Welcome to Womanhood: Pass the Pain Relievers by Jeni Marinucci (@highlyirritable)
- May 11: Growing Pains: Real? Or Not Real? by Dr. Kim Foster (@DrKimFoster)
- April 27: Parents of Children with Autism: How to Deal with Pain Management by Carl Bainbridge (@aparentsprspctv)
- Feb 29: This Is How to Tell How Much Pain Your Kid Is Feeling by Natalie Romero (@mummymadness2)

- Feb 17: How to Prepare for & Manage Your Kid's Post-Surgery Pain by Candace Derickx (@candace_dx)
- Feb 1: Puzzling Pain In Your Kid: How to Identify It and Get Help by Chloe Girvan (@Mom_interrupted)
- Nov 12: How You Can Help Reduce Your Kids' Immunization Pain by Andrea Nair (@andreanair)
- Oct 13: Stomach Aches & Headaches: How to Help Kids Cope with Pain by Dr. Kim Foster (@DrKimFoster)
- Sept 21: Why Aren't Kids Getting Proper Help for Their Pain? by Dr. Christine Chambers (@drcchambers)

Videos

- Aug 25: What This Mom Learned about Emergency Room Pain Management by Nicole King
- May 25: Why Didn't Doctors Believe This Family? by Gayle Grossman-Bly (@NMPSRoom106)
- Jan 18: How a Bikini Wax Inspired a Mom to Help Her Daughter's Pain by Lisa Thornbury (@LisaThornbury)
    - [Blog] Jan 22: Would You Censor This Video? by Erica Ehm (@YummyMummyClub)
- Nov 16: 3 Ways to Instantly Relieve your Baby's Pain featuring Jack Hourigan (@jackhourigan)

Social Media Images

- Sept 15: Social Media Image Tip 12 (My mom is brave)
- Aug 9: Social Media Image Tip 11 (Distraction)
- Aug 3: Social Media Image Tip 10 (Doctor visit cheat sheet)
- June 2: Social Media Image Tip 9 (Growing pain)
- May 19: Social Media Image Tip 8 (Parents know best)
- Feb 29: Social Media Image Tip 7 (Less pain = quicker recovery)
- Feb 22: Social Media Image Tip 6 (How do you know when your kids are in pain when they don't even understand the meaning of the word?)
- Feb 15: Social Media Image Tip 5 (Pain measurement)
- Feb 8: Social Media Image Tip 4 (Pain affects brain development)
- Nov 10: Social Media Image Tip 3 (Breastfeeding for needles)
- Oct 28: Social Media Image Tip 2 (Distraction for needles)
- Sept 30: Social Media Image Tip 1 (Yoga and relaxation)

Facebook Polls

- Sept 12: Facebook Poll w/Giveaway 9 (What did you learn through #ItDoesntHaveToHurt)
- Aug 18:-Facebook Poll w/Giveaway 8-(Share your tips that have increased communication with your family health care providers and helped you work together)
- June 21: Facebook Poll w/Giveaway 7 (What barrier or challenge have you faced when trying to prevent or reduce pain for your child?)
- May 2: Facebook Poll w/Giveaway 6 (What do you do when you think your baby has teething pain?)

- Feb 25: Facebook Poll w/Giveaway 5 (What do you think doctors and hospitals should provide to parents to help manage their child's post-op pain at home?)
- Feb 10: Facebook Poll w/Giveaway 4 (On a scale of 1-5, indicate how you feel about this statement and why: I am confident that I can recognize signs of pain in my child)
- Jan 26: Facebook Poll w/Giveaway 3 (What strategies have you used to reduce the pain of needles for your kids and which methods mentioned in the video will you use?)
- Nov 26: Facebook Poll w/ Giveaway 2 (What strategies have you used before to manage your baby's pain and what new strategy will you use in future?)
- Oct 20: Facebook Poll w/ Giveaway 1 (What strategies do you use when your child has a stomachache or headache?)

Twitter Parties

- Sept 15: Twitter Party 2 Storify
    - Sept 15: Twitter Canada Partnership event for Twitter Party 2 Storify
- Mar 1: Twitter Party 1 Storify

Impacts Metrics and Evaluation

- Our success with the videos and related KT initiatives led to a CIHR-funded *Knowledge to Action Grant* (2015-2017) which supported the development, implementation, and evaluation of the #ItDoesntHaveToHurt social media initiative. The goal of this KT intervention was to increase parent awareness and use of evidence-based information about children's pain, through a partnership between health researchers and an award winning online publisher targeted primarily to Canadian mothers, the YummyMummyClub.ca (YMC). #ItDoesntHaveToHurt spanned a 12-month period (Sept. 2015-Sept. 2016) of targeted sharing and discussion of content about children's pain through blogs, YouTube videos, Twitter parties, Facebook polls, and Instagram images, all posted and promoted on the YMC website and social media. Additional knowledge user partners included NSHRF, the Canadian Pain Coalition, and CAPHC. An advisory panel of parents was actively engaged in all aspects of #ItDoesntHaveToHurt, including content and research methods.
- The initiative had a unique partnership opportunity with Twitter Canada, who hosted a special KT event at their headquarters on Sept. 15, 2016. Special funding for this KT event was secured from the CIHR Scientific Officer's Fund, in partnership with the CIHR's Institute of Musculoskeletal Health and Arthritis (IMHA) and IHDCYH. The event brought together scientists, parents, members of the health community, content creators, and digital influencers who have partnered to develop, implement, and evaluate #ItDoesntHaveToHurt.
- The live event was complemented by a one-hour online Twitter party that allowed parents and scientists from around the world to engage and discuss various topics in children's pain in real time. The Twitter party generated more than 7,000 tweets about children's pain, with over 350 participants and had a reach of over 6 million people. #ItDoesntHaveToHurt trended #1 on social media that evening. The prior #ItDoesntHaveToHurt Twitter party (held

on Mar. 1, 2016) also trended on social media that evening and drew so many parents to linked resources that a children's hospital server crashed under the increased load.

- Since its launch, #ItDoesntHaveToHurt has generated over 130 million impressions (i.e., content views) worldwide
- #ItDoesntHaveToHurt has won multiple awards from both the science and digital marketing industries, including:
    - Best Online Campaign (2016, Canadian Online Publishers Awards)
    - Pain Awareness Award (2016, Canadian Pain Society/Canadian Pain Coalition)
    - Jeffrey Lawson Award for Advocacy in Children's Pain Relief (2016, American Pain Society)
    - Finalist, Best Branded Content (2016, DIGI awards, which recognize the best in Canadian digital media).
- Two videos created as part of the #ItDoesntHaveToHurt initiative (one for the project launch, and another created as part of the initiative content) were awarded prizes from CIHR in the 2015 and 2016 Institute of Human Development, Child and Youth Health Talks video competitions (runner up and first prize, respectively).
- #ItDoesntHaveToHurt was also featured in numerous media articles, including:
    - two articles featured on the CIHR website at the beginning and middle of the intervention
    - several pieces in *The Globe & Mail* and *The New York Times*
- While in-depth analysis is currently underway, our preliminary analysis of the parents who completed online surveys (pre-intervention n = 1,825; post-intervention n = 1,342) and phone interviews (n = 203) on the impact of #ItDoesntHaveToHurt reveals significant improvements in both parent awareness and use of evidence-based information about children's pain based on quantitative and qualitative analysis. For example, our online survey showed that 53.5% of parents reported becoming more aware of pain management strategies for children, 46.3% reported that they had used a *new* pain management strategy, and 47.2% reported using *more* pain management strategies because of #ItDoesntHaveToHurt.
- Similar results were found using our in-depth telephone interviews as well. From pre-intervention to post-intervention, there were significant increases in parent familiarity with 16 different pain management strategies, and significant increases in parent use of skin-to-skin, sucrose, breastfeeding, and technology for pain management in their children. Qualitative analysis revealed that parents were pleased with the information they obtained through the initiative – either as a reaffirmation of what they already knew, "*Just gave us more options...just never know what may work in a given situation*" or by the provision of new information, "*#ItDoesntHaveToHurt has been very informative and given me relevant strategies and helped increase my confidence!*"

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

Muskoka Initiative – Global Child Health

In the area of global health, my research has explored the translation of evidence on maternal child health in low and middle-income (LMIC) countries. Funded by Global Affairs Canada, this large study and a sub-study on the implementation of exclusive breastfeeding in Ethiopia and Mali improved our knowledge of maternal newborn child health and the factors that hinder and facilitate implementation in this context.

Impacts Metrics and Evaluation

- 3 infographics; *see appendix*
- 3 2-page plain language summaries; *see appendix*
- A video describing an overview of the research was also produced, under my leadership, including concept, script, editing and voice over – see https://vimeo.com/131585399
- Zlotkin S; Barwick M. (2014). Smart Collaboration: Working Together to Improve Maternal, Newborn and Child Health. 2014. Available from Huffington Post- Impact http://www.huffingtonpost.com/sickkids-centre-for-global-child-health/smart-collaboration-worki_b_5400013.html
- Barwick, M. (SRA), Barac, R., Zlotkin, S., Salim, L., & Davidson, M. (2016). Factors implicated in successful implementation: evidence to inform improved implementation from high and low-income countries. *Implementation Science*, 11(Suppl 1): A52
- Barwick M, Barac R, Zlotkin S. (2015). An Examination of Exclusive Breastfeeding Implementation in Ethiopia and Mali: Factors Influencing Change. Principal Author. http://www.can-mnch.ca/wp-content/uploads/2015/05/EBF-Research-Report-FINAL-July-29-2015.pdf
- Other publications in progress

PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

Emerging Team in Knowledge Translation and Child and Youth Mental Health

In the area of implementation science and KT, my more recent research accomplishments include CIHR funding for an Emerging Team in Knowledge Translation for Child and Youth Mental Health (2008-2015) for which we are still developing publications. This grant was rated first in this competition. This line of research aims to identify the processes and factors associated with successful implementation of evidence based practice and are informed by key implementation frameworks (Active Implementation Framework, Quality Implementation Framework, and the Consolidated Framework for Implementation Research). Research studies provide the opportunity to test these models in CYMH, and in other contexts (global health, cancer, pediatric obesity) through several collaborative grants.

Impacts Metrics and Evaluation

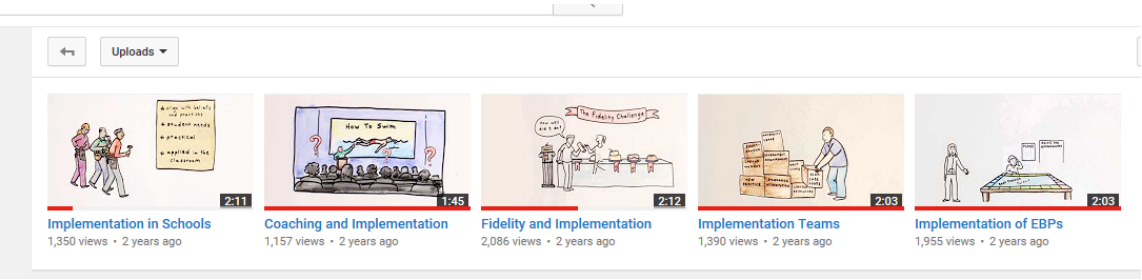
- To date, this team has published 5 papers (CV, papers #2, 16, 20, 21, 26)
    - Kimber M, Barac R, Barwick M (SRA) (*Accepted July 20 2017*)**.** Meaningful Fidelity: Agreement and Acceptability of Implementing the BECCI and MITI for Motivational Interviewing (MI) in Child and Youth Mental Health. *Clinical Social Work Journal.*
    - Barwick M (SRA), Barac R, Akrong LM, Johnson S, Chaban P. (2014). Bringing evidence to the classroom: exploring educator notions of evidence and preferences for practice change. *International Education Research*, 2(4):1-15. doi: 10.12735/ier.v2i4p01. Principal Author. *Altmetrics [25 July 2017]: 730 views; 450 downloads since January 2015; 3 citations; Field weighted citation*[1]*:*
    - Cunningham CE, Barwick MA (SRA), Short K, Chen Y, Ratcliffe J, Rimas H & Mielko S. (2014). Modeling the mental health practice change preferences of educators: a discrete–choice conjoint experiment. *School Mental Health*, 6:1-14. Available from: http://www.ncbi.nlm.nih.gov/pubmed/24563679 . *Altmetrics [25 July 2017]: 1 citation; field weighted citation .27; 1 Tweet; 21 Mendeley readers.*

[1] ***Field-Weighted Citation Impact*** takes into account the differences in research behavior across disciplines. Sourced from SciVal, this metric indicates how the number of citations received by a researchers publications compares with the average number of citations received by all other similar publications indexed in the Scopus database. A Field-Weighted Citation Impact of 1.00 indicates that the publications have been cited at world average for similar publications. A Field-Weighted Citation Impact of greater than 1.00 indicates that the publications have been cited more than would be expected based on the world average for similar publications, for example a score of 1.44 means that the outputs have been cited 44% more times than expected. A Field-Weighted Citation Impact of less than 1.00 indicates that the publications have been cited less that would be expected based on the world average for similar publications, for example a score of 0.85 means 15% less cited than world average. Similar publications are those publications in the Scopus database that have the same publication year, publication type and discipline. Field-Weighted Citation Impact refers to citations received in the year of publication plus the following 3 years. Field-Weighted Citation Impact metrics are useful to benchmark regardless of differences in size, disciplinary profile, age and publication type composition, and provide and useful way to evaluate the prestige of a researcher's citation performance.

- Fearing G, Barwick MA (SRA) & Kimber M. (2014). Clinical transformation: implementation of evidence-based practices from the management perspective. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(4):455-68. doi: 10.1007/s10488-013-0481-9. *Altmetrics [25 July 2017]: 5 citations; field weighted citations 1.07; 6 Tweets; 34 Mendeley readers.*

- Barwick MA (SRA), Bennett LM, Johnson SN, McGowan J, & Moore JE. (2012). Training health and mental health professionals in motivational interviewing: A systematic review. *Children and Youth Services Review*, 34(2012):1786-1795. DOI information: 10.1016/j.childyouth.2012.05.01. *Altmetrics [25 July 2017]: 25 citations; field weighted citations 3.13; 12 Tweets; 48 Mendeley readers.*

- Four additional papers submitted for publication (CV, papers # 3, 4, 5, 8);
- Presented at 23 international and 4 national conferences (see CV for impact indicators);
- Produced several educational video vignettes based on key main messages from the study (see http://www.youtube.com/user/MelanieBarwick/videos).



Barwick, M. Implementation in Schools (video clip). YouTube; 2014 Jul. Available from: http://www.youtube.com/user/MelanieBarwick/videos Impact Indicator (reach, as of 20 July 2017): 1,578 views

Barwick, M. Coaching and Implementation (video clip). YouTube; 2014 Jul. Available from: http://www.youtube.com/user/MelanieBarwick/videos Impact Indicator (reach, as of 1 May 2017): 1,320 views

Barwick, M. Fidelity and Implementation (video clip). YouTube; 2014 Jul. Available from: http://www.youtube.com/user/MelanieBarwick/videos Impact Indicator (reach, as of 20 July 2017): 2,314 views

Barwick, M. Implementation Teams (video clip). YouTube; 2014 Jul. Available from: http://www.youtube.com/user/MelanieBarwick/videos Impact Indicator (reach, as of 20 July 2017): 1,566 views

Barwick, M. Implementation of EBPs (video clip). YouTube; 2014 Jul. Available from: http://www.youtube.com/user/MelanieBarwick/videos Impact Indicator (reach, as of 20 July 2017): 2,295 views

Exemplary Professional Practice

LEADERSHIP IN THE PROFESSION

Canadian Knowledge Translation and Exchange Community of Practice

2006- present	Founder and member, Coordinating Committee, www.kteco.ca

Global Implementation Initiative

2015- present	Member, Governing Board, https://globalimplementation.org/
2015- present	Co-Chair, Global Implementation Conference 2017, Ontario, Canada.

REPORTING GUIDELINES

I recently published *Standards for Reporting Implementation Science* (StaRI) as a collaborative undertaking with several international experts lead by Dr. Hilary Pinnock (U Edinburgh). These two publications have been highly accessed (see CV) and will prove to be quite instrumental in improving the quality of methods and report in implementation science.

> Pinnock H, Barwick M (CA), Carpenter C, Eldridge S, Grandes G, Griffiths C, Rycroft-Malone J, Meissner P, Murray E, Patel A, Sheikh A, Taylor S (2017). Standards for reporting implementation studies (StaRI) Statement. *BMJ 2017;356:i6795*.

This is paper promises to be highly influential in shaping methods and reporting for implementation studies. Despite having been published in April of this year, we already see indications of this impact in terms of reach metrics, with an *Altmetric attention score of 340* (25 July 2017). Compared to all tracked outputs, this paper has done particularly well and is in the 99th percentile: it's in the top 5% of all research outputs ever tracked by Altmetric. *Impact [25 July 2017]: 9 citations; 489 Tweets; 7 Mendeley readers*

Additionally, StaRI was listed as a guideline to follow in NIHR applications. StaRI is listed in the Equator Network: http://www.equator-network.org/reporting-guidelines/stari-statement/

> Pinnock H, Barwick M (CA), Carpenter C, Eldridge S, Grandes G, Griffiths C, Rycroft-Malone J, Meissner P, Murray E, Patel A, Sheikh A, Taylor S. (2017). Standards for Reporting Implementation Studies (StaRI) Explanation and Elaboration Document. *BMJ Open*;7:e013318. doi: 10.1136/bmjopen-2016-013318. *Impact: [25 July 2017]: 3 citations; Altmetric attention score 38; 62 Tweets; 66 Mendeley readers*.

In response to commentary from the authors of the SQUIRE Standards, our group drafted the following response. The SQUIRE authors highlight similarities but overlook the very obvious difference that the hall-mark of StaRI is the distinction between the implementation strategy and the intervention. http://www.bmj.com/content/356/bmj.i6795/rapid-responses

EXEMPLARY PROFESSIONAL PRACTICE

ADMINISTRATIVE ACTIVITIES

International

AMREF Health Africa

2016 – present	Director, Governing Board,	http://www.amrefcanada.org/why-amref/amref-is-african/

Evidence-Based Practice Consortium (USA and Canada)

2009- 2015	Co-Chair, Policy Subcommittee

Global Implementation Initiative

2015- present	Member, Governing Board, https://globalimplementation.org/
2015- present	Co-Chair, Global Implementation Conference 2017, Ontario, Canada.

Seattle Implementation Research Collaborative

2011 Sep- present	Member, Instrument Review Task Force, Comprehensive Review of Dissemination and Implementation Science Instruments, https://www.societyforimplementationresearchcollaboration.org/

University of Huddersfield

2016- present	Member, Regional Advisory Group, *None in Three Study*, Dr. Adele Jones, United Kingdom.

Western Australia Health Translation Network (WAHTN)

2017 – present	Consultant, Knowledge Translation and Research Impact

National

Alberta Pregnancy Outcomes and Nutrition (APrON)

2009- 2012	Scientific Advisor, PI Bonnie Kaplan (U of Calgary) and Catherine Fields (U of Alberta).

Canadian Knowledge Translation and Exchange Community of Practice

2006- present	Founder and member, Coordinating Committee, www.ktecop.ca

Marine Environmental Observation Prediction and Response (MEOPAR) Network of Centres of Excellence

EXEMPLARY PROFESSIONAL PRACTICE

2017- present	Member Knowledge Mobilization Committee, http://www.meopar.ca/

National Centre of Excellence – Children and Youth in Challenging Contexts (CYCC) Network

2015- present	Member, Governing Board, http://www.cyccnetwork.org/

Provincial / Regional

EENet- Evidence Exchange Network (CAMH)

2011- present	Steering Committee

Epilepsy Implementation Task Force for Ontario

2013- 2016	Member, Knowledge Translation Working Group Chairs Dr. Carter Snead (SickKids) and Ms. Brenda Flaherty (Hamilton Health Sciences).

Ontario Ministry of Children and Youth Services

2016	Special Consultant to the Minister, Child and Youth Mental Health, Minister Alex Bezzina
2015- 2016	External Reference Group, Child and Youth Mental Health
2012- 2013	Member, MCYS Measurement Framework, Corporate Scorecard Technical Expert Panel
2010- 2011	Member, Working Together for Kids Mental Health

Provincial Programs Quality Collaborative (Ontario)

2015 – present	Optimizing Clinical Practice in Ontario Task Force Chairs Doris Grinspun/ Jeremy Grimshaw; Executive Sponsor: Deputy Minister Bob Bell
2013 Mar - 2013 Dec	Member, Implementation of Evidence Based Practices Sub-Committee, Ontario Provincial Programs Quality Committee. Chair Dr. Robert Bell, UHN.

Public Health Ontario

2015- 2016	Member, Collective Impact Table on Optimizing Healthy Human Development, Ontario, Canada. Public Health Ontario

Registered Nurses Association of Ontario

2017- present	Best Practice Spotlight Organization (BPSO) Implementation Collaboratory Chairs Doris Grinspun (RNAO) and Anne Sales (U Michigan)

The Second Biennial Evidence-Informed Practice International Invitational Conference

2008- 2010	Member, Organizing Committee, April 2010

University of Toronto and The Change Foundation

2010- 2011	Member, Ginger Council, "Using Online Patient Dialogue for Quality Improvement in Healthcare" – An Innovation Cell and Change Foundation Partnership. Chair Neil Seeman, Innovation Cell, Massey College, University of Toronto

Local

The Hospital for Sick Children

2016 – present	Advisory Board, AboutKidsHealth, http://www.aboutkidshealth.ca/En/Pages/default.aspx
2014 Apr - 2015	Member, Child Health Advocacy and Policy Committee
2013 May- present	Member, Executive Leadership, Centre for Global Child Health
2007 Mar- present	Member, Education Council, Learning Institute

University of Toronto

2015- present	Member, Department of Psychiatry Promotions Committee
2013 – present	Chair, CPA (Creative Professional Activity) Committee, Department of Psychiatry, University of Toronto
2014- present	Member, Social and Behavioural Health Sciences PhD Admissions and PhD Review Committees, Dalla Lana School of Public Health, University of Toronto
2012- 2013	Member, Strategic Planning Group, Pillar 1 – Integration, Education and Quality Mental Health Care Within and Across Health Professions, Department of Psychiatry, University of Toronto
2011- 2013	Member, Chair, CPA (Creative Professional Activity) Committee, Department of Psychiatry, Ontario, Canada.

EXEMPLARY PROFESSIONAL PRACTICE

RECOGNITION OF EXPERTISE

2016 Visiting Scholar, Murdoch Children's Hospital Research Institute, Melbourne Australia (Distinction)

2016 Visiting Scholar, Western Australia Health Translation Network (WAHTN) and University of Western Australia (Distinction)

2014 Visiting Scholar, University of Western Australia, Perth, Western Australia (Distinction)

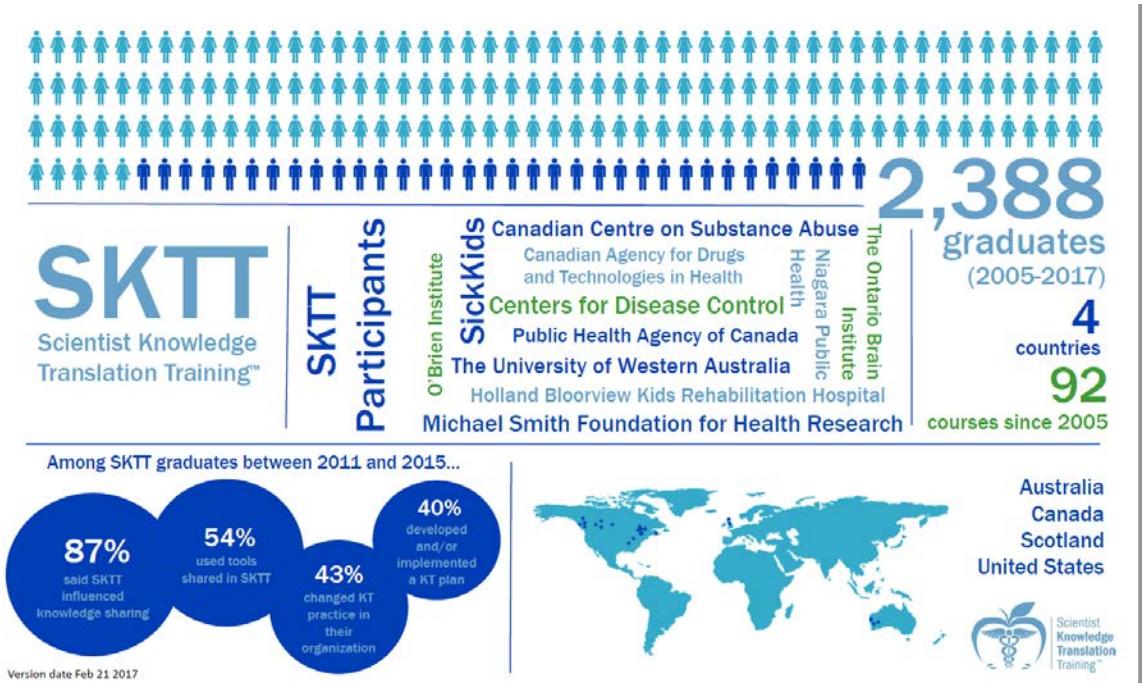
APPENDICES

Appendices

1.1 SKTT Infographic
1.2 SKTT Clients
1.3 SKTT Trainings over Time
1.4 SKTT Australia Infographic
1.5 KTPC Infographic
1.6 Knowledge Translation Planning Template
1.7 KT Game
1.8 Stories from the Floor Monograph
1.9 #itdoesn'thavetohurt social media postings – examples (Christine Chambers, PI)
1.10 Muskoka Initiative KT Outputs: Infographics, video, Knowledge Snaphots
1.11 Accolades

APPENDICES

SKTT INFOGRAPHIC OVERVIEW



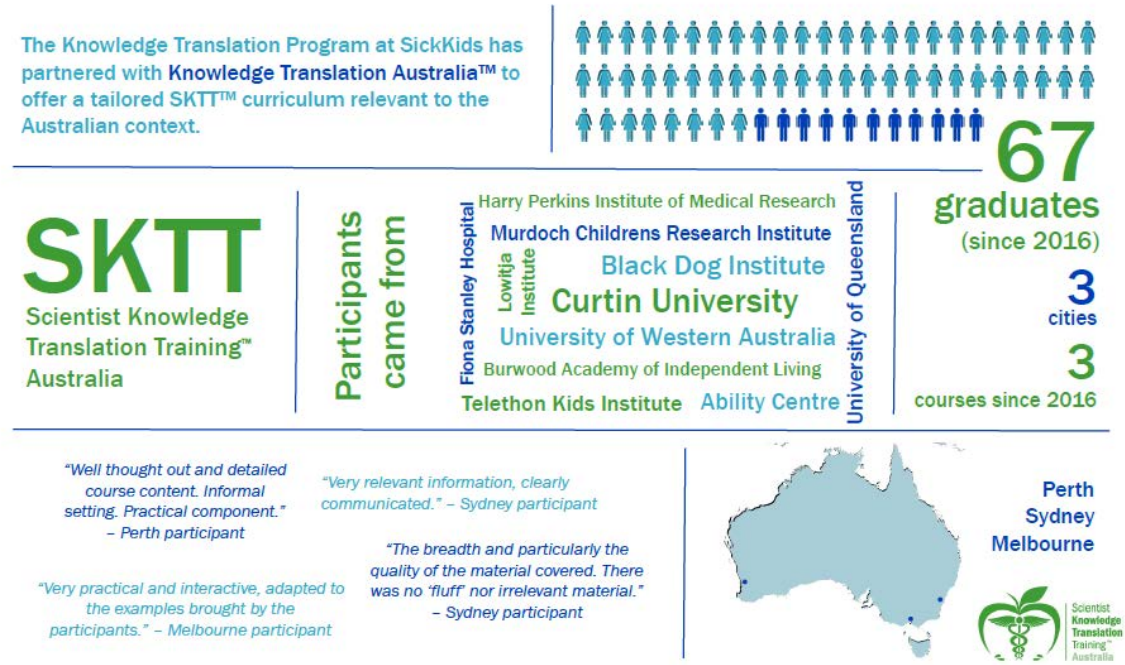
APPENDICES

SKTT CLIENT LIST (2011-2017)

American Institutes for Research	USA
Alberta Innovates Health Solutions	Canada
BC Population Health Data	Canada
BC Women's Health Research Institute	Canada
Bloorview Children's Rehabilitation Hospital	Canada
Canadian Agency for Drugs and Technologies in Health	Canada
Canadian Centre for Substance Abuse	Canada
Cancer Care Ontario	Canada
Cardiac Arrhythmia Network of Canada (NCE)	Canada
Child and Parent Resource Institute	Canada
Center for Disease Control	USA
Centre of Excellence for Child and Youth Mental Health	Canada
Community Networks of Specialized Care	Canada
Gambling Research Exchange Ontario (GREO)	Canada
Glenrose Hospital	Canada
Guelph University	Canada
Hamilton Public Health	Canada
Institute for Clinical and Evaluative Sciences (ICES)	Canada
Michael Smith Foundation for Health Research	Canada
National Institute for Disability & Rehabilitation Research	USA
Niagara Public Health	Canada
Nova Scotia Health Research Foundation	Canada
Ontario Brain Institute	Canada
Ontario HIV Network	Canada
Public Health Agency of Canada	Canada
Sunnybrook Health Sciences Centre	Canada
University of California - Irvine	USA
University of Edinburgh	Scotland
University of Saskatchewan	Canada
University of Toronto, Dept of Family and Community Medicine	Canada
University of Toronto, Dept of Obstetrics and Gynecology	Canada
University of Victoria	Canada
University of Western Australia	Australia
US Department of Education	USA
Various organizations, Melbourne	Australia
Various organizations, Sydney	Australia
Wellesley Institute	Canada

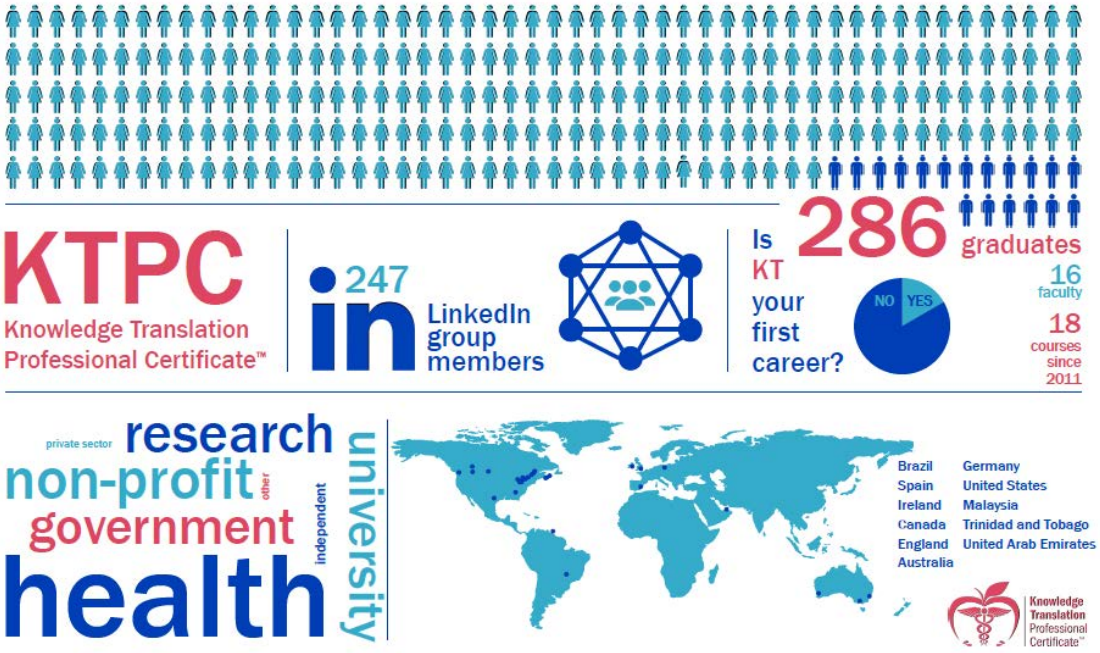
APPENDICES

SKTT AUSTRALIA INFOGRAPHIC OVERVIEW



APPENDICES

KNOWLEDGE TRANSLATION PROFESSIONAL CERTIFICATE INFOGRAPHIC OVERVIEW



APPENDICES

KNOWLEDGE TRANSLATION PLANNING TEMPLATE

Knowledge Translation Planning Template©

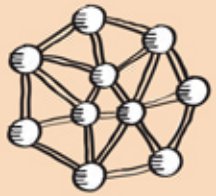
INSTRUCTIONS: This template was designed to assist with the development of Knowledge Translation (KT) plans for research but can be used to plan for non-research projects. The Knowledge Translation Planning Template is universally applicable to areas beyond health. Begin with box #1 and work through to box #13 to address the essential components of the KT planning process.

(1) Project Partners

- ☐ researchers
- ☐ consumers - patients/families
- ☐ the public
- ☐ decision makers
- ☐ private sector/industry
- ☐ research funding body
- ☐ volunteer health sector/NGO
- ☐ practioners
- ☐ other

NOTES

(2) Degree of Partner Engagement



- ☐ from idea formulation straight through
- ☐ after idea formulation & straight through
- ☐ at point of dissemination & project end
- ☐ beyond the project

Consider: Not all partners will be engaged at the same point in time. Some will be collaborators, end users or audiences, or people hired to do specific activities.

(3) Partner(s) Roles

(1) What do the partner(s) bring to the project?

(2) How will partner(s) assist with developing, implementing or evaluating the KT plan?

Action: Capture their specific roles in letters of support to funders, if requested.

▶

(4) KT Expertise on Team

- ☐ scientist(s) with KT expertise
- ☐ consultant with KT expertise
- ☐ knowledge broker/specialist
- ☐ KT supports within the organization(s)
- ☐ KT supports within partner organization(s)
- ☐ KT supports hired for specific task(s)

(5) Knowledge Users (KUs)

Which KUs or audiences will you target?

- ☐ researchers
- ☐ health practitioners or service providers
- ☐ public
- ☐ media
- ☐ patients/consumers
- ☐ decision makers
  - ☐ in organization
  - ☐ in community
- ☐ policy makers
- ☐ private sector/industry
- ☐ research funders
- ☐ venture capitalists
- ☐ volunteer health sector/NGO
- ☐ other: specify ►_____

Consider: Have you included any of your audiences on your research team? If so, who and why (be strategic)?

NOTES

(6) Main Messages

What did you learn, or what do you anticipate learning?

What messages do you anticipate sharing (up to 3 KU audiences can be included on this form)?

Audience 1

Audience 2

Audience 3

OR

☐ No idea yet; messages will emerge during research through collaboration with partners.

Consider: What can you feasibly do within this project, given time and resources? Aim for defining your Single Most Important Thing (SMIT) or Bottom Line Actionable Message (BLAM).

(7) KT Goals

What are your KT Goals for each KU/audience?

Audiences 1	2	3	
☐	☐	☐	***Generate...*** awareness
☐	☐	☐	interest
☐	☐	☐	practice change
☐	☐	☐	behaviour change
☐	☐	☐	policy action
			Impart...
☐	☐	☐	knowledge
☐	☐	☐	tools
			Inform...
☐	☐	☐	research
☐	☐	☐	product
☐	☐	☐	patent
☐	☐	☐	other ►_____

Consider: KT is applicable to all research; even single studies are shared via journal articles. However, intent to change practice, behaviour or policy must be supported by a body of high quality research evidence (synthesis). Always consider legal and ethical principles in your KT efforts.

(8) KT Strategy(s)

What KT strategy(s) will you use?

Audiences 1	2	3	
			Mostly Effective[1]
☐	☐	☐	interactive small group
☐	☐	☐	educational outreach
☐	☐	☐	reminders
☐	☐	☐	IT decision support
☐	☐	☐	multi-prof collaboration
☐	☐	☐	mass media campaign
☐	☐	☐	financial incentive
☐	☐	☐	combined interventions
			Mixed Effects[1]
☐	☐	☐	conferences (didactic)
☐	☐	☐	opinion leaders
☐	☐	☐	champions
☐	☐	☐	educational materials
☐	☐	☐	patient-mediated interview
☐	☐	☐	performance feedback
☐	☐	☐	substitution of tasks
☐	☐	☐	peer reviewed publication
			Limited Effects[1]
☐	☐	☐	CQI - Continuous Quality Improvement
			Effects Unsupported by Synthesis[2]
☐	☐	☐	press release
☐	☐	☐	patent license
☐	☐	☐	arts-based KT
☐	☐	☐	social media
☐	☐	☐	networks
☐	☐	☐	communities of practice
☐	☐	☐	Café Scientifique
☐	☐	☐	webinar
☐	☐	☐	other ►_____

Consider: Multifaceted/combined KT strategies are more effective than single strategies.

(9) KT Process

When will KT occur?

- ☐ integrated iKT[3] – researchers and research users will collaborate to shape the research process, e.g., setting the research questions, deciding the methodology, involvement in data collection and tools development, interpretation of findings and dissemination of research results
- ☐ end of grant KT[3]- KT undertaken at the completion of the research process
- ☐ both

Comment on the specifics of your KT procedures; describe how you are using iKT:

▶

NOTES

(10) KT Impact & Evaluation

(a) Where do you want to have an impact?

- ☐ healthcare/well-being outcomes
- ☐ (clinical) practice
- ☐ policies/systems
- ☐ research & knowledge

(b) How will you know if you achieved your KT goal(s)? Consider:

- ☐ reach indicators *(# distributed, # requested, # downloads/hits, media exposure)*[4]
- ☐ usefulness indicators *(read/browsed, satisfied with, usefulness of, gained knowledge, changed views)*[4]
- ☐ use indicators *(# intend to use, # adapting the information, # using to inform policy/advocacy/enhance programs, training, education, or research, # using to improve practice or performance)*[4]
- ☐ partnership/collaboration indicators *(# products/services developed or disseminated with partners, # or type capacity building efforts, social network growth, influences, collaborativeness)*[4]
- ☐ practice change indicators *(intent or commitment to change, observed change, reported change)*
- ☐ program or service indicators *(outcome data, documentation, feedback, process measures)*
- ☐ policy indicators *(documentation, feedback, process measures)*
- ☐ knowledge change *(quantitative & qualitative measures)*
- ☐ attitude change *(quantitative & qualitative measures)*
- ☐ systems change *(quantitative & qualitative measures)*

(c) Guiding Questions for Evaluation[5]

1) What internal/external factors do you need to consider? Where is the energy for this work? How have similar initiatives been evaluated in the past? *(link this to partners, KUs)*
2) Who values the evaluation of this initiative? What are they saying they need from this evaluation? *(link this to partners, KUs)*
3) Why are you evaluating? For program growth or improvement; accountability? Sustainability? Knowledge generation? *(e.g., to know if the KT strategy met the objectives)*
4) How will literature or existing theories inform how you evaluate the initiative?
5) Which questions/objectives are critical? *(link this to KT goals, process, impact)*
6) Will you focus on process or outcome information? What are your pre-determined outcomes? How will you capture emergent outcomes?
Does this information already exist in your system? *(link to methods, process, impact)*
7) Will methods be quantitative, qualitative or mixed? Do tools exist or will you need to create your own? *(link to KT methods)*
8) What perspective or skill set do you need to help you reach your evaluation objectives? *(link to partners, KUs)*
9) How do your stakeholders wish to receive this information so that it will be valuable and useful to them? How will you engage them throughout? *(link to partners, KUs)*

(11) Resources 

What resources are required?

- ☐ board
- ☐ financial
- ☐ human
- ☐ IT
- ☐ leadership
- ☐ management
- ☐ volunteer
- ☐ web
- ☐ worker
- ☐ other: *(list)*

►

NOTES

(12) Budget Items 

What budget items are related to the KT plan?

- ☐ accommodation
- ☐ art installation
- ☐ evaluation specialist
- ☐ graphics/imagery
- ☐ knowledge broker
- ☐ KT specialist
- ☐ mailing
- ☐ media release
- ☐ media product *(e.g. video)*
- ☐ networking functions
- ☐ open access journal
- ☐ plain text writer
- ☐ production/printing
- ☐ programming
- ☐ public relations
- ☐ reimbursements for partners *(e.g. time, parking, travel)*
- ☐ tech transfer/commercialization
- ☐ teleconferencing
- ☐ travel: conferences
- ☐ travel: meetings/educational purposes
- ☐ web 2.0 *(e.g. blogs, podcasts, wikis)*
- ☐ webinar services
- ☐ website development
- ☐ venue
- ☐ other: *(list)*

Estimated costs for items listed

►

►

NOTE: Be sure to include all KT costs in your budget for funders

(13) Implementation 

Describe how you will implement your KT strategy(s): What processes/procedures are involved? If practice or behaviour change is the focus, how will you ensure the knowledge (intervention) you are transferring retains quality, fidelity, sustainability?

►

Barwick, M. (2008, 2013). Knowledge Translation Planning Template. Ontario: The Hospital for Sick Children.

1) Grol & Grimshaw 2003 The Lancet, 362(i9391): 1225. 2) KT strategies may have support from individual studies. 3) CIHR http://www.cihr.ca/e/29418.html. 4) Sullivan, Strachan, & Timmons. Guide to Monitoring and Evaluating Health Information Products and Services. http://www.infoforhealth.org/hipnet/MEGuide/MEGUIDE2007.pdf. 5) Parker, K (2013). KT and Evaluation. Unpublished; courtesy of Knowledge Translation Professional Certificate, Learning Institute, Hospital for Sick Children.

APPENDICES

STORIES FROM THE FLOOR MONOGRAPH

http://www.sickkids.ca/pdfs/Research/stevens-research/53075-Stories-from-the-floor.pdf

Stories From The Floor

A Knowledge Translation Casebook on Improving Pediatric Pain Practices

Editors:

Kimberley Widger • Bonnie Stevens • Melanie Barwick

CIHR Team in Children's Pain

CONTRIBUTORS

Editors: Kimberley Widger RN PhD CHPCN(C),[1,2] Bonnie Stevens RN PhD FCAHS,[1,2] and Melanie Barwick PhD CPsych.[1,2]

Chapter Authors: Sylvie Charette RN MN,[3] Anne-Marie Krancevic RN BScN,[1] Shelley Lowther RN MN,[4] Kathy O'Leary RN MN,[5] Sandy Taylor RN BN CON(C),[6] Margot Thomas RN MScN CNCCP(C),[7] Darina Tsoller MD,[8] Deepshikha Wilson RN MN.[9]

[1]The Hospital for Sick Children, Toronto, ON; [2]University of Toronto, Toronto, ON; [3]CHU Sainte-Justine, Montréal, QC; [4]IWK Health Centre, Halifax, NS; [5]Stollery Children's Hospital, Edmonton, AB; [6]Children's Hospital Health Science Centre Winnipeg, Winnipeg, MB; [7]Children's Hospital of Eastern Ontario, Ottawa, ON; [8]Montréal Children's Hospital, Montréal, QC; [9]BC Children's Hospital, Vancouver, BC.

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CIHR Team in Children's Pain and TROPIC Grants Investigators

The Hospital for Sick Children and/or University of Toronto or Ryerson University
Bonnie Stevens RN PhD FCAHS (Principal Investigator)
Melanie Barwick PhD CPsych
Fiona Campbell MD FRCA (Site Investigator)
Tricia Kavanagh RN PhD
Shoo Lee MD PhD FRCPC
Jennifer Stinson RN PhD (Site Investigator)
Robyn Stremler RN PhD
Anna Taddio BScPhm PhD
Souraya Sidani RN PhD
Andrew Willan PhD
Janet Yamada RN PhD

IWK Health Centre and/or Dalhousie University
Christine Chambers PhD RPsych
G Allen Finley MD FRCPC FAAP (Site Investigator)
Margot Latimer RN PhD (Site Investigator)
Patrick McGrath OC PhD FRSC

Children's Hospital of Eastern Ontario and/or University of Ottawa
Janice Cohen PhD CPsych (Site Investigator)
Denise Harrison RN PhD (Site Investigator)
Judy Rashotte RN PhD (Site Investigator)

Stollery Children's Hospital and/or University of Alberta
Greta Cummings RN PhD
Carole A Estabrooks RN PhD
Shannon Scott RN PhD (Site Investigator)

BC Children's Hospital and/or University of British Columbia
Liisa Holsti OTR PhD (Site Investigator)
Anne Synnes MDCM MHSc FRCPC (Site Investigator)
Fay Warnock RN PhD (Site Investigator)

Montreal Children's Hospital and/or McGill University
Céleste Johnston RN DEd FCAHS (Site Investigator)
Christina Rosmus RN MSc (Site Investigator)

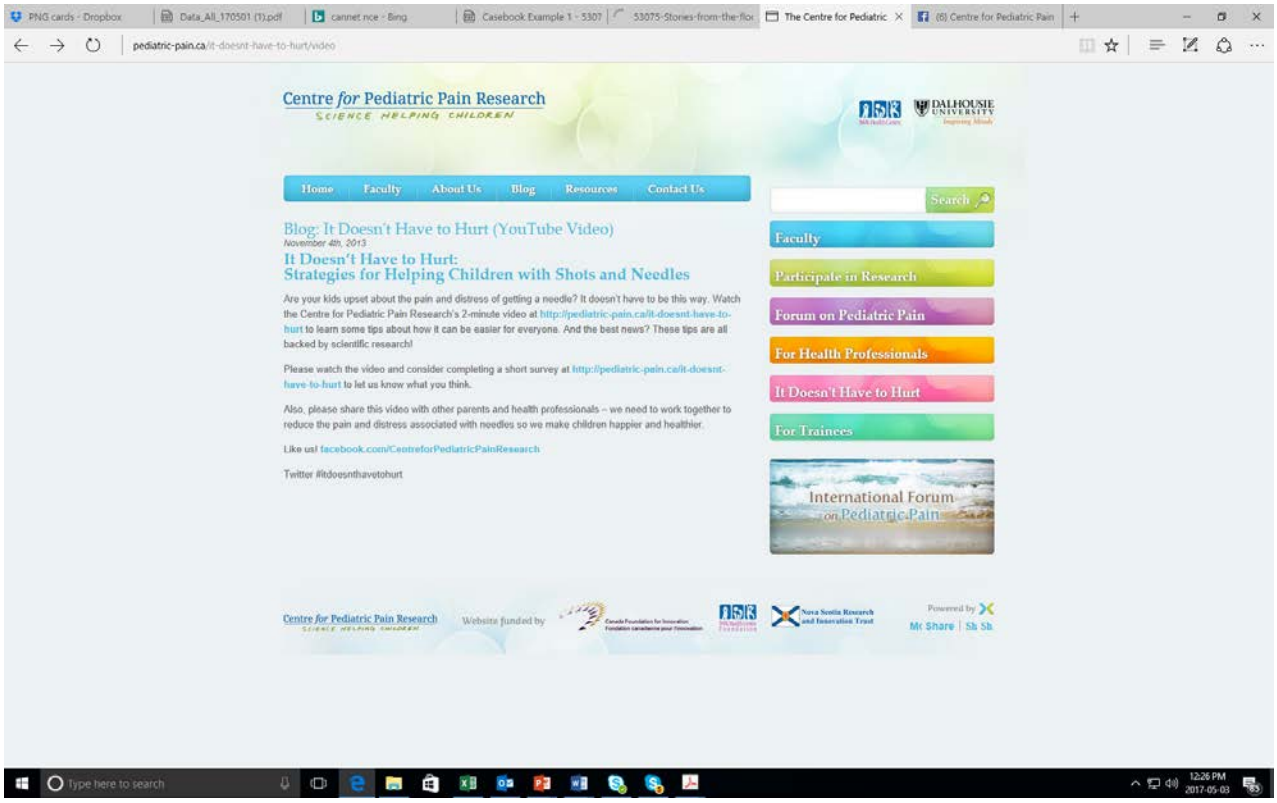
CHU Ste-Justine and Université de Montréal
Sylvie LeMay RN PhD (Site Investigator)
Edith Villeneuve MD FRCPC

Children's Hospital Health Sciences Centre Winnipeg
Doris Sawatzky-Dickson RN MN (Site Investigator)

APPENDICES

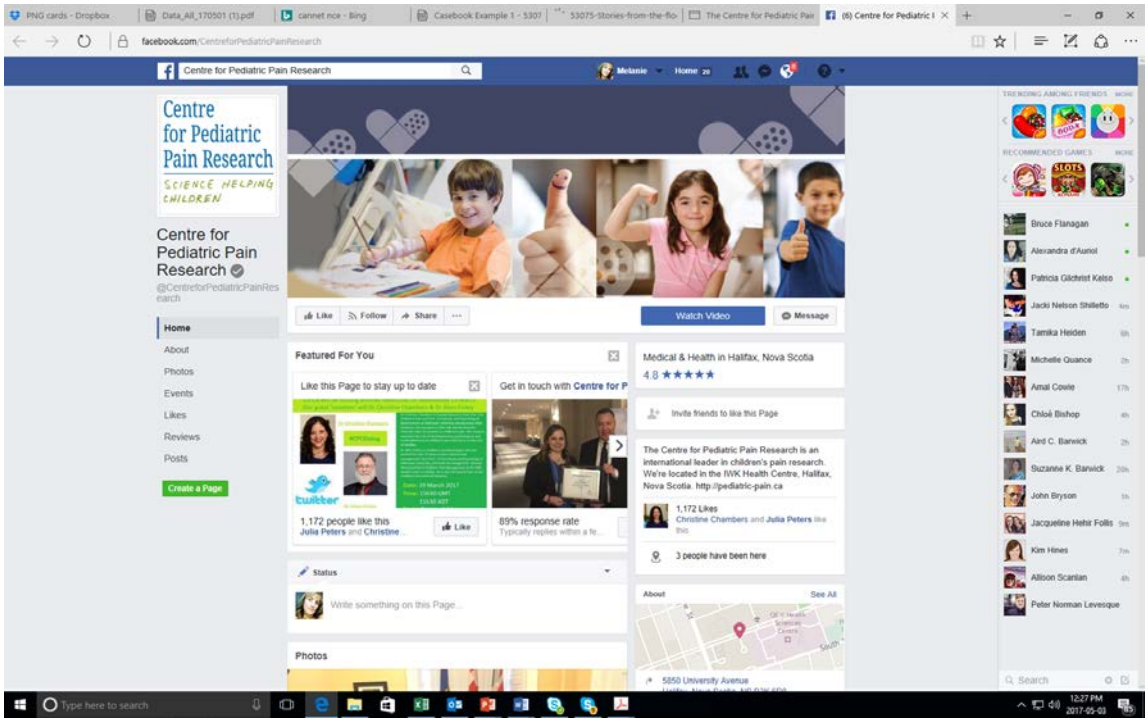
#ITDOESN'THAVETOHURT SOCIAL MEDIA POSTINGS

