Advancing Mental Health Services for Francophone Children and Youth in Ontario

Part 1 - Survey of research utilization, readiness for change, and use of evidence based treatments

Institut Valor • Services aux Enfants et Adultes Prescott-Russell

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Main Messages

- Acquire to resources and research on evidence-based practices is somewhat better (24.1% reported Good/Very Good) than acquire to French-language training (13.8% reported Good/VeryGood) but there is room for improvement in both areas.

- Respondents are largely willing to adopt evidence-based practices if they were intuitively appealing, and were required by leadership figures. They felt quite open to the prospect of training and using EBPs.

- Respondents found EBPs clinically useful, but did not appear to be fully convinced of their value in clinical practice.

- Respondents were quite divided as to whether French-language evidence-based practices are difficult to implement in organizations that are mainly Anglophone, although the majority stated they would like French-language training of EBPs.

- The majority of respondents perceived their organization as doing “somewhat well” in *acquireing, assessing, adapting, and applying* research knowledge, suggesting need for improvement.

- Factors related to time, availability of information, money, staff, and acquire to French-language resources present the most significant *obstacles to acquire* of research-based knowledge.

- The primary *sources of research-based information* are journals, conferences, other organizations, and the largesse of motivated staff members.

- Organizational capacity to assess the reliability and quality of research was rated poorly (“Not Well”) by one-third and only slightly better (“Well”) by fewer than half, suggesting a need for professional development in the assessment of research evidence.

- Fewer than half of respondents evaluated the quality of the child and youth mental health programs provided in their organization as “Somewhat Good,” with 40.7% rating them as “Good.”

- Credibility of the information source is a key factor in assessing the reliability and quality of research, as is some measure of reliance on staff members with research knowledge.

- Obstacles in the capacity to adapt research knowledge included translation of English materials into French, uncertainty regarding how best to adapt research knowledge to a particular environment, and lack of suitable adaptation to Franco-Ontarian culture.

- One-third believed their services are based on research evidence to a “Satisfactory” extent (33.3%) and an equal amount perceived this to a “Large” extent. About a quarter of respondents felt their services were based on “Very Little” or “No” evidence.

- Fully 77% of organizations do not benefit from acquire to a university or college library despite the finding that 57.7% are reportedly affiliated with a university or college.

- In a ranking of most concerning issues, Attention Deficit Hyperactivity Disorder was ranked first most frequently, Attention Deficit Disorder as the second greatest concern, aggression was ranked third most consistently, and depression was fourth in rank, followed by self-harm.

- Respondents ranked client assessment as the main area in which they felt the least competent, followed by treatment selection, working with other sectors, knowing when to close cases and general administration of treatment.

- Respondents generally agree that program needs are in the area of assessing client needs, measuring client performance, raising the overall quality of service, and using client assessments to document program effectiveness. There is inconsistency as to the needs involving assessing client needs, and there is largely not perceived program need in the area of using client assessments to guide clinical and program decisions.

- Training is required in assessing client needs, increasing client participation in treatment, monitoring client progress, and in using computerized client assessment methods.
- Most respondents agreed that pressure for change stems from clients, program staff and supervisors, agency board members, ministry /funders, and accrediting or licensing bodies.

- Offices appear to be adequate for individual and group counseling.

- There is a reported need for more clinical and support staff.

- There was general agreement regarding availability and usefulness of in-service training, but varied views about the extent to which training and continuing education are priorities in their organization.

- There is satisfaction with the availability of personal computers and staff comfort level in computer use, but more varied perceptions of whether client assessments and records are computerized, the swiftness with which computer problems are repaired, and the need for more computers for staff.

- The majority of respondents reported easy acquire to computers and email and have used the internet in the past month.

- Respondents reported regular review of professional journals and treatment materials but did not feel they had enough opportunity to keep their clinical skills up to date.

- There is high sense of self-efficacy among respondents and respondents were positive about their ability to influence coworkers. They also report a willingness to try new ideas and to adapt quickly. There was general agreement regarding trust and cooperation among staff

- There was general agreement in respondent's understanding of organizational goals and objectives and how their services fit within the continuum of services with their community.

- There is a perceived need for supervisory approval, the majority of respondents felt free to try out different therapeutic techniques.

- High stress and heavy workloads reduce program effectiveness, but most felt the pressure did not impede their job efficacy.

- There is evidence to suggest that certain evidence-based practices are in use in Ontario, and that at least one-third of organizations have translated English language EBPs into French for use in their organizations.

- Suggestions for improving mental health services for francophone children and youth. included such things as more education, promotion, and implementation; more training for parents and workshops for employees – particularly in French; reduction of wait list for services; developing policy in favor of the use of evidence-based practices in child and youth mental health; and developing partnerships with anglophone organizations that can offer services that are not currently offered in French.

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Project Overview

The definitive goal of this project is to improve the quality of French language services to Ontario's children and youth and their families, to increase practitioner satisfaction with service delivery, and to ensure a greater effectiveness in the services offered in French. There are two phases to the project: Phase 1: survey of service delivery characteristics, research utilizations, and readiness for change; and Phase 2: a review of evidence-based practices available in French and/or proven reliable with French speaking children and youth. This first report covers Phase 1 of the project.

The project was undertaken in partnership between the Institut Valor and Les Services aux Enfants et Adultes Prescott-Russell (SEAPR), a children's mental heath agency located in eastern Ontario. Dr. Melanie Barwick, Health Systems Consultant, was retained to conduct the survey, review the literature, and write this report. Mr. Martin Hubert acted as Project Manager. The project team also included Ms. Julie Clement, Director, Prescott Russell and Ms. Dominique Guillaumant, Senior Policy Analyst, Corporate Policy Unit, Ministry of Children and Youth Services, rounded out the team.

Methodology

The survey was conducted using SurveyMonkey™, an electronic survey methodology available for web-based surveying. Respondents received a letter via email describing the nature of the project and inviting them to connect to a URL link to complete the survey. The URL link was also posted on the Institut Valor and Services aux Enfants et Adultes Prescott-Russell websites.

A list of respondents was generated by Mr. Hubert in consultation with the project team based at Institut Valor / SEAPR. The survey was posted as open for response on September 14th 2006, and closed on October 17th 2006.

Results

Respondent and Organizational Characteristics

Approximately 18.9% of the original sample responded to the survey. It is possible that respondents had difficulty responding to a French-language survey.

Table 1 – Response Rate

	Total
Original sample	164
Refusals	1
Responses at survey closing	92
Responses with no data	61
Final responses	31
Final response rate (%)	**18.9%**

Twenty-six respondents provided the name of their organization (see Appendix 1), and 28 agreed to be contacted by the Project Manager to provide further information regarding resources available for child and youth mental health services to the Francophone community.
The majority of organizations (12) reported fewer than 25% French-speaking clients. Only 7 agencies reported a French-speaking clientele in the range of 26-50%, 5 reported 51%-75%, and only 6 reported 76%-100% French-speaking clients.

There was a wide variance of full time equivalent staff (FTE) among organizations, with an average of 87.7 FTE. The majority of personnel providing French language services are in direct service lines (52% report greater than 5 people).

Table 2 - Number of FTE providing services in French:

(n=30)	0	1-5	>5
Management level	23% (7)	**60% (18)**	17% (5)
Reception	20% (6)	**67% (20)**	13% (4)
Direct service	3% (1)	45% (14)	**52% (16)**

The number of full time personnel providing French language services uniquely in mental health ranged from 0 to 100, with an average of 10 FTEs.

