Knowledge Mobilization in Child Welfare

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Introduction

In 1976, following a comprehensive review of research on the effectiveness of child welfare policies and services, Sheila Kammeran and Alfred Kahn concluded that "most policies and practice decisions are still based primarily on value judgments and assumptions". Thirty years later, despite repeated calls for systematic evaluation (Magura and Moses, 1986; Pecora, Whittaker, Maluccio, Barth, & Plotnick, 1992; National Research Council, 1993; Gelles, 2001), services to maltreated children and their families continue to be driven by perceptions about need irrespective of evidence of service effectiveness. A recently completed review of all Canadian studies published between 1995 and 2005 using comparison group designs to measure the impact of child welfare services was able to identify 10 studies, 4 of which used randomized designs (Flynn, 2005). Yet child welfare services are one of the fastest growing social service delivery sectors in Canada. The number of maltreatment investigations conducted by child protection authorities has doubled in the last five years with over 200,000 children per year investigated because of suspected child maltreatment (Trocmé, Fallon, Maclaurin et al., 2005). Canada spends 3 to 4 billion dollars per year on direct child welfare services, and the annual indirect costs are estimated to be over 15 billion (Bowlus, McKenna, Day, & Wright, 2003).

Why do we know so little about services to the most vulnerable children in Canada and how can we justify mandatory court ordered interventions on the basis of such limited evidence of intervention effectiveness? While conducting more intervention outcome research is clearly part of the answer (less than one million dollars a year spent in Canada to evaluate a multi-billion dollar service delivery system), the experience from sectors that have invested heavily in research point to the critical importance of developing such research agendas within broader knowledge mobilization strategies (Huberman, 1994; Davis and Chapman, 1996; Dash, Gowman, & Traynor, 2003; Lomas, 2003). From this perspective, the challenge is not to do more research per se, rather it is to develop an organizational culture where the question of intervention effectiveness becomes a central component of decision-making.

This article examines emerging knowledge mobilization models designed to support the more systematic use of research in social services and the development of practice and policy-driven demands for research on the effectiveness of intervention and prevention programs. We start by discussing the limits or traditional knowledge dissemination models through the lens of our own dissemination experience. We then consider some of the research that has been done on the barriers and facilitators of research utilization in health, education and social services. Finally, we present a knowledge mobilization model that is being pilot tested and evaluated in a child welfare agency in Quebec.

The limits of dissemination

Despite ever increasing references to evidence-based policy and evidence-based practice, the challenge of moving evidence into policy and practice requires multi-level and long-

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term strategies that go far beyond traditional dissemination. Collecting evidence through systematic reviews and translating it into terms that can be understood by policy-makers and practitioners does not ensure that the evidence will be acted upon. There is growing concern that traditional dissemination strategies are having only limited impact on policies and practices (Bate & Robert, 2002; Waddell, Lavis, Abelson, et al., 2005). Our experience with dissemination and knowledge mobilization at the Centre of Excellence for Child Welfare (CECW) reflects many of theses challenges. Over the past five years, the CECW has successfully developed an active network of over 500 Canadian researchers, policy makers and service providers.   We have focused our dissemination activities at two levels. The CECW website attracts 8,000 to 10,000 visits a month and the most popular downloads are two-page information sheets summarizing findings from Canadian child welfare studies (www.cecw-cepb.ca). We have also held annual research policy conferences on leading issues (e.g. differential response and reconciliation with aboriginal communities) that have had a documented impact on provincial and federal policies (development of differential response models in Alberta, Ontario and Québec) (see, for example: Trocmé, Knoke, & Roy, 2003; Loxely, DeRivière, Prakash, et al., 2005).

While these strategies have helped to strengthen the CECW network and have increased access to selected research, it has been more difficult to identify impact at the level of individual practice or child welfare agency services and policies (Consulting Audit Canada, 2005). Furthermore, at the provincial and federal level, the CECW is being increasingly asked to develop consultation mechanisms that are more responsive than annual policy symposiums with their fixed themes and 18 to 24 month cycle from

planning to production of the proceedings. One of the fundamental limits of this type of

dissemination model is that the evidence base is too thin in child welfare to adequately

answer many of the policy and service questions currently facing this sector. An iterative

knowledge production / dissemination / utilization process is required to support the

development of a solid and relevant evidence base to support policy and practice

decisions in child welfare.