Website: http://pediatric-pain.ca/it-doesnt-have-to-hurt/video



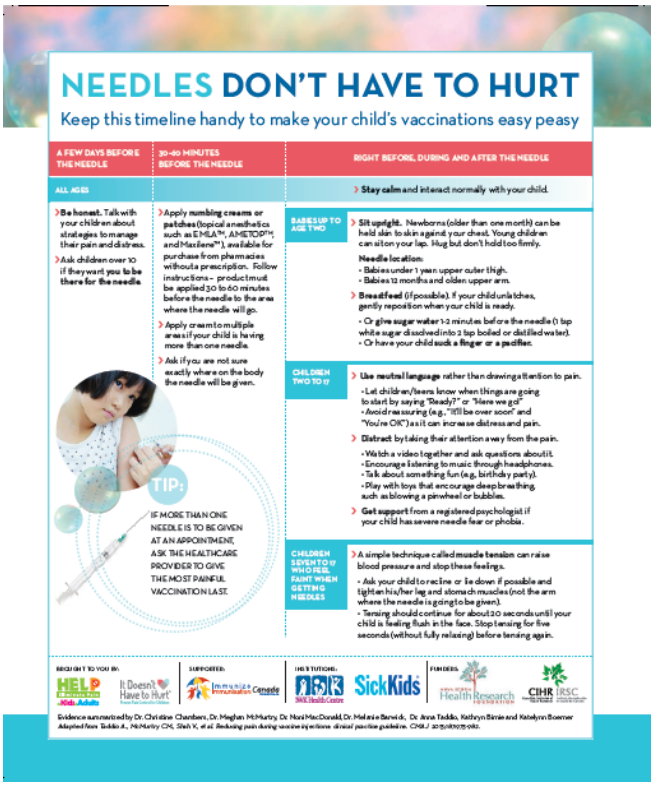
APPENDICES

Facebook page for parents



APPENDICES

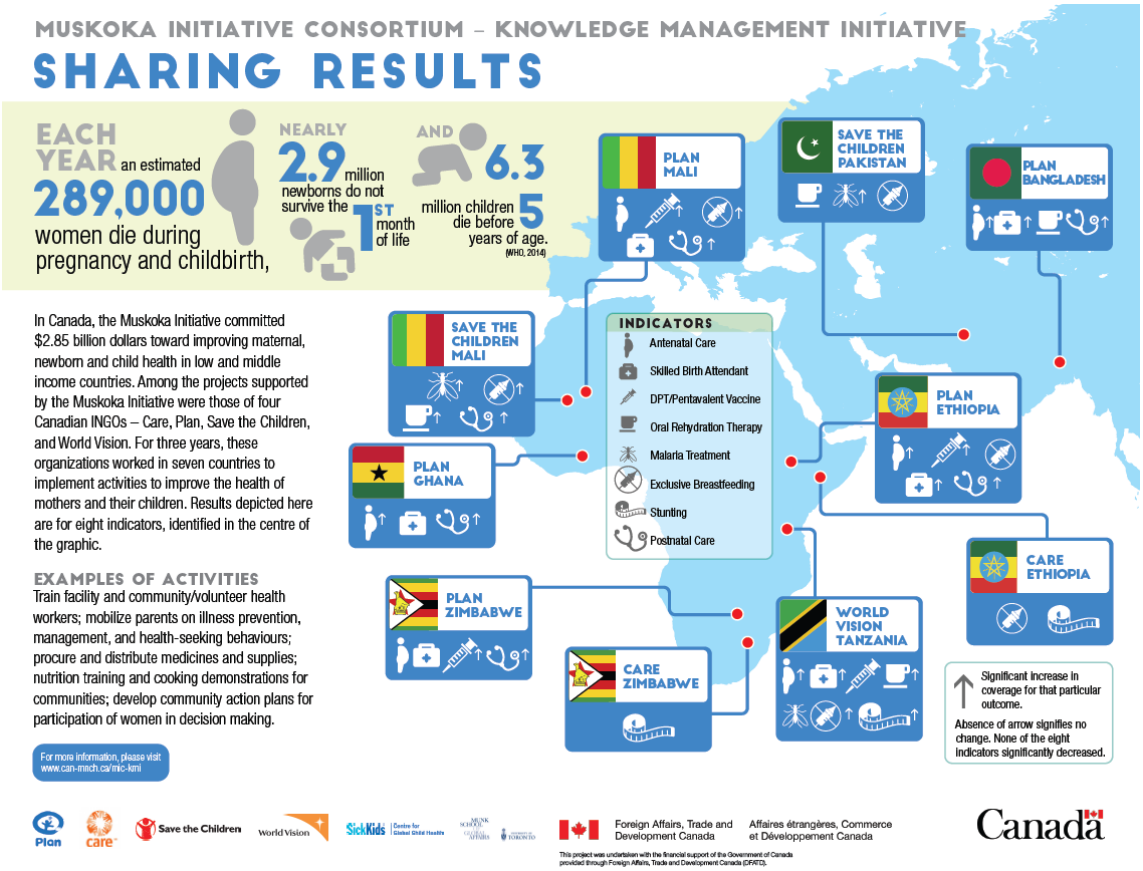
Parents Canada Magazine Entry 2017

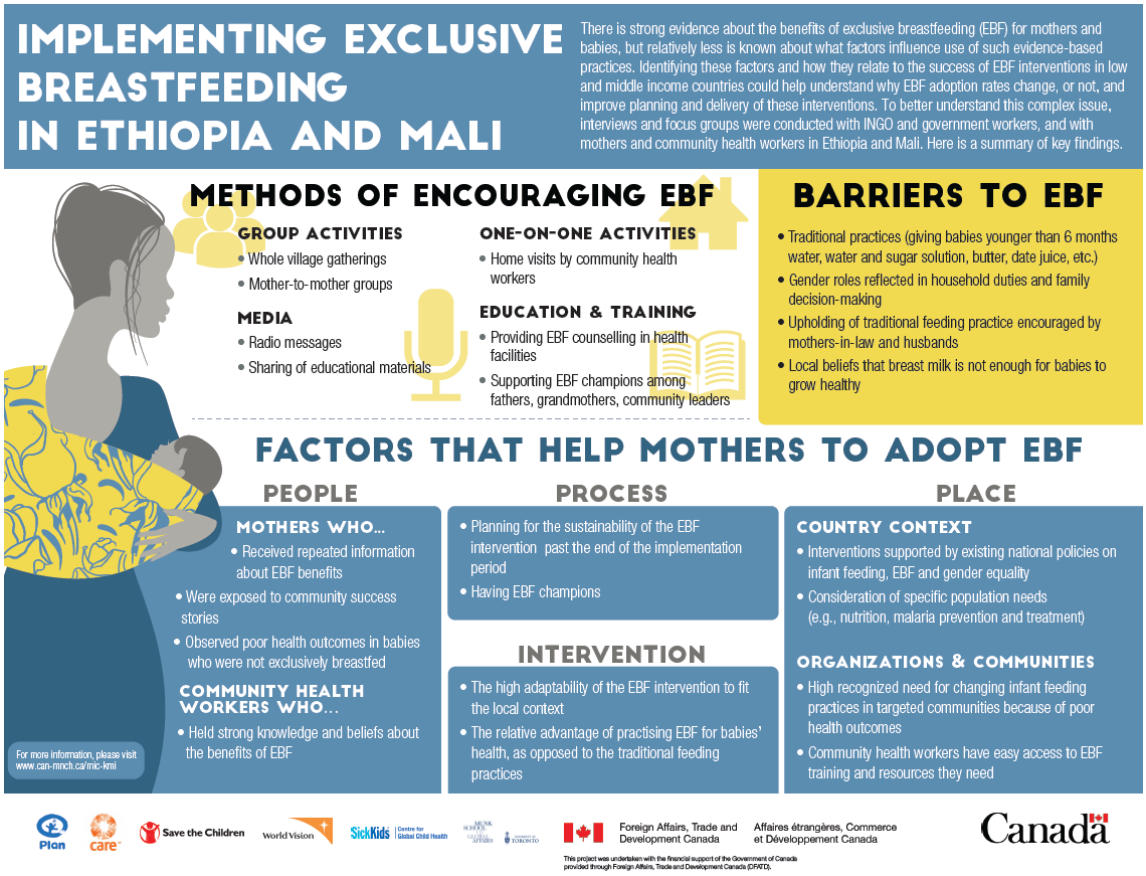


APPENDICES

MUSKOKA INITIATIVE STUDY (GLOBAL HEALTH)

http://www.canwach.ca/knowledge-centre/muskoka-initiative-consortium-results/




IMPLEMENTING EXCLUSIVE BREASTFEEDING IN ETHIOPIA AND MALI
There is strong evidence about the benefits of exclusive breastfeeding (EBF) for mothers and babies, but relatively less is known about what factors influence use of such evidence-based practices. Identifying these factors and how they relate to the success of EBF interventions in low and middle income countries could help understand why EBF adoption rates change, or not, and improve planning and delivery of these interventions. To better understand this complex issue, interviews and focus groups were conducted with INGO and government workers, and with mothers and community health workers in Ethiopia and Mali. Here is a summary of key findings.
METHODS OF ENCOURAGING EBF
GROUP ACTIVITIES
• Whole village gatherings
• Mother-to-mother groups
MEDIA
• Radio messages
• Sharing of educational materials
ONE-ON-ONE ACTIVITIES
• Home visits by community health workers
EDUCATION & TRAINING
• Providing EBF counselling in health facilities
• Supporting EBF champions among fathers, grandmothers, community leaders
BARRIERS TO EBF
• Traditional practices (giving babies younger than 6 months water, water and sugar solution, butter, date juice, etc.)
• Gender roles reflected in household duties and family decision-making
• Upholding of traditional feeding practice encouraged by mothers-in-law and husbands
• Local beliefs that breast milk is not enough for babies to grow healthy
FACTORS THAT HELP MOTHERS TO ADOPT EBF
PEOPLE
MOTHERS WHO...
• Received repeated information about EBF benefits
• Were exposed to community success stories
• Observed poor health outcomes in babies who were not exclusively breastfed
COMMUNITY HEALTH WORKERS WHO...
• Held strong knowledge and beliefs about the benefits of EBF
PROCESS
• Planning for the sustainability of the EBF intervention past the end of the implementation period
• Having EBF champions
INTERVENTION
• The high adaptability of the EBF intervention to fit the local context
• The relative advantage of practising EBF for babies' health, as opposed to the traditional feeding practices
PLACE
COUNTRY CONTEXT
• Interventions supported by existing national policies on infant feeding, EBF and gender equality
• Consideration of specific population needs (e.g., nutrition, malaria prevention and treatment)
ORGANIZATIONS & COMMUNITIES
• High recognized need for changing infant feeding practices in targeted communities because of poor health outcomes
• Community health workers have easy access to EBF training and resources they need
For more information, please visit www.can-mnch.ca/mic-kmi
Plan
care
Save the Children
World Vision
SickKids
Foreign Affairs, Trade and Development Canada
Affaires étrangères, Commerce et Développement Canada
Canada
This project was undertaken with the financial support of the Government of Canada provided through Foreign Affairs, Trade and Development Canada (DFATD).

APPENDICES

MUSKOKA INITIATIVE STUDY – KNOWLEDGE SNAPSHOTS

Muskoka Initiative Consortium - Knowledge Management Initiative

KEY FINDINGS

Sharing Results

WHAT IS THE PROJECT CONTEXT?

Each year, an estimated 350,000 to 500,000 women die in childbirth, nearly 3.6 million newborns do not survive the first month of life, and 5.2 million children die before 12 months of age (WHO 2010). Most of these deaths occur in resource-limited settings found in low- and middle-income countries (LMICs), and most are preventable. In 2000, the 'Millennium Development Goals' were developed as part of a global commitment to reduce poverty and improve the health and well-being of those in such settings by 2015. In Canada, improving maternal, newborn, and child health (MNCH) in specific 'at risk' countries is a top development priority, as demonstrated through the Muskoka Initiative, announced at the G8 summit in 2010.

WHAT DID WE DO?

To this end, four international non-governmental organizations (INGOs) - CARE Canada, Plan Canada, Save the Children Canada, and World Vision Canada - came together to form the Muskoka Initiative Consortium (MIC) in 2012.The overall goal of the MIC was to improve maternal, newborn and child health. The INGOs conducted 10 projects in 7 countries in Africa and Asia (Bangladesh, Ethiopia, Ghana, Mali, Pakistan, Tanzania and Zimbabwe). The specific themes of the INGO projects included: 1) strengthening health systems; 2) reducing the burden of diseases; and 3) improving nutrition.

As part of this work, MIC partnered with The Hospital for Sick Children (SickKids) and the Munk School of Global Affairs at the University of Toronto to develop a knowledge management (KM) strategy to share the findings from the 10 INGO projects. This partnership, referred to as the Muskoka Initiative Consortium – Knowledge Management Initiative (MIC-KMI), set out to identify maternal and child health-related indicators that were common across all 10 projects, and to provide an interpretation of the combined outcomes. All indicator data were collected by the INGOs in household surveys at the beginning of program funding (baseline) and at the end (endline).

WHAT DID WE LEARN?

In total, 13 maternal and child health-related indicators were identified as common to all the projects. All of the common indicators improved from baseline to endline, with the exception of stunting (see figure on the reverse). The magnitude and direction of the change differed across the 10 INGO projects. In general, indicators with lower values at baseline had more room for change, and thus appeared more likely to increase by the end of the project.

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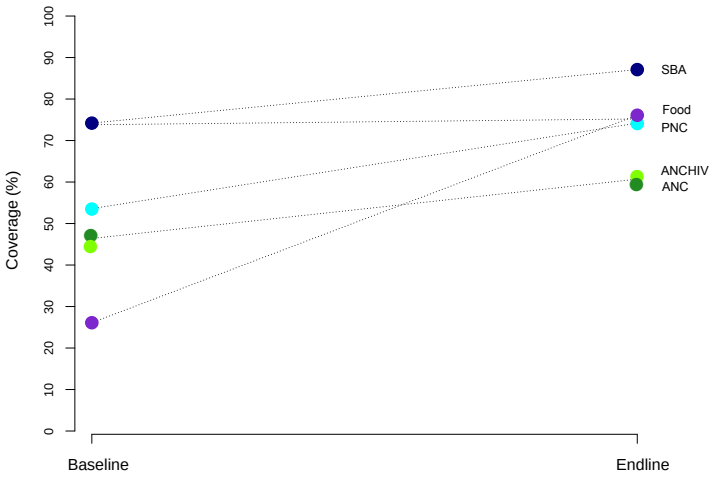
Plan
care
Save the Children
World Vision
SickKids | Centre for Global Child Health
Munk School of Global Affairs
University of Toronto

KEY FINDINGS

Implementing health interventions in LMICs is a complex undertaking and it is difficult to directly attribute changes to program activities. However, the changes observed for many of the indicators appear to be related to the INGO interventions. We based this conclusion on the fact that the observed increases were larger than what would be expected for a short time-period if no activities had been conducted.

a) Maternal health indicators



b) Child health indicators

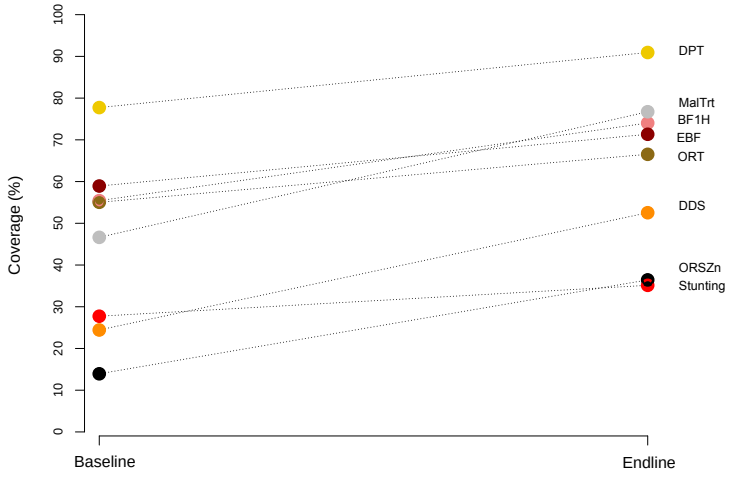


Figure legend: Coverage estimates from baseline to endline for Common Framework indicators related to (a) maternal health outcomes (ANC: antenatal care; ANCHIVtest: tested for HIV in ANC visit; Food: maternal food purchasing; SBA: skilled birth attendance; PNC: postnatal care). (b) child health outcomes from baseline to endline (BF1H: breastfed within 1 hour; DDS: dietary diversity score; DPT3: DPT/penta vaccination; EBF: exclusive breastfeeding; MalTrt: child with malaria-like symptoms received malaria medication; ORT: child with diarrhea-like symptoms provided oral rehydration therapy; ORSZn: child with diarrhea-like symptoms provided ORS and zinc; Stunting)

WHAT DOES IT ALL MEAN?

Changes observed in the common indicators suggest that INGOs' health programming efforts, that included evidence-based strategies like exclusive breastfeeding and antenatal care, have contributed to successful MNCH outcomes. This highlights the benefit of investments to improve the lives of mothers and children.

Looking forward, it should be possible to further improve health outcomes through collaborative INGO-academic partnerships resulting in a stronger evaluation framework and thus more robust understanding of the relationship between interventions and outcomes. Evaluation methodology might be improved by:

- An a priori agreement on common outcomes and a dictionary of standardized questions and questionnaires pertaining to these common indicators; and
- Employing a longer intervention period to adequately assess more complex indicators, like stunting.

This project has provided an excellent opportunity to foster collaboration between the academic and INGO communities. There has been substantial bi-directional learning as INGOs provided vast knowledge and experience around program implementation, whereas academia offered rigorous assessment approaches to assist in the interpretation of outcomes. Ultimately, this collaboration has offered an opportunity to communicate the knowledge and expertise between the INGO and academic sectors.

Citation: © Baxter, J., Chera R., Nathoo, S., Vaivada, T., Barwick, M., Zlotkin, S., with the MIC-KMI Technical Working Group, . Muskoka Initiative Consortium - Knowledge Management Initiative Key Findings: Sharing Results. Toronto ON: The Hospital for Sick Children / Centre for Global Child Health.

For more information, please visit www.can-mnch.ca/mic-kmi

Muskoka Initiative Consortium - Knowledge Management Initiative

KEY FINDINGS

Implementation of Exclusive Breastfeeding in Ethiopia and Mali: Factors Associated with Change

WHAT DO YOU NEED TO KNOW?

Implementation of health interventions is a complex process and many factors can impact outcomes. There is strong evidence that exclusive breastfeeding (EBF) is beneficial for mothers and babies, but very little is known about the factors that affect the success of EBF promotion interventions. Knowing which factors are associated with successful implementation can shape maternal newborn and child health programming approaches and help to explain results. We sought to explore a range of factors associated with successful implementation of EBF in Ethiopia and Mali using a common framework that could inform the work of INGOs and implementation science more broadly.

WHAT DID WE EXPLORE?

Interventions to promote optimal infant and young child feeding practices are a critical part of efforts to reduce infant mortality and morbidity in low- and middle-income countries (LMICs). One component of optimal feeding is EBF, defined as the exclusive provision of breast milk for the first 6 months of life. Breast milk provides the optimal balance of nutrients and transfers antibodies from mother to child, and there is strong evidence supporting the effectiveness of EBF in reducing the burden of disease in populations. Given the widely documented benefits of EBF, specific interventions have been developed to increase EBF rates and it is essential to identify the factors that affect the successful implementation of these interventions.

To date, studies have typically examined a very narrow range of factors related to EBF implementation (e.g., the number of community health workers trained; demographic characteristics of mothers) and linked them with a primary health outcome (e.g., change in EBF rates). As a result, there is little evidence about how contextual factors influence implementation of EBF interventions. This study addressed this knowledge gap by exploring a range of factors associated with successful implementation of EBF in Ethiopia and Mali.

WHAT DID WE DO?

Data was collected through interviews with Canadian and in-country INGO and government workers, and focus group discussions with mothers, community health workers (CHWs), and health extension workers (HEWs) in both countries. We looked at EBF interventions through the lens of five types of factors outlined in the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009): intervention characteristics, inner setting, outer setting, characteristics of individuals, and process. In addition, we included a sixth category of factors related to the characteristics of intervention recipients (e.g., education, socio-economic status, family composition, and traditional and religious beliefs and practices). We related these contextual factors to change rates for EBF in Mali and Ethiopia that were calculated based on survey data collected at the beginning and at the end of the program funding period (2012-2015).

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Canada

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Plan | care | Save the Children | World Vision | SickKids Centre for Global Child Health | Munk School of Global Affairs, University of Toronto

KEY FINDINGS

WHAT DID WE LEARN?

In both countries, we learned that EBF implementation is facilitated by: engaging influential community members as champions for change, including religious leaders, mothers-in-law and fathers; repeated exposure to information on EBF practice and benefits; exposure to testimonials of community members who adopted EBF; and recognition of the strong need for change in the community based on the observed poor health outcomes of infants and children who were not exclusively breastfed. In addition, the predominance of traditional beliefs, knowledge and practices regarding infant feeding as well as gender roles and their impact on mothers' decision-making and workload distribution emerged in both countries as significant considerations relative to EBF implementation and behaviour change.

EBF rates increased from the beginning to the end of the implementation process in both countries. We revealed several CFIR contextual factors that were strongly related to implementation effectiveness in both countries, including: the extent to which the intervention could be adapted to the local context (*adaptation*); the perceived *relative advantage* of EBF compared to traditional feeding practices; addressing the *complexity* of the intervention; awareness of the *needs* of the targeted population, the *resources available*, and taking these into account in program development and implementation planning; a high level of networking with like-minded, external organizations working on the same issues (*cosmopolitanism*); implementing interventions that prioritize the intervention at a national level, through *external policies & incentives*; working in areas where there is a *high tension for change* relative to the status quo; providing implementation agents (e.g., CHWs, HEWs) with access to *information and knowledge* about the intervention; supporting the attitudes toward and value placed on the intervention on the part of implementation agents (e.g., CHWs, HEWs) (*knowledge and beliefs*); and establishing strong *champions* for the intervention.

WHAT DOES IT ALL MEAN?

The identification of key factors that can play a role in implementation success can improve implementation planning and outcome measurement for health interventions in LMIC contexts. Future maternal, newborn and child health programming could benefit from planning that attends to factors linked to successful implementation, and that measure implementation process and outcomes, such as fidelity (i.e., whether the intervention(s) and implementation plans are delivered/executed as intended) and sustainability beyond the funding period. Attending to implementation outcomes, such as fidelity, in addition to health outcomes is critical because it provides important information for interpreting health outcomes.

The emerging evidence suggests that certain modifications would improve the CFIR model, specifically the inclusion of new contextual factors pertaining to supervision of CHWs/HEWs, provision of remuneration to CHWs, attention to the sustainability of the intervention over time, and factors associated with the characteristics of intervention recipients (e.g., education, socio-economic status, family composition, and traditional and religious beliefs and practices).

Reference:

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science, 4,* 1-15.

Citation: © Barwick, M., Barac, R., & Zlotkin, S. (2015). Implementation of Exclusive Breastfeeding in Ethiopia and Mali: Factors Associated with Change. Toronto ON: The Hospital for Sick Children / Centre for Global Child Health.

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Muskoka Initiative Consortium - Knowledge Management Initiative

KEY FINDINGS

Antenatal Care Experiences of Adolescent Mothers in Ghana and Tanzania

WHAT DO YOU NEED TO KNOW?

Antenatal care is the care women receive from healthcare professionals during their pregnancy. Improving antenatal care (ANC) attendance is an important part of the efforts to improve the health and wellbeing of those living in low and middle income countries (LMICs). For adolescent mothers, this is particularly important given the vulnerability of this developmental stage and their increased risk for obstetric complications. Despite its significance, there is limited research on this topic. The present study takes a step towards addressing this knowledge gap by exploring the views of first-time adolescent mothers in Ghana and Tanzania. The purpose of the study was to understand what motivates mothers to attend ANC and how to improve existing services.

WHAT DID WE EXPLORE?

Adolescence is the transitional life stage between childhood and adulthood, characterized by rapid physical and social development. This is a unique period that necessitates tailored support services, particularly for pregnant adolescent women, who face heightened biological risks associated with early pregnancy and childbirth. The Countdown to the United Nations 2015 Millennium Development Goals places a global emphasis on adolescent health and increasing women's uptake of ANC services in LMICs. Despite this, research in these areas has typically occurred in silos, and the specific needs of adolescents have not been carefully explored within the context of ANC services. In particular, the perspectives of adolescents themselves have not featured prominently in the research on uptake of ANC services.

This qualitative research project explored the lived experiences of young women in two regions of Ghana and two regions of Tanzania to better understand what they valued about ANC services, what motivated and enabled them to use these services, and their suggestions for enhancing existing ANC services.

WHAT DID WE DO?

First time mothers, ages 15-19 years, who had delivered within the previous year, participated in focus group discussions about their experiences with ANC services, and shared their opinions of how existing services could be improved to be more adolescent-friendly. Mothers were randomly selected from health centres within World Vision Tanzania and Plan International Ghana's maternal, newborn, and child health (MNCH) program sites, funded by the Department of Foreign Affairs, Trade and Development Canada through its Muskoka Initiative. Data was collected through eight focus group discussions in Tanzania (Singida and Iramba regions) and six in Ghana (Eastern and Volta regions). The overall goal was to understand which components of ANC were working well in the communities studied from the perspectives of adolescent mothers, with a view towards improving overall demand for adolescent-friendly ANC.

Foreign Affairs, Trade and Development Canada | Affaires étrangères, Commerce et Développement Canada

Canada

This project was undertaken with the financial support of the Government of Canada provided through Foreign Affairs, Trade and Development Canada (DFATD).

Plan | care | Save the Children | World Vision | SickKids Centre for Global Child Health | Munk School of Global Affairs, University of Toronto

KEY FINDINGS

WHAT DID WE LEARN?

Adolescent mothers understood that their young age meant they were at higher risk of obstetric complications and viewed ANC services as a way of reducing pregnancy-related risks. Their attitudes towards ANC varied, with some mothers expressing emphatic belief in its importance and others expressing greater ambivalence.

Each expectant mother juggles a unique combination of individual, household, community, and system level factors that impact her ability to access ANC services. Adolescent mothers were motivated to attend ANC to confirm their pregnancy, to feel that they were protecting their own health and the health of their unborn child, and to have access to a skilled birth attendant for delivery, which, in Tanzania, was sometimes conditional on ANC attendance. Household influences included feeling that other mothers and female family members valued ANC and shared positive experiences of healthcare services, and receiving financial and emotional support from the head of the household. Adolescent girls were also encouraged to attend ANC if their peers in the community believed ANC was important and shared positive stories about how nurses treat patients, especially adolescents. System level factors include schools where adolescents could stay enrolled while they were pregnant, and health centre policies and practices that were sensitive to adolescent mothers' needs, especially given the stigma often associated with being unmarried and pregnant. Mothers viewed 'adolescent-friendly ANC' as an environment where staff were friendly and welcoming; where procedures and processes were explained in detailed, plain language; and where they felt comfortable accessing services on their own.

WHAT DOES IT ALL MEAN?

Understanding what motivates adolescents to attend ANC and tapping into their suggestions for improving the ANC experience can help global health and development actors provide ANC services that are more responsive to the needs and circumstances of these young women, consequently improving their health and the wellbeing of their children.

Several strategies for enhancing ANC services emerged from our study, including:

- Enhance training for healthcare providers to deliver ANC in non-judgmental, non-discriminatory ways; adolescent mothers want to be able to trust the healthcare providers and feel a strong sense of connection and rapport.
- Increase one-on-one time with healthcare providers as part of ANC to improve health literacy levels; adolescent mothers wanted to better understand the purposes and rationale behind the services they received.
- Strengthen health systems by providing more consistent access to medications and equipment, more healthcare providers, and more centralized services (laboratory services and counseling at the same location).
- Address discriminatory health centre practices, such as requiring a male partner to accompany the adolescent at her first ANC visit as part of HIV testing and counseling services; this was problematic for many and resulted in some participants being denied services.
- Develop peer support groups; adolescent mothers wanted to be able to share their experiences with other young expectant mothers.

Citation: © Lenters, L., Hackett, K., Barwick, M., & Zlotkin S. H. (2015). Perceptions and Experiences of Adolescent Mothers Accessing Antenatal Care Services in Volta and Eastern Regions, Ghana, and Singida Region, Tanzania Toronto ON: The Hospital for Sick Children / Centre for Global Child Health.

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APPENDICES

CHILD AND YOUTH MENTAL HEALTH OUTCOME INITIATIVE – CAFAS

Sample CAFAS report

Ontario's Children with MENTAL HEALTH NEEDS

2006 Report

Level of Functioning Outcomes for Children and Youth Receiving Mental Health Treatment

CAFAS® in Ontario

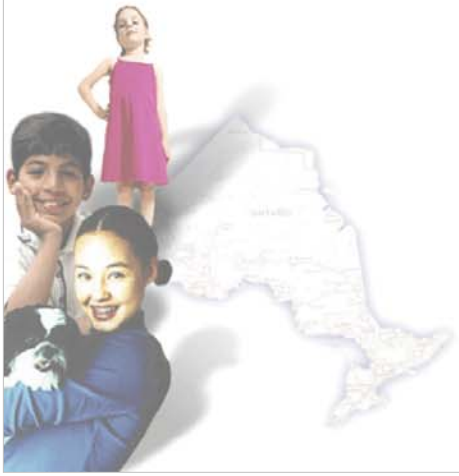
Child and Adolescent Functional Assessment Scale

SickKids®

Ontario's Children with MENTAL HEALTH NEEDS

2006 Report

Level of Functioning Outcomes for Children and Youth Receiving Mental Health Treatment



CAFAS® in Ontario

Child and Adolescent Functional Assessment Scale

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TABLE OF CONTENTS

ABOUT THIS REPORT **1**

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE 1
TRAINING 3
MANDATED USE 3
DATA LIMITATIONS 3
DATA EXPORT AND CONFIDENTIALITY 4
2006 UPDATES 4
CAFAS IN ONTARIO ACTIVITIES 6

ANALYZABLE CASES **9**

CLIENT CHARACTERISTICS **14**

GENDER AND AGE CHARACTERISTICS 14

FUNCTIONING AT ENTRY TO SERVICE **18**

FUNCTIONING AT EXIT FROM SERVICE **31**

CHANGE IN AVERAGE SCORES FROM TREATMENT ENTRY TO LAST CAFAS 34
PROPORTION OF CLIENTS IMPROVED (COMBINING ALL CLIENTS) 40
1. Clinically meaningful reduction in overall impairment based on total score 40
2. Free of severe impairment based on subscale scores 40
3. No SED at Exit (<40) (Restricted to youths with a score at entry CAFAS <40) 40

CHARACTERISTICS OF CLOSED CASES **42**

COMMUNITY VERSUS HOSPITAL TREATMENT **46**

CAREGIVER FUNCTIONING **50**

CAREGIVER CHARACTERISTICS **50**

FUTURE RECOMMENDATIONS **56**

COMPLIANCE 56
TECHNICAL DIFFICULTIES 56
COLLECTION OF THE ONTARIO COMMON DATA SET (OCDS) 56
USING CAFAS FOR PROGRAM EVALUATION 57
NEED FOR A UNIQUE IDENTIFIER 57
RATING OF ALL ELIGIBLE CLIENTS 57
CONTINUED TRAINING IN CLINICAL APPLICATION AND BEST PRACTICE 58

REFERENCES **59**

APPENDIX: ORGANIZATIONS EXPORTING DATA BY REGION **61**

LIST OF TABLES

Table 1.1 New Agencies Added in 2006 5
Table 1.2 Frequency of Training Seminars Conducted in 2006 6
Table 1.3 Community of Practice 2006-07 7
Table 1.4 Presentations 8
Table 1.5 Site Visits 8
Table 1.6 Phone Calls and Emails to Support the Field in 2006 8
Table 1.7 Organizational Data Reports 8
Table 2.1 Number and Regional Distribution of Agencies Mandated to Use CAFAS in Ontario 11
Table 3.1 Age by Sex 15
Table 4.1 Frequency of CAFAS Assessments Over Time 18
Table 4.2 Service Delivery Characteristics Corresponding with Total CAFAS Scores 19
Table 4.3 Severity at Entry to Treatment for Ontario and Regions (%)-2005 22
Table 4.4 Severity at Entry to Treatment for Ontario and Regions (%)-2006 22
Table 4.5 Organizations Having 10 or more Clients Scoring ≥ 140 (Severe Dysfunction) on CAFAS at Entry to Treatment -2006 23
Table 4.6 Annual Comparison of Organizations with Highly Dysfunctional Clients 24
Table 5.1 Distribution of CAFAS Evaluations for Clients with an Exit CAFAS 33
Table 5.2 Number of Evaluations for Cases with an Exit CAFAS (T14) 33
Table 5.3 Severity of Child Functioning for Various Jurisdiction 36
Table 5.4 Subscale Change Scores and Effect Sizes from Treatment Entry to Treatment Exit 38
Table 6.1 Number of CAFAS Evaluations on Record for Closed Cases 42
Table 6.2 Disposition of Closed Cases 44
Table 6.3 Reason for Case Closure 45
Table 8.1 Caregivers at Treatment Entry 50
Table 8.2 Caregivers at Treatment Entry and Last CAFAS 52
Table 8.3 Caregivers at Treatment Entry and Exit CAFAS 52
Table 8.4 Clinical Meaningful Change on Material Needs and Family/Social Support Scale Score - Non-Custodial and Surrogate Caregivers 55

LIST OF FIGURES

Figure 1.1 Training Activities by Month in 2006-07 6
Figure 1.2 Training Events by Region in 2006-07 7
Figure 2.1 Selecting Process for Analyzable Cases in 2006 10
Figure 2.2 Regional Compliance for CAFAS Export in 2005 11
Figure 2.3 Regional Compliance for CAFAS Export in 2006 12
Figure 2.4 Regional Compliance for CAFAS Export in 2004, 2005 and 2006 12
Figure 2.5 Analyzable Cases Submitted by Region 13
Figure 3.1 Gender Distribution of Children and Youth Receiving CMH Services and CAFAS Rating 14
Figure 3.2 Age Distribution at Admission to Treatment 14
Figure 3.3 Distribution of Preadolescent and Adolescent Clients 15
Figure 3.4 Distribution of Preadolescent and Adolescent Clients by Sex 15
Figure 3.5 Percentage of Clients by School Grade 16
Figure 3.6 Percentage of Clients having Complex Characteristics 16
Figure 3.7 Informant Type 17
Figure 3.8 Caregiver – Client Relationship 17
Figure 4.1 Distribution of CAFAS Evaluations for Various CAFAS Evaluations 19
Figure 4.2 CAFAS Rating at Entry to Treatment 20
Figure 4.3 CAFAS Total Score at Entry to Treatment: Ontario and Regions - 2005 20
Figure 4.4 CAFAS Total Score at Entry to Treatment: Ontario and Regions - 2006 21
Figure 4.5 Severity of CAFAS Rating at Entry to Treatment for 2005 and 2006 21
Figure 4.7 CAFAS Total Score at Entry to Treatment by Sex 26
Figure 4.8 Severity of CAFAS Rating at Entry to Treatment by Sex 26
Figure 4.9 CAFAS Total Score at Entry to Treatment by Age Group 27
Figure 4.10 Severity of CAFAS Rating at Entry to Treatment by Age Groups 27
Figure 4.11 CAFAS Scores at Entry to Treatment by Subscale (Mean, Median and Mode) 28
Figure 4.12 Functioning on CAFAS Subscales at Entry to Treatment -2006 28
Figure 4.13 Functioning on CAFAS Subscales at Entry to Treatment -2005 29
Figure 4.14 Average CAFAS Subscale Score at Entry to Treatment (T1) by Sex 29
Figure 4.15 Average CAFAS Subscale Score of Preadolescents & Adolescents by Subscale at Entry to Treatment 30
Figure 5.1 Calculating Last CAFAS 32
Figure 5.2 Time between Entry to Treatment and Last CAFAS 33
Figure 5.3 Percentage of CAFAS Evaluations for Various T Values 34
Figure 5.4 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS 34
Figure 5.5 Change in Average CAFAS Total Score from Treatment Entry to Treatment Exit 35
Figure 5.6 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS By Region 36
Figure 5.7 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS By Sex 37
Figure 5.8 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS By Age Groups 37

Figure 5.9 Change in Average Score on CAFAS Subscales from Treatment Entry to Last CAFAS 38
Figure 5.10 Change in Average Score on CAFAS Subscales from Treatment Entry to Treatment Exit 39
Figure 5.11 Absolute Change in Level of Functioning 39
Figure 5.12 Percentage of Clients Improved on at Least One of the Three Outcome Indicators 41
Figure 6.1 Calculating Closed Cases 43
Figure 6.2 Time between Entry to Treatment and Close Date 44
Figure 7.1 CAFAS Rating at Entry to Treatment: Community-based versus Hospital-based 46
Figure 7.2 Average Entry Subscale Scores by Organization Type (Hospitals & CMHCs) 47
Figure 7.3 Severity on Entry to Treatment: Community-based versus Hospital-based -2006 47
Figure 7.4 Severity on Entry to Treatment: Community-based versus Hospital-based -2005 48
Figure 7.5 Average CAFAS Total Score from Entry to Exit CAFAS (T14) for Community-Based Services and Hospitals 48
Figure 7.6 Change in Average CAFAS Total Score from Treatment Entry to Last Evaluation 49
Figure 7.7 Change in Average Score on CAFAS Subscales from Treatment Entry to Last Evaluation 49
Figure 8.1 Material Needs Subscale for Caregivers at Treatment Entry 51
Figure 8.2 Family Social Support Subscale for Caregivers at Treatment Entry 51
Figure 8.3 Primary Family Material Needs at Treatment Entry and Last CAFAS 53
Figure 8.4 Change in Primary Family Material Needs 53
Figure 8.5 Primary Family Social Support at Treatment Entry and Last CAFAS 54
Figure 8.6 Change in Primary Family Social Support 54

About This Report

This report follows seven years of system-wide training and implementation of a standardized global level of functioning outcome tool in children's mental health organizations. First mandated for use by the provincial government in 2000, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 2003) is used in 106[1] children's mental health organizations, including 22 hospital-based[2] and 84 community mental health centres (CMHCs). In 2006, 13 organizations were added to the roster of CAFAS users across the province, and it is anticipated that more will follow in 2007.

CAFAS data provides standardized system-wide information about the global level of functioning outcomes of Ontario children and youth who receive mental health services in the participating organizations. Use of the tool provides valuable clinical information for the treatment of individual clients, as well as important organizational data when aggregated for all clients seen in a particular setting. At the provincial level, CAFAS data is intended to provide valuable information for system planning, and represent a mechanism for ensuring service quality and accountability.

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE

Outcome measurement leads to improved treatment, enhances clinical science, provides accountability, and maintains the ethical responsibility of practitioners to examine service quality (Barlow, Hayes & Nelson 1984; Ogles, Lambert & Masters, 1996). All too frequently, children receive care that is based on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes (Huang, Hepburn & Espiritu, 2003). The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes (Busch 2002; Dishion, McCord & Poulin, 1999) despite evidence that most children who receive an empirically supported treatment get significantly better and do so more quickly than with other treatments or no treatment (Chambliss & Ollendick, 2001; JCCP 1998).

Global outcome measures, such as the CAFAS, help to standardize the measurement of quality and provide a common language and metric for comparison across programs, regions, and client populations (Busch 2002). Thus, global outcome measures are particularly relevant for system-wide application. Global outcomes provide an index of overall severity that is easier to aggregate than specific measures. They also put into practice National Institute of Mental Health (USA) criteria regarding the importance of measuring the impact of interventions on day-to-day functioning in the client's real life (Newman, Ciarlo & Carpenter, 1999).

The CAFAS (Hodges 2003) is designed to rate functional impairment in children and youth who have or may have emotional, behavioural, substance use, psychiatric, or psychological problems. It consists of behavioural descriptions, (e.g., expelled from school) arranged into four levels of impairment - severe, moderate, mild, and no or minimal impairment – across eight domains of functioning (subscales): school or work, home, community, behaviour towards others, moods and emotions, self-harmful behaviour, substance use, and thinking. The rater[3] reads the items in each subscale, beginning with the severe items, until a description of the client's functioning is found. The score on each subscale is determined by the level of impairment under which the item appears: severe, 30; moderate, 20; mild, 10; no or minimal, 0. Subscale scores are combined to form a total score. Each subscale has an

[1] North East Mental Health Centre in the Northern Region was dissolved.
[2] Of the 22 hospital children's mental health programs using the CAFAS tool, 17 have been transferred from MOHLTC to MCYS as of 2005-2006.
[3] Responsibility for rating the CAFAS falls to the practitioner functioning as primary therapist for the client.

accompanying list of strengths and goals. Available in both paper and electronic form, raters familiar with the software take about 10 minutes to complete the scale.

Use of the CAFAS in practice requires practitioners to use client information typically collected in clinical service as the basis for the rating, and the software produces information required for practice (e.g., a client assessment, reports and treatment plan). Anecdotal reports from practitioners[4] indicate that the CAFAS profile is a valuable tool for engaging the client and family in the early stages of clinical assessment and formulation of the treatment plan. It provides a common language based on clear behavioural indicators that are helpful in sharing the client's areas of strength and dysfunction, and in developing goals for treatment that can later be re-examined. The CAFAS treatment plan forms one piece of a more comprehensive plan that takes into account additional clinical and assessment information. Caregivers can sign the plan and it then becomes an important part of the clinical file for the client.

Knowing something about the client's initial level of disturbance and early response to treatment helps clinicians to identify potential treatment failures, to improve outcomes, and reduce deterioration in the client (Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins, 2001). As such, best practice in Ontario involves rating CAFAS (1) periodically to manage outcome and assess progress; (2) to assist with assessment, formulation, and planning, and (3) to measure overall outcome. As a multi-dimensional measure of global functioning, the CAFAS demonstrates better reliability in the field than unilateral measures (e.g., the GAF and CGAS) that are prone to rater bias (Herman, 1990). Previous research has demonstrated the reliability of the CAFAS (Hodges & Wong, 1996) as well as its concurrent and predictive validity. High interrater reliability has been reported across different sites and with both layperson and clinician raters (Barwick et al., under review; Hodges & Wong, 1996).

Studies of concurrent validity have found greater impairment on the CAFAS to be associated with: more intensive level of care, more restrictive or therapeutic placement, more serious psychiatric disorders, more problems in social relationships, involvement with juvenile justice, school related problems, and child and family risk factors (Hodges & Wong, 1996; Hodges, Doucette-Gates & Liao, 1999; Manteuffel, Stephens & Santiago, 2002). Studies of predictive validity have demonstrated that CAFAS scores at intake predicted: cost of services, service utilization, contact with the law, poor school attendance, and recidivism at either 6 or 12 months post-intake, depending on the study (Hodges et al 1999; Hodges, Doucette-Gates & Kim, 2000; Hodges & Kim, 2000; Hodges & Wong, 1997; Quist & Matshazi, 2000). The CAFAS has been successfully used to assess outcome for youths varying in degree of impairment, referral source, and diagnosis. (Manteuffel et al 2002; Duchnowski, Hall, Kutash & Friedman, 1998; Rosenblatt & Furlong, 1998 Walrath, Mandell & Leaf, 2001). No differences have been observed for the total CAFAS score on gender, race/ethnic group (e.g., comparing Caucasians, African-Americans, and Hispanics), or caregivers' education level (Hodges & Wong, 1997).

In Ontario, a supplemental rating guideline has been developed for rating the CAFAS with Aboriginal children and youth (Barwick, Dilico Ojibway Child and Youth Services, Hodges 2004). In addition, Hodges has recently published a compilation of resources and guide for matching CAFAS profiles to evidence-based treatments (Hodges, 2004). There is also a screening interview (15 minutes) that inquires about the youth's functioning and is administered to a caregiver (or other adult informant). A newly developed CAFAS Advanced Child Management Scale examines caregiver functioning in the areas of: providing directions and follow-up; encouraging good behaviour; discouraging undesirable behaviour; monitoring activities; connecting positively with youth; and problem solving orientation. Lastly, both paper and software versions of the CAFAS scale are available in French.

[4] Practitioners are invited and encouraged to share their experiences of using the CAFAS tool at both client and organizational levels through the "community of practice" forums held regionally. The clinical 'lessons learned' are then shared with other CAFAS users province wide on the CAFAS in Ontario web site: www.cafasinontario.ca

TRAINING

To date, over 5,024 child and youth workers, social workers, psychologists, and psychiatrists have been trained to reliably rate the CAFAS. Training for the reliable use of the CAFAS is standardized using the CAFAS Self-Training Manual (Hodges, 2003) and two-day, face-to-face group training. In addition to detailed scoring information, the manual includes ten case studies or vignettes which must be scored to a prescribed level of accuracy (80% reliability with a criterion) in order for a rater to be deemed reliable. Supplemental assistance and support is provided to individuals until they can attain this criterion.

All practitioners are expected to use the software version of the CAFAS tool; attainment of this standard signifies the organization has 'implemented' the tool. Software training workshops are conducted to train practitioners in navigating the CAFAS software, as well as to provide administrators within each participating organization with the skills needed to manage the CAFAS database that is located on their respective servers.

Annual booster vignettes are completed on the anniversary of each rater's initial achievement to control for rater drift. The extent of rater drift over one-year and two-year gaps, as well as the rater drift among practitioners trained by CAFAS in Ontario versus an in-house trainer are being studied in order to provide recommendations to the province regarding how best to sustain reliability and maintain the quality of the data collected.

MANDATED USE

Organizations are expected, at a minimum, to complete a CAFAS rating as close to treatment entry and treatment exit as possible for all clients entering into treatment. Because the value of outcome measurement lies in its capacity to gauge treatment response, practitioners are also encouraged to complete a CAFAS rating intermittently (e.g., every 3 months) while the client is receiving service(s), thereby providing useful information that can be used to alter the treatment plan as required. The current provincial mandate for CAFAS completion is for entry and exit ratings, however, this is not clinically optimal since it does not encourage practitioners to use the tool for purposes of *outcome management*. Further work (e.g., site visits, communities of practice) is required to assist organizations in appreciating that use of the CAFAS is a part of ongoing clinical service, rather than merely a bureaucratic requirement.

DATA LIMITATIONS

Generally, it should be noted that these data represent a subgroup of children and youth receiving mental health treatment in Ontario. Not all organizations serving children and youth with mental health needs are participating in the use of the tool[5], and not all children receiving treatment services within participating organizations are rated on the CAFAS

Among organizations required to use the tool, there are four exceptions in its application:

- Children and youth receiving services for which no detailed screening or assessment occurs (e.g., prevention, outreach, parenting education groups, support groups);
- Children and youth receiving services that are delivered in 1 to 3 sessions (e.g., crisis, early intervention, single-session intervention). If the client moves from crisis/prevention to longer-term active service, CAFAS is completed as per guidelines;

[5] Several organizations serving children and youth (including those in related sectors such as Education and Child Welfare) both within Ontario and elsewhere in Canada, have expressed great interest in using the tools in their organizations. Where possible, training has been provided on a cost-recovery basis until such time as formal approvals for adding other organizations is obtained by MCYS.

- Children and youth seen at one organization primarily to redirect appropriately to another;
- Children and youth receiving service for problems other than a psychological, emotional, behavioural or substance abuse problem (e.g., developmental impairment). Each organization may decide whether to rate CAFAS for clients with comorbid developmental impairment and mental health problems.

In addition, anecdotal reports indicate that some organizations have initially implemented use of the CAFAS in one program or service, with plans or intent to expand to other program/services. Other organizations perceive the use of CAFAS as an adjunct to clinical practice that reduces direct service, and places a strain on human resources.

At this time, we have no information about services delivered (e.g., specific programs received by each client at the time of CAFAS rating). The standardization of this information will come from system-wide use of the Ontario Common Data Set (OCDS). Similarly, there is a paucity of data on general client characteristics and treatment closure information (e.g., treatment successful, referred elsewhere, etc).

CAFAS data describe level of functioning changes for children and youth receiving treatment, but they do not address whether these changes are due to specific interventions. Information about treatment fidelity or treatment dose is not captured. The data provide descriptive information about children and youth who come into treatment – their areas of functional impairment and strengths at entry to treatment, and at completion or exit from service.

DATA EXPORT AND CONFIDENTIALITY

Organizations using the CAFAS export their data to the Hospital for Sick Children on a quarterly basis. Detailed exporting instructions and procedures ensure data are sent without client identifying information.

Use of CAFAS data for service delivery accountability and planning meets the requirements of privacy legislation according to consultation with the Ontario Privacy Commissioner's Office. A parent brochure outlining use of the CAFAS (and the Brief Child and Family Phone Interview) was completed in 2005 and can be found on the web, in French and English (http://www.cafasinontario.ca/html/downloads.asp).

Detailed exporting instructions and submission schedule are made available to the data liaisons at the hospitals and children mental health centers. These are sent as e-mail reminders on a quarterly basis and are posted on the website at http://www.cafasinontario.ca/html/datamgmt-exporting.asp

2006 UPDATES

The year 2006 marked the first entire year in which organizational data reports were sent to participating organizations. Six to eight weeks after the data is collected, two types of reports are produced:

- A PDF file entitled "Missing and Erroneous Data Report"
- A PowerPoint Presentation of the organization's CAFAS data in relation to the region and the province's aggregate data

The first report (Error Report) is intended for CAFAS raters (clinicians and social workers) responsible for completing the client's evaluations. It provides a series of tables outlining errors or missing data for specific clients, identified by their organizational client number. This is useful information that can be used for cleaning data before the next export submission is due.

The second report is comparative, depicting the organization in relation to their regional data and provincial data.

Two Eastern region organizations, *Équipe D'Hygiene Mentale pour Enfants et Adolescents* and *Centre Psycho-Sociale*, tested beta versions of the French language CAFAS software over the winter of 2004. Although version 5.4 French functions as expected, several revisions are necessary (e.g., some language appearing on specific screens is still in English, and some French phrases or words have been truncated inadvertently). Each screen will be reviewed, and changes made over the next several months.

A Software Development meeting was held in February 2007 with the CAFAS developer/vendor, Dr. Kay Hodges, to discuss ongoing functionality requirements of the CAFAS software. Numerous improvement recommendations, collected from the field and proposed by the implementation team, were shared with Dr. Hodges. We will work together over the next year to incorporate those changes that are feasible.

In 2006, the CAFAS Advisory Committee transitioned to become a CAFAS – BCFPI Advisory Committee, chaired by Melanie Barwick and Brian O'Hara. A Terms of Reference for the committee was drafted by a workgroup, and are included in an appendix. A decision was made to expand the representation of the advisory group in order to capture 1-2 representatives from each region, and to attempt both CMHC and hospital MH clinic representation for each region.

Lastly, 13 organizations across five regions were added to the CAFAS family in 2006 (Table 1.1)

Table 1.1 New Agencies Added in 2006

Region	Agency
Central West	Halton Trauma Centre
	Community Youth Programs
Central East	Peterborough Youth Services
	Family Services Haliburton County
	Fernie House
Northern	Weechi-it-te-win Family Services Inc.
	Sioux Lookout First Nation Health Authority
South West	Anago Resources Inc
	Children's Health Care Network
	CSCN Community Services Coordination Network
	Merrymount Children's Centre
Toronto	Centre Francophone de Toronto
	Native Child & Family Services of Toronto
	Jen's Place

IT Improvements made in 2006 included implementation of version 5.4 of the CAFAS software which became available in February 2006.