Respondent professions were reported as psychologist (20.7%), social worker (17.2%), child and youth care worker (13.8%), education (3.4%), and child welfare (6.9%). A few other disciplines were represented, including: criminologist, coordinator of bilingual services, speech-language pathologist, and nutritionist.

Directors and supervisors not providing clinical service comprised 31% of respondents, with 27.6% being front line staff, and 10.3% directors/supervisors also providing clinical services. Nine (31%) of respondents were in other categories.

Programs in which respondents are most involved are presented below in Table 3.

Table 3 – Programs Represented

	Response Percent	**Response Total**
En établissement	17.20%	5
Day treatment	24.10%	7
Crisis intervention	31%	9
Services intensifs à l'enfance et à la famille	31%	9
Services de santé mentale à l'intention des enfants de 0 à 6 ans	34.50%	10
Intake	24.10%	7
Social Work	24.10%	7
Prevention / Early Intervention	34.50%	10
Aide à l'enfance	17.20%	5
Education	27.60%	8
Service coordination	34.50%	10
Other	65.50%	19

développement des services et programmes en français dans le secteur municipal francophone de l'Ontario

programmes en autisme

Garderies du jour

service de garde

services privés en orthophonie

Services de santé mentale à l'intention des personnes de 16 ans et plus habitant sur le territoire de Prescott-Russell (services individuels et de groupe)
Programme de prévention auprès des femmes victimes de violence Intervention auprès des enfants victimes d'abus Evaluation psychologique Consultation en psychiatrie Zoothérapie Groupes de soutien pour enfants témoins de violence familiale Groupe d'habiletés parentales, Groupe d'habiletés sociales auprès des enfants et comment gérer la colère Section 20 (primaire et secondaire)

Traitement résidentielle, Theraeutic Foster Care, ISSP (CYJ), Accès supervisée (MAT)

diabete

Recherche appliquée et évaluative

services aux jeunes contrevenants
Plutot une agence qui fait des jumulages entre un adult et un enfant afin de hausser l'estime de soi de l'enfant. Mentorat.

sportifs et récréatifs

violence faite aux femmes: femmes victimes, hommes abusifs et enfants exposés à cette violence.

santé mentale adulte et adolescents
consultants experts (médecin, psychologue, achats de service en orthophonie et en ergothérapie)
Liaison entre le conseil scolaire et les agences communautaires

Two-thirds of responding organizations were situated in urban areas (65%), with one-third (34.5%) in rural areas and none in suburban areas. The majority or organizations were situated in the Eastern region (34.5%), followed by Hamilton-Niagara (20.7%), North East (20.7%), North (10.3%), and Toronto (13.8%). There was no representation from Central West, South West, Central East, or South East regions of the province.

Acquire to Evidence-Based Resources, Research, and French Language Training

Just over 40% of respondents reported 'Somewhat Good' acquire to French-language evidence-based research resources and acquire to French-language training. Overall, acquire to resources and research on evidence-based practices is somewhat better (24.1% reported Good/Very Good) than acquire to French-language training (13.8% reported Good/VeryGood). There is room for improvement in both areas.

Table 4 – Acquire to resources and research on evidence-based practices

	Response Percent	Response Total
Mediocre	34.5%	10
Somewhat Good	**41.4%**	**12**
Good	17.2%	5
Very Good	6.9%	2

Table 5 – Acquire to French-language training

	Response Percent	Response Total
Mediocre	37.9%	11
Somewhat Good	**48.3%**	**14**
Good	6.9%	2
Very Good	6.9%	2

85.7% of organizations reported providing clients with French language written information about their services. Slightly fewer, 78.6%, have available French written materials about their complaint process. Fewer still, 67.9%, specifically ask clients if they would like to receive services in French. As for clinical documentation, only 60.7% report always documenting in French, 18% never document in French, and 11% do so occasionally or often.

Attitudes on Evidence-Based Practices

We surveyed practitioner attitudes toward EBPs by including the Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004) into the survey. The EBPAS measures four dimensions of behavioral health service provide attitudes toward adoption of EBPs that were theoretically derived: appeal, requirements, openness, and divergence.

The *Appeal* scale represents the extent to which the practitioner would adopt an EBP if it were intuitively appealing, could be used correctly, or as being used by colleagues who were happy with it. The *Requirements* scale assesses the extent to which the practitioner would adopt an EBP if it was required by an agency, supervisor, or state/province. The *Openness* scale assesses the extent to which the practitioner is generally open to trying new interventions and would be willing to try and use EBPs. The *Divergence* scale assesses the extent to which the practitioner perceives EBPs as not clinically useful and less important than clinical experience (Aarons & Sawitzky, 2006). The EBPAS Total scale score represents one's global attitude toward adoption of EBPs.

Findings on this scale are encouraging, in most areas. The majority of respondents indicated they would be willing to adopt evidence-based practices if they were intuitively appealing, and were required by leadership figures. In addition, they generally felt quite open (readiness) to the prospect of training and using EBPs. Respondents found EBPs clinically useful, but did not appear to be fully convinced of their value in clinical practice.

On two additional questions, not related to the EBPAS, respondents were quite divided as to whether French-language evidence-based practices are difficult to implement in organizations that are mainly Anglophone,although the majority stated they would like French-language training of EBPs.

Table 6 Evidence-Based Practice Attitude Scale

If you received training in a therapy or intervention that was new to you how likely would you be to adopt it if… (n=28)	Not at all	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent
Requirements:					
it was required by a supervisor ?	4	4	1	**14**	5
it was required by your agency or organization ?	4	2	3	**12**	7
it was required by your province ?	3	3	5	**8**	9
Appeal					
it was intuitively appealing ?	4	1	5	**12**	6
it "made sense" to you ?	3	0	3	**12**	10

it was being used by colleagues who were happy with it ?	3	1	3	**14**	7
you felt you had enough training to use it correctly ?	3	0	3	9	**13**
Openness					
I like to use new types of therapy/interventions to help my clients.	3	2	6	**13**	4
I am willing to try new types of therapy/intervention even if I have to follow a treatment manual.	3	4	6	**10**	5
I am willing to use new and different types of therapy/interventions developed by researchers.	4	4	4	**10**	6
I would try a new therapy/intervention even if it were very different from what I am used to doing.	3	4	5	**11**	5
Divergence					
Research based treatments /interventions are not clinically useful.	**16**	5	5	2	0
Clinical experience is more important than using manualized therapy /interventions.	**7**	**7**	**11**	3	0
I would not use manualized therapy/interventions.	**13**	**10**	2	2	1
I know better than academic researchers how to care for my clients.	9	3	**11**	**5**	0

Additional Questions – not part of EBPAS	Not At All	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent
French-language evidence-based practices are difficult to implement in organizations that are mainly Anglophone, and this is a barrier.	6	2	8	3	9
I would like to receive French-language training on evidence-based practices.	2	0	4	8	**14**

Organizational Capacity for Research Utilization: Acquire, Assess, Adapt, and Apply

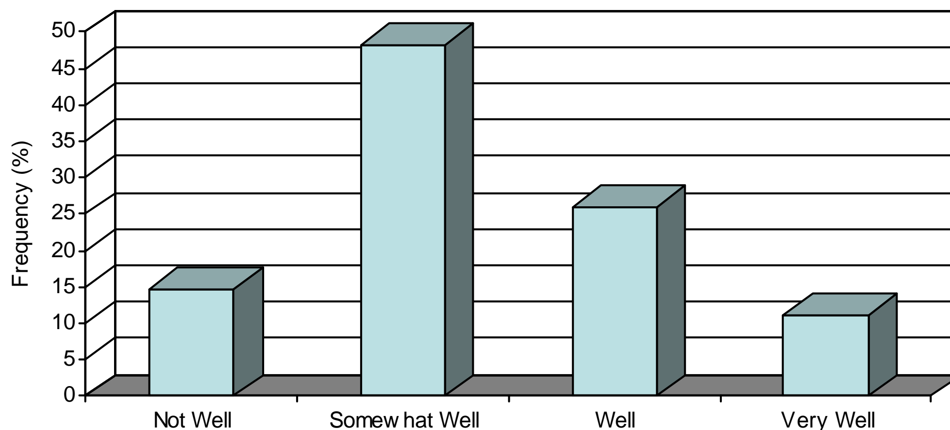
One section of the survey examined capacity for research utilization. The "four A's concept – Acquire, Assess, Apply, and Adapt" was proposed by the Canadian Health Services Research Foundation (CHSRF, 2004) to capture the essential elements of an organization's capacity for knowledge/research utilization. According to the CHSRF, "many organizations would like to make better use of research but aren't sure where to start. Others feel they are doing well, but would also like to know if there are areas in which they could improve" (CHSRF, 2004).