Knowledge mobilization

Knowledge mobilization moves beyond a unidirectional dissemination model by

embedding knowledge utilization and knowledge generation within the core structure of

organizations (Clark & Kelly, 2005). Jonathan Lomas (2003), director of the Canadian

Health Services Research Foundation (CHSRF), argues that the most successful

examples of health services research affecting practice emerge from organizations that

have invested significantly in research and have integrated research at all levels of their

organizational structure, thus creating an organizational culture that values research

(Lomas, 2003).

A number of terms are used in the literature in reference to dissemination: knowledge

mobilization, knowledge exchange, knowledge transfer, and knowledge translation[1].

Dissemination usually refers to the process of sharing research results through either

scientific meetings and publications or through less specialized conference and

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[1] See Graham "Lost in Translation" for a comprehensive taxonomy of these various terms or consult the "knowledge" glossary http://www.onthepoint.ca/resources/documents/KECGlossary.doc

publications targeting professionals or the general public. Knowledge transfer refers more specifically to the latter, e.g., the process of disseminating research findings in terms that can be understood by non-specialists. Knowledge translation, knowledge exchange and knowledge mobilization are used to refer to a more interactive set of activities that cover the full research production, dissemination and utilization cycle. The success of translation / mobilization / exchange is evaluated by the impact on end users (e.g., physicians, social workers, teachers, policy makers).

The CHSRF defines knowledge exchange to be the:

> *"collaborative problem-solving between researchers and decision makers that happens through linkage and exchange. Effective knowledge mobilization involves interaction between decision makers and researchers and results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making"* (http://www.chsrf.ca/keys/glossary_e.php)

For the purpose of this article, we will use the term knowledge mobilization in the same sense as the CHSRF definition of knowledge exchange.

The essential elements for effective knowledge mobilization

While attention is only beginning to be paid to knowledge mobilization in social services, there is a considerable body of research that has focused on this question in the health services. Successful knowledge mobilization initiatives share a number of common elements both in terms of: (1) the production of relevant and timely information through well-integrated partnerships between researchers, policy-makers and service providers as well as through (2) the development of capacity within policy-making and service provider organizations to integrate research information and a culture that supports

evidence-based decision-making (Harvey, Loftus-Hills, Rycroft-Malone, Titchen, Kitson, & McCormack, 2002; Hemsley-Brown & Sharp, 2003; Hemsley-Brown, 2004; and, Rycroft.Malone, Harvey, Seers, Kitson, McCormack, Titchen, 2004). The following two sections of this article present findings from this research, first, with respect to knowledge production and, second, with respect to knowledge utilization.

Knowledge production partnerships

Most knowledge mobilization initiatives have evolved through attempts to extend the impact of research, initially through greater focus on dissemination and, more recently, through the development of research partnerships designed to better integrate research with the needs of policy makers and service providers (Gollop, Ketley, Buchanan, et al., 2006). Denis and Lomas (as cited in Gollop et al., 2006) describe collaborative research as "an evolving research program based on cumulative discovery" between researchers and decision-makers. They argue that collaboration goes far beyond developing research agreements in order to achieve pre-determined objectives. In their experience full collaboration includes: (1) the investment of time and other resources required of collaborative research is identified as worthwhile by both researchers and practitioners; (2) trust is predicated on informal interactions that are essential to the success of collaborative research; (3) in combination with the above, the involvement of people may be more important to the success of collaborative research than the processes put in place, and; (4) collaborative research is a mutual journey between researchers and practitioners that does not have a clear destination This process-intensive collaboration is seen as a

necessary condition to developing research that will be trusted and used by decision-makers (Lomas, 2000; Bate & Robert, 2002).