Technological support for the CAFAS tool was improved by hiring an external IT consultant who was available to make site visits.

CAFAS IN ONTARIO ACTIVITIES

A professional development day was held in February 2007, provided through a partnership between the Ontario Psychological Association, the Ministry of Children and Youth Services, Children's Mental Health Ontario, and Sick Kids Hospital. Held as a pre-conference workshop, the event brought together approximately 170 participants, the majority of whom identified as practitioners. The conference format, having a combination of didactic presentations and a 'community of practice' discussion, was deemed a huge success.

Table 1.2 Frequency of Training Seminars Conducted in 2006

Over the 2005-2006 year, 46 separate training events were held across the province, reaching 428 individuals. It is interesting to note the majority were software orientation training (see Table 1.2).

#	Type of Training
14	Reliability training sessions
11	Train-the trainer sessions
21	Software training sessions
46	Training Events

Figure 1.1 depicts the types of training activities conducted by month during 2006-07, whereas training activities are depicted by region in Figure 1.2.

Figure 1.1 Training Activities by Month in 2006-07

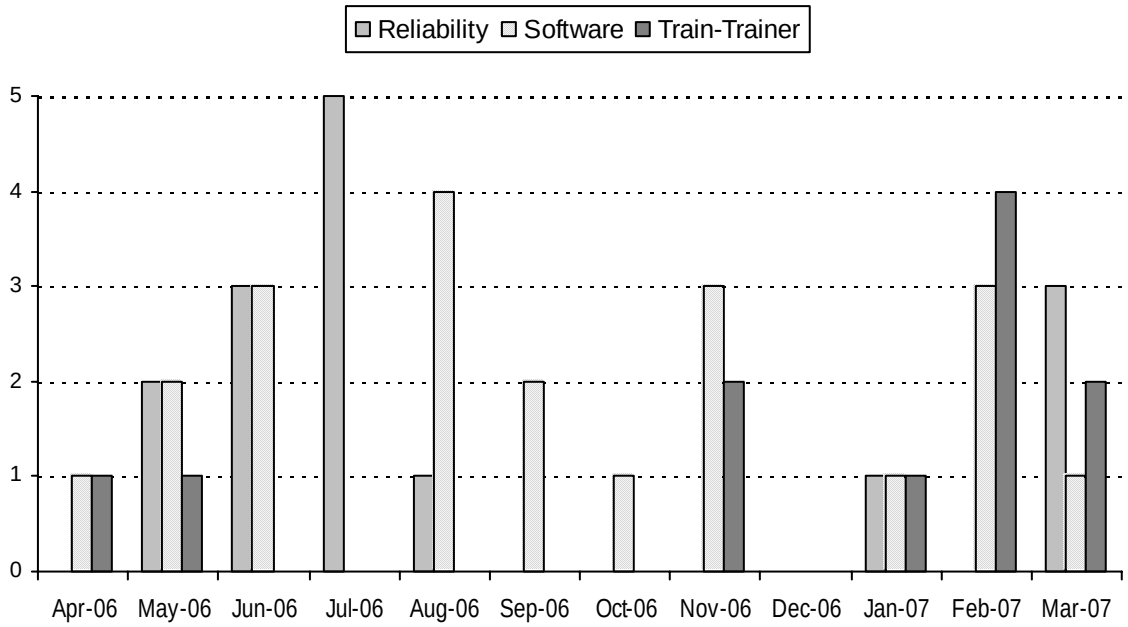
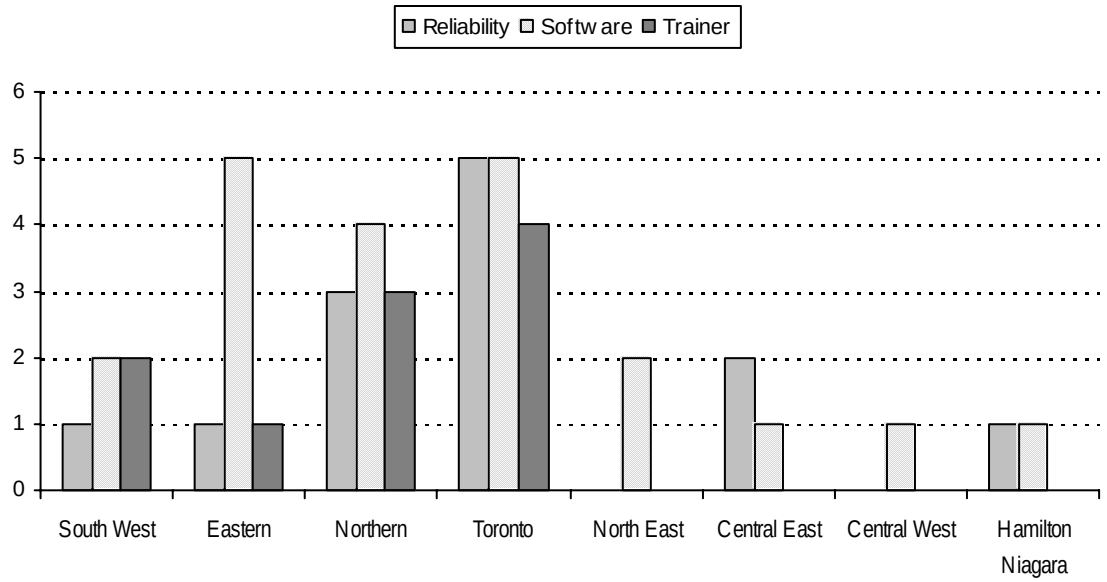


Figure 1.2 Training Events by Region in 2006-07



The majority of training activities took place in Toronto, Northern, and Eastern regions during the past year (Figure 1.2).

We were invited to conduct training for 100 practitioners in Erie County, New York between November 2006 and February 2007. This took 12 days and was conducted on a cost recovery basis.

We continued supporting the clinical application of the CAFAS and BCFPI tools through regional communities of practice across the province, averaging 24 participants per event, and including a total of 287 participants across most regions. There were no requests for a community of practice in the Toronto region this past year.

Table 1.3 Community of Practice 2006-07

Region	City	Date	Participants
South West Region	London	February 15th, 2006	25
South-East Region	Kingston	March 27th, 2006	25
Central East Region	Newmarket	April 19th, 2006	30
Hamilton/Niagara	Hamilton	April 24th, 2006	22
Eastern Region	Ottawa	May 1st, 2006	25
North East Region	North Bay	May 9th, 2006	25
Northern Region	Sault Ste Marie	May 30th, 2006	12
South West Region	London	June 15th, 2006	25
Northern Region	Dryden	June 19th, 2006	15
South West Region	London	September 27th, 2006	25
Central West Region	Mississauga	February 20th, 2007	30
South West Region	London	February 28th, 2007	28

Presentations, on request, were conducted in 4 locations throughout the fiscal year (Table 1.4) and 3 site visits took place in Toronto and Northern regions (Table 1.5).

Table 1.4 Presentations

Region	Date	Location	Attendees
Central East	27-Jun-06	Frontenac Youth Services, Oshawa	20
South-East	22-Sep-06	Child & Youth Wellness Centre of Leeds & Grenville, Brockville	40
Northern	20-Nov-06	Lake-of-the-Woods Child Development Centre, Kenora	12
Toronto	23-Nov-06	Centennial College - Child & Youth Worker Program	60
		Total:	132

Table 1.5 Site Visits

Region	Date	Location	Attendees
Toronto	23-Oct-06	Scarborough General Hospital	10
	13-Sep-06	Youthdale	2
Northern	21-Sep-06	Lake-of-the-Woods Child Development Centre	3

The CAFAS in Ontario team continued to provide support via telephone and email (Table 1.6), totaling an estimated 3,151 phone calls and 6,216 emails per year, fielded by our 3 fulltime staff and tech consultant.

Table 1.6 Phone Calls and Emails to Support the Field in 2006

	Phone Calls		Emails	
	Monthly	Yearly	Monthly	Yearly
Training Coordinator	40-50	480-600	200	2400
Admin Coordinator	120	1440	100	1200
Data Analyst	100	1200		2588
Tech Consultant		31		28
TOTAL:		3151		6216

Additional support to the field was provided through individualized data reports developed on a quarterly basis.

Table 1.7 Organizational Data Reports

Export #	Number of Individual Organization Reports Produced
6	65
7	96
8	100
9	109
TOTAL:	370

Analyzable Cases

In this section of the report we review the procedures followed by practitioners in submitting their cases for the provincial database, and the number of cases that were analyzable for this report.

CAFAS items are primarily behavioural in nature and indicate global severity of impairment in functioning. These behaviours are important and relevant to the child or youth's functioning in "real-world contexts" (Hodges, 2003). An assessment of the impact on the child or youth's everyday functioning is considered to be an essential outcome indicator for evaluating therapeutic change (Kazdin & Kendall & Weisz, 1998).

In Ontario, participating children's mental health service providers are asked to rate CAFAS on the following clients:

- CAFAS should be rated on all children ages 6 years through 17 years who receive mental health services[6];
- Practitioners using the tool must have sufficient knowledge about the client and/or family in order to rate CAFAS reliably.

Organizations are instructed to export specific data variables based on a standard pre-defined filter file that is updated and sent quarterly with the data call. The file was created to assist organizations in including those variables of interest to the analysis. The exported data exclude identifying information that is not part of the Ontario Common Data Set variables (such as names, addresses, race and ethnicity etc.). Data exported for the last quarter of 2006 are for both open (ongoing treatment) and closed cases (treatment ended).

The filter also serves to eliminate over- and under-exporting of required data fields. Thus, the implementation of the export file filter has had a positive impact on the completeness of data submitted. Only four agencies failed to use the file correctly, resulting in 533 cases outside of the required admission date range: 01/01/2005 and 12/31/2006. From the remaining 23,387 exports, 3,628 were outside of the date range required by the present report (01/01/2006 to 31/12/2006). Analyzable submissions also exclude cases missing age or cases outside the age range as well as cases missing the date of the first evaluation (T1)[7] (see Figure 2.1).

The data sample used for this report is composed of:

- All cases admitted to treatment in 2006
- All cases admitted to treatment prior to 2006[8] and either closed in 2006 or still active through 2006

MAIN MESSAGE

This selection method resulted in a sample size double to that attained for analysis in the 2005 annual report

9,634 analyzable cases in the 2005 report

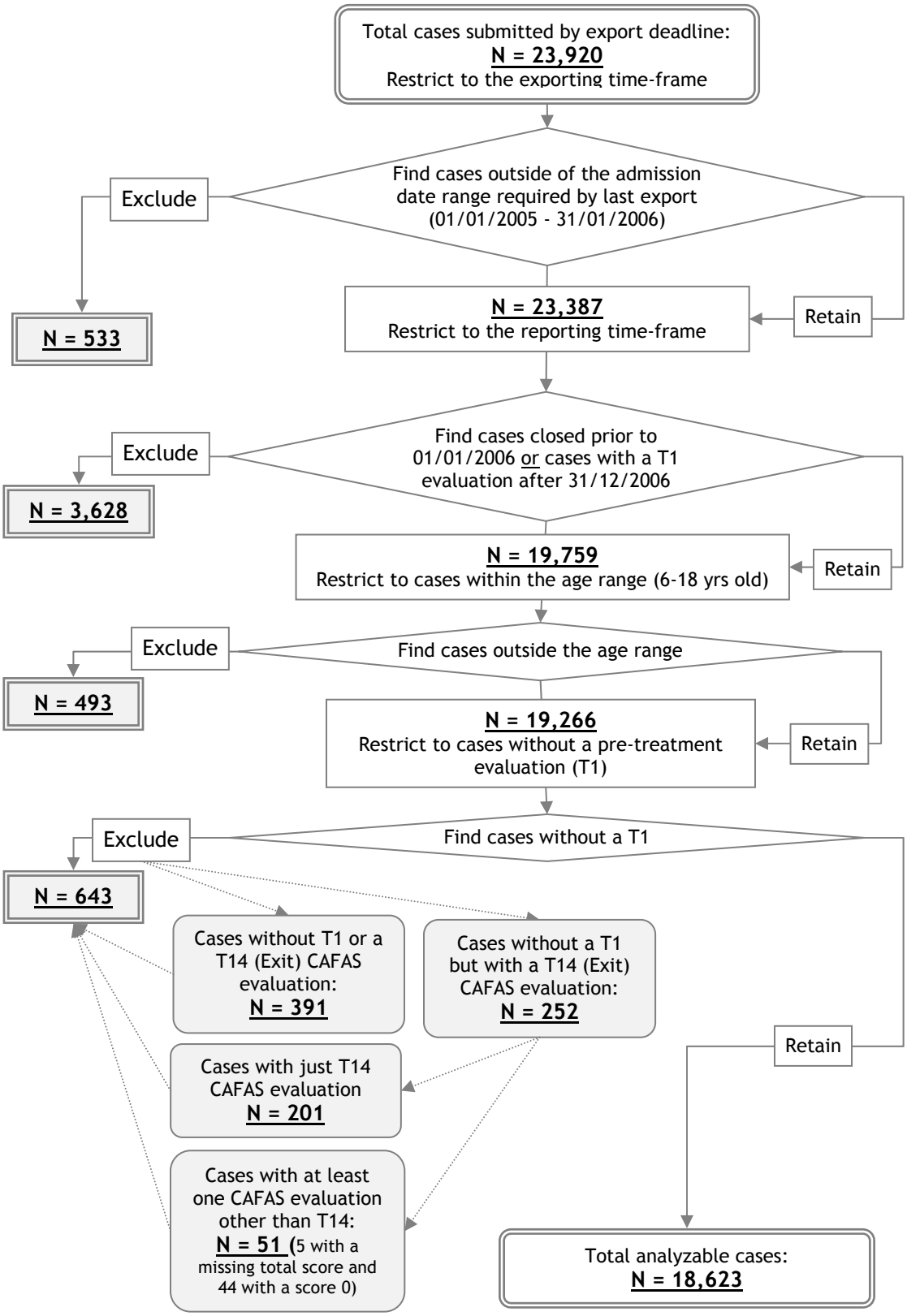
18,623 analyzable cases in the 2006 report

[6] Some clients turn 18 years of age during treatment, therefore, our age parameters are 6-18 years.

[7] A T1 evaluation is a mandatory step in CAFAS. Cases without T1 could result from situations when a client is transferred from one agency to another or from one site to another and new files are opened without keeping the history of the treatment. These situations are not encouraged by CAFAS best practices and they are considered errors.

[8] Does not include cases predating January 1, 2005 due to limitations of our data exports; data integrity was supported by the Common Data Set as of September 2004.

Figure 2.1 Selecting Process for Analyzable Cases in 2006



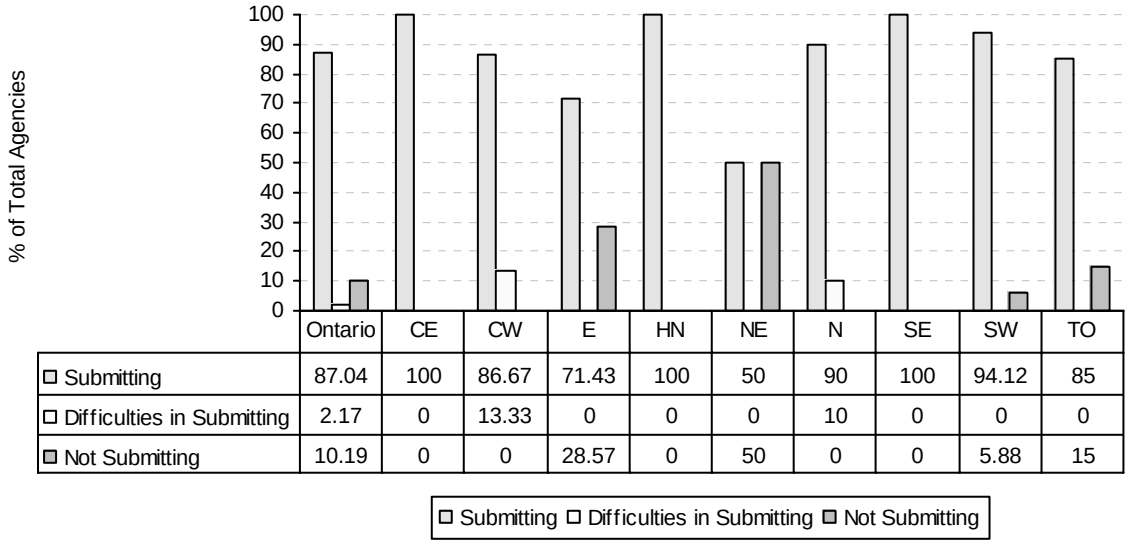
The larger sample size is also a result of improved compliance during this past year (see Figure 2.2 - Figure 2.4). In future, the number of analyzable cases can be elevated by requesting cumulative data at export, allowing that analysis to include cases that have a first evaluation more than 1 year prior to the reporting start date.

MAIN MESSAGE
A higher proportion of organizations submitted CAFAS data in 2006 as compared to 2005.
92.5 % of organizations submitted data for the last export of 2006 compared with 81.31% submitting in the last quarterly export of 2005 (see Figure 2.2 - Figure 2.4).

Table 2.1 Number and Regional Distribution of Agencies Mandated to Use CAFAS in Ontario

Region	Number of agencies exporting data	
	2006	**2005**
Central East	11	11
Central West	14	14
Eastern	14	14
Hamilton-Niagara	9	9
North East	6	6
Northern	9	10
South East	6	6
South West	17	17
Toronto	20	20
Total	**106**	107

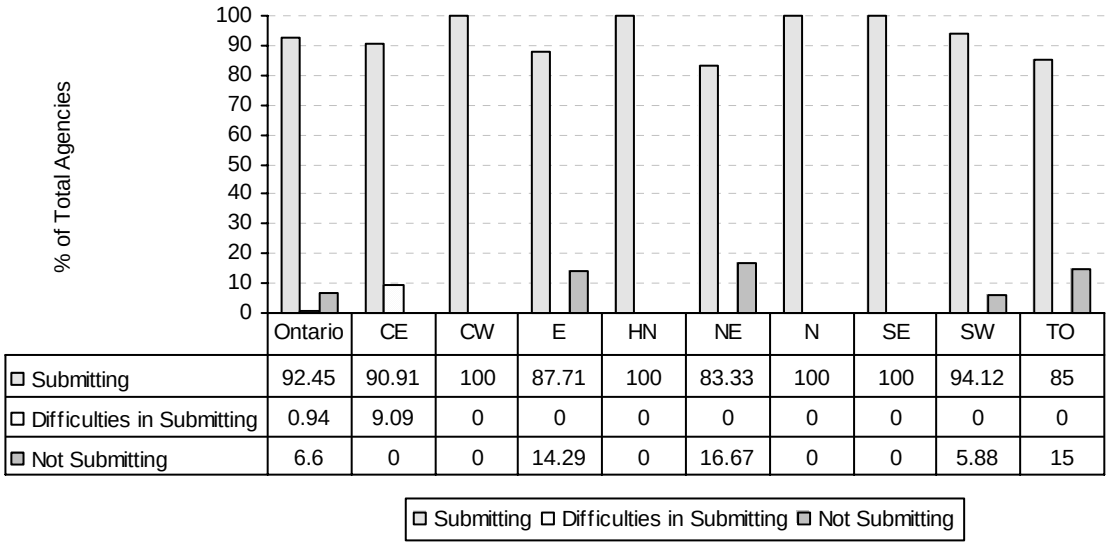
Figure 2.2 Regional[9] Compliance for CAFAS Export in **2005**



	Ontario	CE	CW	E	HN	NE	N	SE	SW	TO
Submitting	87.04	100	86.67	71.43	100	50	90	100	94.12	85
Difficulties in Submitting	2.17	0	13.33	0	0	0	10	0	0	0
Not Submitting	10.19	0	0	28.57	0	50	0	0	5.88	15

[9] CE: Central East, CW: Central West, E: Eastern, HN: Hamilton/Niagara, NE: North East, N: Northern, SE: South East, SW: South West, TO: Toronto

Figure 2.3 Regional Compliance for CAFAS Export in **2006**



A greater number of organizations exporting data in the last three consecutive years led to an increased volume of data received: a 5.43% increase from 2004 to 2005 and 11.14% increase from 2004 to 2006. Factors that contributed to this increase in responsiveness included:

- Closing the data loop by developing aggregate reports for organizations with each quarterly submission;
- The development of data error reports for organizations;
- Improved exporting instructions;
- Development of an automatic filter file to identify the variables requested in the export;
- Provision of on-call support;
- Hiring an external IT consultant who could troubleshoot and visit organizations.

Figure 2.4 Regional Compliance for CAFAS Export in 2004, 2005 and 2006

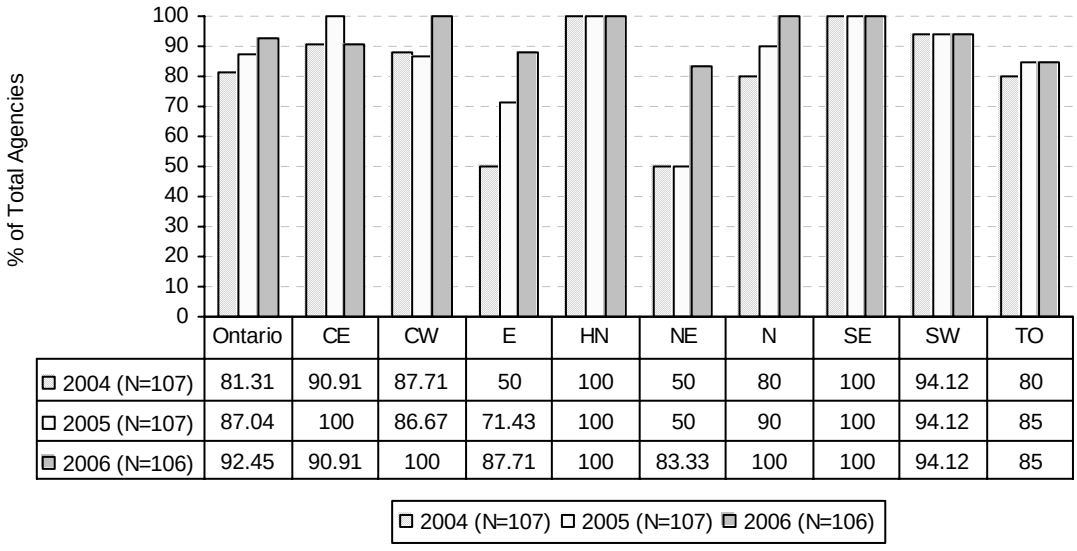
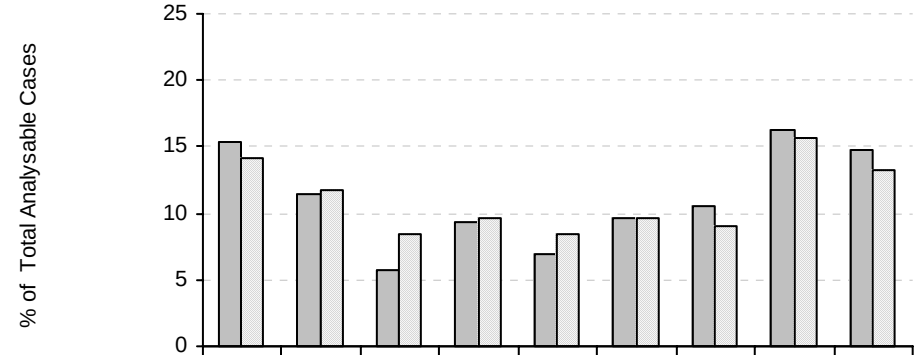


Figure 2.5 Analyzable Cases Submitted by Region



	CE	CW	ES	HN	NE	NO	SE	SW	TO
2005 (N=9,634)	15.3	11.5	5.7	9.3	7	9.7	10.6	16.2	14.7
2006 (N=18,623)	14.2	11.8	8.4	9.7	8.4	9.6	9	15.7	13.2

The South West region submitted the highest number of cases, likely because it is the region with the greatest number of organizations participating in CAFAS.

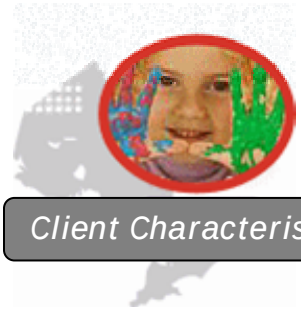
Of the 18,623 analyzable cases:

- 15,984 came from children's mental health agencies
- 2,639 came from hospitals

- 10,232 were boys
- 8,200 were girls

Gender data was missing for 184 cases, either because it was not recorded by the practitioner at the time of the CAFAS rating, or because the gender field was not exported by the submitting organization.

BEST PRACTICE NOTE
In some organizations, the task of 'entering' a client's CAFAS rating into the software program is assigned to a support person, who may not be aware of basic data that is missing from the paper form from which they are entering the data. This is not endorsed as best practice. Rather, the primary clinician is responsible for conducting the CAFAS rating in person, using the software available to each organization.



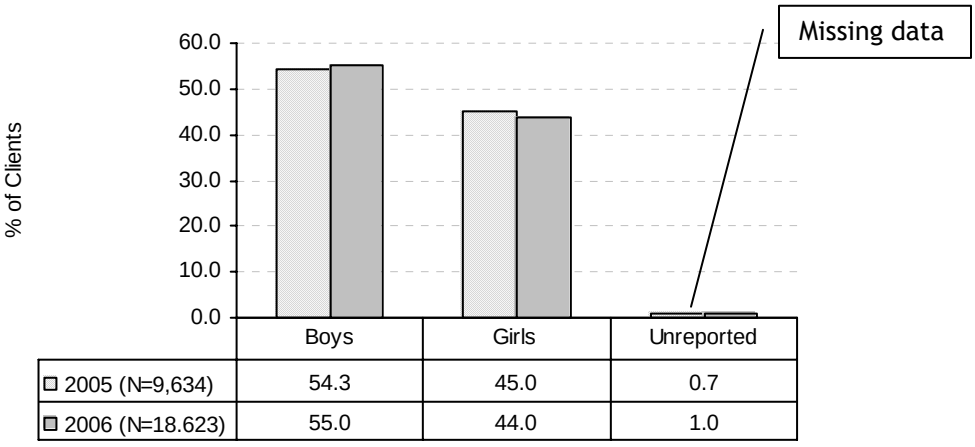
Client Characteristics

This section of the report describes the characteristics of children and youth who received children's mental health services in the participating Ontario service provider organizations during the 2006 calendar year, and for whom CAFAS was rated.

GENDER AND AGE CHARACTERISTICS

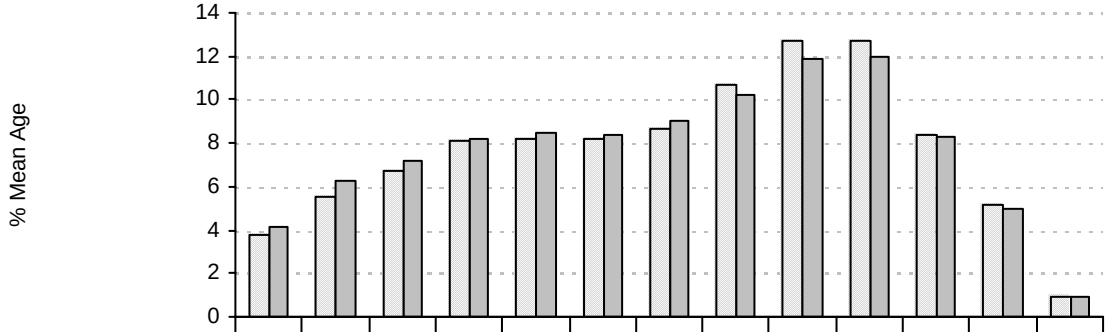
The mean age for this sample of 18,623 children and youth is 11.98 years, with a median of 12.0 years and a mode (most common age) of 15.0 years. Slightly more boys than girls received mental health services in these organizations during 2006 (55% versus 44%). The values are similar to those for 2005 despite almost double the number of cases in the 2006 analyses (see Figure 3.1) The distribution of clients by age remains unchanged (see Figure 1.6)

Figure 3.1 Gender Distribution of Children and Youth Receiving CMH Services and CAFAS Rating



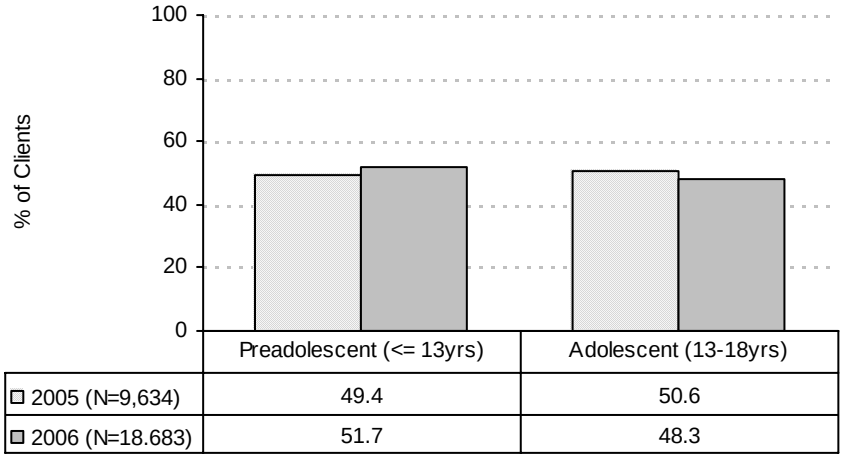
	Boys	Girls	Unreported
2005 (N=9,634)	54.3	45.0	0.7
2006 (N=18.623)	55.0	44.0	1.0

Figure 3.2 Age Distribution at Admission to Treatment



	6yrs	7yrs	8yrs	9yrs	10yrs	11yrs	12yrs	13yrs	14yrs	15yrs	16yrs	17yrs	18yrs
2005 (N=9,634)	3.8	5.5	6.7	8.1	8.2	8.2	8.7	10.7	12.7	12.7	8.4	5.2	0.9
2006 (N=18.623)	4.1	6.3	7.2	8.2	8.5	8.4	9	10.2	11.9	12	8.3	5	0.9

Figure 3.3 Distribution of Preadolescent and Adolescent Clients



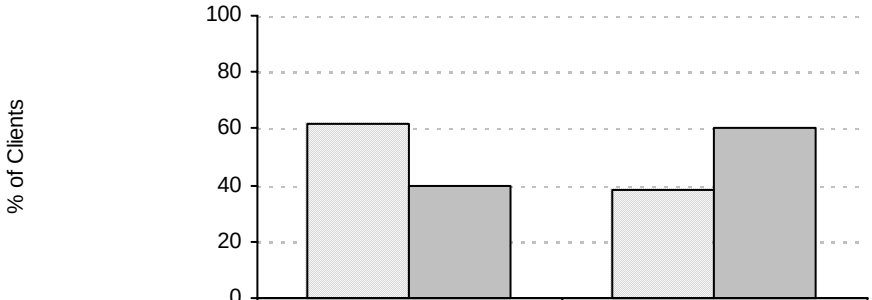
	Preadolescent (<= 13yrs)	Adolescent (13-18yrs)
2005 (N=9,634)	49.4	50.6
2006 (N=18.683)	51.7	48.3

On average, male clients were approximately a year younger than females (see Table 3.1) and this is a change from 2005. The distribution of adolescent (51%) and preadolescent (49%) clients changes in 2006: where it was more equally distributed in 2005, preadolescents show a greater proportion in 2006 due to an increase of 3.4% more cases between 6 and 13 years of age (Figure 3.3). Boys make up two-thirds of the preadolescent group, whereas girls comprise two-thirds of the adolescent group (Figure 3.4).

Table 3.1 Age by Sex[10]

2005	Mean	Median	Mode
Boys (N=5,230)	12.85	14	15
Girls (N=4,335)	11.54	12	13
2006	Mean	Median	Mode
Boys (N=10,232)	11.38	11	10
Girls (N=8,200)	12.71	13	15

Figure 3.4 Distribution of Preadolescent and Adolescent Clients by Sex

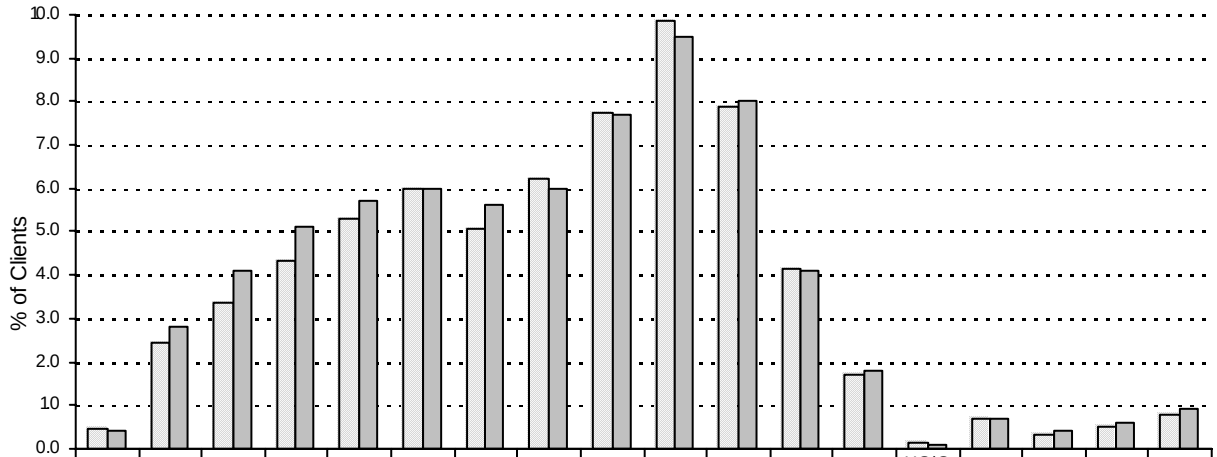


	Preadolescent (<= 13yrs) (N=9,635)	Adolescent (13-18yrs) (N=8,988)
Males (N=10,232)	61.7	38.3
Females (N=8,200)	39.7	60.3

[10] Some gender data for the sample of 18,623 was not reported (7 cases); 184 cases are missing this information.

In 2006, 29.3% of clients were in grades 1 through 6 (vs. 26.4% in 2005) and 25.2% of clients were in the 8-10th grade (Fig.3.5). Very few clients had completed high-school (or GED) (0.1%), seemingly due to the small number of clients in the 17-18 age range. Similarly, fewer than 1% of clients in this sample of 18,623 were identified as school-leavers.

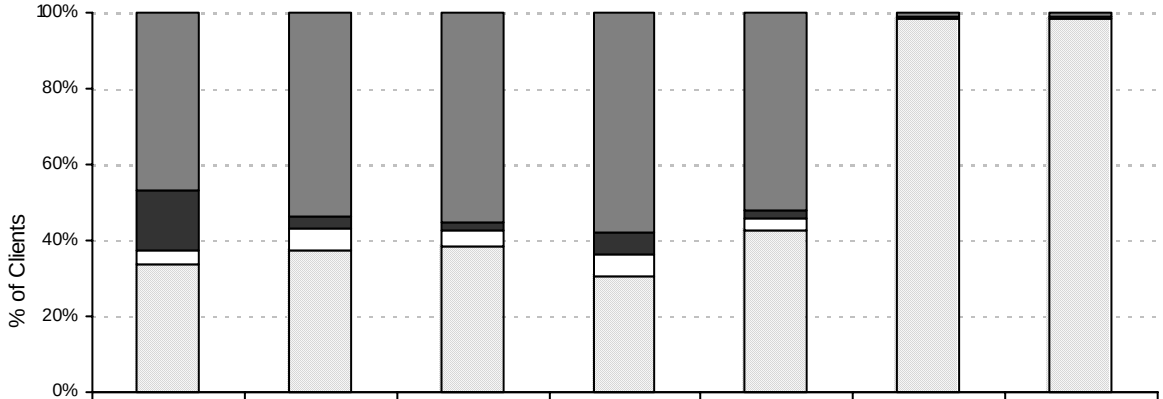
Figure 3.5 Percentage of Clients by School Grade
2005: N=9,634; 2006: N=18,623



	Kindergarten	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	HS/GED Comp	Dropped Out	Ungraded	Other	Unknown
2005	0.5	2.4	3.4	4.3	5.3	6.0	5.1	6.2	7.7	9.9	7.9	4.1	1.7	0.1	0.7	0.3	0.5	0.8
2006	0.4	2.8	4.1	5.1	5.7	6.0	5.6	6.0	7.7	9.5	8.0	4.1	1.8	0.1	0.7	0.4	0.6	0.9

Some data are available that detail complex client characteristics. Approximately 16% of youth were placed outside of the home (Fig. 3.6), whereas 6.5% of families were involved with child welfare. Few youths were reported to have a formal diagnosis of developmental disability (3%), chronic mental illness (2.1%), or concurrent substance use problems (2.2%). However, these figures must be interpreted with caution due to missing data.

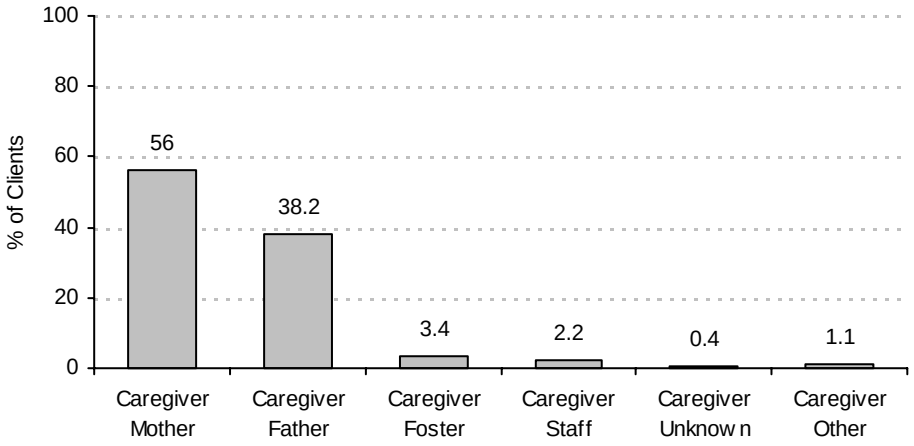
Figure 3.6 Percentage of Clients having Complex Characteristics
(N=18,623)



	Out of Home Placement	Youth With Developmental Disability	Youth With Chronic Mental Illness	Child Welfare Involvement	Disorder Diagnosis (Presence of	Youth involved in Juvenile Justice	Youth Hospitalized
No	46.9	53.7	55.5	60.8	52	1	1.1
Yes	15.8	3	2.1	6.5	2.2	0.2	0.1
Unknown	3.4	6	4.2	6	3	0.2	0.3
Missing Data	33.9	37.3	38.2	32.1	42.7	98.6	98.6

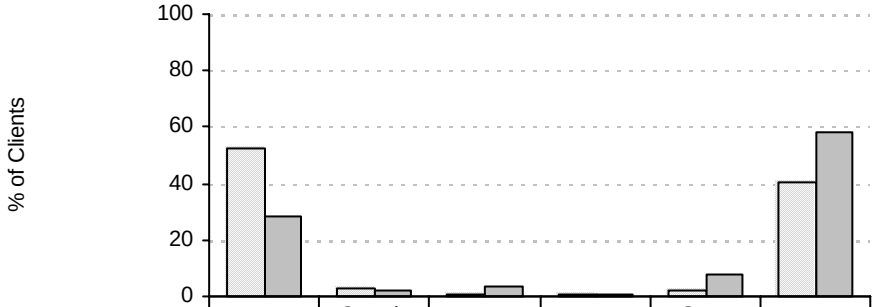
Functional information was provided by a 'caregiver mother' in greater than half (56%) the clients included in this sample, while for 38.2% of the sample rating information was provided by a 'caregiver father' (Fig.3.7). Very small percentages of clients had information provided by a foster parent or other caregiver.

Figure 3.7 Informant Type
(N=18,623)



There is much missing data regarding the nature of the relationship between caregiver and client as reported in Fig.3.8. We can surmise, however, that biological mothers were informants for 52.8% of clients in the 2006 sample, whereas biological fathers comprised 28.1% of informants for this sample. Grandparents and stepparents make up the remainder.

Figure 3.8 Caregiver – Client Relationship
(N=18,623)



	Biological	Grand-parent	Live In	Relative	Step-parent	Missing
Mother Figure	52.8	2.8	0.6	1	2.1	40.7
Father Figure	28.1	1.8	3.2	0.8	8.1	57.9

Functioning at Entry to Service

This section of the report describes clients' global level of functioning at entry to treatment for children and youth who received children's mental health services in designated Ontario service provider organizations during the 2006 calendar year, and for whom CAFAS was rated.

BEST PRACTICE NOTE
Although CAFAS evaluation at entry and exit are the only mandated administrations, best practice dictates that periodic evaluations provide an opportunity to gauge response to treatment and, thus, alter the treatment plan according to progress or lack thereof. It was the developer's intent that T2 be used to identify T1-related information that did not come to the clinician's attention until later in the treatment process. In Ontario, T2 is not recommended and this marker should be ignored.

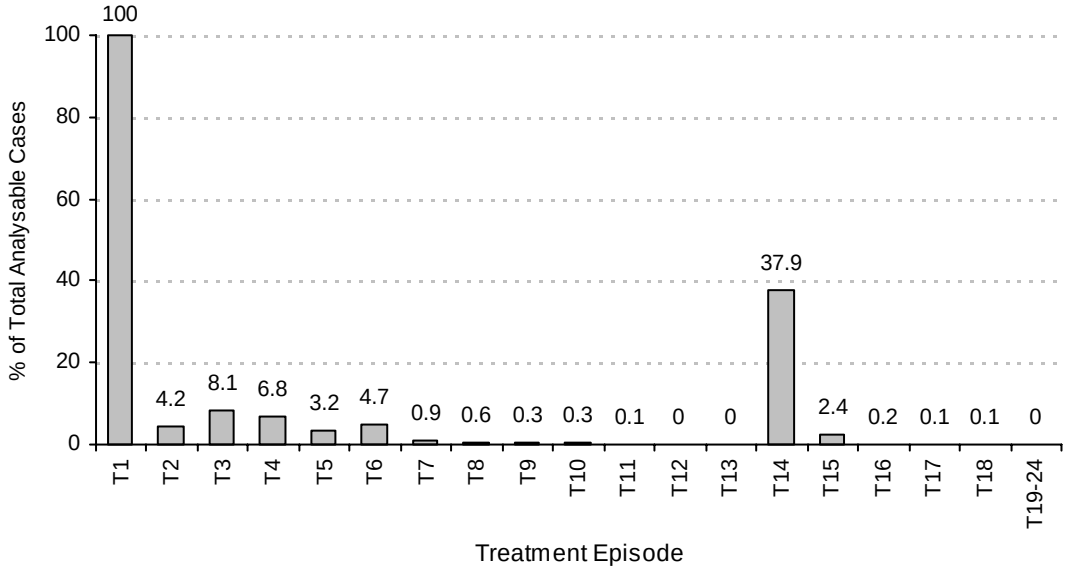
Several observations can be made of the frequency with which CAFAS evaluations are being done for individual clients (Table 4.1). There continues to be a large number of T2 evaluations (N=788) even though use of this time point is not recommended as a best practices. Continued use of T2 evaluations may be due to clinician error, or to identifying alternate entry when a client is transferred from one organization to another or from one site to another.

Of the 31,634 CAFAS evaluations conducted in 2006, 58.9% are T1 (Entry) evaluations, 22.3% are T14 (Exit) evaluations, and when T2's are excluded, the remainder of evaluations from T3-T13 (14.7%) and those post-T14 (1.2%) comprise 16% of all CAFAS ratings. This information provides a useful benchmark against which to track clinician's use of the CAFAS as an outcome management tool that can assist in determining the potential success of a client's treatment plan while the client is still engaged in treatment. An additional view of CAFAS evaluations and their use for periodic assessment is shown in Figure 4.1.

Table 4.1 Frequency of CAFAS Assessments Over Time

T-Value	Frequency	T-Value	Frequency
T1 (1st Evaluation)	18,623	T13(year 5)	2
T2 (2nd Evaluation)	788	T14(Exit)	7,051
T3 (3 months)	1,503	T15(Other)	445
T4(6 months)	1,274	T16(Other)	46
T5(9 months)	605	T17(Other)	15
T6(12 months)	869	T18(Other)	7
T7(15 months)	166	T19(Other)	6
T8(18 months)	118	T20(Other)	4
T9(21 months)	49	T21(Other)	3
T10(24 months)	50	T22(Other)	2
T11(year 3)	6	T23(Other)	0
T12(year 4)	2	T24(Other)	0

Figure 4.1 Distribution of CAFAS Evaluations for Various CAFAS Evaluations



The interpretation of CAFAS scores is guided by the corresponding service delivery characteristics depicted in Table 4.2.

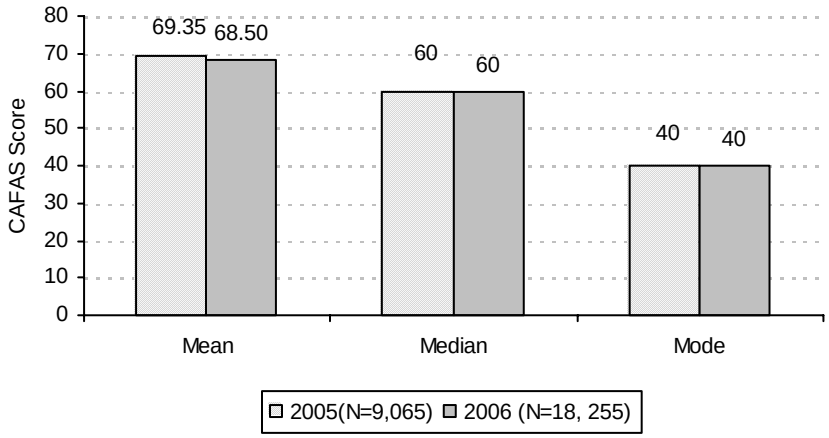
Table 4.2 Service Delivery Characteristics Corresponding with Total CAFAS Scores

Total Score of:	Corresponds to clients who are:
0-30	Likely referred to qualified health professional
40-70	Likely requires outpatient services
80-100	Likely requires outpatient care with additional services of a supportive or intensive nature
110-130	Likely requires intensive, community-based services, although some youths may need acute residential services at some point
> 140	Very intensive services would be required; maybe in residential or inpatient settings at some point

In 2006, 18,255 out of 18,623 cases with a Entry CAFAS, had a valid total score at T1. Two percent of the total analyzable cases did not have a total score at T1.

Central tendency figures shown in Figure 4.2 are similar for the years 2005 and 2006, despite a larger sample in 2006. The average for total score at T1 is just under one percent (.85%) of that for 2005. The majority of clients in this sample (mode = 40) likely require outpatient services based on their level of functional impairment at entry to treatment. A median score of 60 suggests that nearly half probably require outpatient care with additional services of an intensive nature.

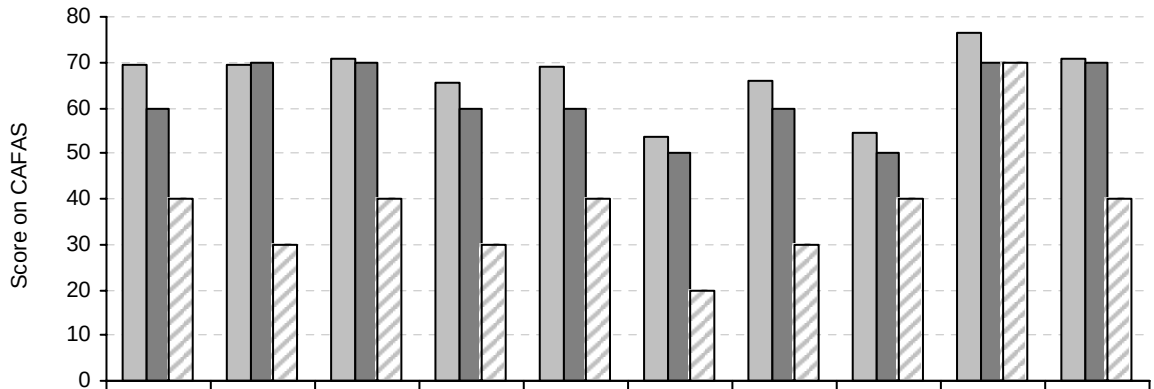
Figure 4.2 CAFAS Rating[11] at Entry to Treatment



Mean levels of dysfunction vary across the province, ranging from a low mean CAFAS total score of 54.16 in the South East region to a high of 73.06 in the Toronto region (Figs. 4.3, 4.4). The most common severity score for the Toronto region (60) largely surpasses the mode for the remainder of the province (40). The North has the most low scores (mode=30), followed by Central East, Eastern, Central West and Central East (mode=40). Toronto, South West and North East regions see a greater number of clients with higher levels of functional impairment

In comparison with 2005 regional data, it appears severity of dysfunction is higher in the NE, CW, E and Toronto regions with larger sample sizes in 2006, and diminishing slightly in the SW. So, annual changes in severity can likely be attributed to a larger sample in 2006.

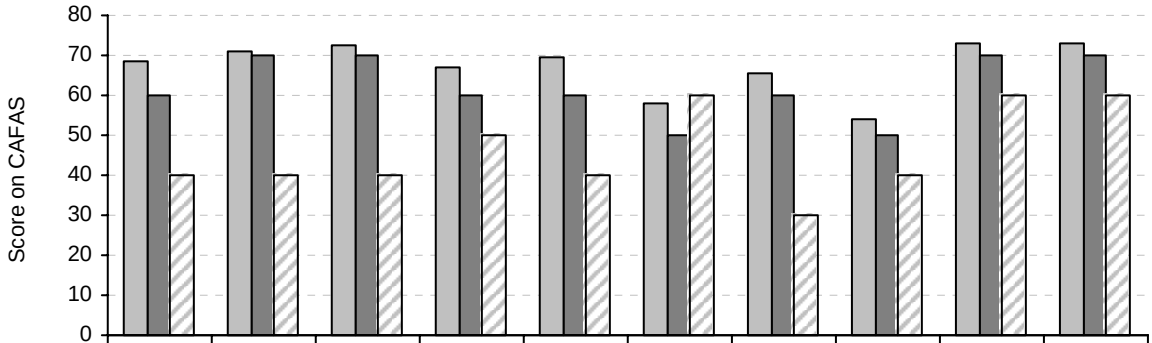
Figure 4.3 CAFAS Total Score at Entry to Treatment: Ontario and Regions - 2005



	Ontario N=9,065	CE N=1,385	CW N=1,047	E N=490	HN N=846	NE N=643	N N=866	SE N=947	SW N=1,502	TO N=1,339
Mean	69.35	69.46	70.65	65.55	69	53.78	66	54.42	76.59	70.65
Median	60	70	70	60	60	50	60	50	70	70
Mode	40	30	40	30	40	20	30	40	70	40

[11] Standard deviation is 41.679 for 2005 and 40.414 for 2006.