Survey questions on this topic explored whether the organization can find the research evidence it needs (Acquire), can assess whether the research is reliable and of high quality, relevant and applicable (Assess), can adapt the information to suit its needs, client population, environment (Adapt); and whether the organization can implement and adopt the research information in their context (Apply). This framework was also used in earlier research with multiple stakeholders and sectors involved in Ontario's

children's mental health system (Barwick, Boydell, & Omrin, 2002; Barwick, et al, 2005). The CHSRF concept of "adapt" is defined somewhat differently than our application in this report. In the CHSRF self-assessment, "adapt" refers to the organization's ability to present their own generated research evidence to decision-makers in a useful format which synthesizes recommendations, conclusions, and key issues. Since most CMHCs do not produce their own research, our use of the "adapt" concepts pertains to the organization's ability to use research knowledge to suit their context.

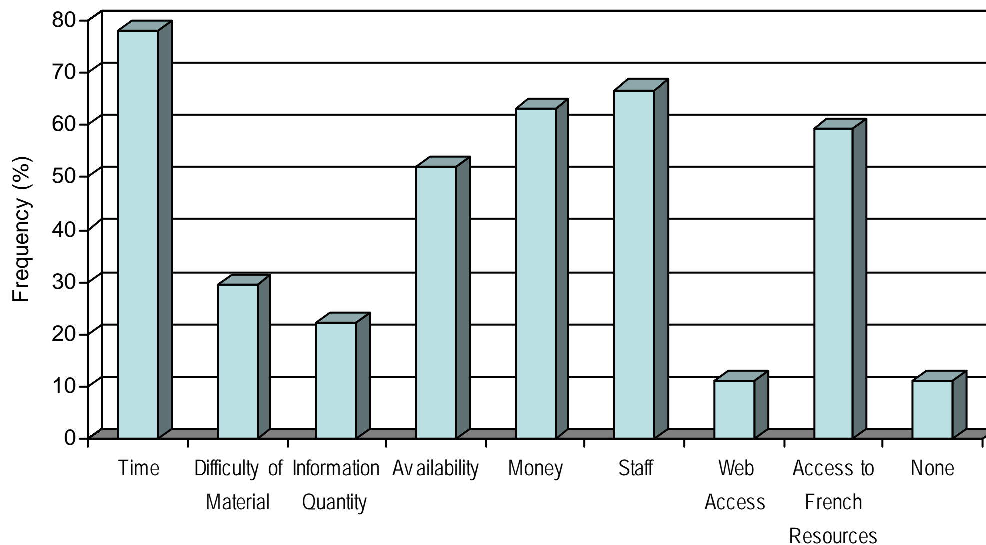
The organizations ability to find and obtain research knowledge is central to their capacity to evolve with new innovations. The majority of respondents perceived their organization as doing "somewhat well" in this regard. Clearly, there is potential here to improve access to research knowledge and this is something that should be addressed because it relates to the eventual implementation of evidence-based practices.

Figure 1 How well is your organization able to ACCESS (find and obtain) research-based knowledge?



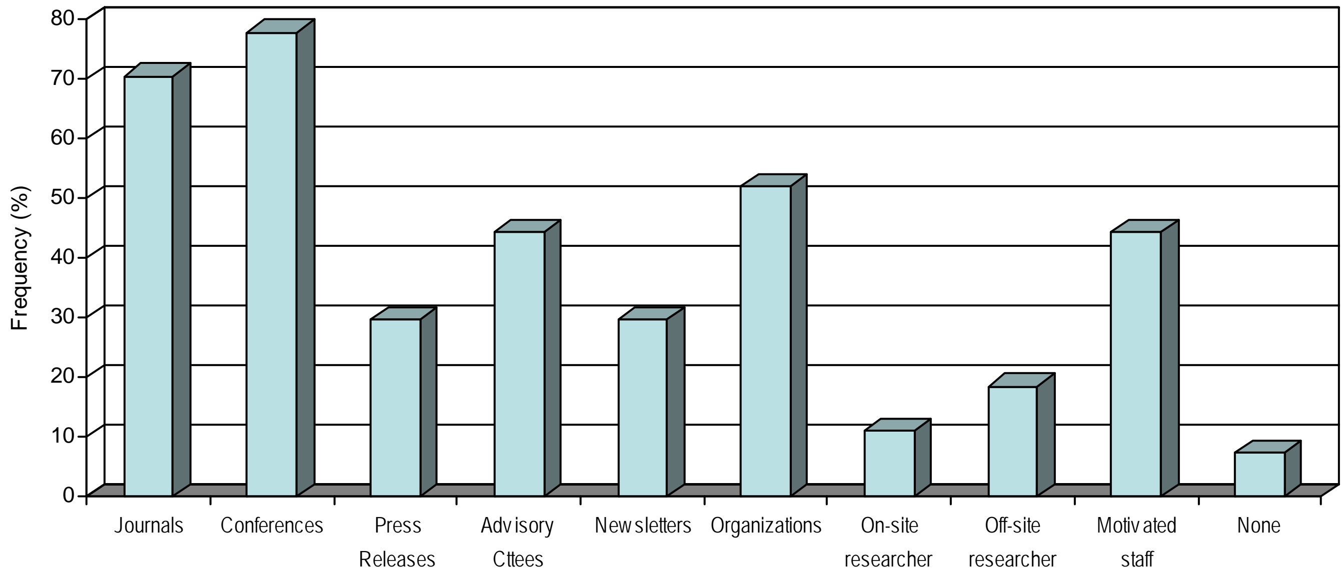
The **barriers to acquiring research knowledge** are presented in Figure 2. Factors related to time, availability of information, money, staff, and acquire to French-language resources present the most significant obstacles.

Figure 2 What barriers are faced by your organization in accessing research-based knowledge?