Building trust between researchers and decision-makers

Successful research partnerships are built on trust between the researchers and the decision-makers and practitioners (CHRSF, nd; Hemsley-Brown, 2004). All invested parties benefit from "learn[ing] about each other's working culture and establish[ing] personal relationships" (CHSRF, nd). The development of communication networks between researchers and practitioners/decision-makers and the involvement of practitioners/decision-makers in the research process has been found to improve research use (Hemsley-Brown, 2004). Trust is developed and nurtured over time and via positive experiences between the partners. Both "unstructured and structured interaction" and "formal and informal" interactions are important for building trust in the relationship and for assessing the progress and planning the next steps (CHSRF, nd).

The relationship between researchers, decision-makers and policy-makers is one of the fundamental factors for promoting research utilization within an agency. Consistent contact (e.g., face-to-face, email, phone), formal and informal exchanges, mutual respect and trust, and open dialogue are imperative qualities of the partnership. The fact that researchers, decision-makers and policy-makers have different career trajectories and skills and are part of different occupational cultures that rarely intersect without a concerted effort underscores the difficulties of establishing a collaborative relationship with a mutual understanding and mutual goals (Dash, Gowman, & Traynor, 2003). For these reasons, consistent efforts must be made to link interested parties on a regular basis

and to clearly identify mutual objectives and goals, processes and resources required, and they must co-construct a dialogue of mutual understanding given that they may speak different professional languages in their respective sectors (Dash, Gowman, & Traynor, 2003).

Relevance and Timeliness

Studies examining the use of health research in the United Kingdom show that use depends on the extent to which research is seen as being relevant to the National Health Services agenda (Hemsley-Brown & Sharp, 2003). Research evidence is less likely to be used if it is not perceived as relevant to the issues that decision-makers are grappling with, and if it is not readily available in a timely manner (Hemsley-Brown, 2004). Topics that are of interest to decision-makers, clear delineation of policy and practice implications of the research findings, and a realistic appraisal of the research findings are critical for addressing this barrier (Hemsley-Brown, 2004; CHSRF, nd). The relevance and utilization of research depends in part on the extent to which policy makers and service providers participate in setting the research agenda.

The importance of context-specific knowledge

In its efforts to move knowledge mobilization beyond better dissemination, the National Health Service Scotland (NHSS) has been exploring the use of action research methods to foster closer ties between the production and use of research. Building on the knowledge mobilization work emerging from the Canadian Health Services Research Foundation, the National Health Services in Scotland recently completed a series of case

studies to examine knowledge mobilization through action research (Sharp, 2005). Key elements in developing effective partnerships between researchers, service providers and policy makers included: (1) putting greater emphasis on local context specific research, (2) integrating tacit knowledge, and (3) building capacity to use research evidence through knowledge brokering (Sharp, 2005; see also Argys, 1985).   The first two elements speak to the importance of broadening the concept of knowledge production beyond traditional university paradigms. Whereas researchers usually focus on trying to generalize knowledge beyond local instances, policy makers and service providers tend to put more value on local knowledge, concerned that material appearing in international journals may not apply to their context.   Policy makers and service providers also value a broader array of types of evidence than researchers do. Rycroft-Malone, Harvey, Seers, et al. (2004) point to four types of evidence used by health service practitioners: research, clinical experience, patient experience and information relative to the local context. While research evidence is most likely to be used when it is supported by other sources of evidence, the authors nevertheless note when different sources of evidence point to opposite conclusions, decision-makers consider the relative credibility of each, and in particular the strength of the methodological designs underlying research evidence.

The importance of moving beyond traditional research paradigms is particularly pertinent in social services where the shortage of evidence poses significant challenges (Mullen, Shlonsky, Bledsoe et al., 2005). In fields where controlled studies are rare and replication research is virtually non-existent, there are few questions that lend themselves to meta-analysis or even to meaningful systematic reviews (Flynn, 2005; Dufour, 2003). Mullen et al., (2005) argue that in such situations one can nevertheless adopt an evidence-

based position by (1) proceeding with the caution warranted by the lack of decisive evidence and (2) by addressing research gaps in an incremental fashion that builds on the analysis of readily available data. While the question of intervention effectiveness may be addressed through well designed controlled studies, an evidence-based approach is one that makes best use of the available evidence (Davis & Chapman, 1996). This does not mean compromising standards, but being explicit about the level of available evidence being used.