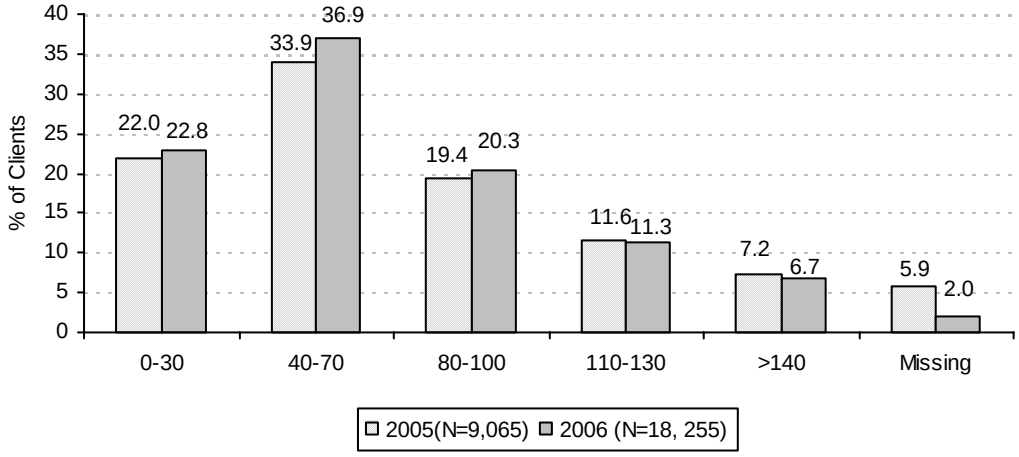
Figure 4.4 CAFAS Total Score at Entry to Treatment: Ontario and Regions - 2006



	Ontario N=18,255	CE N=2,615	CW N=2,156	E N=1,537	HN N=1,750	NE N=1,555	N N=1,740	SE N=1,641	SW N=2,901	TO N=2,630
Mean	68.5	70.76	72.4	67.13	69.27	58.03	65.44	54.16	72.83	73.06
Median	60	70	70	60	60	50	60	50	70	70
Mode	40	40	40	50	40	60	30	40	60	60

Overall level of client dysfunction at entry to treatment in 2006 shows that the largest group of children and youth presenting for treatment (36.9%) are in the 40-70 range on the total CAFAS score, and likely require outpatient services (e.g., weekly contact) (see Fig 4.5). Greater than one-third (40.3%) of clients need more support than traditional outpatient visits (e.g., have a score of 80 or above), and of these, 6.7% are extremely highly impaired. Nearly 23% of clients came into treatment with less significant functional impairment (e.g., a score of 30 or less). Approximately 2% of cases submitted had no total score at entry but this is almost 4% better than last year due to improvements in selection method data quality. The main reason for lack of a total entry score is that one or more of the CAFAS subscales were not or could not be rated.

Figure 4.5 Severity of CAFAS Rating at Entry to Treatment for 2005 and 2006



Severity of functioning across Ontario varies, with certain regions (NE, E, SE) having a larger percentage of clients who appear to be functioning well as compared to the remainder of the province (Table 4.3, 4.4). This pattern holds true for the last two years.

Table 4.3 Severity at Entry to Treatment for Ontario and Regions (%)-**2005** (N=9,065)

	0-30 *Some need for service*	**40-70** *Outpatient needs*	**80-100** *Outpatient plus extra supports*	**110-130** *Intensive needs*	**140+** *Very intensive supports*
Ontario	22.0	**33.9**	19.4	11.6	7.4
CE	20.1	34.6	21.6	11.9	5.4
CW	19.6	35.9	21.8	12.0	6.7
E	25.0	32.9	18.9	11.5	4.3
HN	19.8	36.0	20.2	11.9	5.6
NE	33.2	39.4	15.2	6.3	2.6
N	26.6	31.1	18.8	9.3	7.1
SE	31.1	37.7	14.3	5.5	3.4
SW	19.8	30.5	19.1	14.7	11.4
TO	13.8	31.2	21.1	15.7	11.6

Table 4.4 Severity at Entry to Treatment for Ontario and Regions (%)-**2006** (N=18,255)

	0-30 *Some need for service*	**40-70** *Outpatient needs*	**80-100** *Outpatient plus extra supports*	**110-130** *Intensive needs*	**140+** *Very intensive supports*
Ontario	22.8	**36.9**	20.3	11.3	6.7
CE	19.7	36.9	23.2	12.2	6.7
CW	19.2	36.7	21.1	13.0	8.4
E	22.2	38.4	21.1	11.4	5.0
HN	20.1	37.3	21.9	12.0	5.8
NE	29.4	41.4	17.2	7.9	3.4
N	25.0	37.9	19.2	9.8	5.7
SE	34.1	39.1	14.3	7.1	2.9
SW	21.3	34.4	21.4	12.7	9.6
TO	19.7	33.9	20.3	12.6	9.1

Severity scores tend to look more similar across regions in higher levels of dysfunction. Regions with the highest need for intensive services (scores 110 or higher), and with the highest percentage of clients who are extremely highly impaired (a score of 140 or higher) are South West, Toronto and Central West.

Organizations having more than 10 clients with scores 140 or higher are depicted in Table 4.5 below. Most of these organizations are community mental health centres and six are hospitals (more than last year where only one hospital – Regional Mental Health Centre in London - was included in a similar list).

Table 4.5 Organizations Having 10 or more Clients Scoring ≥ 140 (Severe Dysfunction) on CAFAS at Entry to Treatment -2006

Organization (* denotes agencies also present in this list for the 2005 report; hospitals are highlighted)	Number of clients with total score ≥140 at T1	Number of clients with total score at T1	Percent of sample ≥140
Central East Region:			
Chimo*	13	186	7
Frontenac	24	283	8
Kinark*	70	940	7
New Path Youth and Family Services*	30	451	7
The York Centre	10	78	13
Whitby Mental Health Centre	14	75	**19**
Central West Region:			
Associated Youth Services of Peel*	41	369	11
Cambridge Memorial Hospital	15	41	**37**
Community Mental Health Clinic*	20	263	8
kidsLINK	11	66	17
Lutherwood-CODA*	53	343	15
Peel Children's Centre	12	236	5
Woodview Children's Centre	13	533	2
Eastern Region:			
CHEO (Children's Hospital of Eastern Ontario)	23	213	11
Phoenix Centre	10	191	5
Roberts Smart Centre*	10	41	**24**
Royal Ottawa Healthcare Group	12	143	8
Hamilton-Niagara Region:			
Hamilton Child and Adolescent Services	15	59	25
Community Adolescent Network of Hamilton*	15	40	**38**
Niagara Child And Youth Services	20	441	5
North East Region:			
Algonquin Child & Family Services*	36	730	5
Northern Region:			
Algoma Family Services (joined with Sault Saint Marie Hospital)	34	339	10
Child & Family Centre Sudbury	26	491	5
Children's Centre Thunder Bay (Lakehead Regional Family Centre)*	16	365	4
Dilico Thunder Bay/District*	15	172	9
South East Region:			
Child & Wellness Centre of Leeds & Grenville*	15	394	4
Open Doors for Lanark Children & Youth	11	279	4
Pathways for Children and Youth	15	529	3
South West Region:			
Chatham-Kent Integrated Children's Service*	11	320	3
Child and Parent Resource Institute-CPRI*	71	258	28
Craigwood*	22	144	15

Organization (* denotes agencies also present in this list for the 2005 report; hospitals are highlighted)	Number of clients with total score ≥140 at T1	Number of clients with total score at T1	Percent of sample ≥140
Huron-Perth Centre*	25	437	6
London Health Sciences Centre	11	283	4
Madame Vanier Children's Services*	37	286	13
Maryvale Adolescent and Family Services*	15	68	22
Regional Mental Health Centre*	22	71	**31**
St. Clair Child & Youth Centre*	36	302	12
Toronto Region:			
East Metro Youth Services*	19	150	13
George Hull Centre*	17	162	10
Hincks-Dellcrest Centre	13	279	5
Youthdale Treatment Centre*	149	603	**25**

The South West region continues to top the province in client severity, although 8 out of 9 of the organizations present in the 2006 'severity' list were also present in the 2005 list. These 9 agencies represent greater than half of all agencies submitting data in SW region (Table 4.6).

Table 4.6 Annual Comparison of Organizations with Highly Dysfunctional Clients

Region	2006			2005		
	Organizations with at least 10 clients scoring ≥140 at T1	Total number of agencies	%	Organizations with at least 10 clients scoring ≥140 at T1	Total number of agencies	%
South West	9	17	53	8	17	47
Central West	7	14	50	3	14	21
Central East	6	11	55	3	11	27
Eastern	4	14	29	1	14	7
Northern	4	8	50	3	8	38
Toronto	4	20	20	3	20	15
Hamilton-Niagara	3	9	33	1	9	11
South East	3	6	50	2	6	33
North East	1	6	17	1	6	17

Youthdale Treatment Centre (Toronto region) continues to show a high frequency of clients with scores 140 or higher as compared to other agencies, although the SW region's Regional Mental Health Centre has the highest severity percentage out of the total number of cases within the highly impaired category.

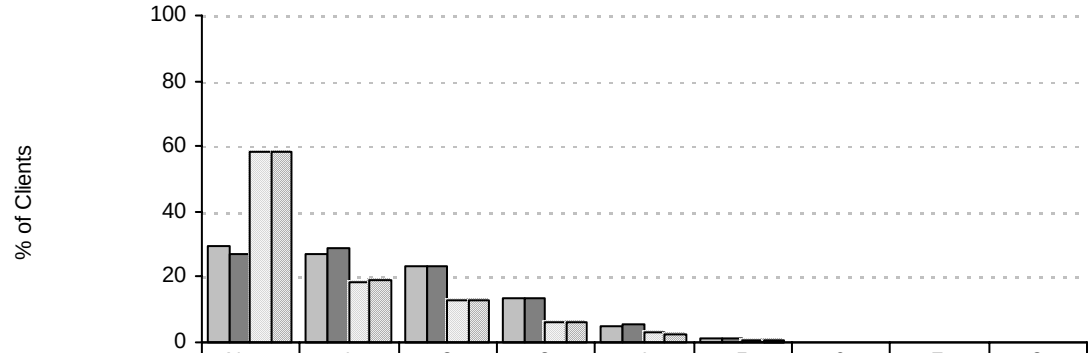
The clinical burden of clients served in these organizations during the 2006 year is depicted below in Figure 4.6. Clinical burden is defined as the percentage of clients rated as either moderately or severely impaired at entry to treatment (e.g., a subscale score of 30 or 20) on none, one, two, etc. of the individual CAFAS subscales.

We see that 73% (vs. 76.7% observed in the 2005), or almost three-quarters of the sample, are moderately impaired on one or more of the 8 CAFAS subscales[12]. More than half, or 43.9 % (same percent for 2005), have multiple impairments at this level of severity (e.g., clients with 2 or more subscales rated as moderate). There is a slight decrease in the percentage of clients with moderate impairment as compared with reported values for 2005. Discrepancies in percentages may be explained by different sample sizes for the two reports (18.623 cases for this report, and 9,634 for 2005).

More than 40% of clients have one or more severe impairments for both 2006 and 2005. No clients had all 8 subscales rated as severely impaired. This data can be used to target those clients who have the highest needs and should receive more intensive treatments.

Figure 4.6 Percentage of Clients Rated Severely or Moderately Impaired on None to 8 of the 8 CAFAS Subscales at Entry to Treatment

(2005:N=9,634 and 2006:N=18, 623 cases with at least some subscale data)



	None	1	2	3	4	5	6	7	8
Moderately Impaired/2005	29.5	27.2	23.1	13.4	5.1	1.5	0.2	0	0
Moderately Impaired/2006	26.9	29.1	23.4	13.7	5.3	1.3	0.2	0	0
Severely Impaired/2005	58.4	18.7	12.6	6.1	2.9	0.9	0.3	0.1	0
Severely Impaired/2006	58.4	19.1	12.7	6.1	2.5	0.8	0.2	0.1	0

[12] The number of subscales with moderate or severe impairment was calculated among all cases with some data. That means that the "none" subscale includes all cases with no scores of 20 or 30 but also missing data.

Boys have a slightly higher mean CAFAS score at entry to treatment compared to girls (Fig 4.7), although they make up fewer of those clients in the low dysfunction group (Fig 4.8)

Figure 4.7 CAFAS Total Score at Entry to Treatment by Sex

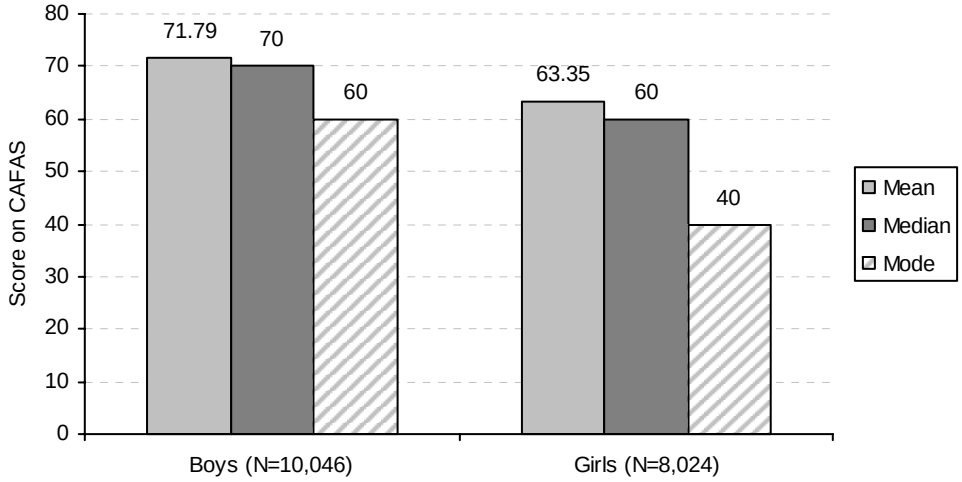
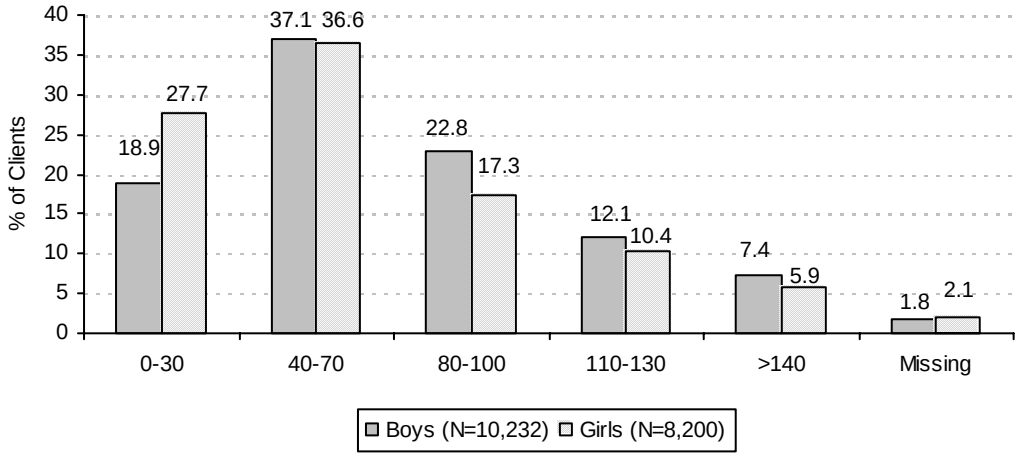


Figure 4.8 Severity of CAFAS Rating at Entry to Treatment by Sex



The same observation can be drawn between a higher entry score for adolescents compared with pre-adolescents (Fig.4.9). Preadolescents are more represented in the mild and moderate dysfunction groups, whereas adolescents surpass preadolescents in the higher levels of dysfunction (Fig.4.10).

Figure 4.9 CAFAS Total Score at Entry to Treatment by Age Group

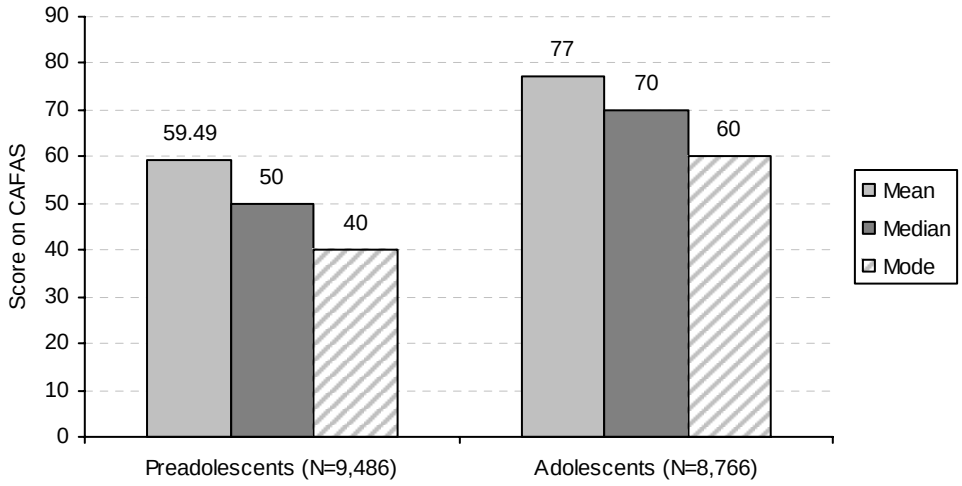
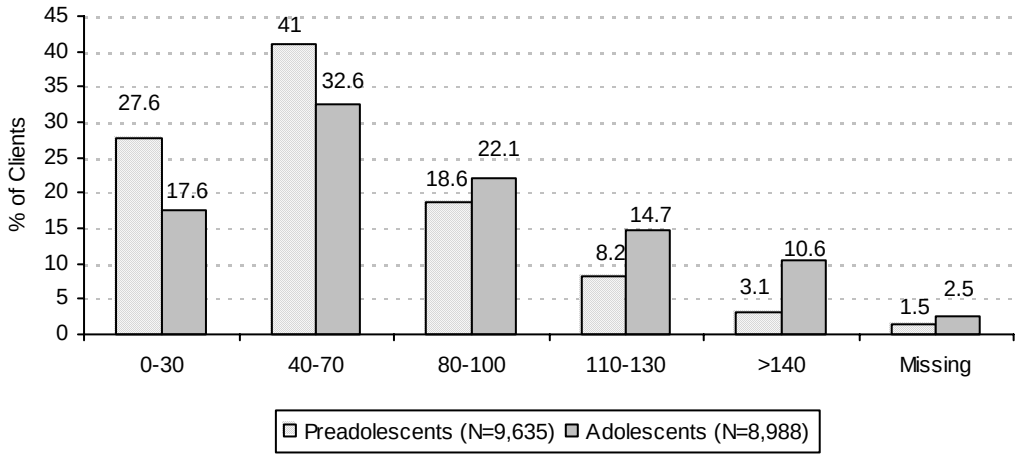
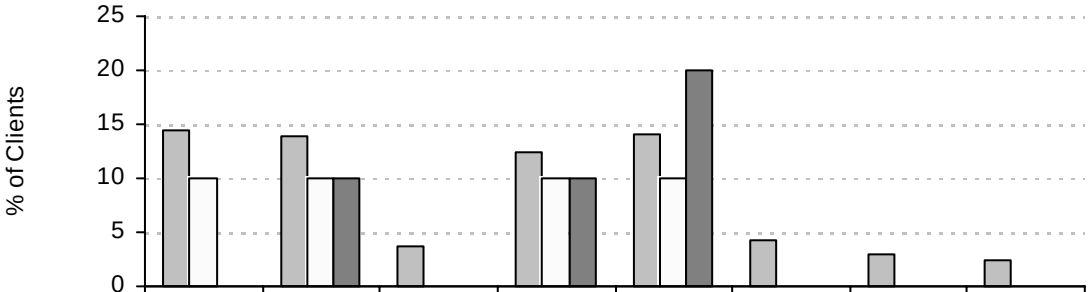


Figure 4.10 Severity of CAFAS Rating at Entry to Treatment by Age Groups



Looking at dysfunction for the CAFAS subscales indicates that client dysfunction is largely evident in the domains of school (ability to function satisfactorily in a group educational environment), home (extent to which child/youth observes reasonable rules and performs age appropriate tasks), behaviour towards others (appropriateness of child's/youth's daily behaviour), and moods and emotions (modulation of child's/youth's emotional life) (Fig. 4.11).

Figure 4.11 CAFAS Scores at Entry to Treatment by Subscale (Mean, Median and Mode)
(N varies between 18,517 and 18,546 because of missing scores on different subscales)



	School	Home	Community	Behavior towards	Moods/ Emotions	Self-Harm	Substance Use	Thinking
Mean	14.49	13.8	3.68	12.37	14.03	4.31	3.01	2.34
Median	10	10	0	10	10	0	0	0
Mode	0	10	0	10	20	0	0	0

This pattern is similar to that reported for both 2006 (Fig.4.12) and 2005 (Fig.4.13). More than 50% of clients present as moderately to severely impaired in the area of schooling, which suggests that they may be best served by including school personnel in the treatment plan. The relatively low levels of dysfunction in the area of community behaviour (respect for the rights of others and their property and conformity to law) may be due to fewer young offenders in this mental health sector sample, as compared to what might be found in a juvenile justice sample.

In this sample, 16.9% had moderate to severe impairment in the self-harm domain (extent to which the child/youth can cope without resolving to self-harmful behaviour or verbalizations); 10.2% were moderate to severe with respect to substance use (child's/youth's substance use and the extent to which it is not appropriate or is disruptive); and 7.0% were moderate to severe in thinking (ability of child/youth to use rational thought processes). The 2006 levels of dysfunction are slightly lower than those observed in 2005 (18.9%- self-harm, 11.2%-substance –use, 7.1% thinking).

Figure 4.12 Functioning on CAFAS Subscales at Entry to Treatment -**2006**
(N varies between 18,528 and 18, 546)

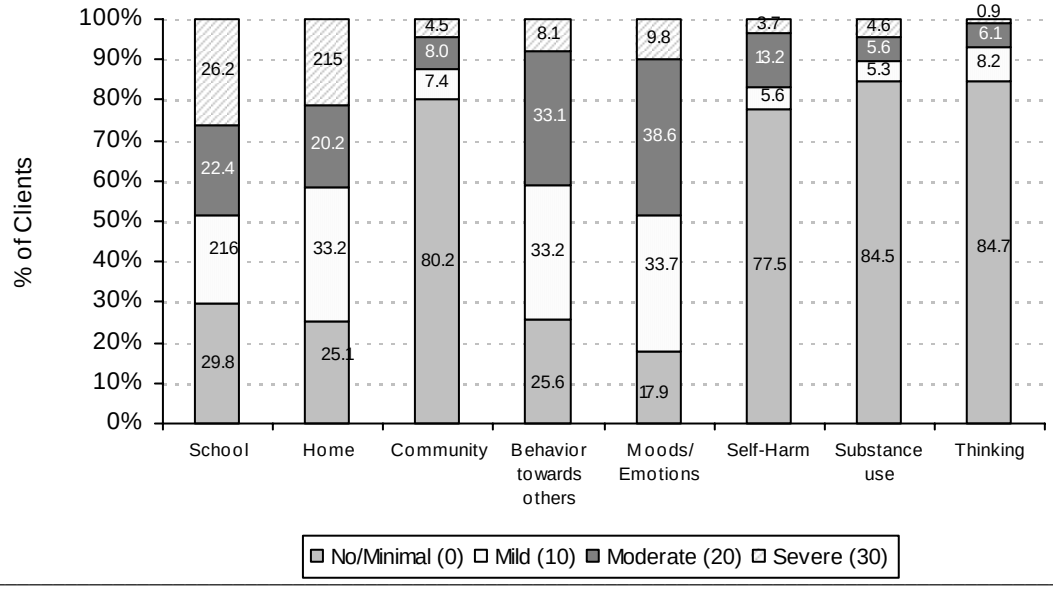
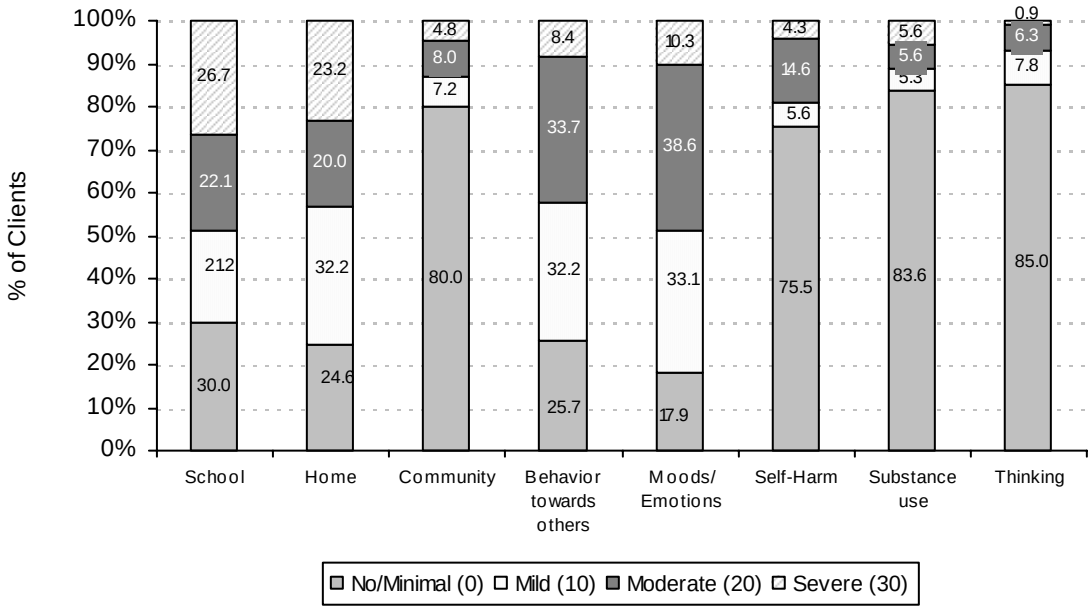


Figure 4.13 Functioning on CAFAS Subscales at Entry to Treatment -**2005**
(N varies between 9,220 and 9,237)



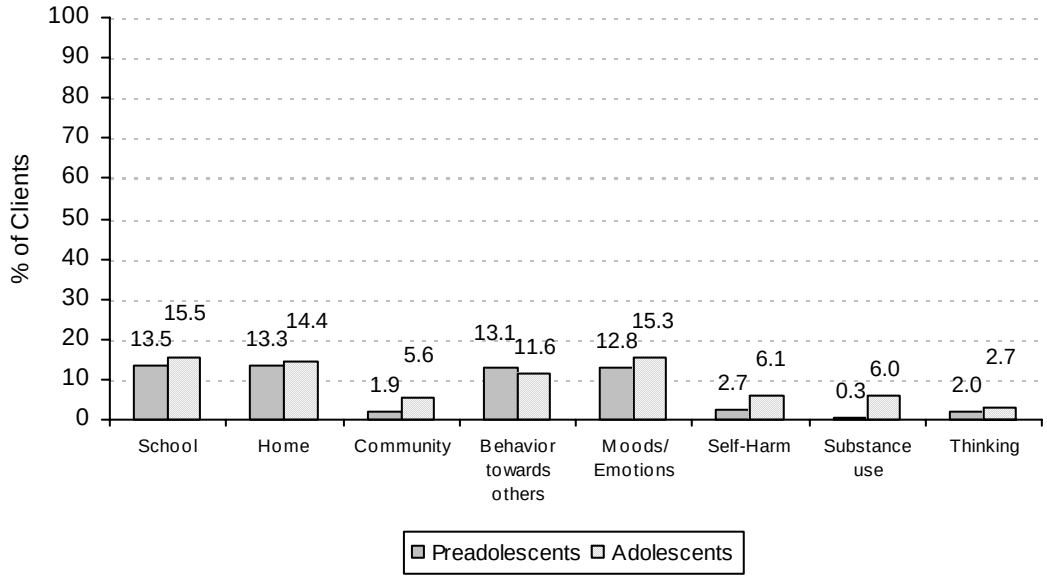
Sex differences in area of dysfunction are evident, with boys demonstrating higher dysfunction in the domains of school, home, community, and behaviour towards others compared to girls (Fig.4.14). Girls were found to surpass boys' level of dysfunction in the domains of moods/emotions, self-harm, and substance use.

Figure 4.14 Average CAFAS Subscale Score at Entry to Treatment (T1) by Sex
(N for Boys varies between 10,183 and 10,195 and N for Girls varies between 8,143 and 8,163 because of missing scores on different subscales)

Difference in levels of dysfunction by age group suggest greater dysfunction for adolescents across all domains except behaviour towards others (Fig.4.15).

Figure 4.15 Average CAFAS Subscale Score of Preadolescents & Adolescents by Subscale at Entry to Treatment

(N for Preadolescents varies between 9,592 and 9,605 and N for Adolescents varies between 8,923 and 8,941 because of missing scores on different subscales)



Functioning at Exit from Service

This section of the report describes clients' level of functioning at the exit from treatment, for children and youth who sought children's mental health services in designated Ontario service provider organizations during 2006 and for whom CAFAS was rated.

Using level of functional impairment as an outcome indicator is useful in helping to determine whether the observed change from pre-to post-treatment is clinically and/or statistically meaningful (Hodges, 2003). In order to determine the proportion of cases that experienced a meaningful improvement, a procedure is used for calibrating outcome that can be applied to each client. This calibration is referred to as "clinical significance" and refers to whether changes are meaningful, as evidenced by having an impact on the clients everyday functioning in the "real world" (Jacobson & Truax, 1991; Kazdin & Kendall, 1998; Kazdin & Weisz, 1998).

CAFAS data permits at least three ways of viewing outcome, of which only two are represented in this report:

1. Change in average scores from treatment entry to treatment exit/last CAFAS evaluation
2. Proportion of clients improved (combining all clients)

The third method involves examining changes in type of client dysfunction over time. Client typologies for CAFAS have not been implemented as an interpretation or clinical strategy across Ontario, as yet.

The following analyses of client outcomes include 7,261 cases that met the following criteria:

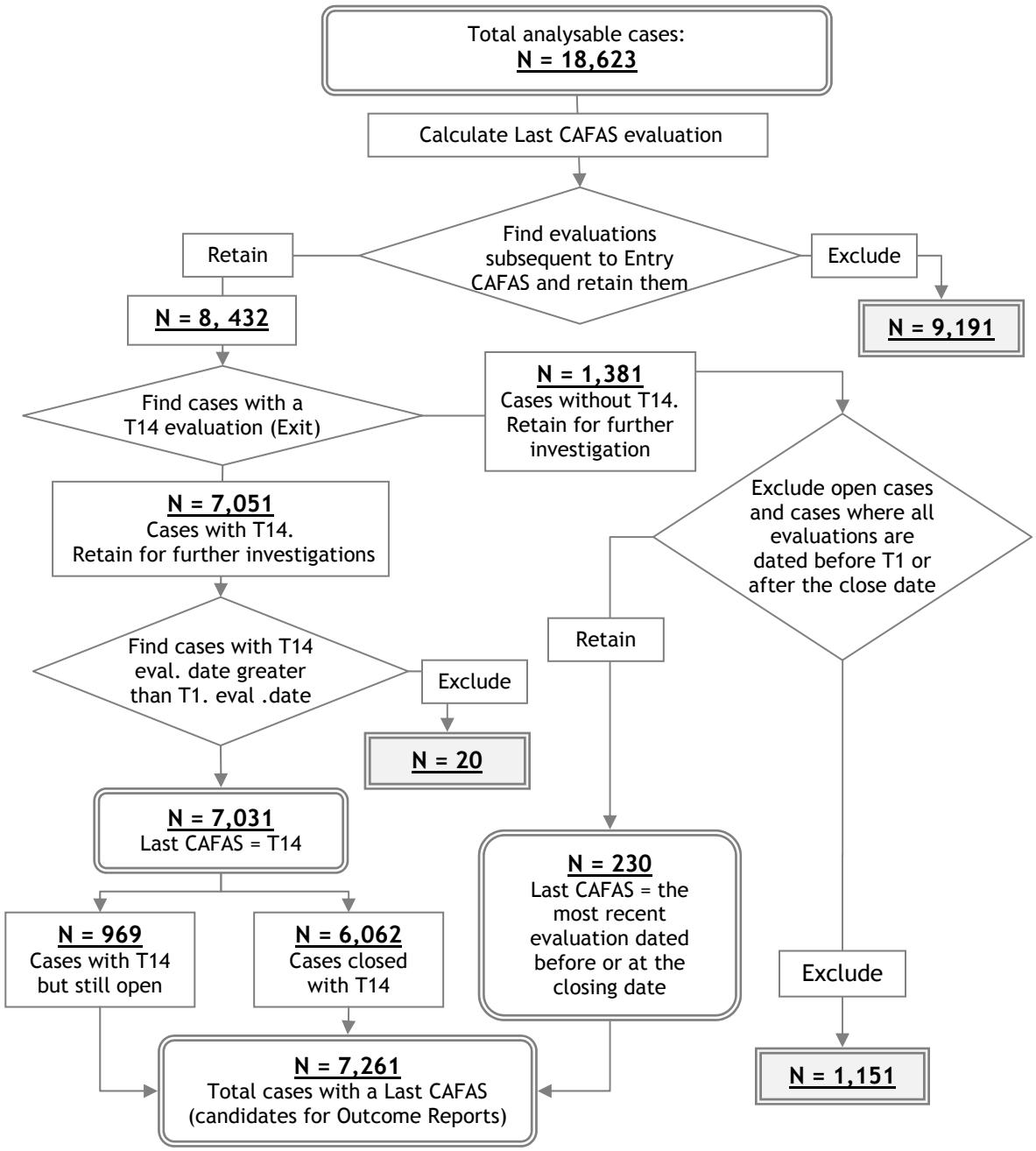
- Were either open or closed cases
- Where treatment was delivered
- Had an Exit CAFAS rating (also referred to as T14)

OR, if the case was closed without a T14

- Had at least one evaluation other than the Entry CAFAS (also referred to as T1) or the optional Entry CAFAS(or T2)

Figure 5.1 describes the process of selecting the last CAFAS evaluation used for outcome measurement.

Figure 5.1 Calculating Last CAFAS



N = 8,255: Cases with valid Total Scores at Entry (T1)
N = 6,998: Cases with valid Total Scores for Last CAFAS
N = 6,927: Cases with valid Total Scores for both Entry (T1) and Last CAFAS
N = 6,783: Cases with valid Total Scores for Exit CAFAS (T14)
N = 6,721: Cases with valid Total Scores for both Entry (T1) and Exit CAFAS (T14)

It is of interest to examine the frequency with which clients rated at exit to treatment were also rated at different time points throughout their service at the particular organization. Table 5.1 depicts the frequency of CAFAS evaluations for the 7,031 cases having an exit evaluation; evaluations tend to drop off as time passes (Tables 5.1 and 5.2).

Table 5.1 Distribution of CAFAS Evaluations for Clients with an Exit CAFAS (N=7,261)

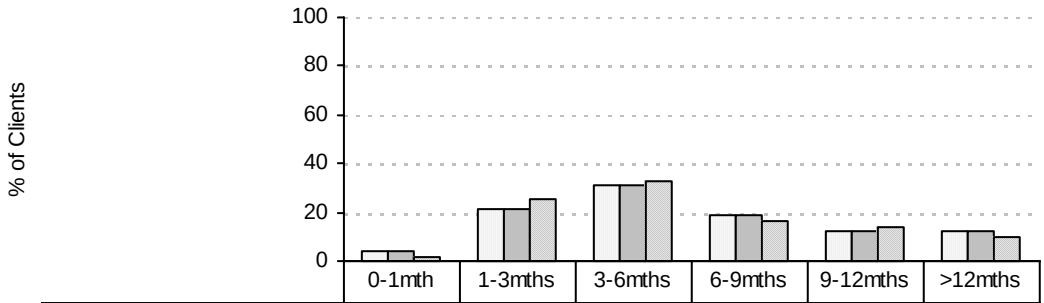
T-Value	Frequency	T-Value	Frequency
T14(Exit)	7,031	T7(15 months)	3
T3 (3 months)	94	T8(18 months)	3
T4(6 months)	54	T9(21 months)	1
T5(9 months)	27	T10(24 months)	2
T6(12 months)	30	T15(Other)	16

Table 5.2 Number of Evaluations for Cases with an Exit CAFAS (T14) (N=7,031)

Number of CAFAS evaluations	Frequency	Number of CAFAS evaluations	Frequency
2 (T1 & T14)	5,932	**7**	15
3	728	**8**	7
4	203	**9**	3
5	89	**10**	0
6	53	**11**	1

A similar interpretation is evident when CAFAS evaluations are depicted according to time (Figure 5.2).

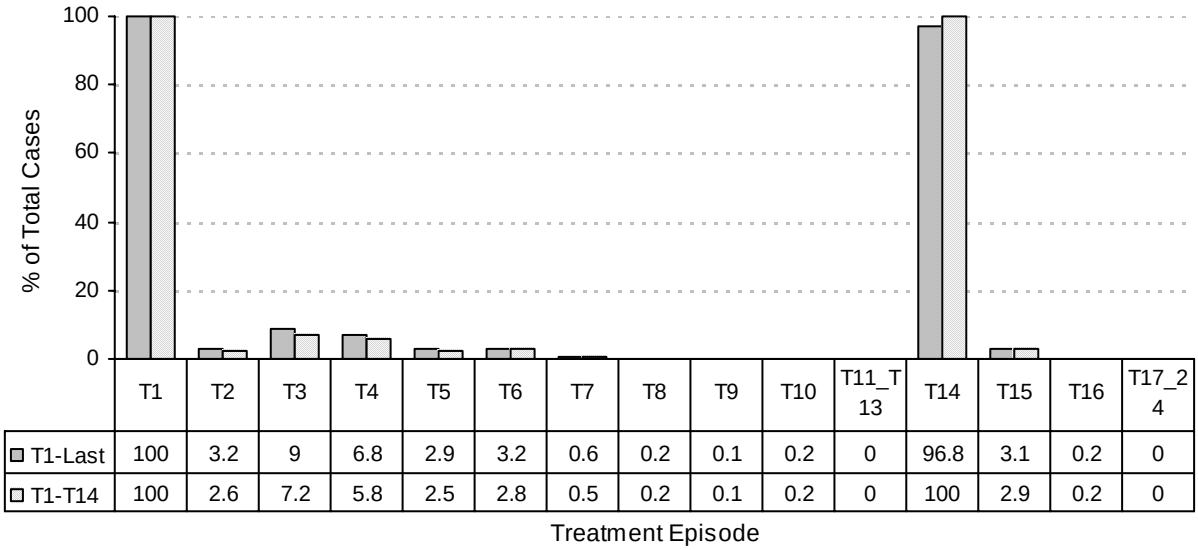
Figure 5.2 Time between Entry to Treatment and Last CAFAS



	0-1mth	1-3mths	3-6mths	6-9mths	9-12mths	>12mths
Cases with Last CAFAS (N=7,261)	3.9	21.4	30.8	18.9	12.7	12.3
Cases with T14 (N=7,031)	4.0	21.3	30.8	19.0	12.6	12.4
Cases without T14 (N=230)	1.3	25.2	33	16.1	14.3	10

Curiously, 3,207 clients having an Entry CAFAS (T1) that was rated more recently, that is, within less than 100 days ago, have no subsequent CAFAS rating. A greater number of clients, 8,155, with Entry CAFAS that were rated more than 100 days ago have no subsequent CAFAS. This suggests that clinicians may only recently have begun the practice of periodic CAFAS ratings, and/or, the longer the time passed since Entry rating, the less likely there is to be a subsequent rating (Fig.5.3)

Figure 5.3 Percentage of CAFAS Evaluations for Various T Values

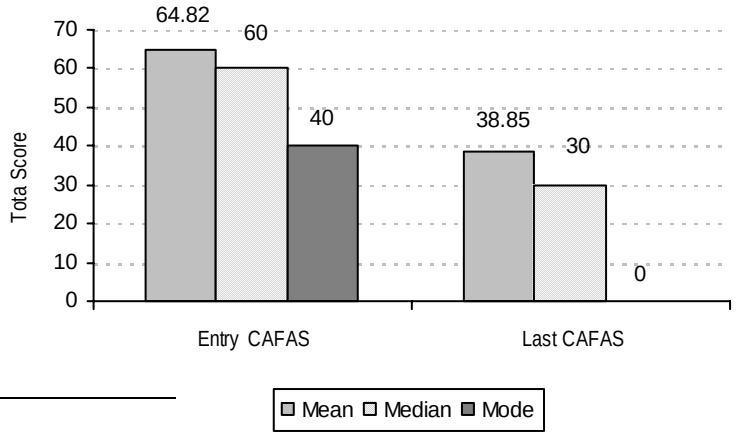


	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11_T13	T14	T15	T16	T17_24
T1-Last	100	3.2	9	6.8	2.9	3.2	0.6	0.2	0.1	0.2	0	96.8	3.1	0.2	0
T1-T14	100	2.6	7.2	5.8	2.5	2.8	0.5	0.2	0.1	0.2	0	100	2.9	0.2	0

CHANGE IN AVERAGE SCORES FROM TREATMENT ENTRY TO LAST CAFAS

The first view of change in dysfunction shows that for the 6,927 cases for which exit data was available, there is a significant statistical improvement in functioning from entry to last CAFAS ($p < .0001$, $t=61.655$).[13] On average, there was a 25.97 point drop (improvement) in impairment from an average CAFAS total score of 64.82 at entry to treatment, to an average total score of 38.85 on the last CAFAS evaluation (Fig.5.4). The results are similar the ones reported in 2005 where there was a reported 25.36 point drop impairment.

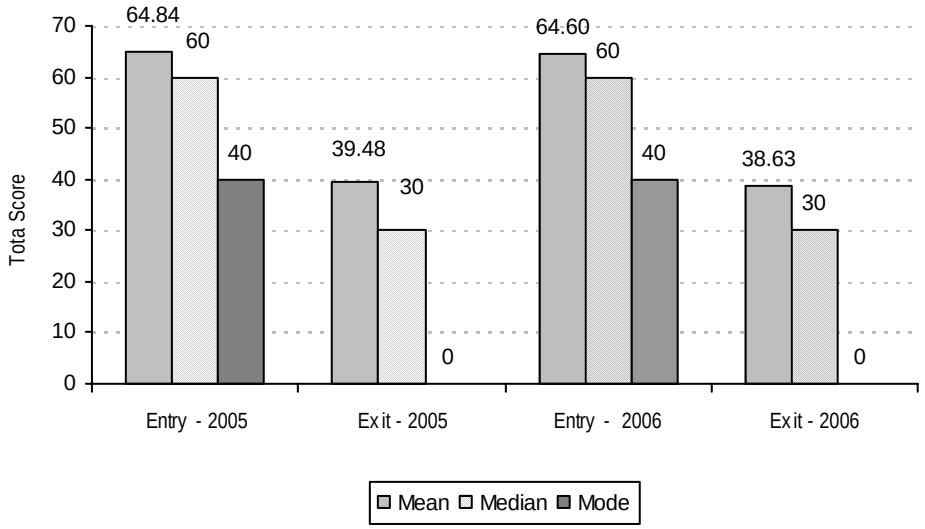
Figure 5.4 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS (N=6,927) 2006



[13] Paired t-test

A comparison of central tendency measures for the years 2005 and 2006 shows them to be quite similar (Fig.5.5).

Figure 5.5 Change in Average CAFAS Total Score from Treatment Entry to Treatment Exit (N=2,164 for 2005 and N=6,721 for 2006)



A difference score of 20 or greater carries clinical significance over and above statistical significance, as reflected by an effect size[14] of 0.65 (vs. 0.63 presented the 2005 annual report in and vs. 0.64 presented in the 2004 annual report). An effect size of 0.6 represents a moderate to large effect in magnitude, and indicates that the mean of the treated group is at the 73rd percentile of the untreated group as defined by Cohen (1988).

A comparison of severity in child functioning for Ontario children and youth, CAFAS data for child and youth mental health populations from other jurisdictions is provided in Table 5.3. Ontario effect sizes appear comparable to those reported for other jurisdictions.

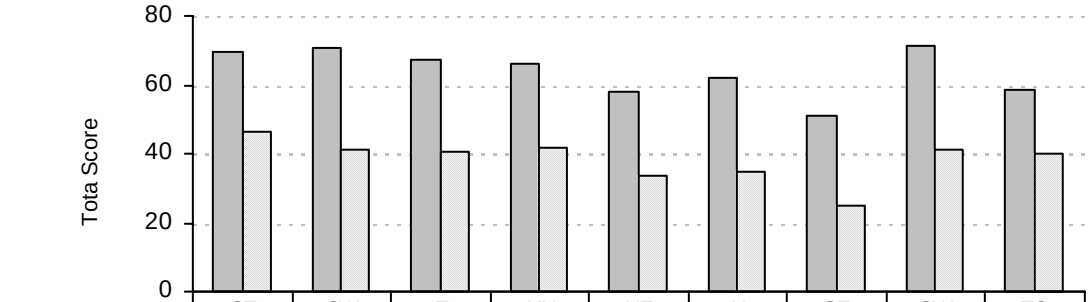
[14] Effect size (ES) is a name given to a family of indices that measure the magnitude of a treatment effect. Unlike significance tests, these indices are independent of sample size. ES measures are the common currency of meta-analytic studies that summarize the findings from a specific area of research. There is a wide array of formulas used to measure ES. Cohen's (1988) definition of ES is used here: $d = M_1 - M_2 / \sigma$, where *d* is defined as the difference between means ($M_1 - M_2$) divided by the standard deviation of either group. In meta-analysis the two groups are considered to be the experimental and control groups. By convention the subtraction, $M_1 - M_2$, is done so that the difference is positive if it is in the direction of *improvement* or in the predicted direction and negative if in the direction of *deterioration* or opposite to the predicted direction. Cohen argued that the standard deviation of either group could be used when the variances of the two groups are homogeneous. Cohen (1988) hesitantly defined effect sizes as "small, d = .2," "medium, d = .5," and "large, d = .8", stating that "there is a certain risk inherent in offering conventional operational definitions for those terms for use in power analysis in as diverse a field of inquiry as behavioural science".

Table 5.3 Severity of Child Functioning for Various Jurisdictions

Author / Source	Sample Description	CAFAS total score Mean (SD)		Diff	Effect Size
		Entry	Exit		
Ontario, 2006	N= 6, 721 children and youth served in community and hospital based mental health organizations.	64.60 σ_1=40.73	38.63 σ_2=39.33	25.98	0.65
Ontario, 2005	N= 2,164 children and youth served in community and hospital based mental health organizations.	64.84 σ_1=40.13	39.48 σ_2=40.53	25.36	0.63
Ontario, 2004	N=964 children and youth served in community and hospital based mental health organizations.	63.85	37.85	26	0.64
Hodges, 2003	N=11,815 youth referred to Michigan State public mental health in fiscal year 2002. Of these, N=2,501 had an intake and discharge CAFAS.	80	56	*Not reported in manual*	0.66
Georgia State, USA, MATCH	N=678 children served by Georgia's Multi-Agency Team for Children who have severe emotional disturbances requiring mental health treatment in a *residential* setting, 64% male and 36% female. 54% Caucasian. Results are for those with an intake and discharge rating, N=125.	135	99	*No standard deviations reported, hence, no effect size calculation.*	
Hodges, Xue & Wotring 2004	N=5, 638 youths with serious emotional disturbance (score above 50) ages 7-17 years served in community mental health service providers in Michigan	89.35 (32.35)	63.14 (38.78)	26.21	0.73

A regional view of CAFAS change shows a range of difference scores, with the largest improvements (30 points) occurring in the South West and Central West regions, and the least amount of change occurring in the Toronto region (Fig.5.6).

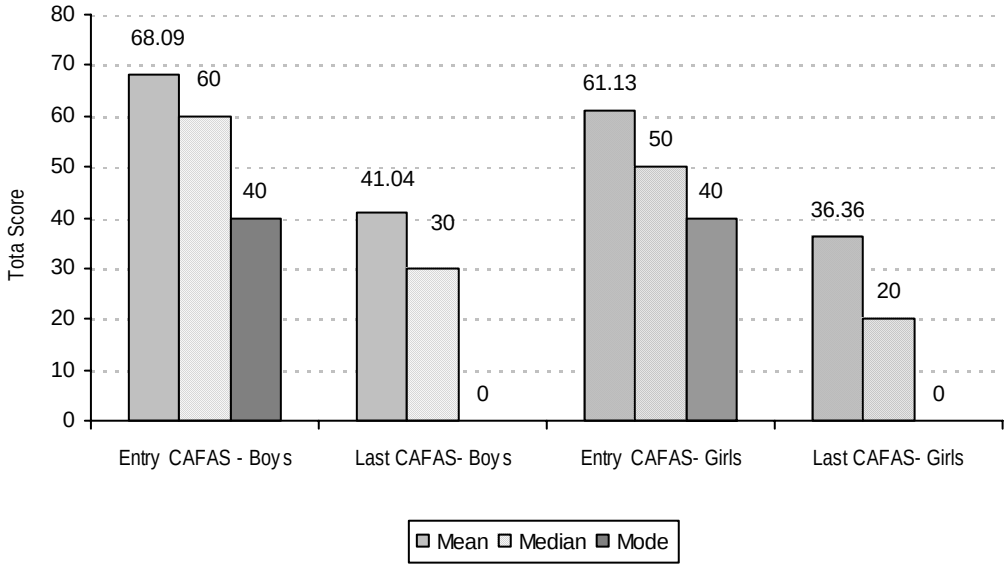
Figure 5.6 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS By Region



	CE (N=862)	CW (N=872)	E (N=509)	HN (N=727)	NE (N=641)	N (N=715)	SE (N=679)	SW (N=1,294	TO (N=628)
Entry Treatment	69.7	70.8	67.0	65.9	57.8	61.9	51.3	71.4	58.5
Last CAFAS	46.6	41.4	40.5	41.9	33.5	34.6	24.7	41.4	40.1

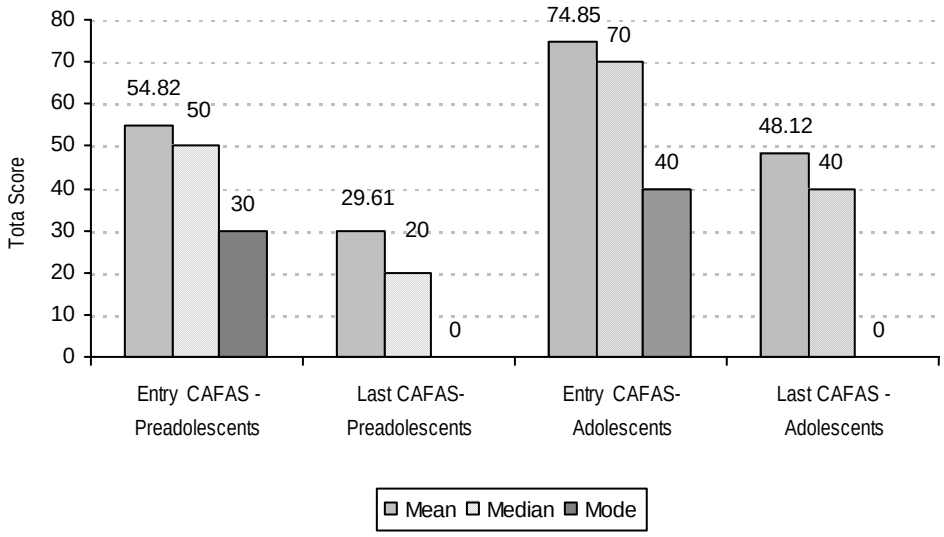
In considering whether there are gender differences in functional improvement we find that boys show slightly larger gains in functioning (difference score of 27.05 versus 24.77) (Fig.5.7)

Figure 5.7 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS By Sex (N=3,659 for Boys and N=3,228 for Girls)



Functional improvements for age groups are evidently less strong, with preadolescents showing a difference score of 25.21 compared to 26.73 for adolescents (Fig.5.8).