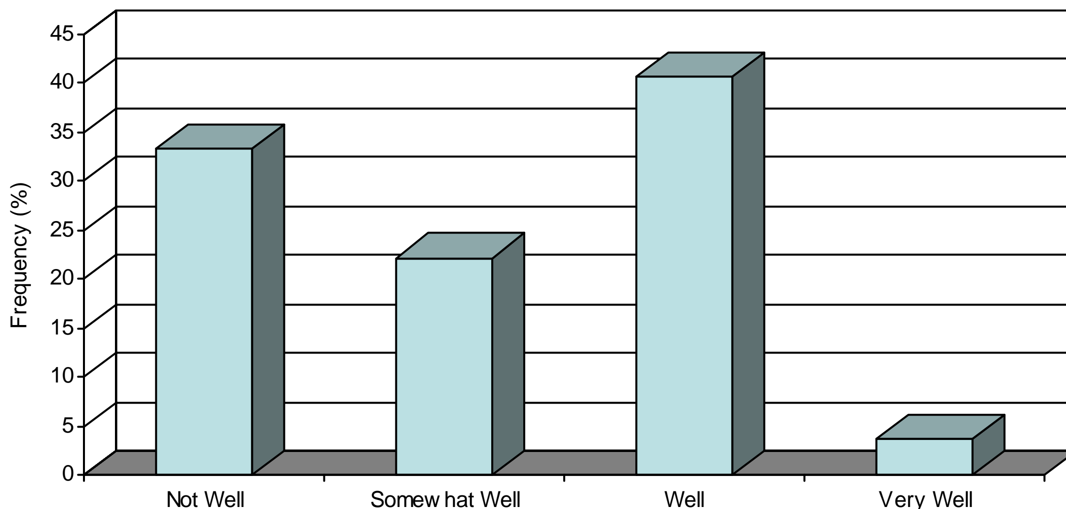
With respect to sources from which organizations acquire research-based information, we find that the primary sources are journals, conferences, other organizations, and the largesse of motivated staff members (Figure 3).

Figure 3 What sources does your organization use to access research information?



Respondents were largely split in how well they perceived their organizations' capacity to assess the reliability and quality of research, with 33.3% saying "Not Well" and 40.7% saying "Well" (Figure 4). This response suggests a need for some type of continuous professional development in the assessment of research evidence. It also leads us to speculate whether educational programs are sufficiently preparing health services workers in their capacity to digest and evaluate the research literature. When asked to comment on how they would evaluate the quality of the child and youth mental health programs provided in their organization, the majority (48.1%) viewed them as being "Somewhat Good" while 40.7% perceived them to be "Good".

Figure 4 How well is your organization able to ASSESS the reliability and quality of research?



When we turn our attention the mechanisms by which organizations assess the reliability and quality of research, we find that credibility of the source is key, as is some measure of reliance on staff members with research knowledge (Figure 5). Fully 44.4% of responding organizations have a member of staff who is responsible for program evaluation, whereas 11% do not evaluate their programs and 11% seek evaluation expertise/support from an external source.

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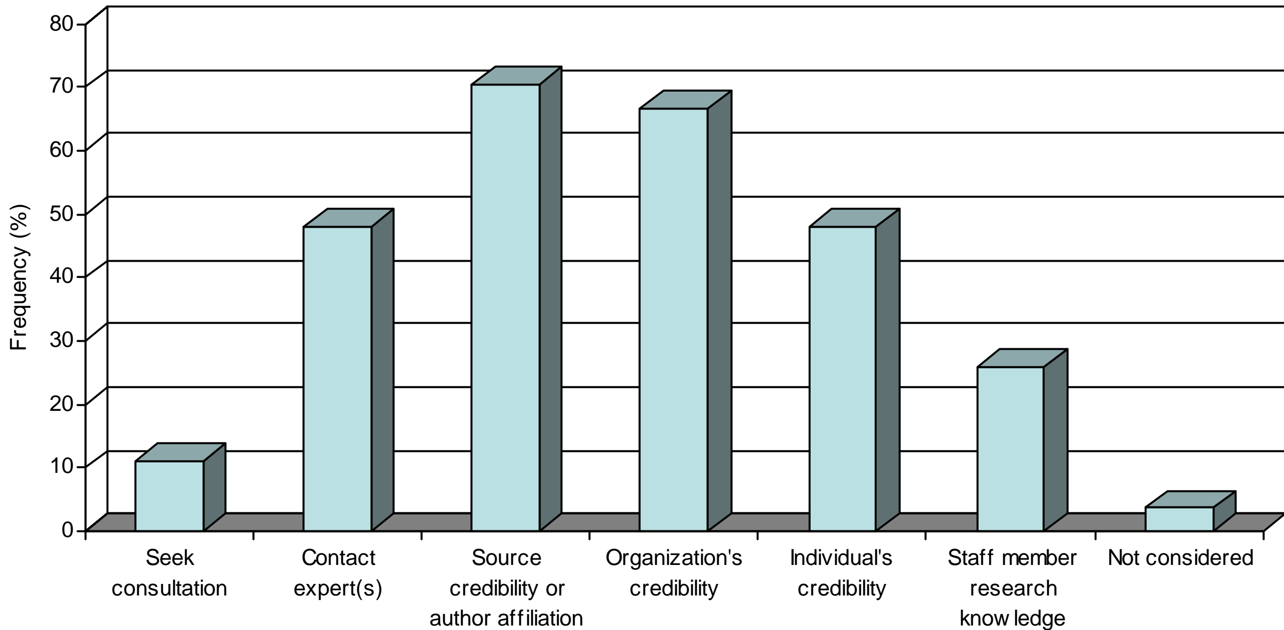
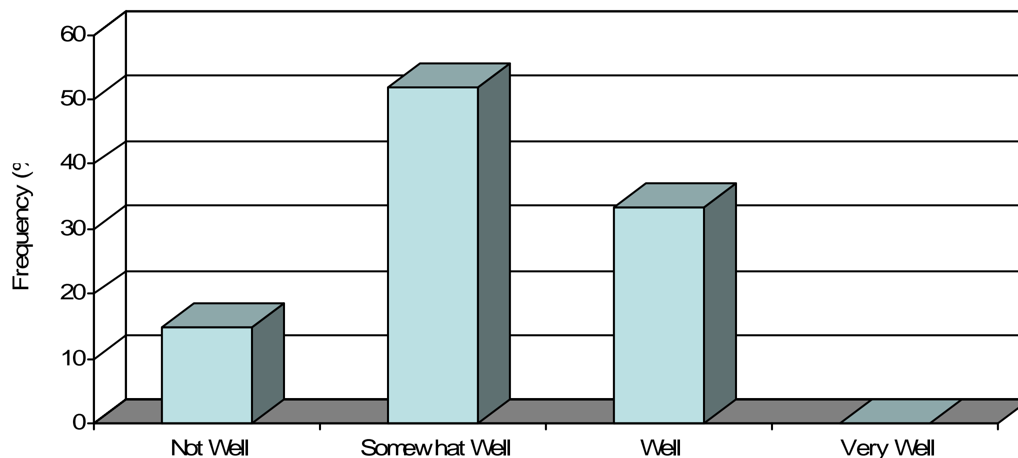
Figure 5 How does your organization assess the reliability and quality of research information?



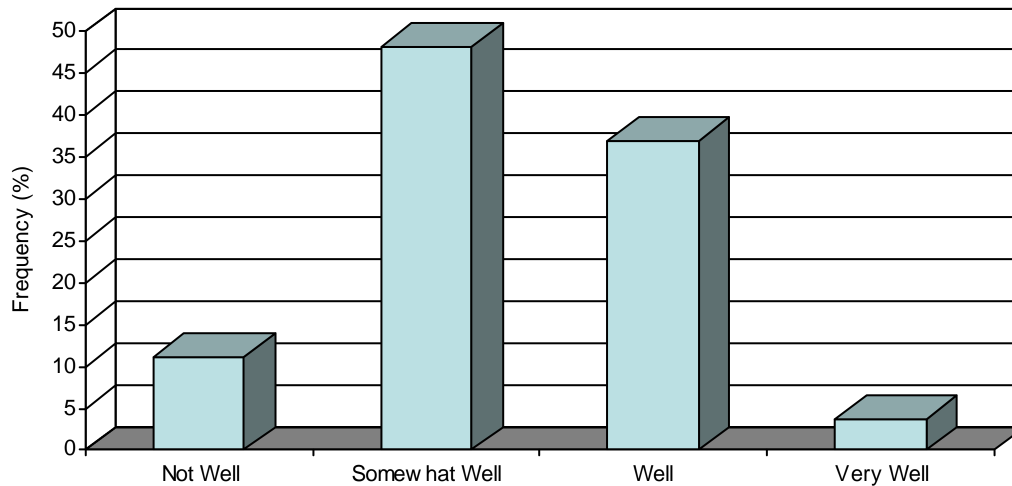
Organizational capacity to **adapt** research to their specific needs was generally rated as “Somewhat Well” (Figure 6). Particular obstacles in their capacity to adapt research knowledge included translation of English materials into French (68%), uncertainty regarding how best to adapt research knowledge to a particular environment (28%), and lack of suitable adaptation to Franco-Ontarian culture (48%). To a lesser extent, information that is difficult to adapt (16%) and the lack of summaries and main messages that could assist adaptation (16%) also presented as barriers in this regard.