In summary, the use of research to inform policy and practice decisions depends on the extent to which the research is perceived by decision-makers as being relevant and credible. Relevance and credibility, in turn, depend on the extent to which research emerges from a partnership between researchers and decision-makers. Effective partnerships require that researchers be prepared to let service providers and policy-makers participate and shape the research agenda, and also make use of a broader range of sources of evidence.

Supporting knowledge utilization

While producing relevant, timely and context-specific evidence is a necessary condition for knowledge mobilization, building capacity to use this information and an organizational culture that values it are equally important factors. Indeed, as previously noted, building the capacity to use research was found in the National Health Service in Scotland (NHSS) research utilization study to be a key factor in determining research uptake (Sharp, 2005).

Hemsley-Brown's review (2004) of research on barriers and facilitators to research utilization, found that the ability to critically appraise research articles and to be comfortable with research terminology was one of the frequently cited barriers to research utilization. A study of the reading habits of 20 professionals from education, engineering, law and medicine found that educators made the least use of professional literature (Latham, 1993, as cited in Hemsley-Brown, 2004). Educators explained that they did not have the time to read research and that when they tried they found the research to be too technical and of limited relevance. Research infrastructure and access to methodological support play an important role in mediating the implementation of research into practice (Rycroft-Malone, Harvey, Seers et al., 2004). The capacity of service provider and policy-making organizations to process, interpret and take ownership for research must be addressed at the planning stage of research projects and not only at the dissemination stage (Rycroft-Malone, Harvey, Seers et al., 2004). Allocated resources must be clearly defined, consistently monitored and targeted, and fit with organizational priorities. Training for staff in skill development for acquiring, understanding, critically appraising, adapting and applying research is vital to an agency's increased likelihood of implementing research.

Kitson, Harvey and McGormak (1998) argue that research facilitators within health service organizations must be a central component for an effective strategy to implement research into practice. They propose a framework for research implementation whereby successful implementation is a function of evidence, context and facilitation. In their model facilitation goes beyond simple research dissemination and implementation roles and refers to a process intensive enabling function (Harvey et al, 2002). While a growing

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number of studies point to the importance of research facilitators in supporting the implementation and integration of research, there is a need for more research on the specific facilitator characteristics that are most appropriate and effective in specific contexts (Harvey et al, 2002).

Beyond capacity, the research of Rycroft-Malone, Harvey, Kitson et al. (2004) and Harvey, Loftus-Hills, Rycroft-Malone et al. (2002) points to the critical importance of leadership in setting a culture where evidence is valued. In a survey of research use by 1989 nurses and nursing administrators, Funk (1995, as cited in Helmsley-Brown, 2004) found that the most frequently cited facilitator was "enhanced administrative support and encouragement for research utilization". The use of research by practitioners hinges on the extent to which managers use and value research (Hemsley-Brown, 2004).

Research that is integrated in the agency's core functioning, rather than a separate activity, is vital to successful implementation of research into practice (Gollop et al., 2006). Integrative research is "characterized by having a research agenda that is set by the organization's needs, the research being undertaken by managers, clinicians and researchers collaboratively, with the results translated directly into practice through integrated management structures and systems" (Lomas, 2003, as cited in Gollop et al., 2006, p. 259). Integrative research demonstrates the importance of creating a research team within an agency and developing a relevant agenda determined by the agency at the outset in order to effectively mobilize knowledge over time (Gollop et al., 2006). Furthermore, agencies need to "first, value research in order to sustain a culture of evidence-based practice, second, increase the critical mass of research-aware staff, and,

finally, learn to recognize use as part of the organization's knowledge creation process"
(Hemsley-Brown, 2004, p. 539).

In summary, knowledge mobilization requires organizations that have the capacity to use
research, make time and resources available to support accessing research and that
demonstrate this commitment by integrating research within core management structures.
In this context, partnerships between researchers, service providers and policy makers
must move beyond shared research projects to develop mechanisms for universities and
related research centres to make their skills and resources available to service
organizations as they move first to evidence-based management, providing the
organizational infrastructure and culture to support evidence-based practice.