Figure 5.8 Change in Average CAFAS Total Score from Treatment Entry to Last CAFAS By Age Groups (N=3,468 for Preadolescents and N=3,459 for Adolescents)



Also of interest is functional improvement across CAFAS subscales. As can be seen in Table 5.4, the largest improvements are made in the domains of moods/emotions and behaviour towards others, and this is a consistent finding across the last two years. School and home functioning also show good degree of change in the expected direction.

Figure 5.9 Change in Average Score on CAFAS Subscales from Treatment Entry to Last CAFAS
(N varies between 7,095 and 7,116 because of missing scores on various subscales)

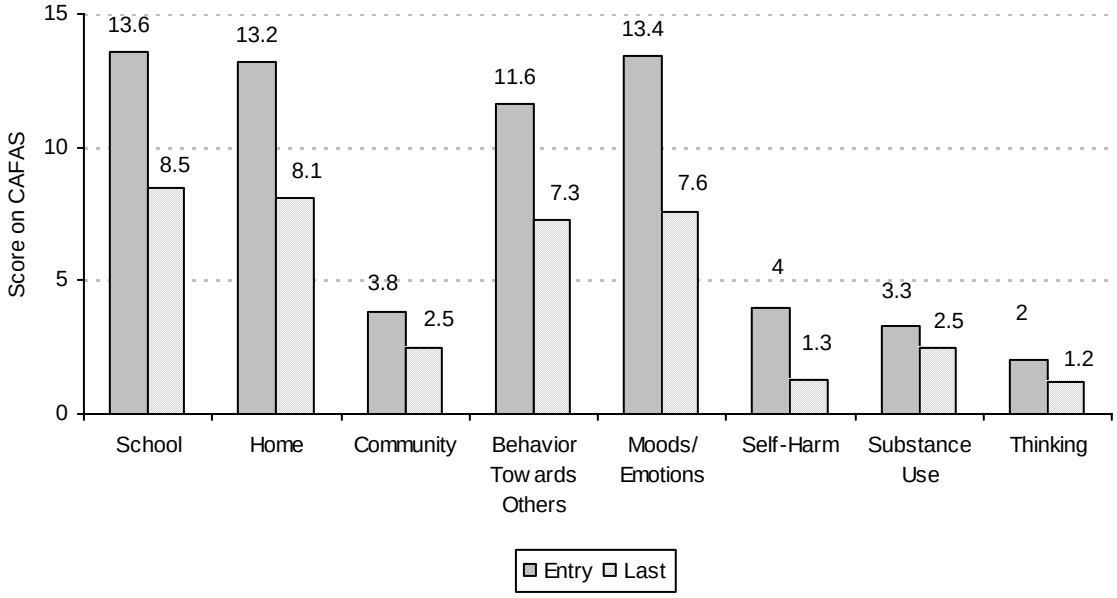
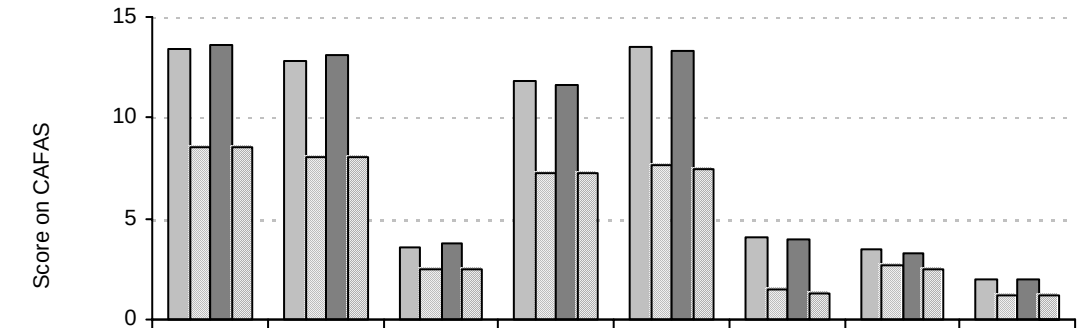


Table 5.4 Subscale Change Scores and Effect Sizes from Treatment Entry to Treatment Exit

Subscale	Mean Difference		t Statistic (.95 confidence interval)		Effect Size	
	Year 2005	Year 2006	Year 2005	Year 2006	Year 2005	Year 2006
School	4.90	5.01	23.02	40.23	.44	.46
Home	4.80	5.05	23.51	41.3	.47	.49
Community	1.08	1.31	7.96	16.47	.14	.17
Behaviour Towards Others	4.55	4.33	25.94	42.17	.52	.50
Moods / Emotions	5.87	5.85	31.26	53.78	.66	.68
Self Harm	2.58	2.69	16.41	28.47	.37	.40
Substance Use	.79	.79	7.16	10.48	.10	.11
Thinking	.81	.76	8.26	13.26	.16	.15

If we capture change by including the Exit CAFAS or T14 score rather than the last CAFAS rating on record (Fig.5.10), there is very little difference with the view presented in Figure 5.9.

Figure 5.10 Change in Average Score on CAFAS Subscales from Treatment Entry to Treatment Exit (N varies between 2,186 and 2,192 for 2005 , N varies between 6,874 and 6,895 because of missing scores on various subscales)

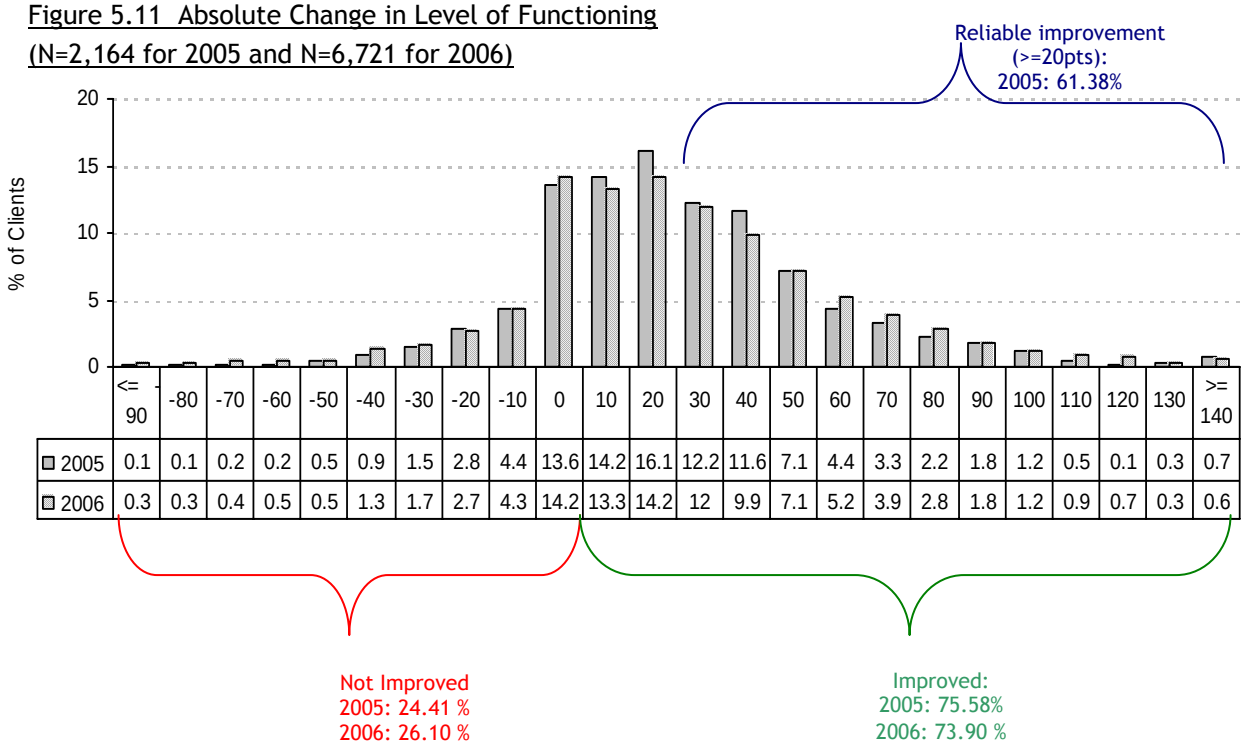


	School	Home	Community	Behavior Towards Others	Moods/ Emotions	Self-Harm	Substance Use	Thinking
Entry- 2005	13.5	12.9	3.6	11.8	13.5	4.0	3.5	2.0
Exit - 2005	8.6	8.1	2.5	7.3	7.6	1.5	2.7	1.2
Entry -2006	13.6	13.2	3.8	11.6	13.4	4.0	3.3	2.0
Exit - 2006	8.5	8.1	2.5	7.2	7.5	1.3	2.5	1.2

Paired t-tests revealed that change effects were statistically significant for each of the eight subscales at $p < .0001$.

Greater than 75% of clients showed functional improvement following service in a children's mental health organization (Fig.5.11). Fewer than 12% of clients showed a decrease in functioning, and fewer than 15% showed no change. These data do not account for treatment dose (frequency, time), and must be interpreted very generally.

Figure 5.11 Absolute Change in Level of Functioning (N=2,164 for 2005 and N=6,721 for 2006)



	<= 90	-80	-70	-60	-50	-40	-30	-20	-10	0	10	20	30	40	50	60	70	80	90	100	110	120	130	>= 140
2005	0.1	0.1	0.2	0.2	0.5	0.9	1.5	2.8	4.4	13.6	14.2	16.1	12.2	11.6	7.1	4.4	3.3	2.2	1.8	1.2	0.5	0.1	0.3	0.7
2006	0.3	0.3	0.4	0.5	0.5	1.3	1.7	2.7	4.3	14.2	13.3	14.2	12	9.9	7.1	5.2	3.9	2.8	1.8	1.2	0.9	0.7	0.3	0.6

PROPORTION OF CLIENTS IMPROVED (COMBINING ALL CLIENTS)

Improvement in level of functioning is operationalized in three ways (3 outcome indicators):

1. Clinically meaningful reduction in overall impairment based on total score

Reduction in overall impairment is scored as successfully achieved if the CAFAS total score from entry to last CAFAS (or the last CAFAS evaluation on record) is reduced by 20 points or more. This indicator ensures that reduction in the CAFAS total score is more than measurement error. A change of 20 points corresponds to approximately a one-half standard deviation for the total CAFAS score, and is equivalent to an effect size of .50 which is defined as a medium effect using Cohen's (1988) guidelines. Hodges (2003) points out that if a Reliable Change Index were calculated using a reliability coefficient of .95 (Hodges & Wong, 1996), the value-defining reliable change for the eight subscale sum would be 20 or more points.

2. Free of severe impairment based on subscale scores

The criterion for successful outcome on this indicator is a score of less than 30 (severe) on each of the eight subscales (e.g., impairment is moderate or less on each subscale). *This indicator is only used for youths who were rated as severely impaired on one or more CAFAS subscales at intake*.

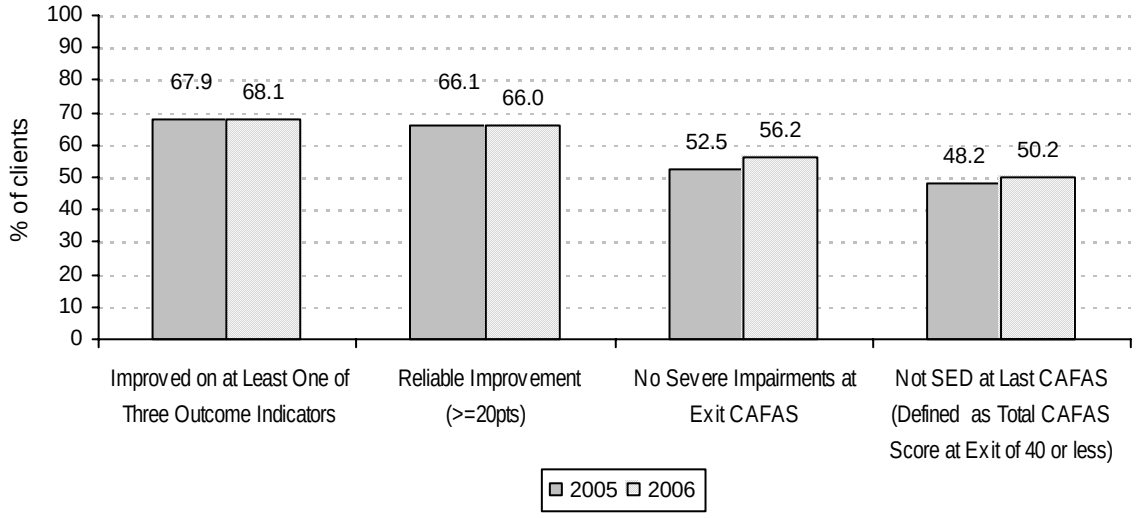
3. No SED[15] at Exit (<40) (Restricted to youths with a score at entry CAFAS <40)

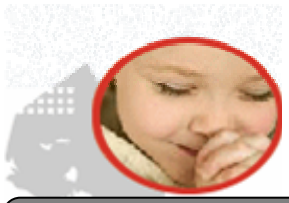
The criteria for this indicator are as follows (from Hodges, 2003): total CAFAS score of 40 or less and all subscale scores are 20 or lower. The reason for the latter criterion was to exclude youths who have a severe impairment (e.g., score of 30) on any of the eight CAFAS subscales. Although very rare, it is possible for a youth to have a total score of 30 or 40, with 30 points due to severe impairment on one subscale. This indicator can only be applied to youths who have a total score of 50 or higher at intake. The cut point of 40/50 was chosen because it has been found to be comparable to a cut point of 61/60 on the Children's Global Assessment Scale (CGAS: Shaffer et al., 1983) or Axis V of *DSM IV*, based on the data from the Ft. Bragg Evaluation Project. A score of 60 on the CGAS has been used as an inclusive definition of Serious Emotional Disorder (SED) (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996). A score of 61 on the CGAS would fall under the description "some difficulty in a single area, but generally functioning pretty well," whereas a score of 60 is summarized as "variable functioning with sporadic difficulties or symptoms in several but not all social areas" (Shaffer et al., 1983). This indicator represents a target end-of-service level of functioning that most likely means that the youth is functioning well enough to be living in the community with a family, and going to school or working. Thus, this indicator is labeled "Free of SED – serious emotional disturbance." Note, however, that it would be too simplistic a conceptualization to assert that a score of 50 or higher represents the presence of SED.

[15] SED – Serious Emotional Disturbance

We find that 68.1% of children and youth (N=6,187) improved in functioning on at least one of the three outcome indicators (Figure 5.12 – here T14 is used as the last CAFAS but findings are similar when last CAFAS on record is the comparator). Sixty-six percent of children and youth (n=6,166) receiving treatment experienced a reduction in the total CAFAS score of 20 points or more, demonstrating a degree of improvement that has been shown to be a clinically meaningful and reliable amount of change. Of the subset of clients that had one or more severe impairments at entry to treatment (N=838), 56.2% had no severe impairments on their last CAFAS evaluation. This is an important finding given that these clients are the most challenging children and youth served by the system. Eliminating severe impairments makes it more likely that "natural helpers" in the community (e.g. coaches, teachers, ministers, neighbours) will be willing and able to assist the child/youth in their development and life roles (Hodges, 2003). Of those clients whose entry CAFAS score was 50 or higher (N=2,546), 50.2% (vs. 48.2% shown in the 2005 annual report) had a lower level of impairment on their last CAFAS rating (defined as 40 or lower for total CAFAS score, and no subscale scores above 20).

Figure 5.12 Percentage of Clients Improved on at Least One of the Three Outcome Indicators (N=2,019 / 2,009 / 838 /1,344 for 2005 and N= 6,187/6,166/2,546/2,546– 2006)





Characteristics of Closed Cases

This section of the report describes the characteristics of cases that have been 'closed' by the organization. Closing a case requires that the clinician complete the Close Episode screen for the client, when it is either known or appears that the client is not returning to services.

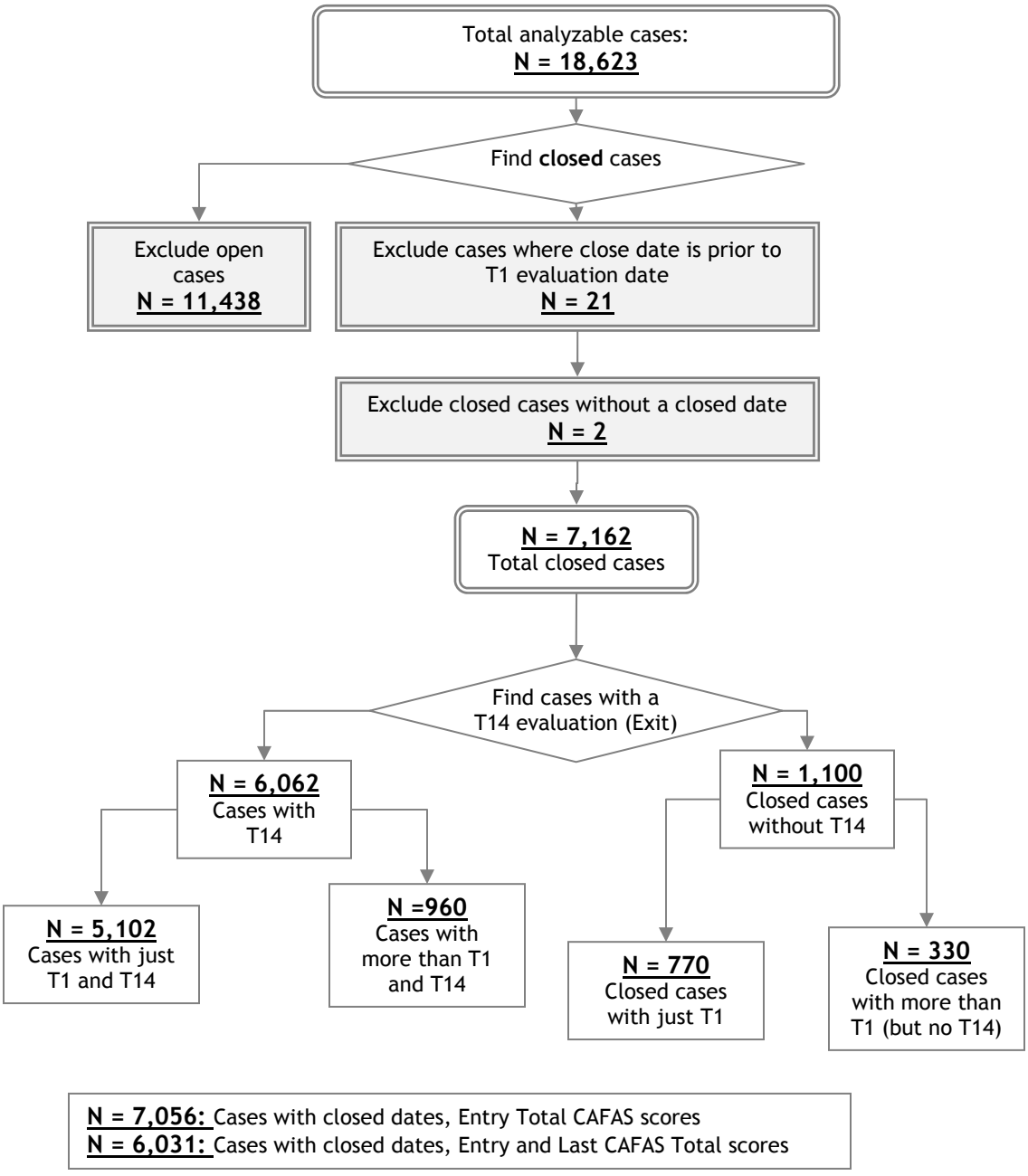
We then examined the frequency of CAFAS evaluations for Closed cases, as in Table 6.1 below. The majority of closed cases have between 1 and 6 CAFAS evaluations. Moreover, most Closed cases have a T1 and T14 (N=5,102).

Table 6.1 Number of CAFAS Evaluations on Record for Closed Cases

Number of CAFAS evaluations	N for closed cases	N for closed cases with T14
1	770 (T1 only)	N/A
2	5,339	5,102 (T1 & T14 only)
4	694	641
5	208	184
6	85	77
7	13	40
8	4	11
9	2	4
10	1	2
11	1	1
Total	N=7,162	N=6,062

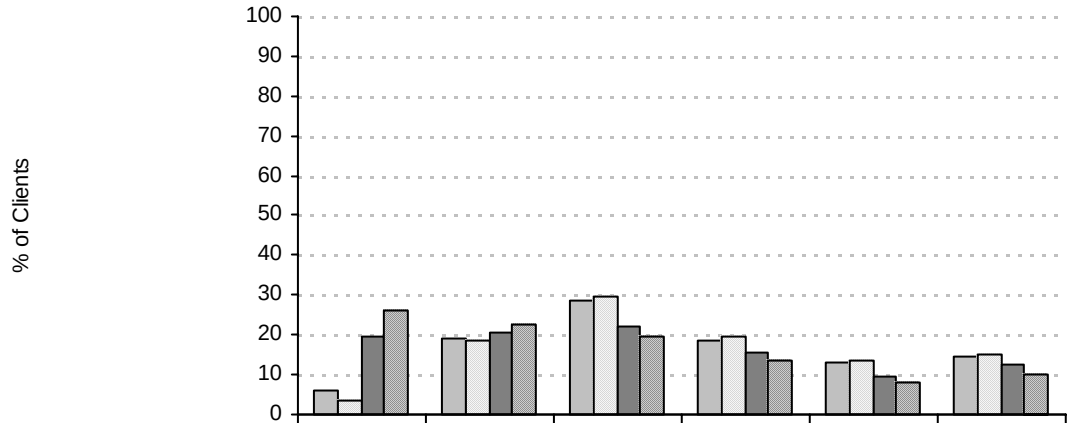
The following decision process was used to determine which cases were 'closed' (Figure 6.1).

Figure 6.1 Calculating Closed Cases



Looking at when, during the course of treatment, cases tend to be Closed provides another perspective. The majority of cases (28.5%) are Closed between the 3rd and 6th month of service (Fig.6.2). When we consider those cases that Closed with only a T1 evaluation, these tend to close earlier, between months 1 and 3.

Figure 6.2 Time between Entry to Treatment and Close Date



	0-1mth	1-3mths	3-6mths	6-9mths	9-12mths	>12mths
All Closed Cases	5.9	19.1	28.5	18.8	13.0	14.7
Closed Cases with T14	3.4	18.8	29.7	19.4	13.6	15.1
Closed Cases without T14	19.6	20.7	21.9	15.6	9.6	12.5
Cases Closed with T1 only	26.2	22.5	19.5	13.6	8.2	10.0

The disposition of Closed cases is depicted in Table 6.2 below. While it is evident from this data that most clients for whom a Close Episode was recorded improved, a large group did not improve.

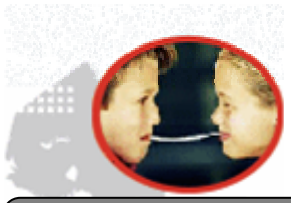
Table 6.2 Disposition of Closed Cases

Outcome	**N** 6,031
Treatment Not Needed Only one CAFAS evaluation was done and there was good reason for not providing treatment (i.e., evaluation only, no treatment needed, or referred to other service). This information is entered when the file is closed.	103
Not Improved Did not improve on any of 3 outcome indicators.	1,761
Improved Improved on 1 or more of 3 outcome indicators.	3,689
Entry Was 0 OR 10 Outcome cannot be evaluated because the Entry CAFAS was a 0 or 10. Since the least "ambitious" outcome indicator requires a reduction of 20 points or more, it is not possible to evaluate outcome if the entry score is less than 20.	478
Likely Drop-Outs But Needed Treatment There was an entry CAFAS but no subsequent CAFAS evaluation and the case appeared to be appropriate for treatment (i.e., case was not coded as "evaluation only", "no services needed" or "referred to other services" when case was closed).	0

The Close Episode also captures the reason underlying the case closure (Table 6.3). Where it was recorded that no treatment was attempted, this was mostly due to 'no shows' and 'withdrawal' from treatment. This suggests a need to examine treatment attrition. Moreover, when treatment was noted as having been interrupted this was largely due to clients quitting.

Table 6.3 Reason for Case Closure

Closed Reason		All closed cases N=7,162	Cases closed with T1 only N=770	Cases closed without T14 N=1,100	Cases closed with T14 N=6,062
No Treatment Attempted	Not Needed	49	14	16	33
	No Show	96	45	52	44
	Withdrew	192	59	70	122
	Other service	67	21	25	42
	Evaluation	35	0	12	23
	Other & Unknown	37	11	13	24
Treatment Interrupted	Quit	1,424	174	235	1189
	Moved	413	38	54	359
	Therapist	53	11	14	39
	Ineligible	65	9	16	49
	Aged	18	0	2	16
	Deceased	3	0	0	3
	Changed	164	14	25	139
	Other & Unknown	230	26	39	191
Treatment Was Accomplished	Successful	2,700	35	294	2406
	Partially Successful	1387	88	159	1228
	Little Success	364	35	58	306
Other and Unknown		127	35	38	

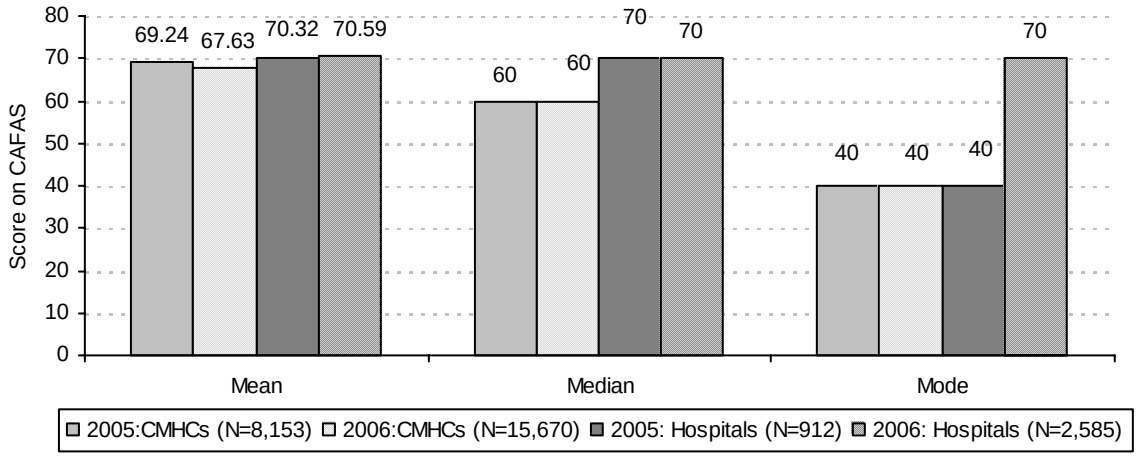


Community vs. Hospital Treatment

This section of the report describes the level of functioning for children and youth served in community-based versus hospital-based services, and for whom we have CAFAS data. As before, these data represent children and youth who sought children's mental health services in designated Ontario service provider organizations during the time frame specified above.

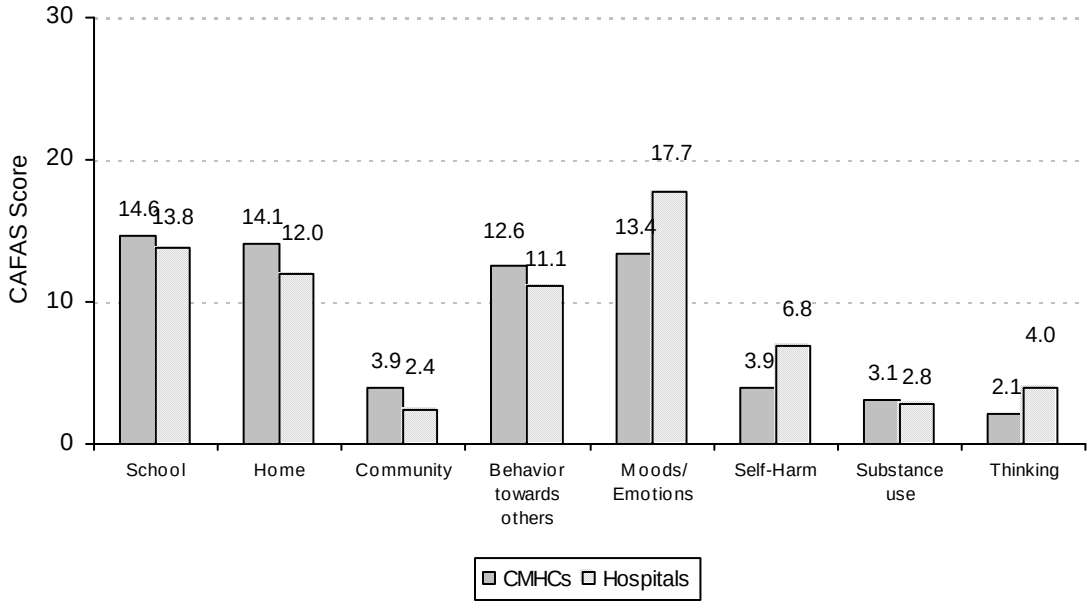
There is no difference in measures of central tendency for those clients served in the community versus those served in hospital settings, with one exception which is a relatively high mode for hospital clients that we believe reflects a bi-modal distribution (Fig.7.1).

Figure 7.1 CAFAS Rating at Entry to Treatment: Community-based versus Hospital-based



Differences in level of functioning across subscale domains are evident, however, with hospital clients showing greater levels of dysfunction in the areas of moods/emotions, self-harm, and thinking (Fig.7.2)

Figure 7.2 Average Entry Subscale Scores by Organization Type (Hospitals & CMHCs)
(N for CMHCs varies between 15,895 and 15,916 and N for Hospitals varies between 2,622 and 2,630 because of missing scores on different subscales)



Differences between the two settings can also be observed when comparing levels of severity, as in Figure 7.3 below. As expected, community based organizations see a higher number of clients in the 0-30 dysfunction range. This findings is similar to that of 2005 (Fig.7.4). The remainder of the picture changes a little over the course of this year compared to 2005, however. Whereas previously, we saw community-based organizations having a greater number of clients in the high dysfunction range (>140), data for 2006 now shows a narrowing of this difference. In fact, difference in severity level across all categories has diminished this year. This data do not support the contention that hospital settings are treating more dysfunctional cases, however, there is a large discrepancy in sample size which may account for this finding.

Figure 7.3 Severity on Entry to Treatment: Community-based versus Hospital-based -**2006**
Community-based (N=15,984); Hospital-based (N=2,639)

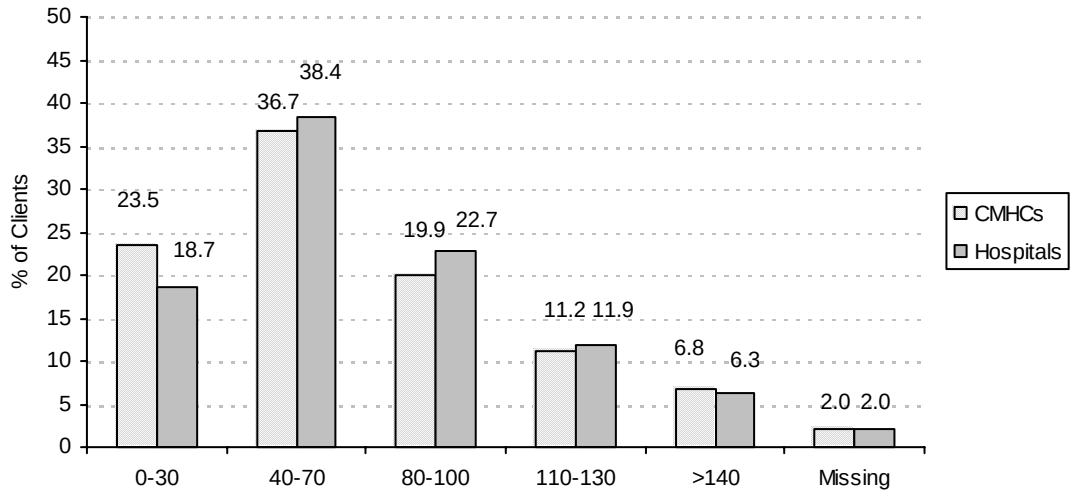
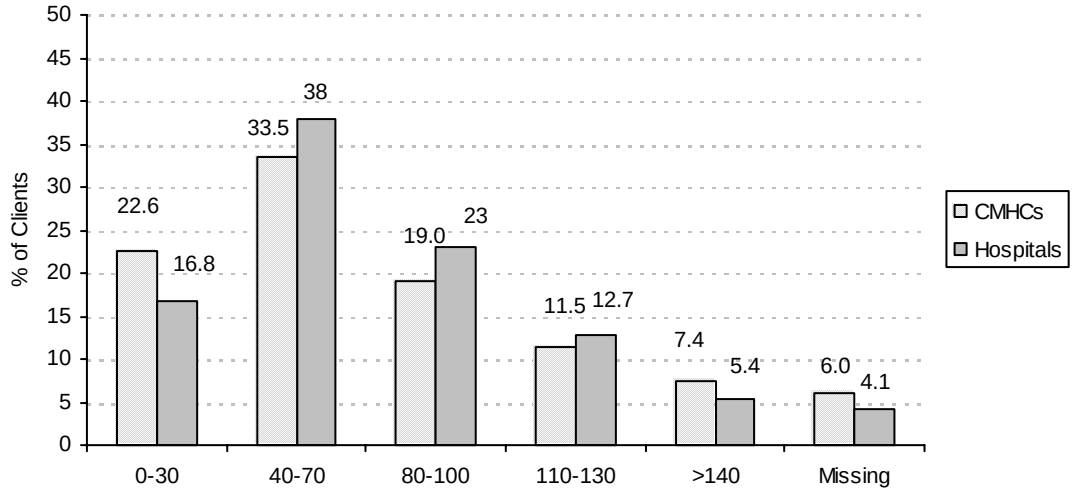


Figure 7.4 Severity on Entry to Treatment: Community-based versus Hospital-based -**2005**
Community –based (N=8,153) versus Hospital-based (N=912)



In summary, severity of functioning at entry to treatment shows little difference between settings (Figure 1.19). A slightly larger percentage of children and youth with very severe dysfunction (6.8%) receive services in community-based settings, compared to 6.3 % who receive treatment in hospital settings. However, the difference is 4 times smaller in 2006 compared with last year (0.5% for 2006 vs. 2% for 2005).

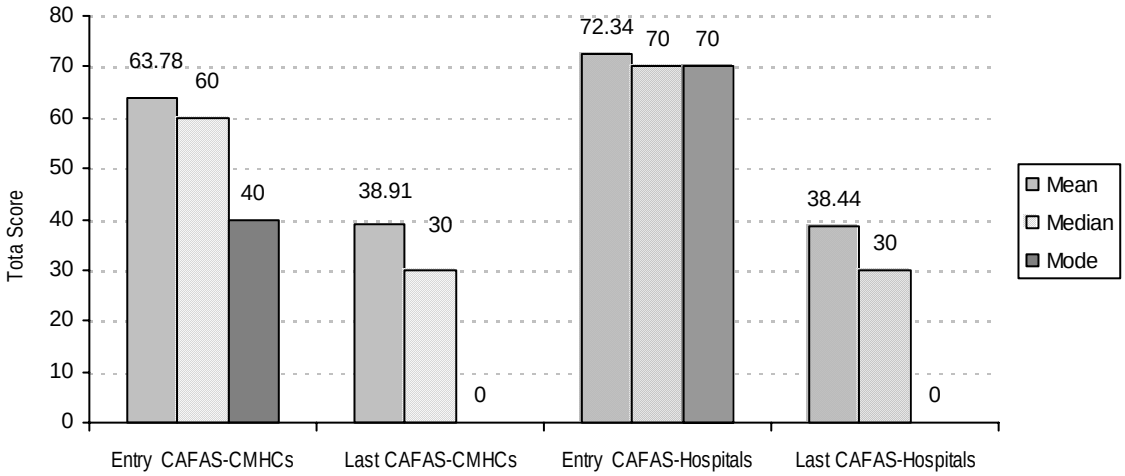
Fewer clients seen in hospital settings (18.7%) have lower levels of dysfunction as compared to clients admitted to community-based services (23.5%).

Differences in level of functioning outcome scores between community-based and hospital-based services are shown in Figure 7.4 below. Hospital-based clients show a larger difference score and effect size (Diff=34.03; SD=35.221, ES=.85) than community-based clients (Diff=24.88; SD=34.67, ES=.62). (Note T14 was used as the outcome criteria).

Figure 7.5 Average CAFAS Total Score from Entry to Exit CAFAS (T14) for Community-Based Services and Hospitals
Total possible CAFAS score=240.

Very similar results are evident for the slightly larger sample that includes scores for cases closed without T14: Hospital-based clients show a larger difference score and effect size (Diff=33.90; SD=35.146, ES=.84) than community-based clients (Diff=24.88; SD=34.91, ES=.62) (Fig.7.5).

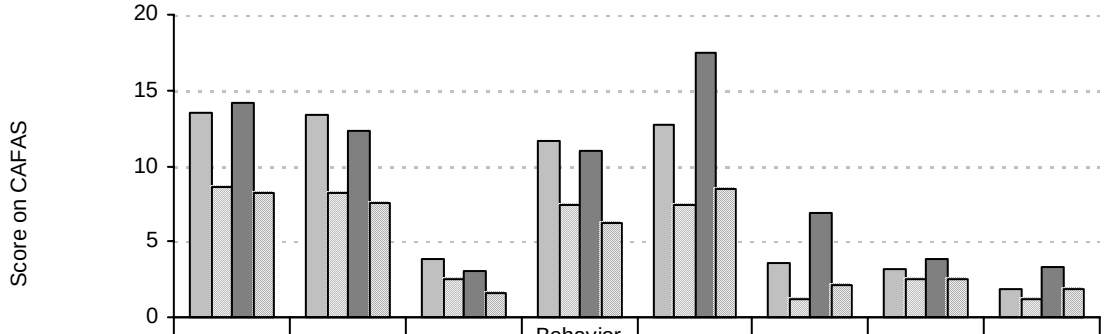
Figure 7.6 Change in Average CAFAS Total Score from Treatment Entry to Last Evaluation (N=6,086 for CMHCs and N=841 for Hospitals); Total possible score= 240.



Level of global functional impairment is similar for children and youth receiving community-based and hospital services.

Figure 7.7 Change in Average Score on CAFAS Subscales from Treatment Entry to Last Evaluation

N for CMHCs varies between 6,238 and 6,254 and N for Hospitals varies between 859 and 864 because of missing scores on different subscales. Total possible score =30.



	School	Home	Community	Behavior Towards Others	Moods/ Emotions	Self-Harm	Substance Use	Thinking
Entry- CMHCs	13.6	13.3	3.9	11.7	12.8	3.6	3.2	1.8
Exit - CMHCs	8.6	8.2	2.6	7.4	7.4	1.2	2.5	1.2
Entry - Hospitals	14.1	12.4	3.1	11.0	17.5	6.9	3.8	3.4
Exit - Hospitals	8.3	7.6	1.6	6.2	8.5	2.1	2.6	1.8

Caregiver Characteristics

CAREGIVER CHARACTERISTICS

This section of the report describes the level of functional impairment of clients' caregivers at entry and exit to treatment. There are two caregiver subscales on the CAFAS scale: Material Needs and Social Support. For these two subscales, the *caregiver* is rated – not the client. Three types of caregivers can be rated on the CAFAS:

(1) Primary Family – the parent(s) who is(are) rearing the client or with whom the client lives most of the time (e.g., biological parent, adoptive parent, where the client was before treatment and where the client will return);

(2) Non-custodial Caregiver – the parent(s) who has a psychological impact on the client yet is non-custodial or is not living in the same home as the client; and

(3) Surrogate Caregiver – surrogate parent(s) (e.g., persons substituting as parent, such as foster parents, group home caregivers, caregivers in residential treatment settings).

Hodges (2003) notes that these scales do not penalize parents or reflect how "good" or "bad" they are. Rather, receiving a score at the Severe, Moderate, or Mild level can mean simply that the client's needs are greater than the resources available to the caregiver.

The Material Needs subscale pertains to caregivers' ability to provide food, shelter, clothing and medical care for the client such that the client's functioning and development of skills are not impeded. The Family Social Support subscale captures the caregivers' capacity to satisfactorily meet the special needs of the client without jeopardizing other family members (level of resources available), to exercise good parental judgment so that s/he can provide a safe, secure, and healthy home environment in which the client's developmental needs can be met (parental judgment and functioning), to protect the client from abuse, or if abuse occurs, provide physical and emotional support to the client (non-abusive environment), provide a home and adequate supervision of the client's activities whether in or outside of the home (supervised home), and lastly, is free of domestic violence, hostility, or pervasive conflict (conflict management).

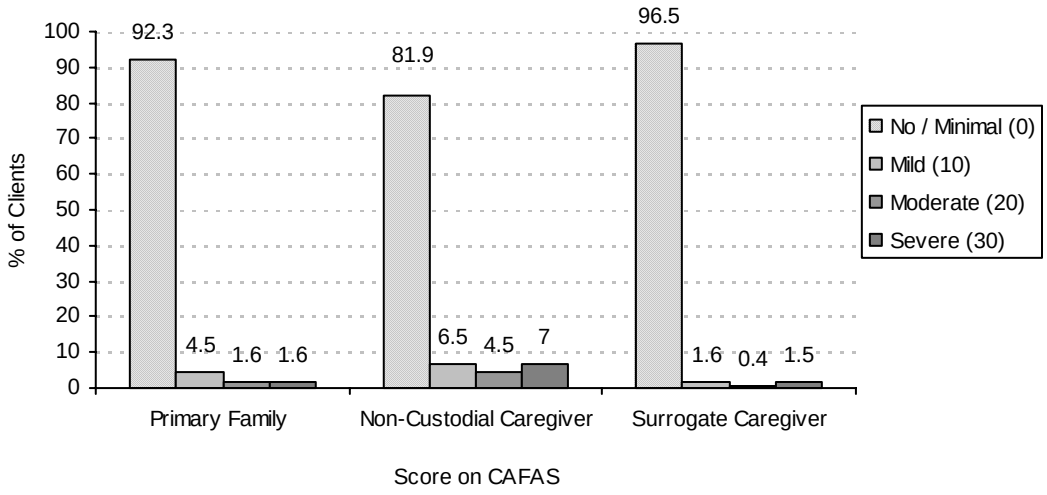
Analyzable caregiver data included cases that are within the analyzable date range for youth (18, 683) but also have scores for Entry CAFAS (T1) (table 8.1) and scores for last CAFAS (see Table 8.2).

Table 8.1 Caregivers at Treatment Entry

		Material Needs Subscale			Family/Social Support Subscale		
		Primary Family	Non-Custodial Caregiver	Surrogate Caregiver	Primary Family	Non-Custodial Caregiver	Surrogate Caregiver
N	Valid	17,987	2,630	857	17,293	2,554	862
	Missing	1,236	15,993	17,766	1,330	16,069	17,761
Mean		1.25	3.67	.69	8.27	13.44	2.74
Median		.0	0	0	10	10	0
Mode		0	0	0	0	0	0
SD		4.87	8.63	4.03	9.05	11.24	6.93

With respect to Material Needs, there is very little dysfunction across all types of caregivers. Non-custodial caregivers show the highest level of moderate and severe dysfunction in this domain, but it is still quite low in frequency.

Figure 8.1 Material Needs Subscale for Caregivers at Treatment Entry



Greater dysfunction is evident in the domain of family social support (Fig.8.2). Again, it is the non-custodial caregivers who demonstrate the greatest level of moderate and severe dysfunction in this domain.

Figure 8.2 Family Social Support Subscale for Caregivers at Treatment Entry

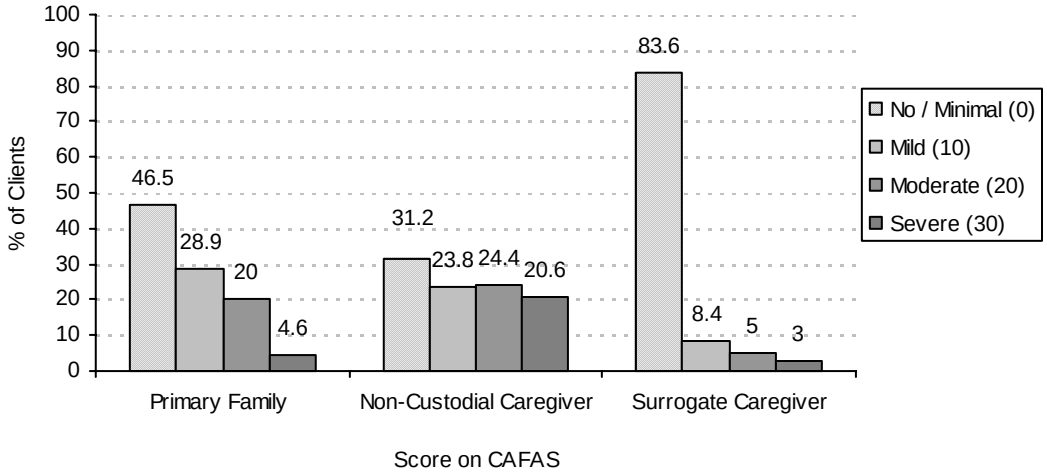


Table 8.2 depicts the level of change evidence across caregiver types from entry to last CAFAS rating, and a similar view in Table 8.3 shows change when T14 is considered the last rating. Non-custodial caregivers make the largest functional gains in material needs, whereas both primary and non-custodial caregivers make the largest gains in social support.

Table 8.2 Caregivers at Treatment Entry and **Last** CAFAS

	Material Needs Subscale						**Family/Social Support Subscale**					
	Primary Family		Non-Custodial Caregiver		Surrogate Caregiver		Primary Family		Non-Custodial Caregiver		Surrogate Caregiver	
	Entry	Last	Entry	Last	Entry	Last	Entry	Last	Entry	Last	Entry	Last
N	6,433		497		139		6,230		489		141	
Mean	1.02	.92	3.38	2.25	.72	.79	8.04	5.89	12.94	10.78	2.62	2.20
SD	4.27	4.06	7.97	6.58	4.45	4.52	8.88	8.38	10.51	10.35	7.04	6.56
Means difference	.11		1.3		-.07		2.22		2.17		.43	
SD of the means difference	4.44		5.92		4.89		8.46		8.60		7.55	

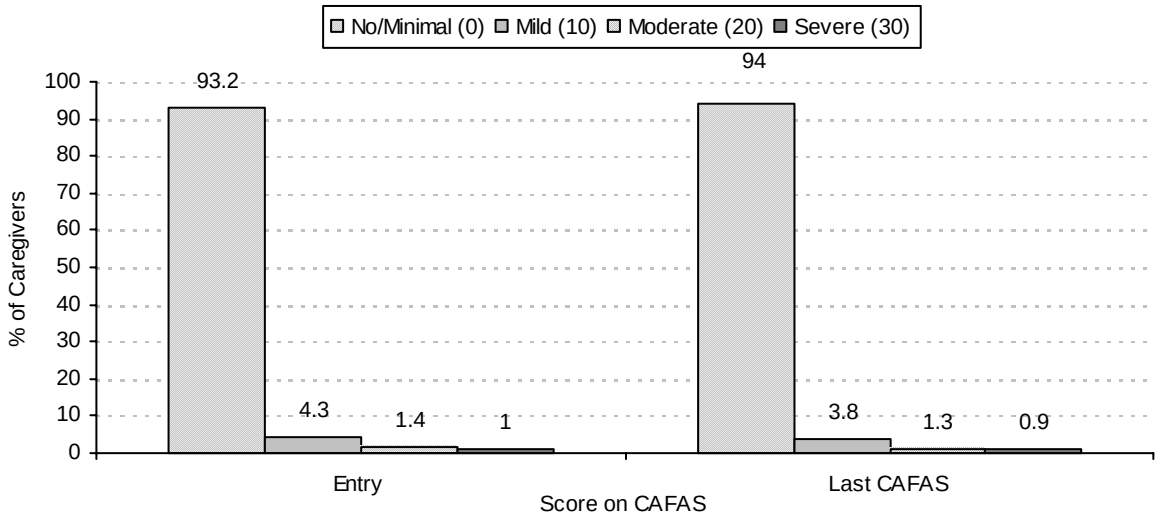
SD=Standard Deviation

Table 8.3 Caregivers at Treatment Entry and **Exit** CAFAS

	Material Needs Subscale						**Family/Social Support Subscale**					
	Primary Family		Non-Custodial Caregiver		Surrogate Caregiver		Primary Family		Non-Custodial Caregiver		Surrogate Caregiver	
	Entry	Last	Entry	Last	Entry	Last	Entry	Last	Entry	Last	Entry	Last
N	6,252		484		135		6,209		475		136	
Mean	1.02	.91	3.37	2.29	.74	.81	8.03	5.88	12.99	10.72	2.65	2.21
SD	4.28	4.06	7.94	6.65	4.51	4.58	8.374	8.879	10.53	10.35	7.12	6.63
Means difference	.11		1.07		-.07		2.15		2.27		.44	
SD of the means difference	4.43		5.84		4.96		8.45		8.54		7.69	

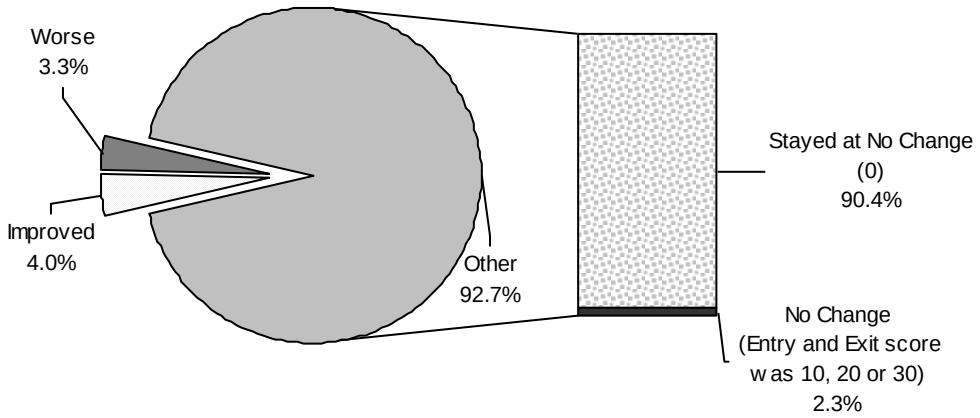
There is little improvement (0.8%) for the primary family, Material Needs Subscale. However, an already high percent of 93.2% of families show no dysfunction in providing the provision of food, shelter, clothing and medical care for the client. All categories of functioning show improvement in this domain (Fig.8.3).