Figure 6 How well is your organization able to ADAPT (modify to meet client or program needs) relevant information from research?



We also surveyed how organizations perceived their capacity to apply research knowledge, and found that as before, the main sentiment was that they could do this “Somewhat Well” (Figure 7).

Figure 7 How well is your organization able to APPLY research information?



Not being sure how to link research with practice (46.2%) and the sentiment that organizational change is difficult (46.2%) presented the most significant barriers to the application of research knowledge. Also problematic was the absence of staff having statistical knowledge (42.3%), or attempting to apply with research knowledge that was not particularly generalizable to the client population (30.8%). Fewer than 20% felt there was not enough information available to enable implementation.

Provision of Evidence-Based Mental Health Services

When asked to account for the extent to which they provide services that are supported by research evidence, impressions were divided equally among those who felt their services were based on evidence to a “Satisfactory” extent (33.3%) and those who felt this was done to a “Large” extent (33.3%). Less that a quarter of respondents (22%) felt their services were based on “Very Little” evidence, and 7.4% felt they were not based on evidence “At All.”

Internet Acquire

In this day and age, acquire to the evidence-base is highly dependent upon acquire to the Internet and electronic databases. Indeed, responses suggest it is very likely (55.6%) that organizations would turn to the internet for resources.

Table 7 - Internet Use

(%) Respondents	unable to use / no acquire	very unlikely	unlikely	very likely
	7.4	0	37	55.6

Academic Acquire

For many organizations, acquire to the evidence base occurs because individual staff members are affiliated with colleges and/or universities. Such connections occur through interpersonal interactions with other individuals within these environments, and/or through acquire to college or university library systems. Fully 77% of organizations do not benefit from acquire to a university or college libarary despite the finding that 57.7% are reportedly affiliated with a university or college.

Mental Health Issues: Most Concerning and Least Prepared

We were interested to learn what respondents considered to be the most significant mental health issue for their clinical practice. Attention Deficit Hyperactivity Disorder was ranked first most frequently, followed by Attention Deficit Disorder as the second greatest concern, aggression was ranked third most consistently, depression was fourth in rank, followed by self-harm.

Table 8 – Ranking of Mental Health Issues

	Rank				
Mental Health Issue (n=21)	**1**	**2**	**3**	**4**	**5**
Depression	21% (4)	16% (3)	16% (3)	**37% (7)**	11% (2)
Bipolar Disorder	12% (1)	**38% (3)**	25% (2)	12% (1)	12% (1)
Seasonal Affective Disorder	0% (0)	0% (0)	0% (0)	0% (0)	**100% (1)**
Obsessive Compulsive Disorder	17% (1)	0% (0)	**33% (2)**	**33% (2)**	17% (1)
Post Traumatic Stress Disorder	0% (0)	**33% (1)**	0% (0)	**33% (1)**	**33% (1)**
Anorexia	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Bulimia	0% (0)	0% (0)	0% (0)	**100% (1)**	0% (0)
L'hyperphagie boulimique	0% (0)	**100% (1)**	0% (0)	0% (0)	0% (0)
Attention Deficit Disorder	9% (1)	**45% (5)**	27% (3)	18% (2)	0% (0)
Attention Deficit Hyperactivity Disorder	**50% (7)**	14% (2)	21% (3)	0% (0)	14% (2)
Schizophrenia	33% (1)	0% (0)	0% (0)	0% (0)	**67% (2)**
Suicide	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Suicidal ideation	12% (1)	12% (1)	12% (1)	25% (2)	**38% (3)**
Suicide Attempt	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Psychosis	0% (0)	0% (0)	**100% (1)**	0% (0)	0% (0)
Self-Harm	0% (0)	0% (0)	0% (0)	20% (1)	**80% (4)**
Aggression / Violence	8% (1)	17% (2)	**33% (4)**	25% (3)	17% (2)
Substance Use: Alcohol	**40% (2)**	**40% (2)**	20% (1)	0% (0)	0% (0)
Substance Use: Drugs	**33% (2)**	17% (1)	0% (0)	17% (1)	**33% (2)**

Respondents were asked to rank the areas in which they felt the least competent. Assessment proved to be the most troubling area, followed by choice of treatment and work with other sectors, and lastly, knowing when to close cases and general administration of treatment (Table 9).

Table 9 – Areas of Least Competence

	Rank		
	1	**2**	**3**
Assessment	**77% (10)**	0% (0)	23% (3)
Treatment selection / decisions	18% (2)	**64% (7)**	18% (2)
Presentation of treatment plan to clients / parents	20% (1)	40% (2)	40% (2)
Treatment	0% (0)	40% (2)	**60% (3)**
Les thérapies impliquant plusieurs intervenants	38% (3)	25% (2)	38% (3)
Working with school and hospital sectors. L'evaluation des progrès cliniques	0% (0)	**67% (6)**	33% (3)
Adapting interventions to clients needs	50% (3)	17% (1)	33% (2)
Case closure	25 (1)	0% (0)	**75% (3)**

Organizational Readiness for Change

The literature identifies major factors seemingly involved in transferring evidence-based practices (EBPs) to practitioners in the field, however understanding how to do it needs improvement (Simpson 2002). Simpson and colleagues have incorporated these major factors as elements in an integrated framework. This kind of infrastructure is particularly important for conducting systematic studies of efforts to disseminate feasible and effective treatment innovations.

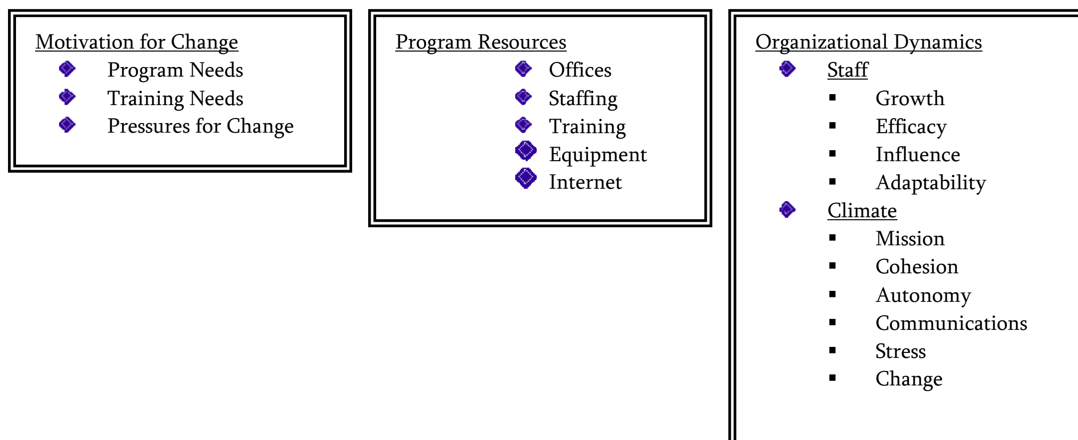
Although "change" at both the personal and organizational levels is constant and universal, making it intentional and positive requires attention and planning. This is especially true at the organizational level, which incorporates the collective attitudes, actions, and relationships of a group of individuals. There is growing consensus that problems in transferring research to practice are more likely to be due to organizational factors (e.g., leadership attitudes, staff resources, organizational stress, regulatory financial pressures, management style, tolerance for change) than how materials are disseminated (e.g., packaging, training, roll-out).