The Batshaw-McGill Evidence-Based Management (EBM) project

The Evidence-Based Management (EBM) project was conceived and developed jointly
by McGill University's Centre for Research on Children and Families (CRCF) and
Batshaw Youth and Family Centres (BYFC), following a request by BYFC for assistance
in developing the agency's capacity to make better use of research, to monitor the impact
of its services and to support the development of more effective services. The EBM
Project is supported by a three-year Social Sciences and Humanities Research Council
(SSHRC) grant under the SSHRC Knowledge Impact in Society program designed to
support "university-based strategic knowledge mobilization initiatives that systematically
enable non-university stakeholder communities to benefit from existing academic
research knowledge in the social sciences and humanities" (SSHRC-KIS Transformation

Program description, nd). Additional partners include the Centre of Excellence for Child

Welfare (CECW), l'Institut de Recherche pour le Développement Social des Jeunes

(IRDS), the Association des Centres Jeunesse du Québec (ACJQ) , University of

Toronto, University of Calgary, and the Alberta Ministry of Children Services.

The initiative was designed to develop and evaluate a child welfare knowledge

mobilization model that places the question of evidence at the forefront of management

and service-delivery decisions in a child welfare agency. The overall objective is to

support the development of an evidence-based management model. We use the term

evidence-based management rather than evidence-based practice because the types of

decisions and evidence we are targeting in this stage focus on broader policy and service-

delivery questions rather than client-specific decisions.

Building on existing models, including the NHSS action-research experience (Sharp,

2005), the Evidence-Context-Facilitation model (Kitson et al 1989; Rycroft Malone et al.,

2006) and the work of the CHSRF (Lomas, 2003), the proposed initiative is based on the

assumption that to develop a strong agency-based research culture, knowledge

mobilization must be driven by (i) questions that decision-makers are faced with in their

day to day activities (i.e., are *relevant*), that (ii) responses to these questions must be

provided in a *timely* fashion (weeks or months, not years), (iii) that these responses

answer the question(s) being asked (i.e., are *accurate)*, and that (iv) they make as much

use as possible of *local* expertise and information, avoiding wherever possible time

consuming and resource intensive supplementary data collection procedures. In other

words, the research implementation loop must be timely, relevant, accurate and local.

The project focuses on developing a knowledge mobilization program within a specific child welfare agency: Batshaw Youth and Family Centres (BYFC). Focusing on a single agency is required to ensure that the knowledge mobilization model is fully implemented throughout the management structure of the organization and does not develop as a satellite project (Lomas, 2003; Sharp, 2005). The overall objective of this first phase is to develop a management culture at BYFC where the question of evidence is at the forefront of all decisions. Managers rather than front-line workers are being targeted given that studies evaluating the effectiveness of knowledge mobilization initiatives in the health and education sectors show that shifting to an evidence-based organizational culture hinges on the extent to which managers value and use research (Hemsley-Brown & Sharp, 2003).

Knowledge mobilization is being developed to assist BYFC in making better use of three forms of evidence: (1) service and client information systems, (2) clinical expertise and (3) existing research and emerging practices.

(1) Tracking client and service outcome indicators

Client and service information is tracked at BYFC in a fully computerized client information system, the Système Clientèle Jeunesse (SCJ), which is part of the province-wide Plateforme Intégration Jeunesse (PIJ). PIJ is one of the most comprehensive child and youth services information systems in North America, but to date its full capacity has been underutilized (see http://www.cecw-cepb.ca/DocsEng/PIBE20E.pdf). PIJ is primarily used by agency social workers to track individual client information. Managers have made limited use of its capacity as a management tool beyond case volume and case processing statistics.