Figure 8.3 Primary Family Material Needs at Treatment Entry and Last CAFAS
(N=6,433)



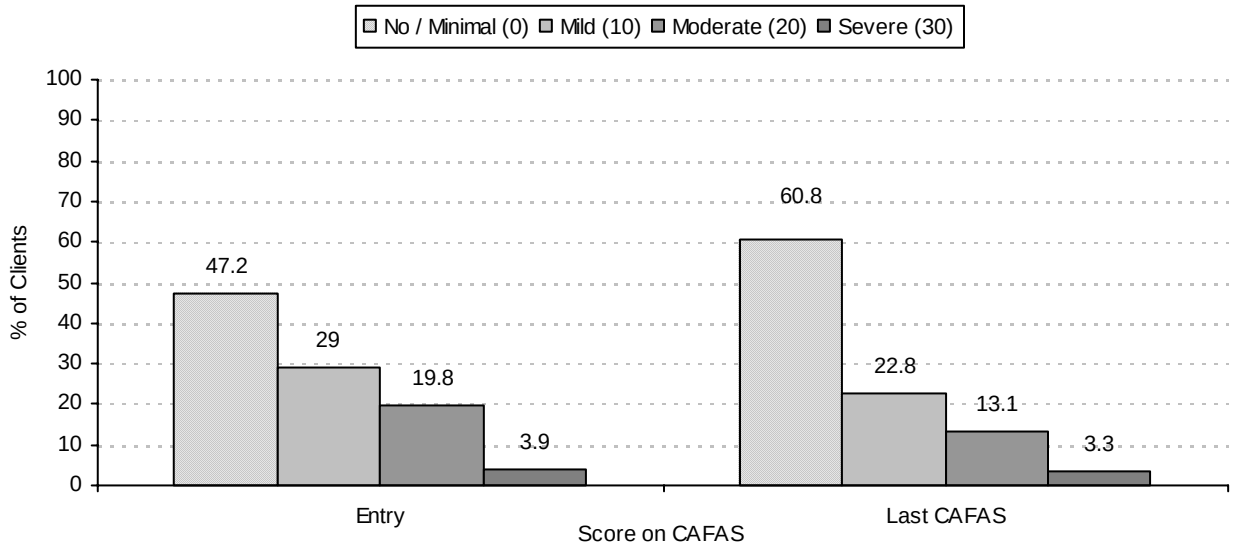
From another perspective, data for 6.433 primary families (over three time more than the data collected in 2005 where N=1,967) show that 4% improved on the Material Needs subscale, 3.3% got worse, and the vast majority 9.7 showed no change, mainly because their scores at entry and exit to treatment were 0 (90.4%) or because there was no change in scores (2.3%) (see Fig.8.4).

Figure 8.4 Change in Primary Family Material Needs
(N=6,433)



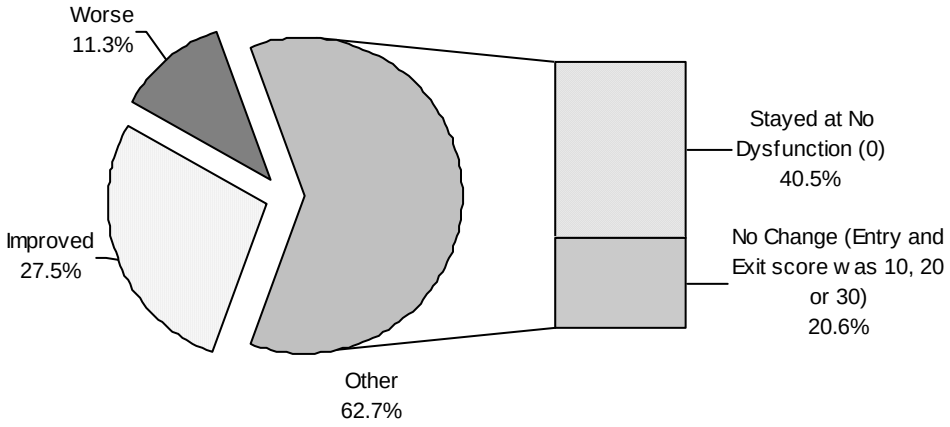
We see improvement for primary family functioning in the provision of social support, with 47.2% of families having no dysfunction in this area rising to 60.8% of families upon exit from treatment. All categories of functioning show improvement in this domain (Fig.8.5).

Figure 8.5 Primary Family Social Support at Treatment Entry and Last CAFAS
(N=6,230)



Data for 6,230 (also over three times more than the data collected in 2005 where N= 1,973) primary families shows that 27.5% improved in the social support domain, 11.3% got worse, and 62.7% showed no change, either because their scores at entry and exit to treatment were 0 (40.5%) or because there was no change (20.6%) (see Fig.8.6).

Figure 8.6 Change in Primary Family Social Support
(N=6,230)



A similar pattern of results for the Material Needs and Family/Social Support subscales were observed for Non-custodial and Surrogate caregivers, respectively (Table 8.3). All categories (severity of functioning) for social support and material resources revealed improvement for both caregiver types across treatment (entry to exit). A large percentage of families showed no change within these domains upon treatment entry to exit – whether characterized by scores of 0 at entry and exit, or no literal change in scores over time.

Table 8.4 Clinical Meaningful Change on Material Needs and Family/Social Support Scale Score – Non-Custodial and Surrogate Caregivers

	Non-Custodial Caregivers					Surrogate Caregivers				
	N	Improved	Worse	No Change		N	Improved	Worse	No Change	
				Stayed at No Dysfunction (Score=0)	No Change (Score other than 0)				Stayed at No Dysfunction (Score=0)	No Change (Score other than 0)
Material Needs	458	11.4	3.5%	85.2%	0%	139	1.4%	2.9%	95%	0.7%
Family/Social Support	489	27.4%	10.6%	22.5%	39.5%	141	9.9%	8.5%	77.3%	7.3%

Future Recommendations

COMPLIANCE

Compliance with CAFAS use across the province is showing slow but steady improvement. In 2006, there were 4 hospital-based and 4 community-based organizations (3.77% each) who did not export data for the final report. In 2005, there were 5 hospital-based (4.67%) and 6 community-based organizations (5.61%) who did not export data for the final report. Looking back at the 2004 CAFAS report, there were 7 hospital-based (6.54 %) and 16 community-based organizations (14.95%) who did not export data for the final report.

Compliance with CAFAS use (e.g., use of CAFAS software tool and export of data to Sick Kids) has yet to achieve 100%. However, a huge step forward was recorded from 2004 to 2006, due to continuous support through phone and email, and the development and dissemination of a variety of instructional documents intended to clarify software installation, data management, and data export data.

TECHNICAL DIFFICULTIES

The addition of an IT consultant to the CAFAS team, as needed, has improved our ability to respond to the technical assistance needs of the field. This was a good decision, and we will retain these services for the upcoming fiscal year.

There continues to be a need to improve computer hardware (e.g., server capacity) and computer literacy, and to assist organizations that have little in the way of IT support – which appears to be the majority of them. With the onset this year of providing organization-specific data reports following each quarterly export, organizations require some level of support in interpreting their "results." This support is provided over the phone or via site-specific visits.

COLLECTION OF THE ONTARIO COMMON DATA SET (OCDS)

Analysis, and hence utility of the CAFAS data, is hindered by the lack of data regarding client and program characteristics. Versions 5.3 and 5.4 of the CAFAS software identify the OCDS clearly on the screen for the rater to see using a maple leaf icon.

Mere identification of the OCDS in the software is necessary but not sufficient to encourage practitioners to rate all of these fields. Support from organizational and provincial leadership will be very important in this regard.

We will continue to look for a solution in 2007 to simplify the management of data by the CAFAS team at Sick Kids. A possible answer will be to ask the organization to export data through an FTP Server.

USING CAFAS FOR PROGRAM EVALUATION

In 2007, CAFAS in Ontario will work with Dr. Kay Hodges to develop a process for using the CAFAS software tool to conduct program evaluation. This is greatly needed and has been much requested by the field.

NEED FOR A UNIQUE IDENTIFIER

Certain questions can be asked of the dataset in the event that CAFAS and BCFPI client level data can be matched. In order that we may link this data, organizations and practitioners would be required to consistently use a unique identifier for each client on both tools.

When the data set includes client characteristic data from the OCDS, and when the data can be linked to BCFPI data, case mix analyses can be done to control for several factors known to have an impact on outcomes, e.g., severity of mental health problems (functioning, symptoms), type of program or service, and type of service provider organization. Case mix adjustment can be useful in behavioural sciences research to "level the playing field" when comparing outcomes for any two or more groups, such as clients in different streams of a mental health care system (e.g., community based versus hospital clinic versus specialized community setting).

We are optimistic that the Ministry's long term data strategy will begin to address this issue across the system.

RATING OF ALL ELIGIBLE CLIENTS

We know little about what percentage of clients receiving treatment in the participating organizations are being rated on the CAFAS. Data from 2004 showed 15,104 clients[16] BCFPI data at intake and 6,594* clients for CAFAS. Of those, only 715 clients with identical Client IDs were found in both CAFAS and BCFPI merged databases suggesting that less than 5% (4.73%) of the clients with a BCFPI intake subsequently received CAFAS evaluations. This needs to be examined further in order to be improved upon, as described in the previous paragraph. Efforts could be made organizationally and provincially to increase this rate.

Starting with October, 2006, the Ministry of Children and Youth Services was adamant that CAFAS, BCFPI, and CYMH fund data for each client be linked. The following announcement was sent to all organizations to require the linking of CAFAS, BCFPI, and CYMH fund data (where applicable) in the following manner:

The BCFPI "Client ID" (Person Screen) - however derived - must be entered onto the CAFAS "Client Identification Number" (Client Identification and Background Screen) and onto the clients' CYMH fund data that is required from MCYS. This procedure requires that the clinician rating CAFAS knows the BCFPI Client ID. BCFPI always predates the CAFAS rating at Time 1 (entry to treatment) and the BCFPI print out must be in the file information available to the designated treatment clinician. In the event that the organization receives BCFPI data from another location/organization, and this occurs following the first CAFAS rating, then organizations must put procedures into place to ensure a data match using the BCFPI Client ID, i.e., go back into CAFAS and enter the BCFPI Client ID.

[16] Based on the Annual Provincial Report 2004

CONTINUED TRAINING IN CLINICAL APPLICATION AND BEST PRACTICE

Further education regarding the utility of the CAFAS tool for client-level treatment and case management, and increased understanding of *outcome management*, is also needed. Human resources limitations may also be an important factor here, as in some organizations with a high volume of clients, it may not be feasible to rate CAFAS for all clients entering treatment, and this needs to be examined on an individual client basis.

The CAFAS team has begun to draft a Best Practice Manual that will be available to the field in early summer 2007. This manual is intended to be an 'evergreen' document that will undergo revision annually. Moreover, it will be available in electronic and searchable format on the CAFAS website.

References

Barlow, D.H., Hayes, S.C., & Nelson, R.O. (1984). The scientist-practitioner: research and accountability in clinical and educational settings. New York: Pergamon

Barwick, M. A., Boydell, K. M., Stasiulis, E., Ferguson, H. B., Blase, K., & Fixsen, D. (2005). Knowledge transfer and evidence-based practice in children's mental health. Toronto, ON: Children's Mental Health Ontario

Barwick, M.A., Dilico Ojibway Child and Family Services, & Hodges, K. (2004). Culturally competent evaluation: clinical considerations for rating the Child and Adolescent Functional Assessment Scale with Aboriginal children and youth. Toronto, ON: The Hospital for Sick Children

Barwick, M.A., Omrin, C., & Basnett, D. (under review). Maintaining reliability in Ontario's outcome initiative: training approaches and rater drift on the Child and Adolescent Functional Assessment Scale.

Busch, A.B. (2002). Validity, reliability, and other key concepts in outcome assessment and services research. In W. W. IsHak, T. Burt & L.I. Sederer (Eds). Outcome measurement in psychiatry: A critical review, pp.35-55. Washington, DC: American Psychiatric Publishing.

Chambliss, D., & Ollendick, T.H. (2001). Empirically supported psychological interventions: Controversies and evidence. Annual Review Psychology, 52, 685-716.

Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Cunningham, C.E., Pettingill, P., & Boyle, M. (2000). The *Brief Child and Family Phone Interview* (BCFPI). Hamilton, ON: Canadian Centre for the Study of Children at Risk, Hamilton Health Sciences Corporation, McMaster University

Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. American Psychologist, 54, 755-764.

Duchnowski, A., Hall, K., Kutash, K., & Friedman, R. (1998). The alternatives to residential treatment study. In Epstein M, Kutash K, Duchnowski A, eds. Outcomes for children and youth with behavioral and emotional disorders and their families: Programs and evaluation best practices (pp. 55-80). Austin, TX: Pro-ed.

Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1996).Prevalence of serious emotional disturbance in children and adolescents. In R. W.Manderscheid & M. A. Sonnerschein (Eds.), Mental health, United States (pp. 71-89). Tiburn, CA: CentraLink.

Hodges, K. (2004). Evidence-based treatments for children and adolescents: A compilation of resources and guide for matching CAFAS profiles to evidence-based treatments. Ypsilanti, MI: Eastern Michigan University.

Hodges, K. (2003). Child and Adolescent Functional Assessment Scale (3rd ed.). Ypsilanti, MI: Eastern Michigan University.

Hodges,. K., Doucette-Gates, A., & Kim, C.S. (2000). Predicting service utilization with the Child and Adolescent Functional Assessment Scale in a sample of youths with serious emotional disturbance served by Centre for Mental Health Services-funded demonstrations. The Journal of Behavioral Health Services & Research, 27, 47-59.

Hodges, K., Doucette-Gates, A., & Liao, Q. (1999). The relationship between the Child and Adolescent Functional Assessment Scale (CAFAS) and indicators of functioning. Journal of Child and Family Studies, 8, 109-122.

Hodges, K., & Kim, C.S. (2000). Psychometric study of the Child and Adolescent Functional Assessment Scale: Prediction of contact with the law and poor school attendance. Journal of Abnormal Child Psychology, 28, 287-297.

Hodges, K., Xue, Y., & Wotring, J. (in press a) Outcomes for children with problematic behavior in school and at home served by public mental health. Journal of Emotional and Behavioral Disorders.

Hodges, K., Xue, Y., & Wotring, J. (in press b). Use of the CAFAS to evaluate outcome for youths with SED served by public mental health. Journal of Child and Family Studies.

Hodges, K., & Wong, M. M. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale. Journal of Child and Family Studies, 5, 445-467.

Hodges, K., & Wong, M.M. (1997). Use of the Child and Adolescent Functional Assessment Scale to predict service utilization and cost. Journal of Mental Health Administration, 24, 278-290.

Huang, L.N., Hepburn, M. S., & Espiritu, R.C. (2003). To be or not to be evidence-based? Data Matters, 6, 1-3. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. Journal of Consulting and Clinical Psychology, 59, 12-19.

JCCP. (1998). Empirically supported psychosocial interventions for children. Journal of Clinical Child Psychology. Special Issue, 27, 138-226

Kazdin, A. E., & Kendall, P. C. (1998). Current progress and future plans for developing effective treatments: Comments and perspectives. Journal of Clinical Child Psychology, 27, 217-226.

Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. Journal of Consulting and Clinical Psychology, 66, 19-36.

Lambert, M.J., Whipple, J.L., Smart, D.W., Vermeersch, D.A., Nielsen, S.L., & Hawkins, E.J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? Psychotherapy Research, 11, 49-68.

Manteuffel, B., Stephens, R. L., & Santiago, R. (2002). Overview of the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program and summary of current findings. Children's Services: Social Policy, Research, and Practice, 5(1), 3-20.

Newman, F.L., Ciarlo, J.A., & Carpenter, D. (1999). Guidelines for selecting psychological instruments for treatment planning and outcome assessment. In M. E. Maruish, (Ed). The use of psychological testing for treatment planning and outcomes assessment, 2nd edition,(pp.153-170). Mahwah, NJ: Lawarence Erlbaum Associates, Inc.

Ogles, B.M., Lambert, M.J., Masters, K.S. (1996). Assessing outcome in clinical practice. Boston: Allyn & Bacon.

Quist, R.M., & Matshazi, D.G.M. (2000). The Child and Adolescent Functional Assessment Scale (CAFAS): A dynamic predictor of juvenile recidivism. Adolescence, 35,181-192.

Rosenblatt, J., & Furlong, M. (1998). Outcomes in a system of care for youths with emotional and behavioral disorders: An examination of differential change across clinical profiles. Journal of Child and Family Studies, 7, 217-232.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., et al. (1983). A Children's Global Assessment Scale (CGAS). Archives of General Psychiatry, 40, 1228-1231.

Walrath, C., Mandell, D., & Leaf, P. (2001). Responses of children with different intake profiles to mental health treatment. Psychiatric Services, 52, 196-201.

Xue, Y., Hodges, K., & Wotring, J. (in press). Predictors of outcome for children with behavior problems served in public mental health. Journal of Clinical Child and Adolescent Psychology.

Appendix: ORGANIZATIONS EXPORTING DATA BY REGION

Admission dates: Jan. 1, 2005 - Dec 31, 2006 *Submitted:* *March 30, 2007*

CAFAS Export Status Summary

Export No: **10**

Central East

Agencies submitting export files	*Hospital*
Blue Hills Child and Family Centre	☐
CHIMO Youth Services & Family Services	☐
Frontenac Youth Services	☐
Kinark Child & Family Services	☐
New Path Youth & Family Counselling Services	☐
Peterborough Regional Health Centre	☑
Southlake Regional Health Centre	☑
Whitby Mental Health Centre	☐
York Central Hospital - Child & Family Services	☑
York Centre for Children, Youth & Families	☐

SubTotal: ***10*** ***Percent /Region:*** ***90.91%***

Agencies with difficulties in submitting export files	*Hospital*
Lakeridge Health Centre - Children's Mental Health Program	☑

Our comments:

CAFAS server crashed and there is no information since Feb,2006. Data will be sent out next round.

Garry Freeman	(905) 576-8711	ext.	gfreeman@lakeridgehealth.on.ca
Lorraine Sunstrum-Mann	(905) 576-8711	ext. 4209	lorraine@lakeridgehealth.on.ca
Shelley Phoenix		ext.	sphoenix@lakeridgehealth.on.ca

SubTotal: ***1*** ***Percent /Region:*** ***9.09%***

Total agencies for region Central East: ***11***

Central West

Agencies submitting export files	*Hospital*
Associated Youth Services of Peel	☐
Cambridge Memorial Hospital - Child & Family Services	☑
Community Mental Health Clinic - Wellington County	☐
Dufferin Child & Family Services - Mental Hlth Prog.	☐
Grand River Hospital	☑
Halton Child & Youth Services -Children's Assessment & Treatment Centre	☐
KIDSLink (Notre Dame of St. Agatha Children's Centre)	☐
Lutherwood - CODA	☐
Nelson Youth Centres	☐
Peel Children's Centre	☐
Thistletown Regional Centre	☐
Trillium Health Centre - Child & Family Counselling Clinic	☑
William Osler Health Centre - Child & Adolescent Clinic	☑
Woodview Children's Centre -Central West	☐

SubTotal: ***14*** ***Percent /Region:*** ***100.00%***

Total agencies for region Central West: ***14***

Eastern

Agencies submitting export files	*Hospital*
Centre Psycho-Social Pour Enfants et Families d'Ottawa-Carelton	☐
CHEO - Children's Hospital of Eastern Ontario - Child & Family Psychiatric Unit	☑
Child & Family Treatment Centre - Tri-County Mental Health Services (Cornwall Gen. Hospital)	☑
Columbus House	☐
Crossroads Children's Centre	☐
Equipe D'Hygiene Mentale pour Enfants et Adolescents	☐
Renfrew County Youth Services - Phoenix Centre	☐
Roberts/Smart Centre	☐
Royal Ottawa Healthcare Group - Regional Children's Mental Health Centre	☑
St. Mary's Home	☐
Youth Services Bureau of Ottawa Carleton	☐
Youville Centre Ottawa-Carleton	☐

SubTotal: **12** ***Percent /Region:*** **85.71%**

Agencies that didn't submit export files				*Hospital*
Governing Council of the Salvation Army (Bethany Hope Centre)				☐
Grace Hustler	(613) 725-1733	ext.	grace_hustler@can.salvationarmy.org	
Rhonda Smith		ext.	rhonda_smith@can.salvationarmy.org	
Services aux enfants & adultes de Prescott-Russell				☐
Jean-Claude Seguin	(800) 675-6168	ext. 2240	jseguin@seapr.ca	

SubTotal: **2** ***Percent /Region:*** **14.29%**

Total agencies for region Eastern: **14**

Hamilton-Niagara

Agencies submitting export files	*Hospital*
Charlton Hall Child & Family Centre (Big Sister Youth Services (Hamilton))	☐
Community Adolescent Network of Hamilton	☐
Haldimand-Norfolk R.E.A.C.H.	☐
Hamilton-Wentworth Region - Child & Adolescent Services (Child & Youth Mental Health Branch)	☐
Lynwood Hall Child & Family Centre	☐
McMaster Children's Hospital (Chedoke)	☑
Niagara Child and Youth Services	☐
Niagara Health System (NGH, WGH, ST.CATHGN)	☑
Woodview Children's Centre -Hamilton Niagara	☐

SubTotal: ***9*** ***Percent /Region:*** ***100.00%***

Total agencies for region Hamilton-Niagara: ***9***

North East

Agencies submitting export files	*Hospital*
Algonquin Child & Family Services	☐
Child & Family Services of Timmins & District (formerly: South Cochrane Child & Youth Services Inc.)	☐
Family, Youth & Child Services of Muskoka	☐
Jeane Sauve Youth Services (Services Familieaux Jean Sauve)	☐
Timiskaming Child & Family Services	☐

SubTotal: ***5*** ***Percent /Region:*** ***83.33%***

Agencies that didn't submit export files				*Hospital*
Payukotayno James and Hudson Bay Family Services				☐
Karen Harrison		ext.	karen.harrison@cas.gov.on.ca	
Lindy Linklater	(705) 336-2229	ext.	lindy.linklater@payukotayno.ca	

SubTotal: ***1*** ***Percent /Region:*** ***16.67%***

Total agencies for region North East: ***6***

Northern

Agencies submitting export files	Hospital
Algoma Family Services	☐
Child & Family Centre in Sudbury	☐
Children's Centre Thunder Bay (Lakehead Regional Family Centre)	☐
Dilico Ojibway Child & Family Services	☐
Family and Children's Services- District of Rainy River	☐
Lake of Woods Child Development Centre	☐
North of Superior Programs	☐
Patricia Centre for Children's & Youth - Kids Matter	☐
Sault Ste. Marie Plummer Memorial (Joined with Algoma)	☑

SubTotal: 9 Percent /Region: 100.00%

Total agencies for region Northern: 9

South East

Agencies submitting export files	Hospital
Belleville General Hospital - Parent, Child & Family Services	☑
Child & Youth Wellness Centre of Leeds & Grenville	☐
Children's Mental Health of Hastings & Prince Edward County-Bellville	☐
Open Doors for Lanark Children & Youth	☐
Pathways for Children & Youth	☐
Youth Habilitation	☐

SubTotal: 6 Percent /Region: 100.00%

Total agencies for region South East: 6

South West

Agencies submitting export files	Hospital
Bruce Grey Children's Services - Keystone	☐
Chatam-Kent Integrated Children's Services	☐
Child & Family Counseling Centre of Elgin & St. Thomas	☐
Child and Parent Resource Institute -CPRI (London)	☐
Craigwood Youth Services	☐
Glengarda Child & Family Services	☐
Huron-Perth Centres for Children & Youth	☐
London Health Sciences Centre - Children's Mental Health	☑
Madame Vanier Children's Centre	☐
Maryvale Youth & Family Services	☐
Oxford Child & Youth Centre	☐
Regional Mental Health Centre- London (St. Joseph's Health Centre)	☑
St. Clair Child & Youth Services	☐
The Inn of Windsor	☐
Western Area Youth Services -WAYS (London)	☐
Windsor Regional Children's Centre	☐

SubTotal: 16 Percent /Region: 94.12%

Agencies that didn't submit export files	Hospital
Woodstock General Hospital - Children's Mental Health Program	☑

Deb McKey	(519) 421-4223	ext. 2342	deb@wgh.ca
Elaine Campbel	(519) 421-4211	ext. 2216	ecampbel@wgh.on.ca
Patricia Edwards	(519) 421-4223	ext. 2285	pedwards@wgh.on.ca

SubTotal: 1 Percent /Region: 5.88%

Total agencies for region South West: 17

Toronto

Agencies submitting export files	*Hospital*
Aisling Discoveries	☐
Central Toronto Youth Services	☐
Child Development Institute	☐
Delisle Youth Services	☐
East Metro Youth Services	☐
Etobicoke Children's Centre	☐
George Hull Centre for Children & Families	☐
Griffin Centre	☐
Hincks-Dellcrest Centre	☐
Integra Foundation	☐
Jerome Diamond Centre (Jewish Child & Family Services of Toronto)	☐
Oolagen Community Services	☐
Rouge Valley Health System-Shoniker Clinic - Centenary Site	☑
Turning Point Youth Services (Joined with Boys Home)	☐
York Town Child and Family Centre	☐
Youthdale Treatment Centres	☐
Youthlink	☐

SubTotal: ***17*** ***Percent /Region:*** ***85.00%***

Agencies that didn't submit export files				*Hospital*
North York General Hospital - Child Development & Counselling Service				☑
Nazira Jaffer	(416) 632-8729	ext.	njaffer@nygh.on.ca	
Sandy Marangos-Frost	(416) 632-8729	ext.	smfrost@nygh.on.ca	
Scarborough General Hospital - Child & Adolescent Psychiatry & Mental Health				☑
Dr. Michael Schwartz	(416) 431-8135	ext.	rplayfor@interlog.com,mschwartz@tsh.to	
Elizabeth Severtson	(416) 431-8200	ext. 6448	esevertson@tsh.to	
Nhan Doan	(416) 461-8200	ext.	ndoan@tsh.to	
Sunnybrook Medical Centre-Child Mental Health				☑
Denise Hayes	(416) 480-6096	ext.	denise.hayes@swchsc.on.ca	

SubTotal: ***3*** ***Percent /Region:*** ***15.00%***

Total agencies for region Toronto: ***20***

Total agencies using CAFAS: ***106***

Total submitting: ***98 (92.45%)***

APPENDICES

GENERAL ACCOLADES FOR CPA

Selected Accolades for CPA

Subject: Kudos to Dr. Barwick AND Joann Starks and Team for an Excellent Webcast
Date: Wed, 23 Feb 2011 16:09:37 -0500
From: Peter West <peter.west@continuousinnovation.ca>
To: webcast@ncddr.org
Kudos to Dr. Barwick for brilliantly taking us on a compelling, important and in-depth journey through the many theoretical and operational factors that impact effective knowledge translation. Kudos to Joann Starks and team for providing a wonderful platform for exchange and interaction.
Appreciatively,
Peter West

From: John Westbrook [mailto:john.westbrook@sedl.org]
Sent: Thursday, February 24, 2011 7:58 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Re: Thank you very much!
Melanie -
Your webcast was outstanding! Hope you enjoyed it a little. We had about 150 registered and about 90 online real time at the beginning. That is good since we usually only have about 50% of the registrants actually make thee webcast. The webcast will be archived and there will be many times that number of people take advantage of it through that method.
Look forward to seeing you soon in Washington!
John

From: Gary Myers [mailto:jgary.myers@gmail.com]
Sent: Friday, March 11, 2011 12:33 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: You Are This Week's Featuring A Knowledge Mobilizer
Hi Melanie,
Each week I feature a knowledge mobilizer on my KMbeing blog. It has also been posted on Twitter. Guess who it is this week? I think you are doing great things to promote KMb as an important process for social benefit.
http://kmbeing.com/2011/03/11/featuring-a-knowledge-mobilizer-melanie-barwick/
Gary Myers
Digital Researcher
KMbeing.com

From: Nandini Saxena [mailto:nandini.saxena@oahpp.ca]
Sent: Thursday, March 24, 2011 2:58 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Ingrid Tyler <ingrid.tyler@oahpp.ca>
Subject: KE planning tool
Hi Melanie,
Thanks for giving us the go-ahead to use your tool at our recent KE Research Retreat. We have found your tool very useful, and so in an upcoming presentation that the OAHPP along with the Peel and Sudbury Public Health Units is giving at the Ontario Public Health Convention on the links between EIDM, KE and the Foundational Standard, we would like to share electronic copies of your tool with reference to your name and the Hospital for Sick Kids on memory sticks (along with materials from the NCCMT). Please let us know what you think of this.
Thanks,
Nandini
Nandini Saxena
Knowledge Exchange Specialist
Ontario Agency for Health Protection and Promotion

From: Michelle Brazas [mailto:Michelle.Brazas@oicr.on.ca]
Sent: Thursday, April 7, 2011 11:16 AM
To: Sarah Bovaird <sarah.bovaird@sickkids.ca>; Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Title update

I just wanted to let you know that I have finally received a new job title that better reflects all of the knowledge translation activities I do (see below). And the clincher was having gained a Professional Certificate in Knowledge Translation that is accredited. My job review process had stalled until that point (by 6 months). It also greatly helped that my boss was in attendance because once I reminded the review committee that I had gained this certification, he stepped up with confirmation.

Just thought you should know, because the accreditation program has had meaningful impact.

Thanks!

Michelle

Michelle D. Brazas, Ph.D.
Manager, Knowledge and Research Exchange
Ontario Institute for Cancer Research
MaRS Centre, South Tower
101 College Street, Suite 800
Toronto, Ontario, Canada M5G 0A3
www.oicr.on.ca

From: Chaudoir, Stephenie [mailto:schaudoir@bumail.bradley.edu]
Sent: Friday, October 21, 2011 5:01 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Measure request

Hi Melanie,

Along with several colleagues at the University of Connecticut, I am conducting a review of measures that constructs that affect the implementation of evidence based health innovations. We came across your study in Implementation Science (2008) and were wondering if you would be willing to share with us a copy of your measurement tool that you used to assess the ability to access, assess, adapt, and apply (based on the Canadian Health Services Research Foundation). Do you have that measure available? If so, would you please forward it to us so that we can include your study in our review?

We would really like to be able to reference your great work in our review.

Best Regards,

Stephenie

Stephenie R. Chaudoir, Ph.D.
Assistant Professor of Psychology
Bradley University
1501 W. Bradley Ave.
Peoria, IL 61625

Hello Melanie,

I just wanted to say another thank you for the amazing learning opportunity over the past two days. I had a really great time and learned so much more than I could have thought. I'm very excited to put what I learned into practice.

It was also a great opportunity to meet you and learn more about what you do. I hope we have more opportunities to work together in the future.

All the best – and good luck at your daughters' dance competition this weekend!

Sarah

Sarah McBain, MISt
Manager, Family Education & Resource Centre
aboutkidshealth.ca
The Hospital for Sick Children

From: Gayle Scarrow [mailto:gscarrow@MSFHR.ORG]
Sent: Monday, April 11, 2011 3:58 PM
To: Melanie Barwick; donna lockett
Cc: Sherel Loo; Bev Holmes
Subject: SKTT sold out
Hi Ladies,
We 'sold' out your workshop in the first 10 minutes that registration opened and have a waiting list of approximately 60 odd people. Congratulations!
Due to the high demand for this kind of training in BC we'd love to be able to say on our website that we will be offering the workshop again in XXX. Are you interested and available in either tagging on another 2 day workshop to your current visit (anytime the rest of the week of May 30th) OR coming back again later this year for another round?
Let me know what you think? I don't think we'll have any trouble filling the spaces. ☺
Cheers,
Gayle
Gayle Scarrow
Knowledge Exchange Manager
Michael Smith Foundation for Health Research
200 - 1285 West Broadway
Vancouver, BC V6H 3X8

From: Cynthia Neilson [mailto:cneilson@iwh.on.ca]
Sent: Wednesday, May 11, 2011 2:05 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Reference
Dear Melanie,
My name is Cynthia Neilson and I am a KTE Associate at IWH. I attended your Scientist Knowledge Translation Training workshop in Jan 2010. Jane Gibson and I are updating our KT Planning Guide and would like to include a reference/link to your KT Research Plan Template. I think that this is a really helpful, well put together resource. Would you be comfortable with this? We would obviously reference your work. I have the 2010 version, if you don't mind us including it, could you send me the most recent copy?
Thank you,
Cynthia Neilson, M.A.
Knowledge Transfer Associate, Institute for Work & Health

From: Gail Barrington [mailto:gbarrington@barringtonresearchgrp.com]
Sent: Monday, November 14, 2011 6:50 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: FW: Thank you for presenting at our Expert Lecture
Hi Melanie
I thought you might be interested in the message I got from Dr. Stufflebeam. It was nice to have him involved even though it was pretty short. We will see what he comes up with.
Take care,
Gail
Gail V. Barrington, PhD, CMC, CE
From: dlstfbm@aol.com [mailto:dlstfbm@aol.com]
Sent: November-11-11 2:30 PM
To: gbarrington@barringtonresearchgrp.com
Subject: Re: Thank you for presenting at our Expert Lecture
Hi Gail,
Thanks for your note. I appreciated, as did the session's attendees, Dr. Barwick's outstanding presentation. I am glad that what little I wedged into the end of the session seemed to reinforce and add a little to her presentation. I brought back the checklist that I had drafted on the way to California and have filed it for possible further work in the future. However, I have a few other projects that will have to take priority. Of course, if and when I get to the stage of preparing a review draft of a "securing evaluation impact checklist" I would welcome input from you and Dr. Barwick.
Sincerely,
Dan

From: Julie Kosteniuk [julie.kosteniuk@usask.ca]
Sent: Friday, December 16, 2011 1:54 PM
To: Melanie Barwick
Cc: Debra Morgan
Subject: SKTT Training Course
Hello Melanie,
I recently took your training course in Saskatoon, and I raved about it to the research team of which I am a part. So much so that they would like me to present on your workshop during one of our upcoming lunch rounds. Would you have material available that our research team could purchase to supplement this presentation, and may I request permission to reproduce your workshop manual? I have cc'd the team's principal investigator on this request, Dr. Debra Morgan.
Best regards,
Julie
Julie Kosteniuk, PhD
Canadian Centre for Health and Safety in Agriculture (CCHSA)
Royal University Hospital
103 Hospital Drive
Saskatoon, SK S7N0W8
Rural Dementia Care: http://www.cchsa-ccssma.usask.ca/ruraldementiacare/

From: Brown, Cary [mailto:cary.brown@ualberta.ca]
Sent: Wednesday, February 1, 2012 4:55 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: KT Planning template-R
Hi Melanie- hope all is well with you. I was wondering if it would be alright for me to use the KT Planning Template with my MScOT students? I would like to give them all a copy to use during a class assignment. I have accessed it through your website and was wondering if you had a PDF version that I can send the students to use or if you would prefer they log in to the website each time?
Many thanks!
Cary
Cary A Brown, FHEA, PhD
Associate Professor, Department of Occupational Therapy
Faculty of Rehabilitation Medicine
University of Alberta
2-64 Corbett Hall
Edmonton, Alberta
Canada T6G 2G4

From: Saulnier, Suzanne [mailto:saulnies@KGH.KARI.NET]
Sent: Tuesday, February 14, 2012 12:27 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: KT Checklist
Hi Melanie
I took part in a KT webinar this week. Your KT checklist was mentioned as a good resource. I am wondering if you would care to share your tool with me or at least direct me to it. Thanks you for your support.
Thank You
Sue Saulnier, RN, BNSc, MEd, GNC(C)
Regional Stroke Education Coordinator
Stroke Network of Southeastern Ontario
Kingston General Hospital
Doran 3, Rm 310
76 Stuart St.
Kingston, ON K7L 2V7

From: Susan S Bazyk [mailto:s.bazyk@csuohio.edu]
Sent: Thursday, April 5, 2012 10:09 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Thank you and question
Hi Melanie,
I wanted to take a moment and thank you and Donna for the excellent session on KT. You provided the just right balance of presenting, discussion and a great packet of resources. The written materials will definitely be used as I continue to learn about and apply KT strategies. I'm already introducing KT in my various local and national interactions.
//
Again - thank you for the terrific session. I loved all of it.
Sue
Susan Bazyk, Ph.D., OTR/L, FAOTA
Professor, Occupational Therapy Program
Director, Master of Science in Health Science
School of Health Sciences
Cleveland State University

From: Darwin@UVic [mailto:darwin@uvic.ca]
Sent: Monday, April 16, 2012 11:04 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Victoria Workshop
You run a good workshop. I enjoyed the exercise and feel that it was worthwhile. If you have a week-long program I would eventually be in interested!
Regards
Barry Glickman

From: Melissa Cheung [melissa.cheung@partnershipagainstcancer.ca]
Sent: Tuesday, April 17, 2012 3:25 PM
To: Melanie Barwick
Subject: Request for permission to reproduce figure
Dear Dr. Barwick,
The Canadian Partnership Against Cancer is seeking permission to reproduce your publication entitled "Scientific Knowledge Translation Plan Template" as a table. The table is part of a guide being published on the Partnership's website at www.cancerview.ca. Some copies may also be printed. It will be printed in English and French, available free of charge. Please let me know if you require any additional information.
Thank you,
Melissa Cheung
Coordinator, Research Portfolio
Canadian Partnership Against Cancer
1 University Ave., Suite 300
Toronto, ON M5J 2P1

From: Susan Tasker [mailto:stasker@uvic.ca]
Sent: Wednesday, April 18, 2012 5:24 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>; 'donna@bodhiseed.ca' <donna@bodhiseed.ca>; Dale Anderson-kmcoord <kmcoord@uvic.ca>
Subject: Thank you
Dear Melanie, Donna, and Dale
A quick note to say two small but big words: Thank you.
Melanie and Donna – Thank you for filling in so many blanks for me about KT. I am excited both about my next steps in the KT learning-process (next steps for me translates to "just start") and for the different KT strategies and approaches I can use for and in my work.
Dale – Thank you for engineering, coordinating and facilitating the training opportunity. I look forward to close connections with KM/KT here at UVic.
Warm regards,
Susan
Susan L. Tasker, PhD, CCC
Assistant Professor, Counselling Psychology
University of Victoria
Tel: 250.721.7827
Fax: 250.721.6190
Email: stasker@uvic.ca

From: Ruth Kampen [mailto:rkampen@uvic.ca]
Sent: Friday, April 20, 2012 3:37 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: SKTT manual
Hello Melanie,
I attended your 2 day workshop last week at UVic. I found it very relevant, informative and interesting. There was a lot of material to digest so it was really helpful to have the manual. I attended on behalf of one of the principal investigators on a MSFHR funded research study, Karen Kobayashi. She was sorry to miss it but needed to be in Toronto conducting grant review work for the Alzheimer Society.
This brings me to my email. I was wondering if you would grant me permission to make a copy of the manual for Karen. I contacted Dale as I recall her saying there were a few extra copies, but those copies have all been claimed. Karen only wants it for personal review as I explained how valuable this manual was during the training and will continue to be. If you are not comfortable with that, we can share a copy, but I thought I would ask.
Thank you again for the great workshop. I look forward to incorporating the knowledge and skills gained last week to this current project and future research.
Warm Regards,
Ruth
Ruth Kampen
ACaDeME Project Coordinator
Department of Sociology
University of Victoria

From: **Borsika A. Rabin** <borsika.a.rabin@gmail.com>
Date: Wed, May 30, 2012 at 2:40 PM
Subject: Asking for your advice regarding an online D&I Planning Tool
To: Melanie Barwick <melaniebarwick@gmail.com>
Melanie,
You might remember me from last year's NIDRR KT Center grant review that we served on.
I have been leading an NCI funded pilot project for the development of an online, interactive Dissemination and Implementation Planning Tool. One piece of work that was integral in the preparation of our first draft was your KT Planning Template which I find extremely useful, comprehensive, practical, and well organized. As we have pretty crazy timeline for this work, I was hoping to touch base with you regarding a few questions and was hoping to do so via conference call. Would you be available for an hour call sometimes in the next couple of weeks or so? Who should I work with to get on your calendar?
Thank you for your consideration!
Borsika
Borsika A. Rabin, M.P.H., Pharm.D., Ph.D.
Staff Researcher/Research Coordinator
CRN Cancer Communication Research Center
Institute for Health Research
Kaiser Permanente Colorado

From: Linda Waterhouse [mailto:Linda.Waterhouse@gov.ns.ca]
Sent: Wednesday, August 29, 2012 10:55 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: SKT workshop
Melanie,
Everyone is still buzzing over your workshop! You more than delivered what they were looking for, congratulations to you and Donna! Regards,
Linda
Linda Waterhouse
Program Assistant
NS Health Research Foundation
PO Box 2684
Halifax, NS B3J 3P7

From: Janet Rossant
Sent: Friday, June 29, 2012 10:24 AM
To: Helen Bougadis <helen.bougadis@sickkids.ca>; Stanley Zlotkin <stanley.zlotkin@sickkids.ca>; Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: SENT ON BEHALF OF DR. STANLEY ZLOTKIN

Dear Stan and Melanie
That is great news- congratulations indeed- it is a great base on which to promote both global health and SickKids leadership in the area
Well done
Janet
Janet Rossant, Ph.D.
Senior Scientist and Chief of Research
Lombard Chair in Paediatric Research
Research Institute, The Hospital for Sick Children
Departments of Molecular Genetics, and Obstetrics and Gynecology
University of Toronto

From: Helen Bougadis
Sent: Friday, June 29, 2012 10:13 AM
To: Executive Office; Denis Daneman; James Wright; Janet Rossant; Richard Hegele; Manohar Shroff
Subject: SENT ON BEHALF OF DR. STANLEY ZLOTKIN

Dear Colleagues
I heard earlier this week that a proposal on maternal and child health and nutrition that was submitted by Melanie Barwick and me, with the assistance of Elaine Gergolas, on creating a 'Knowledge Management Structure' for the four largest NGOs in Canada was approved. Apparently our proposal was the "unanimous first choice of all of the reviewers" and thus we were chosen to be awarded the RFP funding. The funding is $1 million over three years.
As a result of the Muskoka (G8) meeting two years ago, Mr. Harper allocated a few hundred million dollars for maternal and child health initiatives. Most of the money went to the four largest Canadian NGOs (Save the Children, CARE, Path and World Vision). The RFP which we responded to is from a Coalition of these four large NGOs who received their project funding from CIDA. Our role is to create a Knowledge Management platform to collect the results of their implementation projects (5 projects in Africa and two in South Asia), to analyze their results and to share them broadly.
I am the leader on the project along with Melanie Barwick (for the Knowledge Transfer component). We have a wide range of collaborations and collaborators including the SickKids Learning Institute and the Research Institute, and the Munk Centre for Global Affairs at the U of T. The collaborators are Wayne Arnold from the Research Institute, Zulfi Bhutta from the Agha Khan University (and SickKids), Diego Bassani from Paediatrics and SKI, Dan Roth and Shaun Morris from Paediatrics, Kyla Hayform (a post-doc in infectious diseases from U fo T), Janice Stein, Director of the Munk School of Global Affairs and Joseph Wong, Canada Research Chair in Health, Development and Democracy from the Department of Political Science at the U of T. I believe this is really a great (and smart) group of 'partners'.
Best,
Stan
Stanley Zlotkin CM, MD, PhD, FRCPC
Vice President, Medical and Academic Affairs
Hospital for Sick Children
Professor, Paediatrics, Nutritional Sciences and Public Health, University of Toronto

From: Mary Jo Haddad
Sent: Wednesday, August 22, 2012 4:21 PM
To: Kelly Warmington <kelly.warmington@sickkids.ca>
Cc: Jonathan Kronick <jonathan.kronick@sickkids.ca>; Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: Thank you

Hi Kelly, you and Melanie did a terrific job articulating our journey in KT and the opportunities that lie ahead. I look forward to your leadership and evolution of KT at SickKids. Melanie, congratulations on an impressive contribution to SickKids and the world of KT.
Kind regards, Mary Jo
Mary Jo Haddad, CM, MHSc, LLD, BScN
President and CEO
The Hospital for Sick Children
555 University Avenue, Suite 1410
Toronto, Ontario M5G 1X8

From: Kristy Wittmeier [mailto:KWittmeier@exchange.hsc.mb.ca]
Sent: Wednesday, August 29, 2012 12:03 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Knowledge Translation Planning Template
Hello Dr. Barwick,
I have recently come across your Template, and think it would be a wonderful resource for some of the clinicians / researchers that I frequently work with here in Winnipeg at our Health Sciences Centre.
I am wondering if there are any conditions on the use of this tool. Am I able to print and use it with colleagues, or do we need permission / to order copies from you directly?
Thank you in advance,
Kristy Wittmeier, PT, PhD
Physiotherapy Innovations & Best Practice Coordinator
Winnipeg Health Sciences Centre
Winnipeg Regional Health Authority
Assistant Professor, Department of Pediatrics
University of Manitoba
RR183A 800 Sherbrook Street
Winnipeg MB

From: Raluca Barac
Sent: Wednesday, October 31, 2012 6:46 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: :)
Hi Mel,
I just wanted to say that I think that you are a fantastic boss and mentor for me and I am very lucky to be working with you!
Have a good night!
Raluca

From: Randy Fransoo [mailto:Randy_Fransoo@cpe.umanitoba.ca]
Sent: Tuesday, November 6, 2012 6:01 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: KT Planning Template
Hi Melanie,
Just about to use your template in a graduate course starting in January – but figured I should touch base to see if there's been any revisions since May 2010 that I should know about?
Thanks!
Randall Fransoo, PhD
Research Scientist, Manitoba Centre for Health Policy; Assistant Professor, Community Health Sciences
McDole Professorship Award recipient (2010-2013)
Faculty of Medicine, University of Manitoba

From: Geri Briggs [mailto:Geri_Briggs@carleton.ca]
Sent: Friday, February 1, 2013 4:00 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Use of KM checklist
Melanie,
David Phipps shared you KM Planning Checklist with us at the SSHRC start-up meeting for partnership projects. I am the co-lead of the Knowledge Mobilization Hub of the CFICE project, and have adapted the content from your form to our needs with clear sourcing that it has been adapted from your work.
I`m emailing in order to check with you to ensure you are ok with that.
Thank you.
Geri Briggs B.Ed, MCE
Co-Manager, Community First: Impacts of Community Engagement (CFICE)
Director, Canadian Alliance for Community Service-Learning (CACSL)
Room 2112, Dunton Tower, Carleton University
Ottawa, ON, K1S 5B6

From: Jacqui DeBique [mailto:jdebique@pogo.ca]
Sent: Tuesday, February 12, 2013 2:45 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: David Malkin <dmalkin@pogo.ca>; David Malkin <david.malkin@sickkids.ca>; Madeline Riehl <mriehl@pogo.ca>
Subject: Knowledge Translation Grid
Hello Melanie,
At Monday's meeting of POGO's Research Unit (PRU), one of your SickKids colleagues mentioned a wonderful knowledge translation grid that you have created. The thought was this would be a very useful tool to aid the PRU in implementing its communications plan. I wonder if you would consider sharing this with us and emailing a copy to me.
I look forward to hearing back!
Kind regards,
Jacqui
Jacqui DeBique
Communications & Knowledge Transfer Manager
Pediatric Oncology Group of Ontario - *Celebrating 30 years of collaborating for kids with cancer*

From: Mary Jo Haddad
Sent: Wednesday, March 27, 2013 4:54 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Jim Garner <jim.garner@sickkids.ca>; Marilyn Monk <marilyn.monk@sickkids.ca>; Laurie Harrison <laurie.harrison@sickkids.ca>; Jeff Mainland <jeff.mainland@sickkids.ca>; Jonathan Kronick <jonathan.kronick@sickkids.ca>
Subject: Thank you
It is always wonderful to hear praise and accolades about SickKids staff when the CEO is with the Ministry of Health. Today was all about Melanie Barwick!
One of the subgroups of the Provincial Programs Quality Committee (QBP and HSFR) co-chaired by Bob Bell and Karen Michell were reporting back to the steering committee where I sit, along with the ADMS.
Bob recognized and thanked SickKids for the extraordinary loan of our very talented Melanie Barwick. When his subgroups of experts came together on implementation, they thought they knew how to implement and Melanie, taught them they didn't have it right. Thank you for helping to drive the Implement science strategy within the province and helping to put evidence into change management strategy. Be prepared as you will most likely be asked to present to other groups inside the MOH.
It would be wonderful to invite Melanie to do a session with our team in the near future. Perhaps Susan can coordinate for us as part of our executive commitment to learning.
Melanie, on behalf of all of us thank you! MJ

Mary Jo Haddad, CM, MHSc, LLD, BScN
President and CEO
The Hospital for Sick Children
555 University Avenue, Suite 1410
Toronto, Ontario M5G 1X8
//
From: Jonathan Kronick
Sent: Wednesday, March 27, 2013 5:02 PM
To: Mary Jo Haddad <maryjo.haddad@sickkids.ca>; Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Kelly McMillen <kelly.mcmillen@sickkids.ca>
Subject: Re: Thank you
Well done Melanie. I'm not surprised but it's nice to hear about this important work.
Jon
Jonathan Kronick
Chief of Education
The Hospital for Sick Children
Professor of Pediatrics
University of Toronto
Toronto, Ontario

From: Doris Payer [mailto:Doris.Payer@camh.ca]
Sent: Thursday, May 9, 2013 6:55 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Thank you & LinkedIn
Hi Dr. Barwick,
I wanted to thank you again for a very informative and helpful session yesterday - it made KT practice much more tangible/feasible/comfortable. And I hope I didn't give the impression that I think I work in a KT-unfriendly environment, I know that's not the case - it's just that as a not-yet-independent scientist, taking someone else's vision (and way of doing things) and running with it can come with its own challenges, regardless of institutional support. In any event, I'm really looking forward to trying out (/sneaking in) some of the new tools, and please do let me know if you ever come across any opportunities in drug use/addiction that I might have missed.
Thank you again, and I hope we can be in touch! (I tried to connect with you on LinkedIn and discovered we already were -- we met very briefly at the KTE CoP mixer some months back – but it wouldn't send my message there. Apologies if it shows up 4x tomorrow.)
Doris
Doris E. Payer, Ph.D.
Post-Doctoral Fellow - Addiction Imaging Research Group
Centre for Addiction and Mental Health (CAMH) Research Imaging Centre

From: Mary Ann O'Brien [mailto:Maryann.Obrien@utoronto.ca]
Sent: Thursday, June 6, 2013 11:16 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: requesting permission to use documents
Hi Melanie,
I attended the workshop that you led in the Department of Family and Community Medicine earlier this year.
I am requesting permission to email the knowledge translation planning template and the knowledge translation planning worksheet to approximately 10 researchers in the Health Services Research Program of the Ontario Institute of Cancer Research.
With best wishes,
Mary Ann O'Brien, PhD
Assistant Professor
Department of Family and Community Medicine

From: Tracy Solomon
Sent: Friday, September 6, 2013 7:09 PM
To: Gail McVey <gail.mcvey@sickkids.ca>; Anneke Rummens <anneke.rummens@sickkids.ca>; Melanie Barwick <melanie.barwick@sickkids.ca>; Brenda Gladstone <brenda.gladstone@sickkids.ca>; Pepler, Debra (pepler@yorku.ca) <pepler@yorku.ca>; Bruce Ferguson <bruce.ferguson@sickkids.ca>; Kelly McMillen <kelly.mcmillen@sickkids.ca>; Katherine Boydell <katherine.boydell@sickkids.ca>
Subject: KT training
Just back from two days doing Melanie's KT training course. Awesome. So helpful. So much work has clearly gone into the materials. My head is spinning with ideas.
Melanie is a great trainer - deep knowledge base and also so approachable. It was like having a nice, informative chat with her on the couch (talk show host in your next life Mel?). Another jewel in our crown.
Great weekend.
Tracy