Texas Christian University (TCU) Program Change Model

Simpson (2002) presents a process model of program change that describes the introduction of new knowledge into a program or organization. This process includes exposure to new knowledge (i.e., new practice), adoption of the practice or knowledge, implementation or exploratory use, and practice or routine use. If fully realized, the transfer process can then lead to program or organizational change and improvement. Each of these stages of transfer can be impacted by organizational attributes. Of particular importance are institutional and individual readiness (e.g., motivation and resources), and organizational dynamics, such as climate for change and staff attributes.

The literature identifies several important factors that appear to influence the change process. The TCU Organizational Readiness for Change (ORC) assessment focuses on the following dimensions and subscales:

Figure 8 TCU ORC Dimensions



Motivational readiness by leaders and staff members (defined as perceived need and pressure for change) combines with personal attributes (e.g., professional growth, efficacy, influence, and adaptability) to facilitate implementation of new knowledge or practices. Organizational climate factors (e.g., clarity of mission and goals, staff cohesion, communication, and openness to change) and institutional resources (e.g., staffing levels, physical resources, training levels, and computer usage) are additional components to consider. Motivational readiness is critical, however, and is subject to external influences from funding agencies and peers. It also has a facilitating effect on organizational climate, and increased motivation by the leader can lead staff to reshape organizational goals and increase their readiness for change (Lehman et al., 2002).

The TCU Organizational Readiness for Change (ORC) assessment includes 115 Likert-type (5-point agree-disagree) items for measuring the 18 domains depicted in Figure 4.10. Its development was guided by the recent literature on technology transfer (Backer, David, & Soucy 1995), training transfer (Goldstein 1991), organizational development and change (Judge, Thoresen, Pucik & Welbourne 1999; Porras & Roberston 1992) and organizational climate (Furnham & Gunter 1993; James & McIntyre 1996; Koys & DeCotiis 1991).

Organizational-level assessments are perhaps the most challenging because they require data to be taken from individuals within the organization and than aggregated in ways that “represent” the organization. The ORC was adapted for use in this context. the clinical staff version was reduced to 67 items. Also, some of the language was changed to be more appropriate for the children’s mental health sector rather than addictions facilities, for whom the measure was initially developed and evaluated. The ORC focuses on organizational traits that predict program change, and it can be useful as a diagnostic tool for planning interventions to improve organizational functioning. For this study, items were retained if they were deemed sufficiently relevant by the project team and CMHO Sub-committee.

Organizational Readiness for Change Subscales

Motivational Readiness for Change

Motivational forces for change are complex but include perceptions of current status in regard to clinical (e.g., assessment and services) as well as organizational (e.g., clinical and financial recording) functioning (Lehman et al. 2002). Unless motivation is “activated,” individuals within an organization are unlikely to initiate change behaviors.

Program need for improvement is a reflection of perceived strengths and weaknesses of a program or organizations. Leadership concerns may focus more on patient flow, assessment and reporting systems, referral systems, billing records etc., while clinical staff may be more sensitive to patient assessment needs and acquire to services.

Respondents generally agree that program needs are in the area of assessing client needs, measuring client performance, raising the overall quality of service, and using client assessments to document program effectiveness (Table 10). There is inconsistency as to the needs involving assessing client needs, and there is largely not perceived program need in the area of using client assessments to guide clinical and program decisions.

Table 10 Need for program improvements

Program Needs: Your organization needs assistance with (n=21)	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Assessing client needs	5	**5**	3	**5**	3
Matching needs with services	3	5	3	3	**7**
Increasing program participation by clients	3	2	5	**6**	5
Measuring client performance	3	3	0	**7**	**7**
Raising overall quality of service	3	3	1	**7**	**7**
Using client assessments to guide clinical and program decision	4	**7**	1	3	6
Using client assessments to document program effectiveness	3	3	4	4	**7**

Most respondents agree that training is required in assessing client needs, increasing client participation in treatment, monitoring client progress, and in using computerized client assessment methods (Table 11).

Table 11 Training needs

Training Needs: You need training for:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Assessing client problems and needs	4	4	3	**5**	**5**
Increasing client participation in treatment	2	3	4	**7**	5
Monitoring client progress	3	3	4	**7**	4
Using computerized client assessments	4	0	3	**9**	5

Pressure for change can come from internal (e.g., staff) or external (e.g., regulatory and funding) sources. These pressures vary in intensity and form a summative index in which only at higher levels are they likely to reach sufficient threshold for a decision to take action. Most respondents agreed that pressure for change stems from clients, program staff and supervisors, agency board members, ministry /funders, and accrediting or licensing bodies. Respondents were divided with respect to pressures from community action groups (Table 12).

Table 12 Pressures for change

Pressures for Change: *Current pressures to make organizational changes come from:*	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Clients in the program	4	4	2	**11**	0
Program staff members	2	5	1	**9**	4
Program supervisors or managers	3	3	2	**9**	4
Agency board members	5	3	3	**7**	3
Community action groups	3	5	**6**	5	2
Ministry and other funders	2	3	3	**9**	4
Accreditation or licensing authorities	2	4	4	**8**	3

Adequacy of Resources

In addition to the psychological climate that envelops an organization, facilities, staff patterns and training, and equipment also are important considerations for determining organizational behavior (Brown, 1997, Burrington, 1987, Jones & James, 1979, Pond et al., 1984). In some instances, organizational change might be highly desirable but unlikely due to staff workloads, clinical practice, and resources. Five resource areas were assessed:

Office items refer to the adequacy of office and physical space available. Inadequacy of these resources reduces the ability of staff to incorporate new treatment approaches and is likely to be related to an overall lack of financial resources.

Most respondents agreed that offices and equipment, although they are adequate for individual and group counseling, are inadequate. It is unclear what it is that individuals feel is inadequate. (Table 13).

Table 13 Offices

Offices: (n=21)	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Your offices and equipment are adequate	**8**	**9**	1	3	0
Offices here are adequate for conducting group counseling	4	2	4	**6**	5
Offices here allow the privacy needed for individual counseling	5	1	**6**	**6**	3

Staffing focuses on the number and quality of staff members available to do the work. The perceived lack of human capital is supported by anecdotal reports in the field over the last decade. In addition, most respondents agreed that larger support staff is needed to help program needs. Responders were divided as to whether staff are generally well trained and whether staff turnover is a concern (Table 14).

Table 14 Staffing

Staffing	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
There are enough clinicians here to meet current client needs	**8**	**7**	4	1	1
A larger support staff is needed to help meet program needs ®[1]	2	3	4	**8**	4
Frequent staff turnover is a problem for this program ®	5	**8**	2	**6**	0
Clinical staff here are well-trained	1	**6**	5	**8**	1

***Training** resources* concern management and financial support for clinical staff training and development. There was general agreement regarding the availability and usefulness of in-service training, however, responders were divided as to the extent to which training and continuing education are priorities in their organization. Perhaps because it is often training that is cut first when financial constraints loom large. Responders were also divided in whether workload and pressure diminished their enthusiasm for continued professional development (Table 15).