Indicators were selected and operationalized over an intensive 18 month consultation process with a reference group that brought together selected managers and senior clinicians from all the SCJ service departments. Using the previously developed indicators from the National Outcomes Matrix framework (NOM: (Trocmé, MacLaurin et al., 2000)), we met every 6 weeks with the reference group to review the emerging indicators. Decisions had to be made about a number of complex issues, including the timeframes for tracking indicators (for example, should recurrence of maltreatment be tracked 12, 24 or 36 months after services are completed), definitions of critical service events (for example, how to distinguish between planned home visits and failed reunifications) and what types of services to include in an indicator (for example, all services provided from first point of contact, or only services provided after the initial assessment evaluation is completed). For some indicators over a dozen different operational definitions were developed and compared and various graphic and tabular methods for representing the data were compared. Reference group members needed to learn to understand how to construct consistent definitions for numerators and denominators, and to understand the differences between cross-sectional, retrospective and prospective methods for tracking cases. Figure 1 provides an example of the case flow decisions that had to be made. As illustrated, we ended up developing three different cohorts for tracking cases: a service cohort that tracks all events occurring within 36 months of referral for all cases referred during a fiscal year, a recurrence cohort tracking cases closed within a fiscal year, and a placement cohort tracking cases up to 36 months after the initial placement. Inclusion and exclusion criteria were also set in a similar fashion.
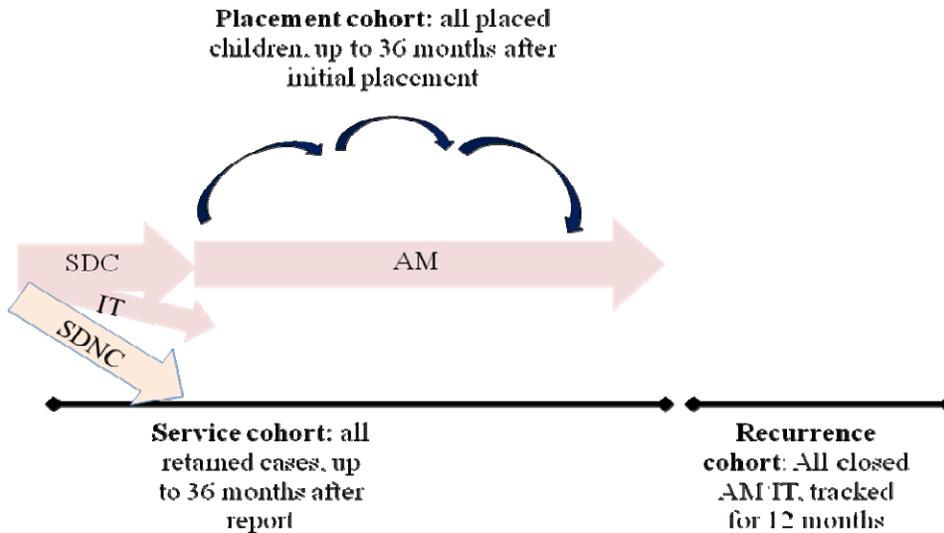
Figure 1: Outcome indicator tracking cohorts, EBM 2008

To date we have finalized six indicators and are working on three additional ones. Using modified data to maintain confidentiality[2], Table 1 is an example of the type of status report that is being tracked by the indicators. There has been little change across the four fiscal years covered to date, with the exceptions of a possible increase in placement rates and in the proportion of children delayed by more than a year at school. The indicators provide the agency with a baseline against which the impact of new initiatives can be measured. It is also noteworthy that relative to managers' expectations, several indicators proved to be far more positive than expected. For instance, the average number of placement changes (mean = 2.03, with 60% of placed children experiencing no or only one placement change) was far lower than expected. Managers were also surprised that the placement rate was so low (ranging from 35% to 40%), given that