From: Carter Snead
Sent: Tuesday, July 2, 2013 11:56 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Kirk Nylen <knylen@braininstitute.ca>
Subject: Re: Invitation
Fantastic news Melanie. Your participation will make a huge difference. Carter
Sent from my iPhone
//
From: Carter Snead
Sent: June-27-13 3:34 PM
To: Melanie Barwick
Cc: Kirk Nylen
Subject: Invitation

Dear Melanie,
Recently, acting upon a recommendation by Ontario Health and Technology Assessment Committee (OHTAC) and Health Quality Ontario (HQO), the Ontario Ministry of Health and Long Term Care (MOHLTC) has resourced a strategy to provide comprehensive care for those 70,000 adults and children in Ontario who have epilepsy. See *OHTAC Recommendations: Care for Drug-Refractory Epilepsy in Ontario* (http://www.hqontario.ca/en/documents/eds/2012/Epilepsy

OHTACRec2012.pdf)and a copy of the report of the Epilepsy Expert Panel which is enclosed. To this end an Epilepsy Implementation Task Force has been struck to implement the recommendations of OHTAC.
I am a co-Chair of the Ontario Epilepsy Implementation Task Force, along with Brenda Flaherty of Hamilton who is the other co-Chair. In addition to implementing a plan to insure universal and equitable access to quality, evidence-based epilepsy care, we also aim to develop a knowledge transfer strategy that targets primary care providers and neurologists across the province to change attitudes about caring for patients with epilepsy, increasing awareness, and expanding knowledge base of these practitioners. I have appointed Kirk Nylen from the OBI, who is on the Task Force and who has an interest in knowledge translation, to head the working group for knowledge translation for the Task Force.
I am writing to ask if you could join Kirk on this working group. A knowledge transfer strategy is critical to insuring the success of any plan for comprehensive care of adults and children in Ontario with epilepsy. Your contribution in this regard would be invaluable given the insight you bring to the table concerning creation and implementation of knowledge translation strategies.
For your information, I have enclosed the OHTAC Expert Panel report on Epilepsy, the Terms of Reference of the Task Force, and a list of the members of the Task Force.
I really hope that you can join us in this hugely important and innovative effort. Let me know.
Carter

From: Notarianni, MaryAnn [mailto:mnotarianni@cheo.on.ca]
Sent: Tuesday, September 10, 2013 8:34 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: KT Plan template
Hi Melanie,
I hope you're doing well. It was lovely to meet you at the GIC.
Your KT plan template is an excellent tool and I wanted to highlight it as a resource that they may be useful to some child and youth mental health and addictions communities of interest that the Centre will be supporting in collaboration with EENet this year. One of the CoIs that we're supporting is Francophone so I'm looking into French KT/KE planning tools. Is your template available in French? If not, would the Centre have permission to translate the content (with proper attribution)?
Thank you for your time,
MaryAnn
MaryAnn Notarianni, MSW
Manager, Knowledge Exchange
Ontario Centre of Excellence for Child and Youth Mental Health

From: JTrpkovski@GiftofLife.on.ca [mailto:JTrpkovski@GiftofLife.on.ca]
Sent: Monday, September 30, 2013 8:05 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: Meeting follow up
Hi Melanie
Thank you so much for coming to speak to our group. Your talk has definitely started the group thinking about implementation in a different light.
I am going to share the resources with the team. I suspect once they have had time to review and consider how to incorporate some of the information we will ask you back for a follow-up session. I think there is real opportunity at TGLN to build a robust implementation strategy as we move our work forward on the provincial level.
Thanks again for a great presentation.
Julie
Julie Trpkovski
Vice President, Transplant
Trillium Gift of Life Network
Register today at BeADonor.ca
One donor can save up to eight lives and improve life for up to 75 others
522 University Avenue, Suite 900, Toronto ON M5G 1W7

From: Deanne Langlois-Klassen [mailto:Deanne.Langlois-Klassen@albertainnovates.ca]
Sent: Thursday, October 3, 2013 6:03 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Using the KT Planning Template within a workshop at the RTNA conference
Hi Melanie,
I had the pleasure of meeting you this summer at the SKTT course you taught in Edmonton. Since then, I have been tasked with developing a workshop around assessing the impact of KT for the RTNA conference here in Alberta next week. Within the workshop, I would like to use your KT Planning Template as a partial means of providing the participants with a mock KT case scenario and a solid starting point. Please let me know if you have any concerns about the use of the KT Planning Template within this workshop.
Very best,
Deanne Langlois-Klassen, PhD | Senior Health Research Analyst | Alberta Innovates – Health Solutions

1500, 10104 – 103 Avenue NW | Edmonton, Alberta T5J 4A7 | deanne.langlois-klassen@albertainnovates.ca

From: Christine Chambers [mailto:christine.chambers@dal.ca]
Sent: Sunday, February 16, 2014 6:33 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>; donna_lockett@hotmail.com
Subject: THANKS
Dear Melanie and Donna, on behalf of my team, thank you so much for an outstanding KT workshop last week. I feel much more confident in my abilities in this area and because of your workshop I feel that the KT section of my upcoming grant submission will be very strong!
It was great seeing you both. Well done!
Christine
Christine T. Chambers, PhD RPsych
Canada Research Chair in Pain and Child Health
& Professor of Pediatrics and Psychology
Dalhousie University and IWK Health Centre

From: Ciliska, Donna [mailto:ciliska@mcmaster.ca]
Sent: Thursday, April 24, 2014 7:36 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: use of your Knowledge Translation Planning Template
Hi Melanie
I would just like to keep you informed that we are referring to your planning template (without modification, and with referencing) for two on-line learning module specific to public health practitioners.
One is narrowed to implementation, refers to your tool, and uses one screen shot of your tool (Page 2). The 2nd module, totally related, is about evaluation and again refers to your tool, with a screen shot of pages 3 and 4. I am hoping to drive public health practitioners to your excellent website, and the use of this practical tool. These modules are being offered at no cost, on-line, through the National Collaborating Centre for Methods and Tools.
Donna
Donna Ciliska, RN, PhD
Professor, School of Nursing
McMaster University, Hamilton ON

From: Shona.MacPherson@scotland.gsi.gov.uk [mailto:Shona.MacPherson@scotland.gsi.gov.uk]
Sent: 14 May 2014 10:59
To: s.morton@ed.ac.uk
Subject: RE: MELANIE BARWICK SEMINAR
Sarah
Just wanted to pass on our thanks to you and Melanie for meeting members of our Directorate last week. Thanks especially to you for facilitating the meeting. Feedback was very positive and I hope you and Melanie thought worthwhile too.
Thanks again.
Shona
Shona MacPherson
Business Manager
Directorate for Children and Families, Scottish Government
2-AN Victoria Quay

From: David Malkin
Sent: Thursday, May 22, 2014 10:54 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: Thank you
Hi Melanie
Thank YOU! Your talk was terrific and really raised some very important food for thought for everyone. Definitely was a very successful day and the venue (which I had never heard about before) was perfect.
All the best
David
David Malkin, MD
Staff Oncologist, Division of Hematology/Oncology Senior Scientist, Genetics & Genome Biology Program The Hospital for Sick Children

From: Nicole Kitson - Grants [mailto:grants@uvic.ca]
Sent: Monday, June 9, 2014 12:59 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Permission to duplicate materials
Hi Melanie,
I have your book entitled, "Scientist Knowledge Translation Training" (authored by you, Donna Lockett, and the Knowledge Brokering for Pediatric Healthcare Research Team, Version Feb 22, 2012) from a KT training session you conducted at UVic a couple of years ago. I would appreciate permission to duplicate your book for our Awards Officer and KT/KM Coordinator in Research Services (2 copies total). It is an excellent resource for guiding researchers towards improved KT both pre- and post-awards. Would that be alright?
Thank you and have a great week,
Nicole
Nicole Kitson, PhD
Senior Grants Officer
Office of Research Services | University of Victoria
Administrative Services Building | Room B227 | 3800 Finnerty Road | V8W 2Y2

From: John.Froggatt@scotland.gsi.gov.uk [mailto:John.Froggatt@scotland.gsi.gov.uk]
Sent: Thursday, June 12, 2014 12:05 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: Request re: our meeting in May
Melanie,
I'm sorry about the delay in replying. I was very grateful to you for coming to talk to me and other Scottish Government colleagues. We all found your knowledge of, and insights into, the challenges of implementation, and ways to address them, very helpful, as we all seek to ensure our policies gain traction and secure the kind of change we are looking for.
Those present were:
Deborah Smith
Deputy Director: Children's Rights & Wellbeing
Directorate for Children & Families
Carolyn Wilson, Lead Policy Officer, Family Nurse Partnership, Child and Maternal Health Division
Children and Families Directorate
Judith Ainsley, Head of Early Years Quality Improvement Unit, Children and Families Directorate
Ros Gray, Rosamund.gray@scotland.gsi.gov.uk Early Years Collaborative, Children and Families Directorate
Tom McNamara, Head of Youth Justice and Children's Hearings, Children and Families Directorate
Dr Catriona Hayes, Statistician, Leading Improvement Division, The Quality Unit
Dr Nick Bland, "What Works", Local Governance & Reform Analytical Division, DIRECTORATE FOR LOCAL GOVERNMENT AND COMMUNITIES
I hope this is helpful
Best wishes
John
John Froggatt
Deputy Director, Child and Maternal Health
Children and Families Directorate | Child and Maternal Health Division
2B North
Victoria Quay
1 Commercial Street
Edinburgh
EH6 6QQ

From: Kyabaggu, Ramona [mailto:kyabagg@mcmaster.ca]
Sent: Thursday, September 25, 2014 2:55 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: FW: NEW RESOURCES for Implementation of Evidence - Educational Video Clips
Hi Dr. Barwick,
I have just reviewed your implementation videos and they are excellent. We would like to write a summary on your implementation videos for the NCCMT Registry of Methods and Tools. When you have an opportunity, would you be able to send me some information about the research that informed the development of your videos (i.e., research on the implementation of evidence-based practices in child and youth mental health (and schools), funded by CHIR.)? Is there a related publication or relevant information on the method of development of the videos that I should be aware of before drafting the summary?
Your assistance is much appreciated,
Thank you
Ramona Kyabaggu, MSc

Knowledge Broker

National Collaborating Centre for Methods and Tools (NCCMT)
McMaster University
McMaster Innovation Park (MIP),
175 Longwood Road South, Suite 210A,
Hamilton, ON, L8P 0A1

From: Margaret JONES [mailto:margaret.jones@ecu.edu.au]
Sent: Tuesday, October 7, 2014 11:24 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Tamika Heiden (theiden@ktaustralia.com) <theiden@ktaustralia.com>
Subject: RE: Follow up re: KT and Organizational Capacity
Dear Melanie,
It is we at ECU who are all truly indebted to you for sharing your translation knowledge, experience and insights. My warmest thanks to you for including ECU in your itinerary - it was very generous of you. Thank you, too, for your presentation - I shall circulate it to all attendees.

Melanie, I look forward to working with you, and with Tamika, in the future, to grow Research Translation at ECU.
I sincerely hope you enjoy the rest of your visit to Perth and to Australia. Safe trip home.
Best regards,
Margaret.
Professor Margaret Jones
*Director, O*ffice of Research & Innovation
Edith Cowan University
Office: (61 8) 6304 5401
Mobile: (61 0) 417 557 694

From: Diana Kaan [mailto:diana.kaan@hc-sc.gc.ca]
Sent: Wednesday, November 12, 2014 1:26 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Kelly Warmington <kelly.warmington@sickkids.ca>
Subject: Re: [Caution: Message contains Suspicious URL content] RE: questions re the KT planning template
Hi,
Thank you for the information as well as the link. It's true that the Public Health Agency KT planning tool references your tool.
Regards,
Diana
Strategic Policy Branch
Health Canada | Government of Canada

From: Diane Duncan [mailto:dduncan@ucalgary.ca]
Sent: Tuesday, October 20, 2015 4:29 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: coaching and implementation
Hi Melanie,
Thanks so much for providing this reference.
My colleague and I found your workshop extremely helpful. The tools, resources and connections with other interested stakeholders will be invaluable as we build a KTA framework for our program.
Kind regards,
Diane
Diane Duncan, BScPharm, BA, PMP
Manager, Physician Learning Program
Continuing Medical Education and Professional Development
Cumming School of Medicine, University of Calgary

From: Peter Deane [mailto:peter.deane@anu.edu.au]
Sent: Wednesday, October 26, 2016 1:21 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Gabriele Bammer <Gabriele.Bammer@anu.edu.au>
Subject: Bringing Evidence-based Treatments into Practice videos are featured in I2S News – September/October 2016
Dear Melanie,
You may be interested to know that your YouTube videos from the Knowledge Translation and Implementation series "Bringing Evidence-based Treatments into Practice" are:
* showcased as a tool on the I2S website at - http://i2s.anu.edu.au/resources/implementing-evidence-based-practice-four-brief-videos
* featured in the most recent edition of Integration and Implementation Sciences (I2S) News (a PDF copy is attached and a summary of the newsletter is below)
You may also be interested in the other resources described in I2S News. These are the latest additions to a more extensive resource bank available on the I2S website at http://i2s.anu.edu.au/resources.
We would be grateful if you would draw the I2S website and I2S News to the attention of colleagues who may be interested in these resources.
Best wishes,
Gabriele Bammer and Peter Deane
Peter Deane
Integration and Implementation Sciences Team
Research School of Population Health
College of Medicine, Biology & Environment
The Australian National University, Acton, ACT, 2601

From: Christine Chambers [mailto:Christine.Chambers@Dal.Ca]
Sent: Thursday, December 1, 2016 9:41 AM
To: Bonnie Stevens <Bonnie.Stevens@sickkids.ca>; Melanie Barwick <melanie.barwick@sickkids.ca>; CampbellYeo, Marsha <Marsha.CampbellYeo@iwk.nshealth.ca>; Holly.Witteman@fmed.ulaval.ca; jbender@ehealthinnovation.org; Anna Taddio (anna.taddio@utoronto.ca) <anna.taddio@utoronto.ca>; Jennifer Stinson <jennifer.stinson@sickkids.ca>; RAN GOLDMAN (rangold99@hotmail.com) <rangold99@hotmail.com>; Kathryn O'Hara (koharua@gmail.com) <koharua@gmail.com>; Jeffrey Mogil, Dr. <jeffrey.mogil@mcgill.ca>; Tracy Moniz (Tracy.Moniz@msvu.ca) <Tracy.Moniz@msvu.ca>
Cc: Dol, Justine <Justine.Dol@iwk.nshealth.ca>; Parker, Jennifer A <JenniferA.Parker@iwk.nshealth.ca>
Subject: RE: #IDHTH update Nov 29th
Also, I forgot to mention that, at the beginning of November, our provincial minister of health (Leo Glavine)'s office reached out to me and asked that I come down to Province House because they were making a resolution about children's pain. I have no idea how this all came about, but it was pretty exciting!
I received a copy of the official resolution yesterday that was read out and voted upon - see attached.
So, #ItDoesntHaveToHurt is officially part of the history of the province now! LOL!
C.
Christine T. Chambers, PhD RPsych
Canada Research Chair in Children's Pain (Tier 1)
Professor of Pediatrics and Psychology & Neuroscience
Dalhousie University and IWK Health Centre
Halifax, Nova Scotia

From: Christine Chambers [mailto:Christine.Chambers@Dal.Ca]
Sent: Monday, December 19, 2016 9:43 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>; Holly.Witteman@fmed.ulaval.ca
Subject: FW: #KidsCancerPain: Tools to Help Assess Your Child's Cancer Pain
Have to laugh . . . when the head of communications at CIHR emails to essentially say that our work has changed the way they are thinking about KT to the public and that we have shown the way with our work . . . . and I can't keep my research program CIHR funded ;)
C.
//
From: McColgan, Andrew (CIHR/IRSC) [mailto:Andrew.McColgan@cihr-irsc.gc.ca]
Sent: Friday, December 16, 2016 11:36 AM
To: Christine Chambers
Cc: Forsythe, Allison (CIHR/IRSC)
Subject: Fw: #KidsCancerPain: Tools to Help Assess Your Child's Cancer Pain
Hi Christine,
This is another great campaign.
I talked to Terry Foster earlier this week. We're exploring how we can work with YMC to support public directed knowledge translation of CIHR funded research using social media and digital comms tools. You've really shown us the way with your work.
Have a great holiday season!
Andrew

From: Kelly McMillen
Sent: Wednesday, December 28, 2016 11:03 AM
To: Melanie Barwick <melanie.barwick@sickkids.ca>; Kelly Warmington <kelly.warmington@sickkids.ca>; Srdjana Filipovic <srdjana.filipovic@sickkids.ca>; Samantha Metler <samantha.metler@sickkids.ca>
Subject: SickKids highlights from 2016... includes SKTT Australia
Hi KT Team,
In case you didn't see this post, I thought you might be interested in seeing the reference to SKTT Australia in the attached highlights from 2016: http://my.sickkids.ca/news/Lists/Posts/Post.aspx?ID=3626
Thanks,
Kelly
Kelly McMillen | Director, Learning Institute

From: Gloria Ingram [mailto:vprdir@sfu.ca]
Sent: Monday, January 16, 2017 9:00 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Canada Research Chair Opportunity at Simon Fraser University
Dear Dr. Barwick,
I are writing to let you know about an exciting opportunity at Simon Fraser University. We are seeking applications and nominations to fill a Tier I Canada Research Chair in Youth Mental Health.
We are seeking an outstanding and innovative researcher who is internationally-recognized in the field of adolescent mental health with a focus on one or more of the following areas: program implementation and evaluation; diversity and culturally sensitive programming; determinants of mental health; and intersectoral and upstream approaches to enhancing mental health. The preferred candidate could have a disciplinary background in health, education, the social sciences (e.g., psychology), or other related disciplines.
You have been identified as an expert in this field and we are contacting you to see if you might be interested in the position. For your reference, a copy of the position advertisement is attached. Should you wish to learn more, or alternatively if you know of someone you would like to recommend, please do not hesitate to contact me by return e-mail.
Sincerely,
Gloria Ingram
Director, Office of the Vice-President, Research
Simon Fraser University

From: David J Phipps [mailto:dphipps@yorku.ca]
Sent: Saturday, January 28, 2017 9:43 AM
To: Rowland Lorimer <lorimer@sfu.ca>; Melanie Barwick <melanie.barwick@sickkids.ca>; Michael Johnny <mjohnny@yorku.ca>; Gary Myers <garym@yorku.ca>
Subject: Re: your special issue
Thanks for this Rowley. I am copying my co-authors on the Barwick paper so they know of the wonderful activity on our article. I know that I have promoted this article in seminars and on social media. It speaks to an ongoing tension at the interface of communications and KT, something that I encounter with many (actually most) audiences.
Cheers
David
David J. Phipps, Ph.D., MBA / Executive Director, Research & Innovation Services
Division of Vice-President Research & Innovation / Office of Research Services
YORK UNIVERSITY
//
From: Rowland Lorimer <lorimer@sfu.ca>
To: dphipps@yorku.ca,
Date: 2017-01-27 01:33 AM
Subject: your special issue

HI David:
I am going to copy you on a message I am sending to a senior author about her article in your special issue. In general, I'd like to say that the issue fares quite well in the attention the various articles received. And whereas Hynie ranked first in combined html and pdf views, because of a ton of html views, Barwick's Knowledge Translation and Strategic Communications: Unpacking Differences and Similarities for Scholarly and Research Communications ranked first in pdf views. with 12,655.
Let me know if you have any insight into this marvelous level of usage.

Rowly Lorimer
178 Short Road
Salt Spring Island, BC

From: Lee, Alex [mailto:Alex.Lee@cancercare.on.ca]
Sent: Wednesday, March 29, 2017 12:49 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: RE: slide deck
Hi Melanie,
Thanks for sending the invoice and e-copy of your slides. The feedback I received from the attendees was overwhelmingly positive, we're going to take this information back and discuss how to better incorporate implementation science concepts into our work.
Best regards,
Alex

From: Fiona Hill-Hinrichs [mailto:fhill-hinrichs@canet-nce.ca]
Sent: Wednesday, March 29, 2017 2:33 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Cc: Norah Cuzzocrea <ncuzzocrea@canet-nce.ca>
Subject: Fwd: KT workshop slide decks
Hi Melanie,
Do you typically share your slides in PDF with attendees?
Let me know…
Also - we are getting a lot of great verbal feedback on the workshop - hoping people take the time to do the survey!
Many thanks.
Fiona
Fiona Hill-Hinrichs
Director of Communications & Knowledge Mobilization
CANet - Cardiac Arrhythmia Network of Canada

From: **Colin Mckerlie** <Colin.Mckerlie@phenogenomics.ca>
Date: Sat, Apr 1, 2017 at 2:03 AM
Subject: RE: Social Media Workshop follow-up
To: "theiden@ktaustralia.com" <theiden@ktaustralia.com>
Hi Tamika,
Thanks very much to you and Melanie for an excellent session. I am a self-identifying social media luddite, but yesterday's session has me excited to change. Thanks as well for the slides. They will be very helpful as I start to build my professional Twitter and Linkedin profiles, and hope when I send my first Tweet (please RT) and Linkedin connection request that you'll provide me with expert feedback and suggestions for changes.\
Best regards,
Colin
Dr. Colin McKerlie
Senior Associate Scientist, SickKids
Professor, Dept. of Laboratory Medicine & Pathobiology
Director, TCP Research Partnerships
The Centre for Phenogenomics (TCP)
25 Orde Street, Room G-105
Toronto ON Canada M5T 3H7

From: **Nicole Webb** <Nicole.Webb@smu.ca>
Date: Sat, Apr 1, 2017 at 1:19 AM
Subject: Re: Social Media Workshop follow-up
To: "theiden@ktaustralia.com" <theiden@ktaustralia.com>
Cc: workwellness <workwellness@smu.ca>, Lucie Kocum <Lucie.Kocum@smu.ca>
Hi Tamika,
Thank you so much for your e-mail. I have completed the survey. Yesterday was invaluable. I changed my Twitter handle, downloaded Hootsuite, used Pexels, and improved my LinkedIn.
Just wow! I cannot wait to apply everything I have learned. I look forward to following your advice and really soaking everything in over the next few days. I have 4 FB pages, 3 Twitter accounts, 3 LinkedIn accounts, and an Instagram. Your Hootsuite suggestion may have just saved my sanity. Top notch workshop. I cannot wait to see you back in Canada or virtually in a webinar.
Cheers,
Nicole

From: Outlaw, Ann [mailto:aoutlaw@air.org]
Sent: Friday, May 26, 2017 3:18 PM
To: Melanie Barwick <melanie.barwick@sickkids.ca>
Subject: Thank You!
Dear Melanie,
Thank you very much for providing an excellent webinar to our staff yesterday. I've heard from multiple people that this was the best webinar they've ever attended – which is huge accolades coming from adult learning researchers!
You've opened up minds about how our work relates across our company and conversations about how to link and share has begun. Thank you for that. People are also asking questions about your presentation. Would you be open to me emailing you these questions so I can send out a post webinar Q/A document? This is an additional ask, so I understand if you wish to decline. We can bring these questions up at the later in person training (which I will get information to you as soon as I know it!).
Also, I appreciate your professionalism, being more than ready, and flexibility with our tech problems. People are praising my work, when really it was just you! I feel a little like I'm cheating so I thought I'd pass the gratitude along!!
I hope you have a nice weekend,
Ann
Ann Williams Outlaw, MA
Technical Assistant Consultant
American Institutes for Research
aoutlaw@air.org
202-403-5608

APPENDICES

LETTERS OF RECOGNITION AND COLLEAGUE TESTIMONIALS

July 11 2017

Dear Members of the Promotion Committee,

It gives me great pleasure to write this letter of support as a colleague of Dr. Melanie Barwick, as she applies for promotion to Full Professor in the Department of Psychiatry at the University of Toronto. I have had the privilege of working with Dr. Barwick for close to two decades and as such, feel very well qualified to comment on her career trajectory and to fully endorse her promotion at this level. She more then meets the requirements for promotion as she has undoubtedly established a very extensive global reputation in her field of interest (knowledge translation [KT] and implementation science), is deeply engaged in scholarly work, and has demonstrated excellent teaching skills in her leadership role in the Learning Institute and beyond – effectively sharing best practice in KT with other scholars, practitioners and policy makers via certified workshops and other dissemination realms.

Her outstanding CV along with her research and CPA dossiers speak for themselves; they indicate that Melanie has been incredibly active on so many levels, substantively and methodologically, individually and collaboratively. Rather than repeat the outstanding successes in research, teaching and creative professional activity that are very well documented in her dossier, I will comment on areas that may not be as clear in these application documents – namely on Melanie's role as a scientist who truly contributes to the field of health and mental health in a collaborative and participatory way, and on the ways in which I have observed her working style with others – both those junior and senior in status to her.

Despite an incredibly wide array of research and KT projects, Melanie always finds time to liaise with others and is very generous with her time, sharing her knowledge base. I have seen her in many committee contexts and she is a keen, motivated and enthusiastic contributor, offering up novel ideas and suggestions. My program of research is very much participatory and collaborative in terms of the research projects that I lead and in my experience over my entire career, I would rate Melanie in the top 1% in terms of a colleague and collaborator who is a pleasure to work with and who never fails to contribute in a meaningful way.

Melanie is an exceptional leader in the field and has been responsible for spearheading truly innovative research and training globally. As just one example, her SKTT program has trained thousands of scholars and practitioners in 4 countries. Her KTPC course is the only one of its of its kind attracting participants from across the world. Of particular note is that these novel training workshops generate revenue that is further invested in Sick Kids. This is but one example of many that illustrate Melanie's commitment to and success in furthering the field of knowledge translation and implementation science in a significant way.

There is no doubt that the Department of Psychiatry and The Hospital for Sick Children are most fortunate to have Dr. Barwick. She is an outstanding scientist in every respect – research, teaching and training, and creative professional activity. Since relocating to Australia, I have been privileged to continue my collaboration with Melanie (at least on some small level) and look forward to potential opportunities in future. It has been one of the heights of my career to have had the opportunity to collaborate with Melanie.

Respectfully submitted,

Katherine Boydell MHSc, PhD
Professor of Mental Health
Black Dog Institute
University of New South Wales
Hospital Road, Randwick, NSW 2031
k.boydell@unsw.edu.au

DALHOUSIE UNIVERSITY
Inspiring Minds
Faculties of Medicine and Science

July 27, 2017

Dr. Jim Kennedy
Chair Promotions Committee
Department of Psychiatry
University of Toronto

Re: Promotion to Full Professor of Dr. Melanie Barwick

Dear Dr. Kennedy:

It is a sincere honour and a privilege to write this very strong letter of support for Dr. Melanie Barwick, who I understand is applying for promotion to Full Professor. I have known Dr. Barwick for about a decade now, and until recently most of our interactions were as part of a larger funded team grant that was led by a mutual colleague. However, after taking her Scientist Knowledge Translation Training (SKTT) course when it was sponsored by the Nova Scotia Health Research Foundation in February of 2014, I reached out to her with a request to collaborate on a CIHR grant application in the summer of 2014. Thankfully the grant was funded, and over the last 3 years Dr. Barwick has become one of my most valued and reliable collaborators. Dr. Barwick is unique in that she understands the academic world, but is able to think differently and creatively about knowledge translation. She is a true visionary, and has led the way nationally and internationally in creating training and capacity for knowledge translation, long before knowledge translation became trendy.

Dr. Barwick is a co-investigator on my CIHR Knowledge-to-action Operating Grant, *It Doesn't Have to Hurt: A science-media partnership to mobilize evidence about children's pain to parents*. She has been a significant, consistent, and creative contributor to that project. In fact, when I first had the idea for the project she was the very first person I reached out to, and her input and suggestions had a critical impact on how I approached the grant and subsequent funded work. As a member of the research team Dr. Barwick was involved in grant development, providing expertise related to evidenced-based information, and dissemination of content. The resulting work has been highly successful (the current reach is >130 million content views worldwide) and has been acknowledged with multiple awards from the science and digital marketing industries, including Gold Winner for Best Online Campaign at the 2016 Canadian Online Publishers Awards.

I'm a huge fan of Dr. Barwick's knowledge translation training tools, such as the Scientist Knowledge Translation Plan Template and KT Game available on her website. I frequently use both these tools myself in my own teaching and presentations and they are always met with tremendous enthusiasm. Dr. Barwick has been incredibly generous in her development and sharing of KT tools and resources.

Christine T. Chambers, Ph.D. R.Psych. • Departments of Pediatrics & Psychology and Neuroscience
IWK Health Centre • 5850/5980 University Avenue • PO Box 9700 • Halifax NS B3K 6R8 Canada
Tel: 902.470.8877 • Fax: 902.470.7249 • christine.chambers@dal.ca

I have also included Dr. Barwick as a co-investigator on four knowledge sharing grants from the Nova Scotia Research Foundation (NSHRF; $39,991 total funding, 2015-2018). Two of these grants aim to extend the work of #ItDoesntHaveToHurt. In the second of these projects, we are creating a video case study with knowledge users, stakeholders, and partners, to share evidence of the impact of the #ItDoesntHaveToHurt initiative. In another NSHRF grant, Dr. Barwick and our team are collaborating to fill a knowledge gap for researchers to create a social media tool kit for health researchers. Another recently completed NSHRF grant was a knowledge translation project with ParentsCanada to disseminate the evidence-based guidelines developed by the HelpInKids&Adults (led by Dr. Anna Taddio, University of Toronto), in a parent-friendly tear-out format in their magazine, Needles Don't Have to Hurt. This advertorial has received considerable attention and reach online and was invited for special trainee presentation at the recent Society of Pediatric Psychology meeting.

More recently as a result of her valuable contributions to #ItDoesntHaveToHurt, I invited her as a co-investigator on another research project, "Making Cancer Less Painful for Kids" aimed at tackling the problem of pain in children with cancer. The #KidsCancerPain social media campaign was funded (2015–2017) by a Canadian Cancer Society Knowledge-to-action Grant ($100,000). Melanie was involved as a member of the research team and was in grant development, providing expertise related to evidenced-based information, and dissemination of content. All the campaign content can be viewed on http://pediatric-pain.ca/kidscancerpain. We have a paper currently in press related to this research (Tutelman, P., Chambers, C., Stinson, J., Parker, J., Fernandez, C., Witteman, H., Nathan, P., Barwick, M., Campbell, F., Jibb, L., & Irwin, K. (in press). Pain in children with cancer: Prevalence, characteristics, and parent management. *Clinical Journal of Pain*) and have a student poster recently invited for special oral presentation at the International Society of Paediatric Oncology conference in Washington in October.

I continue to value Dr. Barwick's collaboration and expertise through an invitation to serve as a Program Expert on my CIHR Foundation Grant, "*Optimizing Parents' Roles in Children's Pain Management and Practice Change*," which is currently under final stage review.

In sum, I highly value Dr. Barwick as a creative, outside-of-the box thinker and visionary whose input and expertise has had a tremendous impact on my own research and academic outputs. She is a valued and treasured collaborator and an incredible resource for our research community. I look forward to our continued work together.

Please contact me at (902) 470-8877 or christine.chambers@dal.ca should you have any questions or require any additional information.

Sincerely,

Christine T. Chambers, PhD
Canada Research Chair (Tier 1) in Children's Pain
Professor of Pediatrics and Psychology and Neuroscience (cross-appointments in Anesthesia, Pain Management & Perioperative Medicine and Psychiatry), Dalhousie University
Centre for Pediatric Pain Research, IWK Health Centre

April 26, 2017

Melanie Barwick
The Hospital for Sick Children,
180 Dundas St. W.,
Ste 2600 Toronto,
ON M5G 1X8

Dear Ms. Barwick,

On behalf of the Quality Improvement and Patient Safety Forum Organizing Committee, we would like to invite you to participate in our event as a Workshop Lead during our **Knowledge Translation Workshop** on **Monday October 23, 2017** at **10:45a.m** at the Metro Toronto Convention Centre, South Building.

This is a 90 min. speaking opportunity, we would appreciate your expertise on the importance of knowledge translation and tips to enable the quality improvement community to transfer knowledge to other settings.

The 2nd Annual Quality Improvement and Patient Safety Forum attracts approximately 700 quality improvement leaders, clinicians, educators and researchers from across the province. This event is hosted in partnership by the Centre for Quality Improvement and Patient Safety (C-QuIPS), Improving & Driving Excellence Across Sectors (IDEAS), and Health Quality Ontario. Our conference provides delegates with the opportunity to:

- Enhance skills and knowledge on the latest QI and patient safety research and evidence through dynamic, interactive workshops;
- Participate in a growing QI and patient safety community with opportunities for networking and professional development
- Be recognized for achievements through poster awards

We strongly believe your participation as a Workshop Lead would greatly enhance the success of our Knowledge Translation Workshop. Kindly let us know if you wish to accept our official letter of invitation on or before Wednesday May 3rd by responding to this email. Should you wish to accept Health Quality Ontario's Event Manager, Maya Kwasnycia, will be in touch with further moderator instructions and event information.

If you are unable to attend kindly let us know by the above noted delegate, however we would strongly encourage you to send a delegate on your behalf to this exciting annual sold out event! Registration will open on September 7, 2017.

Thank you for your time and consideration.

Sincerely,

GILLIAN RITCEY
Director
IDEAS (Improving & Driving Excellence Across Sectors)
Institute of Health Policy, Management & Evaluation, University of Toronto
Health Sciences Building, 155 College St, Suite 425
Toronto, ON M5T 3M6
Email:gillian.ritcey@utoronto.ca
Phone: 416-978-1538

Ministry of Children and Youth Services
Policy Development and Program Design Division

Children and Youth at Risk Branch

101 Bloor Street West
2nd Floor
Toronto ON M5S 2Z7
Phone: (416) 327-0115
Fax: (416) 212-2021

Ministère des Services à l'enfance et à la jeunesse
Division de l'élaboration des politiques et de la conception des programmes

Direction pour l'enfance et la jeunesse à risque

101, rue Bloor ouest
2e étage
Toronto (Ontario) M5S 2Z7
Tél : (416) 327-0115
Téléc : (416) 212-2021

Ontario

May 31, 2017

Dr. Arun Ravindran, Chair
Promotions Committee
University of Toronto, Department of Psychiatry
250 College Street
8th floor
Toronto, Ontario
M5T 1R8

Dear Dr. Ravindran,

I am pleased to provide this letter of support for Dr. Melanie Barwick who has applied for the position of Full Professor in the Department of Psychiatry at the University of Toronto.

Dr. Barwick has made a significant contribution to the child and youth mental health (CYMH) sector in Ontario, over many years. She has provided leadership in a range of capacities, and in particular with respect to CYMH evidence-informed practices, outcome measurement, assessment and outcome tools, and implementation science for quality service delivery.

By way of background, the Ministry of Children and Youth Services (MCYS) has historically provided funding to over 400 agencies to deliver mental health services to children and youth. In 2000, a subset of these agencies (approximately 120) were funded to use a standardized tool- the Child and Adolescent Functional Assessment Scale (CAFAS) to collect information about the impact of services on child and youth outcomes. The use of this tool within these agencies was largely supported through the Hospital for Sick Children, under the leadership of Dr. Barwick. The data collected through CAFAS and analyzed by Dr. Barwick and her team helped measure and capture child and youth outcomes in the CYMH sector, promoted evidence-informed service delivery and led to a broader shift of the data culture within the sector.

Dr. Barwick went above and beyond contractual obligations and provided advice to MCYS through participation in numerous provincial groups and expert panels. This included provision of advice on clinical needs assessment and outcome tools, CYMH information and data needs, CYMH performance indicators, effective

approaches for knowledge mobilization and advice as to how to implement change successfully on the ground.

In 2010/2011, MCYS collected information on the use and usability of CAFAS and other data collection tools. This analysis, and the work of Dr. Barwick and her team on the CAFAS tool, has informed MCYS' current data strategy, which enables evidence-informed policy and service delivery.

Dr. Barwick is recognized and respected as an expert in CYMH in Ontario, attested by the many conferences and presentations she makes using the data derived through the CAFAS tool and her experience with implementation of evidence-informed practice in the province of Ontario.

We are appreciative of the support, advice and contribution which Dr. Barwick has made to the CYMH sector in Ontario, and for the leadership she has demonstrated over many years with respect to child and youth mental health. We expect she will continue to have an influence on our work as we continue to improve the CYMH service system in Ontario.

Sincerely,

Marian Mlakar
Director
Children and Youth at Risk Branch

Ontario Centre of Excellence
for Child and Youth
Mental Health
Centre d'excellence de l'Ontario
en santé mentale des
enfants et des adolescents
Bringing People and Knowledge Together to Strengthen Care.
Rassembler les gens et les connaissances pour renforcer les soins.

June 5, 2017

Re: Melanie Barwick, Application for Promotion to Full Professor

Dear Members of the Promotions Committee:

It is my sincere pleasure to provide this letter of support for Dr. Melanie Barwick's application for full professor in the Department of Psychiatry and The Dalla Lana School of Public Health, University of Toronto. Dr. Barwick has had many notable achievements as a researcher and scientist, and she is a leader in the fields of knowledge translation/exchange and implementation science, both nationally and internationally.

In my position at the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre) as the Director of Knowledge Mobilization, I have had the pleasure of working with Dr. Barwick on several occasions. Our Centre is a leader for child and youth mental health in the province, as we work to build connections, share knowledge and use our expertise in knowledge translation/exchange to enhance the skills of direct service providers to put evidence into practice. Our primary stakeholders are agency leaders and practitioners working in child and youth mental health agencies; given their commitment to providing high quality care to service users, they greatly value the knowledge gleaned from high quality research that underlies any change effort they take on within their organization.

While all scientists with an academic appointment recognize the currency of grants and journal publications, there is a need to ensure the translation of scientific knowledge into a format that can be used by direct service providers to enhance their work with clients. Dr. Barwick's deliberate efforts to strengthen evidence-informed practice in a range of child and youth mental health and health-related settings are numerous and notable.

For example, Dr. Barwick played a critical role in advancing outcome measurement in the province's child and youth mental health sector from 2000 – 2015. As the lead implementer of the Child and Adolescent Functional Assessment Scale (CAFAS) (funded by the Ministry of Children and Youth Services), Dr. Barwick led the training and implementation of this tool across Ontario's child and youth mental health agencies, and was instrumental in developing CAFAS annual reports that provided detailed information on child and youth mental health outcomes throughout the province. This knowledge was in turn used by agencies as part of their ongoing program evaluation efforts, and contributed to ongoing enhancements to service delivery within each organization.

For many years now, Dr. Barwick has been a leader in fields of knowledge translation/exchange (KTE) and implementation science (IS). Since 2010, Dr. Barwick has created and delivered an innovative training curriculum for professionals working across sectors in the area of KTE (the Knowledge Translation Professional Certificate program). After almost 20 sessions, over 200 graduates have left this

intensive session with concrete skills and strategies in KTE to advance their work. Further, Dr. Barwick has contributed to the ongoing professional development of those working in knowledge brokering roles as a founding member of the Knowledge Translation and Exchange Community of Practice. This group is a network of KTE practitioners and researchers who share relevant tools and experiences, provide knowledge and support to one another, build KTE capacity across sectors and advance knowledge about how to do KTE well. This community plays an essential role for those of us working in this field as we advance our practice, and Dr. Barwick's vision for this group has been critical to its success.

As her CV shows, Dr. Barwick has also made significant contributions to the related area, IS. She has led innovative research projects on IS in global health and health, and has produced important findings in the study of the various methodologies used in IS. Of note is Dr. Barwick's research with several of Ontario's child and youth mental health organizations looking at factors affecting the adoption and implementation of evidence-based services. In addition to producing valuable, actionable findings, her study supported agencies to build their capacity to use a planned implementation approach to initiating organizational change. In 2010, our Centre collaborated with Dr. Barwick to develop evidence-based learning modules to guide implementation efforts focused on supporting child and youth mental health practitioners to effectively implement new practices in their organizations. This tool has been downloaded over 5000 times over the last 6 years, and continues to be a valuable resource for our stakeholders. Dr. Barwick also plays a critical leadership role in growing the field of IS practitioners. Modules. She is a member of the board of directors for the Global Implementation Initiative, and was recently lead organizer of the Global Implementation Conference in Toronto, which hosted over 600 delegates from across the world.

Finally, I would like to comment on Dr. Barwick as a colleague. Melanie is an incredible researcher who is interested not in "research for research sake"; rather she is committed to ensuring that her work produces specific change that will ultimately support the mental health of our children, youth and families. She is a generous colleague (both intellectually as well as in her day-to-day interactions with collaborators), and an energetic, thoughtful and bright academic. I am pleased that the committee is considering Dr. Barwick's application for Full Professor and believe she is an excellent candidate for this designation. Her exceptional research and leadership in the related fields of KTE and IS are producing both academic and "on-the-ground" impacts that are being felt by children, youth and families both here in our province, and more broadly across the country and internationally.

Sincerely,

Purnima Sundar, PhD
Director, Knowledge Mobilization
The Ontario Centre of Excellence for Child and Youth Mental Health
psundar@cheo.on.ca
613-737-2297 ext. 3769

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HUDDERSFIELD
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23 May 2017

PRIVATE & CONFIDENTIAL

Dr Melanie Barwick
Child & Youth Mental Health Research Unit, Psychiatry
Child Health Evaluative Sciences, Research Institute
Peter Gilgan Centre for Research and Learning
The Hospital for Sick Children
686 Bay Street
Toronto, M5G 0A4
CANADA

Dear Melanie

I can now confirm you have been awarded the title of Visiting Professor within the School of Human & Health Sciences at the University of Huddersfield. This honorary title is awarded for a period of 5 years in the first instance and will commence on 1 October 2017.

I would like to thank you for accepting this award and know that colleagues in Human & Health Sciences are looking forward to working with you.

Yours sincerely

Siobhan Campbell
Director of Human Resources
Tel: 01484 472224
Email: s.e.campbell@hud.ac.uk

Cc: Paul Bissell, Dean, Human & Health Sciences

None in Three

www.noneinthree.org

This project is funded by the European Union

April 19th 2016

Professor Melanie Barwick
Sick Kids Hospital
Toronto
Canada

Dear Professor Barwick

I am writing to inform you of a new collaborative project for preventing domestic violence which will be implemented in Barbados and Grenada as a pilot for the Caribbean, in collaboration with government departments and NGOs from these countries.

This two-year European Union funded research (in partnership with The Sweet Water Foundation, Grenada), builds on the current legislative, policy and programmatic thrust towards ending gender-based violence in the region. It offers a complementary approach to existing research and is very much aligned with UN, UNICEF and WHO goals on eliminating violence. The project, which was launched to coincide with International Women's Day (March 8th 2016), is entitled 'None in Three' (the name is inspired by the statistic that one in three women and girls will face physical or sexual violence in their lifetime) and is based on the belief that such violence is not an inevitability. In the first year, the project involves new research which aims towards improving access to justice and services for women in especially vulnerable circumstances, such as those living with HIV, pregnant women, disabled women, women from sexual minorities and women who have been trafficked. Research will also be carried out with men and youth to see what can be learned from male perspectives on preventing victimization. The research findings will be used to inform training which will be made widely available for key stakeholders and front-line staff.

In the second year, the primary goal of *None in Three* will be to design and implement a cultural/gender-sensitive and age-appropriate immersive computer game for use as educational tools to build victim empathy, emotional intelligence skills and to foster anti-violence attitudes and behavioural change among children and young people. This work will be subject to rigorous scientific testing to establish base-line data on attitudes that can contribute towards violence and also, to determine the cognitive and behavioural effects of exposure to games designed to challenge such attitudes. Our project team includes a Professor of Digital Games Technology who will lead the design of the computer games in partnership with reference groups and schools in both countries and, a specialist in Forensic Psychology/Criminology. The project is being implemented in each country by local experts.

Alongside both activities we are rolling out a social media campaign which aims to engage with people from all levels of society who wish to join us in making a stand against domestic violence. In this way, we seek to engage the general public as activists and supporters.

In order to ensure that our findings have maximum regional and international impact, we have established a Regional Advisory Group (RAG) and we would be privileged if you would agree to be a member. As an Implementation Scientist with an international reputation, your participation in the project would help us to consider more deeply the factors required for successful implementation and replication, especially of the computer game aspect of the project. The function of the RAG will be to:

I. Comment on project outputs
II. Support the promotion of '*None-in-Three'* in the region and internationally
III. Support regional dissemination and wider adoption of interventions that have been positively evaluated for benefit

The Regional Advisory Group will not be required to attend any physical meetings but instead will be asked to comment on information produced at three project points: at its commencement (implementation plans); at the mid-point review and on completion of the project evaluation. This does not of course, preclude members of the RAG from making comment at any other time, sharing information of their own or indeed, of contributing to publications. I am sure there would be many reciprocal benefits to our collaboration and I hope you will accept this invitation.

I look forward to hearing from you.

Yours sincerely,

Professor Adele D. Jones, PhD
The Centre for Applied Childhood, Youth and Family Research

Project Director: Professor Adele Jones a.d.jones@hud.ac.uk
+44 (0) 7540 671231
The University of Huddersfield, Queensgate, Huddersfield HD13DH, UK
Telephone +44 (0) 1484 422288 Ext. 3237
Vice-Chancellor: Professor Bob Cryan BSc MBA PhD DSc

April 26, 2017

Melanie Barwick
The Hospital for Sick Children,
180 Dundas St. W.,
Ste 2600 Toronto,
ON M5G 1X8

Dear Ms. Barwick,

On behalf of the Quality Improvement and Patient Safety Forum Organizing Committee, we would like to invite you to participate in our event as a Workshop Lead during our **Knowledge Translation Workshop** on **Monday October 23, 2017** at **10:45a.m** at the Metro Toronto Convention Centre, South Building.

This is a 90 min. speaking opportunity, we would appreciate your expertise on the importance of knowledge translation and tips to enable the quality improvement community to transfer knowledge to other settings.

The 2nd Annual Quality Improvement and Patient Safety Forum attracts approximately 700 quality improvement leaders, clinicians, educators and researchers from across the province. This event is hosted in partnership by the Centre for Quality Improvement and Patient Safety (C-QuIPS), Improving & Driving Excellence Across Sectors (IDEAS), and Health Quality Ontario. Our conference provides delegates with the opportunity to:

- Enhance skills and knowledge on the latest QI and patient safety research and evidence through dynamic, interactive workshops;
- Participate in a growing QI and patient safety community with opportunities for networking and professional development
- Be recognized for achievements through poster awards

We strongly believe your participation as a Workshop Lead would greatly enhance the success of our Knowledge Translation Workshop. Kindly let us know if you wish to accept our official letter of invitation on or before Wednesday May 3rd by responding to this email. Should you wish to accept Health Quality Ontario's Event Manager, Maya Kwasnycia, will be in touch with further moderator instructions and event information.

If you are unable to attend kindly let us know by the above noted delegate, however we would strongly encourage you to send a delegate on your behalf to this exciting annual sold out event! Registration will open on September 7, 2017.

Thank you for your time and consideration.

Sincerely,

GILLIAN RITCEY
Director
IDEAS (Improving & Driving Excellence Across Sectors)
Institute of Health Policy, Management & Evaluation, University of Toronto
Health Sciences Building, 155 College St, Suite 425
Toronto, ON M5T 3M6
Email:gillian.ritcey@utoronto.ca
Phone: 416-978-1538

Alberta Innovates Health Solutions

www.aihealthsolutions.ca
1500 – 10104 103 Avenue NW
Edmonton, Alberta, Canada T5J 4A7
Tel 780-423-5727 Fax 780-429-3509
Toll Free 1-877-423-5727

Dear Dr. Barwick,

The AIHS Strategic Implementation Process (SIP) begun in early 2011 has now reached the conclusion of its first phase. With your help, we have made important progress over the past year with the launch of several new funding mechanisms, advancement on a knowledge translation strategy for the organization, and identification of key considerations regarding needs and priorities for innovation platform investment to best support health research in Alberta.

Your contribution to this process was no small thing. In total, 48 individuals volunteered on the process's Working Groups and Oversight Committee and collectively contributed over 1,000 person-hours of meeting time. We can only guess at the additional hours each of you spent preparing for meetings and speaking with your peers and other stakeholders to seek their input or to answer their questions about our progress.

At the end of this phase of the Strategic Implementation Process, AIHS has:

- announced five new broad envelopes of programs reflective of the consultative design process under the Highly Skilled People direction;
- articulated key strategies for AIHS's Knowledge Translation strategy;
- identified strategies and focuses for articulation of priorities in the Innovation Platforms area.

Additionally, we heard from you and from our stakeholder communities that AIHS has an important and unique role to play as a research management organization as influencer, broker, facilitator, convener, manager, and innovative leader in Alberta's health research and innovation system. We will continue to value and reference the feedback we received through the SIP as we evolve, and to seek additional and specific input as required through an ongoing, resourced stakeholder engagement function at AIHS.

Our next steps over the coming four to six months are to compile an assessment of Alberta's health research strengths cross-referenced against the areas of strategic health focus outlined in AHRIS, and against data on the health status of Albertans (current and emerging) that will inform AIHS's strategic planning. As well, we will be updating the community on our new Knowledge Translation Strategy, and seeking input into articulation of needs for investment in important health research innovation platforms.

We believe that your representation and involvement in the Strategic Implementation Process was critical to increasing awareness and understanding of AIHS's new strategic direction across the research and innovation system. Your involvement was certainly critical to informing our awareness and understanding of the issues and concerns our stakeholders held, and to identifying both solutions and creative strategies AIHS can employ to deliver on our mandate.

Your commitment and generous contribution of your time and knowledge has benefited Alberta Innovates – Health Solutions immeasurably. Thank you.

Please note that we will be contacting you in the near future to ask for your assessment of the process itself.

Sincerely,

Jacques Magnan, CEO

Pamela Valentine, Vice President of Research & Innovation

Alberta

Funded by the Government of Alberta

Black Dog Institute

May 1, 2016

Dear Melanie,

This letter is to formally invite you to spend the week of September 26th with us at The Black Dog Institute, University of New South Wales (UNSW).

We are planning an exciting week where you will have the opportunity to meet with the broader UNSW community (via knowledge translation training course), with University of Wollongong members of our joint implementation project focused on rolling out interventions targeting young males in organised sports clubs, and finally via talks with Black Dog staff in research education and clinical arenas.

Although there will be no remuneration, we are able to cover your accommodation for the duration of your stay here in Sydney.

We very much look forward to welcoming you to Sydney, to hearing about the innovative and ground breaking work you are engaged in and to explore future collaborative opportunities.

Warmest regards,

Katherine Boydell | Professor of Mental Health
Black Dog Institute
Hospital Road, Randwick NSW 2031
T: 02 9382 8501
k.boydell@unsw.edu.au

www.blackdoginstitute.org.au

Dear colleagues,

Late in 2016, Healthway contracted Curtin University to test an online system that could track the impact of current and past-funded Healthway research. As part of this project, numerous key informants were interviewed and a significant number of Primary Investigators were asked to trial a data-capturing system known as Researchfish. In some instances individuals were asked to assist with both strategies.