Table 15 Training

Training:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Staff training and continuing education are priorities in this organization	5	6	1	6	3
You learned new skills or techniques at a professional conference in the past year	2	0	2	**12**	5
This organization holds regular in-service training	2	1	1	**11**	6
You prefer workshops based on scientific evidence	3	3	3	4	**8**
You frequently have difficulty in applying concepts learned at conferences	1	6	3	**11**	0
You are satisfied with the training you received in workshops you attend in the last year	1	2	3	**14**	1
Workload and pressure in your organization reduces your motivation to pursue additional training	2	**8**	3	**7**	1

Computer acquire deals with adequacy and use of computers. Greatest agreement lies with the availability of personal computers and staff comfort level in computer use. Responders were more varied with respect to whether client assessments and records are computerized, the swiftness with which computer problems are repaired, and the need for more computers for staff (Table 16).

[1] ® indicates item was reverse-scored.

Table 16 Computer Acquire

Computer Acquire:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Client assessments here are usually conducted using a computer	**5**	**5**	4	**5**	2
Computer problems are usually repaired promptly at this organization	2	**5**	3	**7**	4
Most client records here are computerized	3	**6**	3	4	**5**
You have a computer to use in your personal office space at work	1	1	1	4	**14**
Computer equipment in this organization is mostly old and outdated ®	**8**	6	4	2	1
You feel comfortable using computers	1	1	1	6	**12**
More computers are needed in this organization for staff to use ®	**5**	**5**	3	**4**	**4**

E-communications refer to the use of e-mail and the Internet for professional communications, networking, and information acquire. In 2002, it was estimated that over 18.5 million North Americans used the Internet, including 16,800,000 Canadians (Nielsen Net Ratings May 2002). Research has only begun to look at Internet use among health care professionals. One study of computer use among nurse suggests that Internet use at work is low among nurses compared with other groups despite adequate workplace acquire (Estabrooks, O'Leary, Ricker, & Humphrey, 2003). That study showed that while 57.8% of nurses had acquire to a computer, only 45.2% used it. Only 5.1% used a computer to look for practice information on the Internet while at work. In this study, the majority of respondents reported easy acquire to computers and email and have used the internet in the past month (Table 17).

Table 17 E-communications

E-communications:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
You used the Internet in the past month	2	1	0	3	**15**
You have easy acquire for using the Internet at work	1	2	1	4	**13**
You used the Internet to get work-related information	1	0	0	**13**	7
You have convenient acquire to email at work	1	0	1	4	**15**
Organizational policy limits staff acquire to internet or email	**10**	2	2	5	2
You require better acquire to the internet in your organization	**9**	3	4	4	1

Staff Attributes

Research on managerial coping (Judge et al. 1999), professionalism (Bartol 1979, Hall 1968) and behavioral change models (Fishbein 1995) converge on similar dimensions of attitude and functioning that influence organizational change. These have been reduced to four key areas.

Growth measures the extent to which the clinician values and perceives opportunities for professional growth. Low value or opportunities for growth will likely be associated with low readiness for change and

low value in adopting new technologies. Respondents reported regular review of professional journals and treatment materials but did not feel they had enough opportunity to keep their clinical skills up to date.

Table 18 Growth

Growth:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
You read about new techniques and treatment information each month	2	**6**	**5**	**6**	2
You have enough opportunities to keep your clinical skills up-to-date	3	**8**	5	5	0
You regularly read professional journal articles or books on treatments	2	5	2	**11**	1

Efficacy measures staff confidence in their own clinical skills. Clinical practitioners with low efficacy will be less likely to readily adapt to change and those with high efficacy more effectively seek, use, and integrate new information (Brown et al. 2001). There is high sense of efficacy among respondents.

Table 19 Efficacy

Efficacy:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
You usually accomplish whatever you set your mind on	1	0	2	**14**	4
You are effective and confident in doing your job	1	1	1	**14**	4

Influence is the willingness and ability of a clinical practitioner to influence coworkers. Its purpose is to identify opinion leaders in the organization. Technology transfer and organizational change will be most effective when the opinion leaders “buy” into change and use their influence to sell change to others in the organization. Respondents felt good about their ability to influence coworkers.

Table 20 Influence

Influence:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
You frequently share your knowledge of new ideas with other staff	1	2	2	**9**	7
Staff generally regard you as a valuable source of information	1	1	3	**12**	4
Other staff often ask your advice about program procedures	1	0	4	**14**	2

Adaptability is the ability of staff to adapt to a changing environment. Respondents demonstrated a willingness to try new ideas and to adapt quickly.

Table 21 Adaptability

Adaptability:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
You are willing to try new ideas even if some staff members are reluctant	1	0	4	**10**	6
You are sometimes too cautious or slow to make changes ®	1	9	3	**7**	1
You are willing to adapt quickly when you have to shift focus	4	3	4	**10**	0

Organizational climate

Collective appraisals (e.g., based on aggregated ratings) of an organizational environment indicates its "climate." Several dimensions are commonly identified and many are relevant to organizational change. In general, these revolve around mission and goals, group cohesion and cooperation, and openness. The ORC includes six scales in this dimension.

Clarity of mission and goals involves staff awareness of agency mission and management emphasis on goals. Organizations that lack mission or goal clarity are less likely to effectively identify their needs and thus are not likely to manage change in ways that improve program functioning. There was general agreement in respondent's understanding of organizational goals and objectives and how their services fit within the continuum of services with their community.

Table 22 Mission

Mission:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
You understand how this program fits as part of the treatment system in your community	1	3	**9**	**7**	1
This organization operates with clear goals and objectives	2	1	3	**10**	5

Staff cohesiveness focuses on work group trust and cooperation. There was general agreement regarding trust and cooperation among staff, although little in the way of weekly staff meetings which provide opportunity for staff to interact with one another (Table 23).

Table 23 Cohesion

Cohesion:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
There is too much friction among staff members ®	5	**10**	5	0	1
Mutual trust and cooperation among staff in this organization is strong	1	1	5	**11**	3
Your organization has staff meeting every week	**9**	3	1	6	2

Staff autonomy addresses the latitude counselors are allowed in working with their patients. In this area, results were mixed. There was agreement regarding requirements for supervisors to revise treatment plans, and many undecided respondents regarding the extent to which they have authority in treating their clients. The majority of respondents felt free to try out different therapeutic techniques (Table 24).

Table 24 Autonomy

Autonomy:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Treatment planning decisions for clients here often have to be revised by a supervisor	3	2	3	**7**	**6**
Clinicians here are given broad authority in treating their own clients	1	1	**11**	7	1
Clinicians here often try out different techniques to improve their effectiveness	1	2	2	**14**	2

Openness of communication focuses on management receptivity to suggestions from staff and the adequacy of information networks to keep everyone informed. There was general agreement regarding the good quality of communication (Table 25).

Table 25 Communication

Communication:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
The formal and informal communication channels here work very well	2	4	2	**13**	0
Staff members always feel free to ask questions and express concerns in this organization	1	1	3	**12**	4
Communication with other organizations having similar interests would be useful	1	1	1	**11**	7

Stress measures perceived strain, stress, and role overload. Generally, there was a sense of experiencing stress, with the effect that heavy workloads reduce program effectiveness, but most felt the pressure did not impede their job efficacy (Table 26).

Table 26 Stress

Stress:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
You are under too many pressures to do your job effectively	3	**8**	3	6	1
Staff members often show signs of stress and strain	1	2	5	**10**	3
The heavy workload here reduces program effectiveness	3	3	4	**10**	1

Openness to change concerns management interest and efforts in keeping up with change. While there was general agreement to the exchange of staff ideas for improving treatment, openness to using new technology, and encouragement in trying new techniques, respondents were divided with respect to whether novel treatment ideas are discouraged by staff and whether staff members are resistant to change (Table 27).

Table 27 Change

Change:	Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly
Novel treatment ideas by staff are discouraged ®	**15**	2	8	**10**	0
You frequently hear good staff ideas for improving treatment	1	2	3	**13**	2
The general attitude here is to use new and changing technology	1	2	4	**9**	5
You are encouraged here to try new and different techniques	1	2	3	**13**	2
Certain members of staff resist change	3	**6**	3	**6**	3

Evidence-Based Practices in Use

It is not often easy to get a reliable account of evidence-based (EBPs) or manualized therapies currently in use. Those endorsed as in use by respondents are found in Table 28, in order of greatest frequency. In addition to those programs listed below, respondents listed the following as being in use in their organizations: Bébé Fête, Zoothérapie, Russell's Anger Management,et Habiletés sociales et Habiletés parentales, Thérapie par le jeu, MindMasters et MiniMindmasters, Cléo et les habiletés , Théorie du contrôle, Sexual Treatment Outpatient program, TAPP-C (fire setting), la thérapy d'art, jeux, and IMPACT. Note that there was no decision made regarding the level of evidence base underlying these therapies.

Table 28 Evidence-Based Practices Reportedly in Use

Formation des parents sur le comportement	44.40%	8
Thérapie du comportement cognitif	38.90%	7
Programme de prévention de l’intimidation	33.30%	6
Formation du personnel enseignant le comportement	27.80%	5
Intervention intensive en matière de comportement	27.80%	5
Stop Now and Plan (SNAPP)	22.20%	4
Wraparound	22.20%	4
Thérapie narrative	16.70%	3
Brief Strategic Family Therapy (BSFT)	11.10%	2
COPE	11.10%	2
Earlscourt Under 12 Outreach Program (ORP)	11.10%	2
Partenariat entre l’infirmière et la famille	11.10%	2
Aggression Replacement Training (ART)	5.60%	1
Formation sur l’efficacité de la famille	5.60%	1
Families and Schools Together (FAST)	5.60%	1
Thérapie familiale fonctionnelle	5.60%	1
Formation des aptitudes à la vie quotidienne	5.60%	1
Multidimensional Treatment Foster Care (MDTFC)	5.60%	1
Thérapie multisystémique	5.60%	1
Soutien du comportement positif	5.60%	1
Promoting Alternative Thinking Strategies (PATHS)	5.60%	1
School Transitional Environmental Program (STEP)	5.60%	1
The Incredible Years	5.60%	1
Earlscourt Girls Connection	0%	0

Jeu du bon comportement	0%	0
Comment aider l'enfant irrespectueux	0%	0
Homebuilders	0%	0
Je peux résoudre mes problèmes	0%	0
Jumeler les intérêts des familles et du personnel enseignant	0%	0
Programme préscolaire Perry	0%	0
Projet Towards No Drug (Project TND)	0%	0
Right from the Start	0%	0
Modèle enseignement-famille	0%	0

Two-thirds (63.2%) of responders reported that they had not translated manuals or English language programs into French, but over one-third (36.8%) reported that they had and that these programs were in use in their organization.

Thirteen respondents took the time to share their thoughts on how they would improve mental health services for francophone children and youth. Suggestions included such things as more education, promotion, and implementation; more training for parents and workshops for employees – particularly in French; reduction of wait list for services; developing policy in favor of the use of evidence-based practices in child and youth mental health; and developing partnerships with anglophone organizations that can offer services that are not currently offered in French.

Conclusions

There is a need to improve acquire to resources and research on evidence-based practices and to make French-language training in EBPs more available to practitioners in child and youth mental health. It is encouraging to note that those working in the field are generally responsive, open, and ready to receive such training, however there is continued uncertainty as to the value of research-based treatment. This suggest that there are likely some pockets of resistance to change in this sector, and practitioners who may require better information as to the value of EBP for their clients.

The majority of respondents perceived their organization as doing "somewhat well" in *acquireing, assessing, adapting, and applying* research knowledge, suggesting need for improvement. Factors related to time, availability of information, money, staff, and acquire to French-language resources present the most significant *obstacles to acquire* of research-based knowledge. Traditional mechanisms for receiving research based information are still pursued, such as journals and conferences, yet there is evidence to suggest that practitioners may benefit from more interactive knowledge sharing (Barwick et al., 2005).

Fewer than half of respondents favorably evaluated the quality of the child and youth mental health programs provided in their organization. Very few respondents believed that the services provided in their organization were based on research evidence. One of the obstacles may be little connectivity to the research base via college and / or university affiliations.

Client assessments were there was least competent, followed by treatment selection, working with other sectors, knowing when to close cases and general administration of treatment. Identified needs included Training is needed in assessing client needs, measuring client performance, raising the overall quality of service, and using client assessments to document program effectiveness. There was inconsistency as to the needs involving assessing client needs, and there is largely not perceived program need in the area of using client assessments to guide clinical and program decisions.

There is high sense of self-efficacy among respondents and respondents were positive about their ability to influence coworkers. They also report a willingness to try new ideas and to adapt quickly. There was general agreement regarding trust and cooperation among staff. There was general agreement in respondent's understanding of organizational goals and objectives and how their services fit within the continuum of services with their community.

There is evidence to suggest that certain evidence-based practices are in use in Ontario, and that at least one-third of organizations have translated English language EBPs into French for use in their organizations.

Suggestions for improving mental health services for francophone children and youth included such things as more education, promotion, and implementation; more training for parents and workshops for employees – particularly in French; reduction of wait list for services; developing policy in favor of the use of evidence-based practices in child and youth mental health; and developing partnerships with anglophone organizations that can offer services that are not currently offered in French.

The findings presented here are very similar to those espoused by Anglophone sector child and youth mental health practitioners and leaders in a provincial study (Barwick et al., 2005). There is a need for training – particularly in French, and there is a perceived need to move in the direction of EBPs for French language clients that have been validated in French. Phase two of this project will delve into the availability of French-language EBPs, and make recommendations for how to develop this course of action in Ontario.

References

Aarons GA (2004). Mental health provider attitudes toward adoption of evidence-based practices: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research, 6(2), 61-74.*

Appendices

Appendix A – Respondent Organizations

SEAPR
AFMO
Niagara Child and Youth Services
Contact Niagara
Services à l'enfant et à la famille Algonquin
La Boîte à soleil coop inc.
Société de l'aide à l'enfance de S.D.&G.
La garderie Au coin des petits
CSP Grand Nord de l'Ontario
Centre communautaire de santé mentale Prescott-Russell
Equipe psycho-sociale
Ctre de l'enfant et de la famille
Winchester Diabetes Program
Centre de recherche sur les services communautaires
Services a l'enfance et a la famille de Timmins et du district
Big Brothers Big Sisters of Sudbury
SSI Canada
Maison des jeunes
Centre de santé mentale du nord-est Services cliniques axés sur le développement
Société catholique de l'aide à l'enfance de Toronto
Service familial de Sudbury
Services de santé mentale Base des Forces canadiennes Petawawa
Le Guichet pour Francophones de la région Champlain
Centre de santé communautaire Hamilton/Niagara
Services aux enfants et adultes de Prescott Russell
CSDNEO