Healthway is extremely grateful for the support you provided as part of this project and I would like to thank you for your contribution. In particular, we recognise the significant time commitment that was required and that this request occurred at a particularly busy time of the year. This work is very important to us as it is critical that Healthway is able to introduce strategies to capture the real-world impact of its research moving forward and without your assistance, such an initiative would not be possible.

We expect the outcomes of this project to be considered by the Healthway Board at the end of April. After this time, we will be keen to share the findings with everyone who assisted us.

In the meantime, please don't hesitate to contact me should you have any queries.

Kind Regards,

Dr Jo Clarkson

Institute for Knowledge Mobilization
8425906 CANADA INSTITUTE

31 March 2016

Invitation to be a Keynote Speaker at the 2016 Canadian Knowledge Mobilization Forum

Dr. Melanie Barwick
The Hospital for Sick Children
Department of Psychiatry
555 University Avenue, Burton Wing
Toronto, ON M5G 1X8, Canada

Dear Dr. ~~Barwick~~ Melanie,

On behalf of the Board of the Institute for Knowledge Mobilization and the volunteer Organizing Committee of the 2016 Canadian Knowledge Mobilization Forum, I am inviting you to be a Keynote Speaker.

The Forum is the leading practitioner focused conversation on evidence-based decision supports in Canada. We are fortunate to be holding the event in Toronto at the Peter Gilgan Centre for Research and Learning of the Hospital for Sick Children on June 28 and 29, 2016.

The theme for this year is *Systems and Sustainability – Creating Enduring Knowledge Mobilization*. Knowledge mobilization is about ensuring that sound evidence has an impact on decision-making and practice so what we can improve outcomes over time.

It would wonderful for our audience to learn more about how your work in child and youth mental health, and your knowledge translation training efforts can be scaled to inform the broader systems that universities, hospitals, governments and civil-society organization use and depend on to deliver services to the full spectrum of Canadians and beyond.

The Institute for Knowledge Mobilization is a registered non-profit corporation with a declared institute designation based in Ottawa, Canada but serving a network across Canada with connections around the globe.

Please feel free to contact me at your convenience. I look forward to the continued opportunity to work and learn from you.

Yours sincerely,

Peter Norman Levesque
President, Institute for Knowledge Mobilization

ADVANCING RESEARCH
SEDL
IMPROVING EDUCATION

November 6, 2013

Dr. Melanie Barwick
The Hospital for Sick Children

Dear Melanie,

I want to personally thank you for the excellent job you did on the recent KTDRR online conference, *Knowledge Translation Measurement: Concepts, Strategies, and Tools*. Without your help, the conference would not have been as successful as it was!

The feedback we have gotten to this point indicates that the participants clearly liked and felt benefitted by their participation in the conference. We had great attendance over the three days of the conference with an average daily attendance of about 126.

At any rate, I want you to know how much I truly appreciate your effort in supporting the implementation of the online conference. I hope you found it a pleasurable experience and feel open to working with us again in the future!

Sincerely,

John D. Westbrook, PhD

Voice: 800-476-6861
Fax: 512-476-2286
www.sedl.org
4700 MUELLER BLVD., AUSTIN, TX 78723

McGill

School of Physical and Occupational Therapy
McGill University
3654 Promenade Sir-William-Osler
Montreal, Quebec H3G 1Y5

École de physiothérapie et d'ergothérapie
Université McGill
3654, promenade Sir-William-Osler
Montréal (Québec) H3G 1Y5

(514) 398-4500
(514) 398-6360 (fax/télécopieur)
www.mcgill.ca/spot

January 18, 2016

Dr. Melanie Barwick
Hospital For Sick Children
686 Bay St.
Toronto, ON M5G 0A4

Sent by email to: melanie.barwick@sickkids.ca

RE: INVITATION – KEYNOTE SPEAKER

Dear Dr. Barwick,

We would like to formally invite you, on behalf of McGill University's School of Physical and Occupational Therapy and Edith Strauss Rehabilitation Research Project Steering Committee, to be a Keynote Speaker at our upcoming **1st National Knowledge Translation Conference in Rehabilitation.** This event will be held on **May 4-5, 2016** in downtown Montreal, Quebec. The overall aim of the conference is to enhance academic and clinical partnerships to close the gap between research knowledge and its implementation in clinical practice. We expect attendance of at least 150 delegates, including researchers, professional and graduate students, health care professionals, clinical managers/administrators, and decision-makers interested in knowledge translation.

We would like to invite you to open a plenary session on May 5, 2016 with a presentation related to the following theme entitled: *"Strategic initiatives for KT in Rehabilitation"*. We will forward a draft Conference Program in January to give you an idea of the other themes and speakers.

Given your extensive work in this area it would be a great honor to have you as part of our 1st National Knowledge Translation Conference in Rehabilitation.

Please let me know if you have any questions or would like additional information. We look forward to your response and we thank you for your consideration.

Sincerely,

Sara Ahmed, PT, PhD
Associate Professor, McGill University
Chair of Edith Strauss Rehabilitation Research Project
3654 Promenade Sir-William-Osler
Montreal Quebec, H3G 1Y5

Annette Majnemer OT, PhD, FCAHS
Director, School of Physical & Occupational Therapy, McGill University
3654 Promenade Sir-William-Osler
Montreal Quebec, H3G 1Y5

Instructions to Authors regarding Case Study

The idea of the case study is to facilitate reflection that will have an impact on practice, and to simultaneously refine the theories of that practice. They are most valuable with there are multiple perspectives needed to provide a full account of the research issues. They provide an opportunity for others to learn from both success and failure experiences associated with addressing complex, messy, situations. The goal is to learn from the process in order to contribute to better decision-making in other settings or as the project unfolds.

Although there a wide range of formats for the writing case studies, we are hoping that in your presentation and analysis that you cover

1) the problem being addressed and the background context. Who were the stakeholders, and what was their role in process?
2) What strategy did you adopt to derive a solution, and what was the solution you chose to implement?
3) What was the evidence base used, and what gaps exist in this evidence base.
4) Describe some of the key complexities that had to be evaluated in deriving a solution (e.g., risks being balanced, diverse target populations, logistical issues, political agendas, competing stakeholder interests, funding, among others)
5) Identify critical challenges encountered through the implementation process.
6) What was learned? Were the outcomes anticipated or consistent with expectations? What are the transferrable practices and lessons that could be useful in other programs?

Murdoch Childrens Research Institute
Healthier Kids. Healthier Future.

Melanie Barwick, PhD, CPsych
Head, Child and Youth Mental Health Research Unit (CYMHRU)
Senior Scientist CHES Research Institute
Peter Gilgan Centre for Research and Learning, 11-9718
The Hospital for Sick Children

12 May 2016

Dear Melanie,

It is with great pleasure that I write to invite you to attend the Murdoch Childrens Research Institute (MCRI) as an expert advisor to MCRI on how to advance research translation and specifically, to advice on the Melbourne Children's Campus Research Translation and Impact Framework project.

I confirm the following arrangements:

Dates: Saturday Oct 8 – Friday Oct 21

Flights: We will reimburse you for a business class flight from Toronto to Melbourne and return.

Expenses: We can provide a per diem of $440 per day for the number of days you are working on MCRI related activities (including weekends).Please provide us with a letter specifying the dates and total days you will be requesting a per diem for and your bank account details. We will pay this 6-8 weeks before your arrival to ensure you are not out of pocket

Activity: We will start organising a schedule of activities for your visit in October which will include:

- a series of meetings with key people at various levels of MCRI and RCH,
- an in-house MCRI seminar presentation
- meetings with key external project stakeholders incl NHMRC, State Government,
- a presentation to a national network of knowledge brokers
- possibly a webinar with ARACY.

In addition, I'd like you to spend time with my staff team to share our work with you and receive your feedback etc.

Once you accept the invitation I will work toward finalising the schedule of activity and will forward it to you in advance of your visit. I look forward to receiving your letter of acceptance.
Kind regards
Sue

Sue West
Group Leader (Policy, Equity and Translation)
Murdoch Childrens Research Institute
Associate Director, Centre for Community Child Health, The Royal Children's Hospital

ADVANCING RESEARCH
SEDL
IMPROVING EDUCATION

March 12, 2012

Dr. Melanie Barwick
Community Health Systems Resource Group, Learning Institute
The Hospital for Sick Children
555 University Avenue
Toronto, Canada MSG IX8

Dear Melanie,

I am writing to ask for your help in a new proposal we are writing to allow us to continue our work in the knowledge translation area of disability and rehabilitation. The funding priority changes SEDL's National Center for the Dissemination of Disability Research into the Knowledge Translation Center on Disability and Rehabilitation Research Center. We are interested in building upon your past work with the Center.

I am planning on supporting one webcast per year for NIDRR grantees that will focus on their voiced needs in terms of knowledge translation planning and implementation. The staff would collect information from NIDRR grantees and work with you to organize and react to it. I am imagining that some voiced needs may prompt us to consider adjustments in planning procedures. This may have us develop ways to augment your Scientist Knowledge Translation Plan Template in order to tailor guidance for the NIDRR disability and rehabilitation researcher grantee in planning.

At the current point, I am planning on one webcast of about 90 minutes per each of the project's five years (staring October 1, 2012). The project could budget $5,000 per year to support your time in preparation and in conducting the annual webcast. Timing for the webcast would be worked around your schedule and arrangements for the technical webcast support would be made by the project staff.

If this sounds like something you would like to do, I will need a letter that will be included in the proposal. I will attach a draft that may assist you in developing a letter. Make whatever changes you would like in your letter.

If I could hear from you on or before March 24, it would help us a great deal. If you have questions, do not hesitate to email or call me.

Sincerely,

John D. Westbrook

John D. Westbrook, PhD
Program Manager, Disability Research to Practice Program

Voice: 800-476-6861
Fax: 512-476-2286
www.sedl.org
4700 MUELLER BLVD., AUSTIN, TX 78723

WAHTN
Western Australian Health Translation Network

16 May 2016

Dr Melanie Barwick
Head, Child and Youth Mental Health Research Unit
The Hospital for Sick Children
555 University Avenue
Toronto, Ontario
Canada M5G 1X8

Via email: melanie.barwick@sickkids.ca

Dear Dr ~~Barwick~~ Melanie

Letter of Invitation
Western Australian Health Translation Network - Distinguished Visiting Professors Program

I am writing as Executive Director of the Western Australian Health Translation Network (WAHTN) to formally invite you to travel to Perth, Western Australia as part of the WAHTN's Distinguished Visiting Professors Program.

The WAHTN is an umbrella organisation that links together health and medical investigators with physicians and allied health professionals across; all 5 Western Australian Universities; 6 Medical Research Institutes; 6 public hospitals; 2 private health care providers; the Western Australian Department of Health and the Office of Science.

Details of your visit would include, meeting key staff at WAHTN to discuss knowledge translation and to facilitate and conduct the Scientist Knowledge Translation Training course over a two day period for a variety of health professionals across our network.

We would be delighted if you could be in Perth between the dates of 24 – 28 October 2016 and as mentioned, WAHTN will provide you with business class airfares return from Toronto – Melbourne – Perth (in conjunction with the Murdoch Children's Research Institute), expenses whilst in Perth will be covered by WAHTN and we will also provide you with an AUD$1,000 per day consulting fee.

We are very much welcoming the opportunity to collaborate with you.

Yours sincerely

Professor John Challis
Executive Director
WAHTN

September 17, 2013

Ms. Mary Jo Haddad
President & CEO
The Hospital for Sick Children
555 University Avenue
Toronto, Ontario
M5G 1X8

Re: Leading Practice Submission

Dear Ms. Haddad:

We are pleased to inform you that your Leading Practice submission "Knowledge Translation Professional Certificate TM" has met all required criteria. Congratulations on your achievement!

We will provide you with a certificate, which we hope you will display proudly. The successful submission will be posted on the website of Accreditation Canada at http://www.accreditation.ca/knowledge-exchange/leading-practices

Prior to posting online, Accreditation Canada may edit and will translate the Leading Practice; however, the content and concept of the submission will not be changed.

Please note that we will formally recognize accepted Leading Practices during Accreditation Canada's annual Quality Conference in 2014. Later this year, we will send you a notice asking you whether you plan to register at the conference and would like to receive formal acknowledgement at that time.

On behalf of Accreditation Canada, we thank you for your commitment to providing sustainable, creative and innovative services, and for sharing your experiences with your peers. In doing so, you are helping make health care safer and more quality focused for clients and their families.

Sincerely,

Suzanne Larocque

Suzanne Larocque,
Chair, Accreditation Decision Committee

c.c: Ms. Amanda Hurdowar, Quality Analyst
Ms. Jennifer Pepper, Quality Analyst, Quality & Risk Management
Ms. Julie Langlois, Accreditation Specialist

Institute for Clinical Evaluative Sciences
G1 06, 2075 Bayview Avenue
Toronto, Ontario M4N 3M5
www.ices.on.ca

Thursday, February 23, 2017

Dr. Melanie Barwick
Head, Child and Youth Mental Health Research Unit (CYMHRU)
Senior Scientist, Child Health Evaluative Sciences, Research Institute
The Hospital for Sick Children
E-mail: melanie.barwick@sickkids.ca

Dear Dr. Barwick,

Thank you for agreeing to review the report titled, "*The Mental Health of Children and Youth in Ontario: Scorecard Update*" by the MHASEF Research Team. A draft of the report will be available in mid-March and you will have two weeks from receipt of the report to provide your feedback.

This report is intended for a wide audience including researchers, healthcare providers and policymakers and is written in a narrative style using plain language. As such, the structure and language of the report may differ from a typical peer-reviewed publication. Some sections typically found in peer-reviewed publications such as detailed results and methods descriptions may be found in the chart pack and technical appendix that are associated with the main report. While these deliverables have been attached for reference, they are not included as part of your review.

We would like a critical review of this report. Provided below are some questions to help guide your review of the report. They are not meant to limit the review and feedback you provide nor do we require a specific response to each question.

1. *Is the purpose and significance of this report clearly described?*
2. *Are the key findings clearly presented and do they logically follow from the indicator results?*
3. *Is the text consistent with and supported by the exhibits?*
4. *Are the exhibits appropriate, necessary and clear?*
5. *Are the policy implications identified and are they justifiable based on the report's findings?*

Please send your review by e-mail to Julie Yang (julie.yang@ices.on.ca). For your time and energy, an honorarium of $400 will be provided to you.

Sincerely,

Julie Yang,
Senior Research Project Manager
julie.yang@ices.on.ca

16 December 2016

Melanie Barwick PhD CPsych
Head, Child and Youth Mental Health Research Unit (CYMHRU)
Senior Scientist, Child Health Evaluative Sciences, Research Institute
Leadership, SickKids Centre for Global Child Health
Course Director: Scientist KT Training and Knowledge Translation Professional Certificate
Associate Professor, Department of Psychiatry and The Dalla Lana School of Public Health, University of Toronto
SickKids
555 University Avenue
Toronto, Ontario
Canada M5G 1X8

Dear Melanie,

I am writing to express our gratitude for your contribution to our work at the Murdoch Childrens Research Institute (MCRI) as a Visiting Fellow during October 10-21 2016.

In February we initiated the Melbourne Children's Research Translation and Impact Framework project, developed to identify existing capacity and opportunities for furthering research excellence and impact at Melbourne Childrens. Our campus includes the Royal Children's Hospital (RCH) and the University of Melbourne.

Your thoughtful consideration of the breadth and complexity of the project provided helpful guidance prior to campus visit in October, particularly in light of the ongoing consultation and scheduled piloting of research and engagement assessment projects at a national level in Australia.

Your contribution to how knowledge translation and research impact are both conceptualised and actualised on campus was highly valuable. During your visit you engaged with a broad range of stakeholders including representatives from government departments and peak bodies, and campus staff across the spectrum – from executives and research theme leaders to students. Your schedule included:

- six presentations to MCRI/RCH and external audiences
- meetings with key projects and research theme leaders
- contributing to the development of the project framework
- contributing to the development of a RCH grant proposal to pilot the framework and further develop the knowledge translation/research impact work on campus
- a brief report on your time spend as a Visiting Fellow.

Presentations:

- 2016 October 19 Invited Presentation. Lessons learned from the international KT environment. Murdoch Childrens Research Institute. Melbourne Australia
- 2016 October 19 Invited Presentation. KT 101. Overview and sticky issues. Australian Institute of Family Studies, Melbourne Australia.
- 2016 October 18 Invited Presentation. Considerations for integrating evidence into clinical care. Murdoch Childrens Research Institute. Melbourne Australia
- 2016 October 13 Invited Presentation. Mapping uncharted waters in the science and practice of implementation: a journey to research impact. Murdoch Childrens Research Institute. Melbourne Australia.
- 2016 October 11 Invited Presentation. Bushwhacking Knowledge Brokering: Building Organizational Capacity and a New Profession. Murdoch Childrens Research Institute. Melbourne Australia
- 2016 October 11 Invited Presentation. Facilitating evidence informed policy. Murdoch Childrens Research Institute. Melbourne Australia.

Meetings:

- 2016 October 21 Team, Melbourne Childrens Research Translation and Impact Framework Project
- 2016 October 20 Ju-Lin Lee, Kids in Communities Study, MCIR
- 2016 October 20 Leanne Mills, Head, Office of the Director at Murdoch Children's Research Institute
- 2016 October 20 Team, Melbourne Children's Research Translation and Impact Framework Project
- 2016 October 18 Team, Melbourne Children's Research Translation and Impact Framework Project
- 2016 October 18 Kristina Bennett and Andrea Krelle, Centre for Adolescent Health
- 2016 October 17 Team, Melbourne Children's Research Translation and Impact Framework Project
- 2016 October 17 Will Siero, Project Manager Generation Victoria
- 2016 October 13 Team, Melbourne Childrens Research Translation and Impact Framework Project
- 2016 October 12 Team, Melbourne Children's Research Translation and Impact Framework Project
- 2016 October 11 Dr. Christine Kilpatrick, CEO, RC
- 2016 October 10 Internal Advisory Group, Melbourne Children's Research Translation and Impact Framework Project
- 2016 October 10 External Advisor Group, Melbourne Children's Research Translation and Impact Framework Project
- 2016 October 10 Professor Katie Allen, Theme Director Population Health, and Food and Allergy CRE

Deliverables

1) Project Proposal, RCH Foundation
2) MCRTI Literature Review revision

It was a pleasure to work with you and learn from your extensive expertise in this field. Your contribution has had a significant impact on the project and the understanding of knowledge translation and research impact on campus. I look forward to continued collaboration to ensure that this work makes an ensuring contribution to optimising the health and wellbeing of children.

Sincerely

Ms Sue West
Associate Director, Centre for Community Child Health
Senior Manager, Policy and Service Development
Group Leader, Policy, Equity and Translation
Murdoch Childrens Research Institute
The Royal Children's Hospital, Melbourne
50 Flemington Road
Parkville, Victoria 3052
Phone: +61 3 9936 6741
Email: sue.west@mcri.edu.au

Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

April 28th, 2015

Dr. Melanie Barwick
The Hospital for Sick Children
180 Dundas St. W., Ste 2600
Toronto, ON
M5G 1X8

RE: Letter of Appointment to be a Member of Public Health Ontario's (PHO) Healthy Human Development (HHD) Collective Impact Table

Dear Dr. Melanie Barwick,

On behalf of Public Health Ontario (PHO), and Co-Chairs, Drs. Andrea Feller and Cindy-Lee Dennis, I am pleased to invite you to be a member on the Healthy Human Development (HHD) Collective Impact Table effective April 01st 2015 and ending March 31st 2017 based on the terms and conditions set out in this letter.

Background

The first comprehensive Strategic Plan for Ontario's Public Health Sector, Make No Little Plans, was launched in 2013. A Healthy Human Development (HHD) Collective Area of Focus Table was convened in January 2014. The Table's stated purpose was to develop a limited number of tactical areas of focus in this area, and an implementation plan. Through ongoing consultation with policy makers and public health practitioners, the HHD Table has prioritized the area of parental mental health in the perinatal period to support healthy child development as the initial area of focus.

The principles of collective impact underpinned the approach of the HHD Table. For the purposes of the HHD Table, collective impact brings together a range of public health sector representatives partners and experts to develop a common agenda and vision, shared measurement, continuous communication, through a strong commitment to achieve lasting provincial impact within existing resources.

Membership and Responsibilities

Healthy Human Development Collective Impact Table (HHD CIT) will consist of approximately 15-17 members and will meet by teleconference and/or in-person bi-monthly. Approximately 3-4 in-person meetings are anticipated annually.

The specific responsibilities of the Table are to:

1. Identify essential partners required for collective impact initiatives addressing early years priorities within public health.
2. Provide scientific and practice-based advice to support collective impact in focused sector priorities, in the area of healthy human development and early child development interventions, including bringing to attention new and emerging research, evaluation and monitoring reports to ensure that areas of focus and priorities are informed by the most recent available evidence.

3. Identify tools, training and other supports required for implementation to achieve collective impact.

Table Members are responsible for:

- Attending and providing expert advice at Table meetings and working group meetings.
- Identifying relevant literature, including new and emerging research evidence.
- Identifying issues and items for discussion, and participating in discussions.
- Reviewing material in advance of meetings.
- Providing expert review of reports produced by PHO, including drafts and related materials such as evidence briefs, conference presentations and other communications.
- Chairing and/or participating on working groups as required.
- Championing HHD collective impact and action plan implementation through partners.

Conflict of Interest

The HHD CIT is best served by members with differing areas of expertise and perspectives related to the achievement of the committee's mandate, who can provide their expertise and advice in an open, fair and objective manner. Any situation that might interfere with your ability to meet those standards when acting as a member of the HHD CIT shall be considered an actual, potential or perceived conflict of interest and shall be disclosed immediately to the president and CEO who is PHO's Ethics Executive.

Confidentiality

During the term of your appointment, and after the termination or expiry of your appointment, you shall not directly or indirectly use for personal or any other type of gain any confidential information obtained through the performance of the chair's duties as a member of the HHD.

To decline your membership on the Table, or if you have any questions about membership, please contact me - Dr. Ingrid Tyler, Public Health Physician, PHO HHD Table Internal Lead, at **ingrid.tyler@oahpp.ca**

I am looking forward to this opportunity to work with you to support public health's work in healthy human development.

Sincerely,

Ingrid Tyler MD, CCFP, MHSc, MEd, FRCPC
Public Health Physician, Health Promotion Chronic Disease and Injury Prevention
Public Health Ontario | Santé publique Ontario
480 University Avenue, Suite 300 | 480, avenue University, bureau 300
Toronto, ON M5G 1V2
t: 647 260 7302 e: ***ingrid.tyler@oahpp.ca***

Ministry of Children and Youth Services

Policy Development and Program Design Division

Children and Youth at Risk Branch

101 Bloor Street West
2nd Floor
Toronto ON M5S 2Z7
Phone: (416) 327-0115
Fax: (416) 212-2021

Ministère des Services à l'enfance et à la jeunesse

Division de l'élaboration des politiques et de la conception des programmes

Direction des enfants et des jeunes à risque

101, rue Bloor Ouest
2e étage
Toronto ON M5S 2Z7
Tél. : (416) 327-0115
Téléc. : (416) 212-2021

Ontario

May 26, 2016

Melanie Barwick,
Senior Associate Scientist CHES Research Institute,
Hospital for Sick Children
(melanie.barwick@sickkids.ca)

Dear Melanie:

In early 2015 you were invited to participate in a Child and Youth Mental Health (CYMH) Data and Performance Measurement External Reference Group (ERG). Throughout 2015-16 as an ERG member, you contributed important advice to the ministry regarding our plans for CYMH data and performance measurement, helped identify activities necessary to achieve an information-based culture within the sector and provided important input into the conceptual design for the CYMH Business Intelligence (BI) Solution, which is currently tracking through the approvals process.

I wanted to take this opportunity to personally thank you for the role you have played in this critical work. Our work on data and performance measurement is foundational to the implementation of *Moving on Mental Health* and, in particular, will benefit and support lead agencies as they begin to assume greater responsibility and accountability for the CYMH service system.

With most of the lead agencies now identified, and the establishment of the CYMH Partnership Table and Lead Agency Consortium in late 2015, we are making changes to ensure appropriate structures and connections are in place to support this work on data and performance measurement as we continue to move forward. A Data Working Group is being established at the request of the Partnership Table, which will have a slight shift in focus from providing strategic advice to the ministry, to focusing more specifically on data and supports required for lead agency implementation in 2017.

The Working Group will be comprised of lead agency senior management, and will have more formal connections with the CYMH Partnership Table and Lead Agency Consortium. It is anticipated that your expertise will continue to be of value to this work, as we build an information-based culture across the CYMH sector.

Once again, thank you for the time, effort and valuable expertise you have contributed to the work on CYMH data and performance measurement. We could not have come this far without you.

Sincerely,

Marian Mlakar, Director
Children and Youth at Risk Branch

c: Patrick Mitchell
Judy Switson
Claire Fainer
Terri Sparling

MEOPAR
MARINE ENVIRONMENTAL OBSERVATION
PREDICTION & RESPONSE NETWORK

Re: Invitation to join MEOPAR's Knowledge Mobilization Committee

Dear Melanie,

It is my pleasure to invite you to be a member of MEOPAR's newly-created Knowledge Mobilization (KM) Committee.

The Marine Environmental Observation, Prediction and Response (MEOPAR) Network is a national not-for-profit that aims to reduce risk and strengthen economic opportunity in Canada's marine sector. MEOPAR advances its mission through research, training and partnership activities. Our current research portfolio includes 65 research projects at 24 Canadian universities, working with more than 100 partners in Canada's government, NGO, and industry sectors.

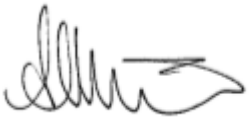
MEOPAR's focus is to create benefits to the Canadian economy and society. Great research may be our foundation, but success will be measured on the extent to which we mobilize our knowledge.

The KM Committee will play a key role in shaping MEOPAR's direction. We want a committee focused on action and results. We want help in shaping our research, training and partnerships programs to ensure that results are in demand by end users.

MEOPAR is seeking professionals from across Canada with expertise in knowledge mobilization or knowledge translation: intellectual property law, commercialization, marine technology development, government operations and regulations, public policy, academic-industry partnerships, research/science communication strategies, etc.

I expect that the KM Committee will meet by teleconference at least twice a year. Face-to-face meetings will be discussed by the members and convened if necessary. I estimate the workload to be about 20 hours/year; more may be required in the Committee's first year. Any travel expenses related to committee work will be covered by MEOPAR.

If you are interested in helping shape the direction of a world-class research network and working with other leading KM professionals across the country, please let me know by **February 28th, 2017**. We'd like to host our first teleconference in March.



Stefan Leslie

Executive Director, MEOPAR

902-494-4386
Stefan.Leslie@meopar.ca

Institute of Health Policy, Management and Evaluation
Graduate Students' Union
University of Toronto
Health Sciences Building
425-155 College Street
Toronto, ON Canada M5T 3M6
gsu.hpme@utoronto.ca
March 10, 2017

Melanie Barwick, Ph.D., C.Psych.
Head, Child and Youth Mental Health Research Unit (CYMHRU)
Senior Scientist
Child Health Evaluative Sciences, Research Institute
The Hospital for Sick Children

Dear Dr. Barwick,

The Institute of Health Policy, Management and Evaluation Graduate Students' Union (IHPME-GSU) at the University of Toronto will be hosting our 13th annual Research Day on **Wednesday, May 3rd, 2017** at the University of Toronto and we would be delighted to have you be a member of our expert panel plenary on this year's theme of **"Insight to Impact: Achieving Health System Change"**

Research Day is our flagship student led event in the calendar year and features a plenary expert panel discussion, followed by concurrent scientific sessions of student oral and poster presentations from our graduate students and a keynote speech by a distinguished guest of the Institute. The event is always very well attended by students, faculty, and alumni of IHPME, as well as invited guests and interested colleagues from across the University and the healthcare sector.

The panel discussion is expected to take place between 9:30 am and 11:00am. You were enthusiastically recommended by the members of the Research Day Planning Committee and we would be honoured by your attendance. This year our panel discussion will explore various pathways to health system change through our panelist descriptions of the practical facilitators and/or barriers to this process. We are particularly interested in your perspective as a specialist in health systems and knowledge translation, and feel that your expertise in child and youth mental health will provide a unique and valuable perspective to a discussion of health systems. **Panelists will be provided with a list of more specific probing questions prior to the event.**

Complimentary breakfast and lunch will be served to all attendees and invited guests. The IHPME Research Day oral and poster sessions, keynote, and cocktail reception will follow the expert panel plenary. A preliminary conference schedule, as well as other conference details and updates, will be available in the coming weeks at:

http://ihpme.utoronto.ca/events/ihpme-research-day-2017/

If you have questions or suggestions, please do not hesitate to contact me at any time. Thank you for your consideration, and I look forward to our continued correspondence.

Sincerely,

Shawna Cronin & Shantel Walcott
Co-Chairs, Research Day Planning Committee
Institute of Health Policy, Management and Evaluation
University of Toronto

cc: Dr. Adalsteinn Brown
Dr. Rhonda Cockerill

SAMI
Social Aetiology of Mental Illness
Étiologie sociale de la maladie mentale

Social Aetiology of Mental Illness Training Program

Centre for Addiction and Mental Health

455 Spadina Ave.
Suite 300
Toronto, Canada
M5S 2G8

Fax: 416-979-0564

Email:
Sami-information
@camh.net

Website:
Knowledgex.camh.net/
Researchers/areas/sami

Dr. Melanie Barwick
Associate Scientist and Scientific Director KT
Learning Institute/Research Institute
The Hospital for Sick Children
180 Dundas St. West, Suite 2600
Toronto, ON M5G 1Z8

Letter of Acknowledgement

Thursday, January 02, 2014

Dear Dr. Barwick,

Thank you for making the ten week SAMI Intensive course for the 2013-14 cohort of the Social Aetiology of Mental Illness CIHR Training Program such a success.

Your talk was invaluable and helped the Fellows to get a comprehensive overview of the field and to develop their projects.

You will be aware that the last cohort of SAMI Fellows (2012-13) were successful in publishing seventeen papers. In addition, there are a further six manuscripts submitted. SAMI Fellows also presented at seven conferences and symposiums. All this was only possible because of the training they received from you, our faculty. We are hoping that the Fellows you helped to train this year will be similarly successful.

Thank you for sharing your insight, expertise and time with the Fellows.

We look forward to continued collaboration with you.

Sincerely,

Kwame McKenzie MD, FRCPsych (UK)
Director of Social Aetiology of Mental Illness CIHR Training Program
Medical Director, Underserved Populations

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

CIHR IRSC

UNIVERSITY OF TORONTO

mysickkids

2016 was a wonderful year at SickKids! Here's why…

Tuesday, January 3, 2017

SickKids topping the charts as a great place to work

SickKids was once again named one of Canada's Top 100 Employers and one of Greater Toronto's Top Employers by Mediacorp Canada Inc. We were also named a Top Employer for Canadians Over 40. SickKids was recognized for investing in our staff through ongoing training and development and helping staff prepare for the future through retirement education sessions. Community involvement, both locally and globally, and our commitment to creating a healthy work environment through our robust wellness program were also noted as reasons for selection.

A few days after that award, SickKids was named one of Canada's Top 40 Research Hospitals by Research Infosource Inc. SickKids earned second place on the annual Top 40 list for overall research spending, a jump from third place last year. SickKids also ranked first for institution intensity (research spending as a percentage of total hospital spending) and second for researcher intensity (research spending per researcher) in the medium-sized hospital tier. This recognition is a testament to the outstanding work of our researchers and their success in competing for grants.

Earlier in the year, Forbes recognized SickKids one of Canada's Best Employers for 2016. The list, which consists of the top 250 employers across 25 industries in Canada, was created based on feedback from more than 8,000 Canadian workers. These individuals were asked to determine, on a scale of zero to 10, how likely they were to recommend their employer to someone else.

Picking up steam on our journey to eliminating preventable harm

Since March 2015, the Caring Safely initiative has come to embody SickKids' commitment to patient and staff safety. We are building significant momentum and beginning to see the impact of our staff's determination, creativity and resourcefulness as we implement new processes and training to improve safety and reduce preventable harm. We have worked together in many new ways including developing a more robust, timely, and transparent serious safety event review process, as well as implementing an all-staff education curriculum and standardized care bundles to prevent hospital-acquired conditions. As we approach the end of the year, we are pleased to report that 4,000 staff have been trained in the error prevention curriculum.

We are embracing collaboration, locally and internationally. By working with the Children's Hospitals Solutions for Patient Safety, a collaborative of North American paediatric hospitals that is working towards the shared goal of eliminating preventable harm, we are able to learn from organizations that share our goal, some of whom began their safety journeys years ago. In the past year, two of our peer paediatric hospitals in Canada, the Children's Hospital of Eastern Ontario and the IWK Health Centre, have joined in the collaborative and have looked to us to guide the first steps of implementation. The success and enthusiasm of our peers, and our increasing partnership with patients and families, gives us confidence we can collectively achieve our goal of eliminating preventable harm.

Reducing unnecessary tests and treatments

Unnecessary tests and treatments do not add value to care. In some cases they can potentially expose patients to harm, they can lead to even more testing to investigate false positives, and often they can contribute to a patient's stress levels. These tests and treatments also put an increased strain on the resources of our health-care system.

In early 2016, SickKids announced its participation in Choosing Wisely Canada, a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments to help make smart and effective choices that will ensure high-quality care. As part of the campaign, national medical specialty societies have developed lists of "Five Things Clinicians and Patients Should Question." As a paediatric health centre that cares for children

with highly complex and specialized medical conditions, SickKids has created its own initial recommended list of tests and treatments that our staff should aim to restrict to those patients who would likely benefit from them.

By implementing these recommendations, SickKids will be able to improve the quality of clinical care and build on the excellent care experience we already deliver to our patients and families.

Test identifies child's one in a million disease

While the merits of whole genome testing, a laboratory process that looks at a person's entire DNA sequence at one time rather than just parts of it, have been recognized by researchers, it has yet to become a standard practice for clinicians looking for a diagnosis. When investigating a potential genetic condition in a child, the current standard-of-care genetic test is chromosome microarray analysis, which only looks at copy number changes in genes and misses smaller genetic changes.

A study led by the Centre for Genetic Medicine at SickKids compared standard genetic testing to whole genome sequencing in 100 patient cases at SickKids and found that whole genome sequencing identified genetic variants that could help with diagnosis in more than one-third of the patients. This represented a four-fold increase compared to the diagnostic rate using the standard chromosome microarray analysis, which only found genetic variants in eight per cent of the cases. In one of the cases, whole genome sequencing revealed that the patient had a very rare condition called pantothenate kinase-associated neurodegeneration (PKAN) -- the incidence is literally one in a million.

The results of this study indicate that whole genome sequencing can and should be used at the first-tier genetic test in individuals with developmental delay and/or congenital abnormalities to help doctors determine prognosis, guide treatment or begin appropriate surveillance and prevention programs.

Emergency preparedness: ready to spring into action

This year was a significant one in terms of emergency preparedness at SickKids. Although they are challenging to carry out, particularly with a busy hospital to run, exercises simulating the emergency are critical to ensuring that we are able to react nimbly and effectively in the case of any real emergency.

In August, SickKids held an evacuation exercise. A mock fire triggered the call to evacuate and staff safely ushered patients (dolls, stuffed toys and mannequins) from one unit to another, making sure all patients had proper identification bands, their medical charts, any required medical equipment and medications. At the Operating Room desk, staff members waited for additional instructions or announcements. A public call centre was established so families and the public – played by volunteers -- could contact SickKids for information. In the Emergency Measures Command Centre, leaders representing departments from across the organization were busy coordinating the hospital-wide emergency response.

The exercise was a success, helping to identify processes that are working well and those that need improvement.

In addition to the mock drill, SickKids staff members who could be called to the Emergency Measures Command Centre during a real emergency all received training this year on the latest incident management best practices.

Systems and analytics: integrated, smarter and more efficient

Across SickKids, from clinical areas to administrative offices to research labs, new business systems and processes introduced this year are changing the way we work and providing greater insight into our operations.

A major finance and human resources systems modernization project went live, automating many paper-based processes and integrating formerly disparate systems, helping to improve efficiency and the timeliness and quality of information shared across the hospital. This is just the start of our journey to better integrate, analyze and report data and information. Earlier this year, SickKids introduced an interactive business intelligence platform that is helping to transform data analysis and reporting. Leaders across SickKids are now able to analyze key measures such as average length of stay, patient volumes, emergency wait times and more. This deeper insight into our patient population and operations is already leading to more informed, accurate and meaningful decision-making, enabling SickKids to further improve program efficiency and effectiveness.

Excellence in teaching and learning – at home and abroad

Each day SickKids strives to provide better care than the day before, a pursuit of excellence that depends on learning, the critical link between new knowledge and its application in the care of a sick child.

In 2016, the SickKids Learning Institute celebrated the **graduation of the inaugural class of the SickKids Teaching Scholars Program**, which included 21 graduates representing paediatrics, nursing and professional services. A second class is now completing the 10-month program, created to enhance teaching expertise among health-care professionals whose focus is child health.

Scientist Knowledge Translation Training™ Australia

To provide effective patient care, we must use knowledge generated from research and create effective changes in health policy and/or practice. This process of moving knowledge into action is referred to as knowledge translation. The Knowledge Translation (KT) Team within the SickKids Learning Institute supports health science researchers and clinicians with various KT initiatives, including teaching a comprehensive and successful Scientist Knowledge Translation Training (SKTT) course. **This fall, SickKids launched SKTT Australia in Melbourne, Sydney and Perth**, with the intention of expanding our reach to address a worldwide need for professional development in knowledge translation.

Surveillance approach to detecting tumours yields remarkable results

A cancer surveillance system dubbed the “Toronto Protocol” is being touted as the next best thing to finding a cure to an inherited cancer disorder called Li-Fraumeni syndrome. Patients with Li-Fraumeni carry a substantially higher lifetime risk of developing cancers such as bone cancer, leukemia and breast cancer.

Research led by SickKids shows that children and adults with this inherited cancer susceptibility can benefit significantly from the Toronto Protocol, which helps detect tumours early, enables quicker treatment and improves overall survival. The protocol involves a combination of tests which are available at virtually every hospital, including blood work, ultrasound of the abdomen and pelvis every three to four months, and annual MRIs of the whole body and brain. The new research observed more patients over a longer period of time and yielded remarkable results: the five-year survival rate was 89 per cent for people who underwent surveillance compared to only 60 per cent for those who did not undergo surveillance.

Not only does this data support the use of genetic testing in at-risk individuals, it also raises the awareness of the importance and value of surveillance strategies for early tumour detection, not only in the context of patients with Li-Fraumeni syndrome, but also for those with other cancer-susceptibility syndromes.

Improving the health of children worldwide

Our reach and positive contributions extend the world over.

The SickKids Centre for Global Child Health was involved throughout the year in supporting the United Nations’ Global Strategy for Women’s, Children’s and Adolescents’ Health, as part of the Sustainable Development Goals (2015-2030). The centre contributed to major international reports on early childhood development, stillbirths, adolescent health and other pressing global child health issues.

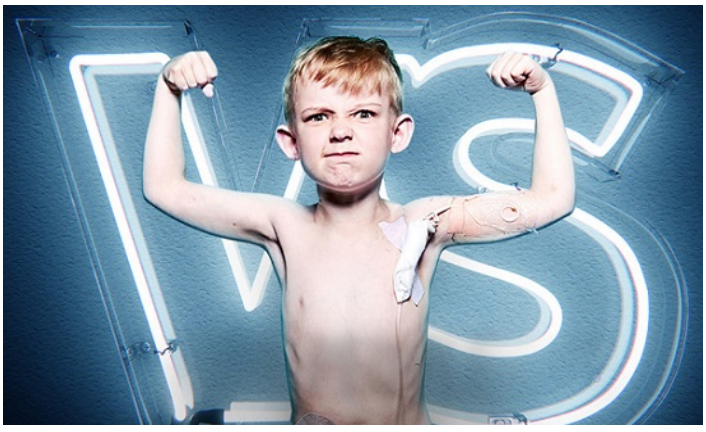
The centre has also been working with Canadian partners to improve the lives of children and their families in resource-poor environments, where the largest number of deaths to children under five occurs. In collaboration with local health systems partners, the centre launched the first paediatric haematology/oncology nursing education program in the Caribbean and expanded specialized paediatric nursing education to the northern regions of Ghana.

SickKids International (SKI) continued its collaborations with health-care institutions, governments and organizations around the world to help create sustainable, high-quality paediatric care by providing training and expert advisory consultation.

The SKI team is leading our efforts in South Africa, where we are working with the Nelson Mandela Children's Hospital in Johannesburg, a new hospital which will be the fifth on the African continent and an important addition to Southern African health care. Our participation in the project has been made possible through a federal grant and philanthropic donations.

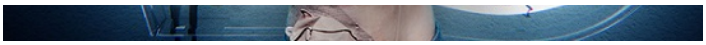
SKI is also working with the Chinese government, which has made improving paediatric services within the country a priority. In March, SKI began a five-year project with Shenzhen Children's Hospital to teach the skills needed to develop new protocols and improve paediatric cancer care. This builds on work already underway at Tianjin Economic-Technological Development Area International Cardiovascular Hospital, where a SickKids team is providing paediatric cardiac assessment education, as well as helping nurses, pharmacists and other hospital staff to upgrade their existing skills and learn new ones.

Bold and fierce: SickKids VS



This year's SickKids brand campaign, SickKids VS the greatest challenges in child health, has garnered a lot of attention since launching in October. The various campaign elements represent a bold shift in tone of voice, highlighting the fierce side of our patients, families and staff, and the fight that occurs on behalf of our patients at the hospital each day.

Real staff, real parents and real patients adds a special component to the final product. More than 500 staff members



helped out either in front of the camera or behind the scenes and approximately 50 patient families agreed to be filmed.

That's a wrap on 2016! Thanks to all our staff, volunteers, patients, families, community partners and supporters for everything you do to help us along our journey. Happy New Year from everyone at SickKids!

Posted by Carolyn Gooderham at 9:21 AM in Daily News

15 Like Comment ...

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0 comments

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Post

Wellesley Institute
advancing urban health
10 Alcorn Avenue, Suite 300, Toronto, ON Canada M4V 3B2
tel 416-972-1010 fax 416-921-7228 www.wellesleyinstitute.com

Dear Melanie Barwick,

Thank you for supporting the Wellesley Junior Fellowship this year by speaking during our September curriculum. Your session on Knowledge Translation helped the fellows better understand how research evidence can be translated in different ways to meet the goals of the project, and how they can strategically design their knowledge translation plans to meet the policy goals of their own work.

Check out our WJF Program update at the bottom of this letter to learn about what the program has accomplished in its first year of development. We could not have done it with out the help of thought leaders like you.

Thank you for lending your time and expertise to support the fellowship,

Emma Ware
Director of Fellowships and Integration

Kwame McKenzie
Chief Executive Officer

Wellesley Institute
advancing urban health
10 Alcorn Avenue, Suite 300, Toronto, ON Canada M4V 3B2
tel 416-972-1010 fax 416-921-7228 www.wellesleyinstitute.com

Wellesley Junior Fellowship 2015-16 Year in Review

The Wellesley Junior Fellowship (WJF) program helps Wellesley Institute meet its strategic goals by building capacity in the next generation of professionals to improve the health and health equity of the Greater Toronto Area by leading, researching and driving social policy change.

Selected for their potential to anticipate, understand and creatively engage in pressing issues facing Toronto, our fellows help to bring fresh new ideas into Wellesley institute.

The program broadens Wellesley's stakeholder network, by engaging thought leaders from across the GTA in teaching, mentoring and collaborating on program activities.

During the course of the program fellows produce high quality Wellesley Institute project work. Fellows join our growing community of talented researchers to drive change on the social determinants of health through applied research, effective policy impact, knowledge mobilization, and innovation.

Admissions:

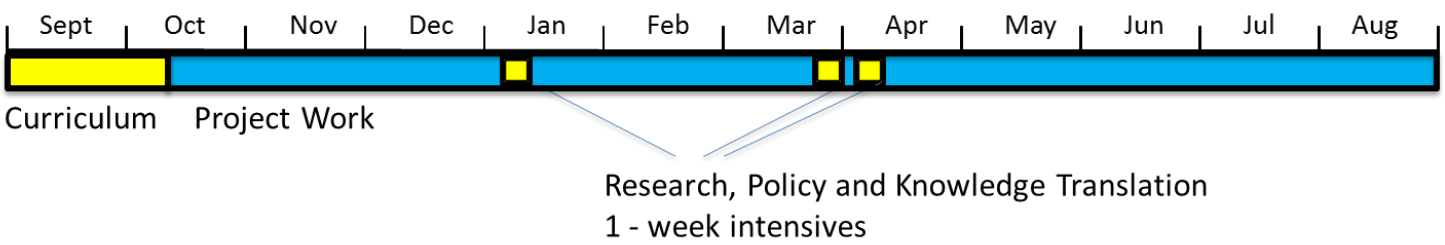
	Year 1 (2015-16)	Year 2 (2015-16)
WJF applications:	149	51*
BSc. (MA equiv.) applicants:	8	1
Masters applicants:	118	50
PhD applicants:	23	0
Number of fellows selected:	4	4

**** Note that in Year 2 our aim was to receive fewer, but higher quality applications for the Wellesley Junior Fellowship.***

Curriculum:

Fellows received 8 weeks of curriculum:

- 5 weeks in September focused on introducing them to WI's mission and vision, as well as project development;
- 1 week Research intensive in January to prep them for the upcoming research phase of their projects;
- 2 weeks in late March/ early April to enhance their policy and communication skills for the knowledge translation phase of the project.



Teaching, Mentorship and Support:

	# 5 week	1 week research	2 week policy / KT	Total
Total speakers during WJF curriculum	33	7	5	45
External Speakers	25	5	2	32
Total Hours of Lecture	46	9	5	50
Hours of Interactive Workshop	23	4	17.5	44.5
Hours of Project Development Feedback	17	4	5	25
Staff hours on teaching and feedback sessions	86	4	12	102
Staff hours of project development feedback	17	4	5	25
Staff hours on program development	111	12	32	155

WJF Junior Fellows Inaugural Cohort 2015- 2016:

Dhvani Katakia, Master of Public Health (Health Promotion), Dalla Lana School of Public Health
Policy interventions to decrease the incidence of asthma in children living in poor-quality housing

Rebecca Cheff, Master of Public Health (Health Promotion), Dalla Lana School of Public Health
Opportunities for Social Determinants of Health Advocacy in Community Health Centres

Nadha Hassen, Master of Public Health (Health Promotion), Dalla Lana School of Public Health
Examining the Impact of the Built Environment on Mental Health in Low-Income, Immigrant Populations

Juan Camilo Sanchez; Master's Degree in Public Policy, 2-Year Joint Erasmus Mundus Program
Social Capital Interventions that Improve refugee health outcomes

Group Project. The Real Cost of the Three Month Wait: Examining the Impacts of the 3 Months OHIP Wait Period for Landed Immigrants in Ontario

Waypoint
CENTRE *for* MENTAL HEALTH CARE
CENTRE *de* SOINS *de* SANTÉ MENTALE

KNOWLEDGE TRANSLATION IN MENTAL HEALTH & ADDICTIONS CONFERENCE

This certificate is awarded to

Melanie Barwick

In thanks and recognition of your keynote address

Mapping Uncharted Waters in the Science of Implementation

Presented on
June 18th, 2015

Howard Barbaree

Dr. Howard Barbaree, VP Research & Academics

Laura Ball

Laura Ball, Conference Chair

Advancing Understanding. Improving Lives.

Wellesley Institute
advancing urban health
10 Alcorn Avenue, Suite 300, Toronto, ON Canada M4V 3B2
tel 416-972-1010 fax 416-921-7228 www.wellesleyinstitute.com

July 9, 2015

Dear Dr. Melanie Barwick,

The aim of the Wellesley Junior Fellowship (WJF) is to build the next generation of professionals who will work to improve the health of the Greater Toronto Area by leading, researching and driving social policy change.

We begin the program with a 5 week intensive curriculum (Sept 7-Oct 9th) designed to increase the student's capacity for impacting health and health equity in the GTA.

We invite you to present during the Knowledge Translation module of our WJF curriculum; to share your expertise, advise and inspire our Junior Fellows.

Suggested Session Details:

Date[1]: Monday, September 14, 2015

Time: 9:00 AM-10:25 AM

Location: Wellesley Institute 10 Alcorn Avenue, Unit 300

Module: Knowledge Translation (KT) - Integrated KT Planning

Session Topic: Intro to Integrated KT Planning

Learning Objective: Learn the basics of Integrated KT. What is it, what are its variations, what are the basic steps, and why is it important for the junior fellows.

Notes About your Session: This session will kick off a whole week dedicated to KT and communications training. Your talk would precede a session by Dr. John Lavis who will discuss unique considerations for KT aimed at influencing social policy. Later in the afternoon, Dr. Yogendra Shakya and Sarah Alley will be invited to talk about their resent work on using reflexivity and journaling to bolster a KT strategy. The fellows will be building integrated KT plans for their research projects, and we hope this session will help introduce them to a conceptual and practical skillset to create a research and integrated KT plan aimed at influencing policy.

We would be happy to provide additional details about the program and to discuss any suggestions or revisions you may have regarding the content of your session. Feel free to send any reading materials as

[1] Note that this is a tentative date and time. We would be happy to discuss an alternate schedule if this does not work for you. We will send out a calendar invitation for your schedule once confirmed.

preparation for your session. To discuss, please get in touch with our Program Manager, Emma Ware (416 – 972 – 1010 x 221; emma@wellesleyinstitute.com)

Please find below information about WJF learning objectives as well as out WJF 2015-16 Junior Fellows and their project topics.

We look forward to hearing from you.

Best Regards,

Kwame McKenzie

CEO, Wellesley Institute

Emma Ware

WJF Program Manager and Coordinator

WJF Learning Outcomes

WI Institute Vision and Mission:
Learn and engage in the vision and mission of the Wellesley Institute

Basic Knowledge:
Gain exposure and access to basic knowledge, skills, and tools for doing policy, research and knowledge translation.

Creativity and Innovation:
Gain knowledge, skills and tools for generating innovative and creative ideas for identifying and solving health inequities in Toronto

Integrated Strategies:
Develop pragmatic strategies to unify policy, research and knowledge translation approaches

Leadership and Collaboration:
Cultivate the ability mobilize, motivate, lead and collaborate with diverse networks and stakeholders

WJF Junior Fellows Inaugural Cohort 2015- 2016

Andrew Do:
Resolving Social Exclusion through Public Spaces in Toronto's Neighbourhoods

Rebecca Cheff:
Opportunities for Social Determinants of Health Advocacy in Community Health Centres

Nadha Hassen:
Examining the Impact of the Built Environment on Mental Health in Low-Income, Immigrant Populations

Juan Camilo Sanchez:
Refugees in the GTA: Overcoming Labour Market Barriers