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[2] Since the agency status reports have not yet been publicly released, we have weighted the data so that it gives examples of the observed trends but masks the data sufficiently to maintain confidentiality.
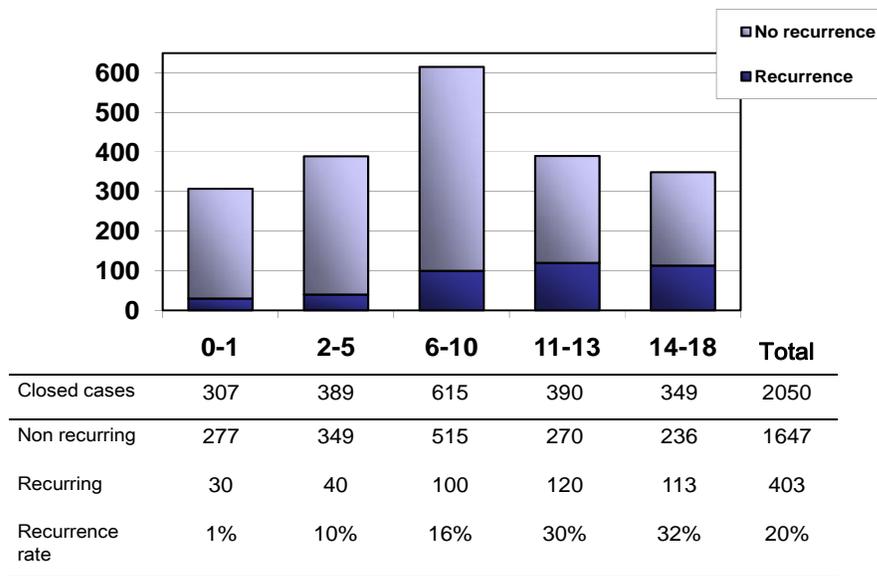
cross-sectional yield a higher ratio of placed children, an artifice of the fact that cases

involving placement are kept open for longer periods of time than cases where there is no

placement.

Table 1: Child welfare service outcome indicators, 2002 to 2005 *

	02-03	03-04	04-05	05-06
Recurrence Closed in FY and re-substantiated within 12 months.	19%	21%	19%	20%
School Delay At least 1 year behind age appropriate grade compared to norm	30% 8%	35% 7%	32% 5%	37% 4%
Placement Rate Investigated children who experience at least one placement (>3 days) within 36 months of initial investigation	35%	36%	39%	40%
Moves in care Placement changes (>3 days) or reunification breakdowns within 36 months of initial placement	2.06	2.03	2.03	
Time in care (% current status / mean days per current status) ***Return home*** ***Adoption*** ***Other*** ***Still in care***	426 *43% / 245* *1% / 818* *31% / 598* *25% / 999*	383 *40% / 204* *1% / 594* *28% / 462* *31% / 950*	443 *42% / 246* *3% / 741* *24% / 473* *31% /964*	
Court Involvement Children who experience at least one court event within 36 months of initial investigation	43%	40%	37%	44%

(*) = weighted data based on administrative statistics analyzed at BYFC

Each indicator is analyzed at a first level by breaking it down by the primary reason for

the agency's involvement and by the age of the child. These analyses are presented in

tabular form accompanied by bar graphs to assist in the interpretation of the data. Figure

2 provides an illustration using the breakdown of recurrence rates by age. The breakdown

by age has drawn the agency's attention to the fact that recurrence is primarily an issue

with their adolescent population. The bar graph provides an important additional

reminder, namely that although 6 to 10 year olds recur at half the rate of older

adolescents, there are nearly as many 6 to 10 year olds with recurring problems than 14 to

18 year olds. This first set of cross tabular analyses have helped to draw attention to

specific sub-groups of children that are at higher risk than expected to experience poor

outcomes. For instance, managers were surprised by higher than expected placement

disruption rates for infants in care.

	0-1	2-5	6-10	11-13	14-18	Total
Closed cases	307	389	615	390	349	2050
Non recurring	277	349	515	270	236	1647
Recurring	30	40	100	120	113	403
Recurrence rate	1%	10%	16%	30%	32%	20%

Figure 2: Recurrence by age, (weighted data based on administrative statistics analyzed at BYFC)

The full potential of the indicators as management tools will emerge over time. The rich

case-level data lends itself well to multivariate modeling which will assist managers

understand the factors associated with poor outcomes. Comparisons across agencies and

between provinces will also help establish criteria to assess acceptable thresholds for

different indicators.

(2) Accessing clinical expertise

Clinical expertise can be easily disregarded as a source of evidence in monitoring the quality of programs. While a number of well-developed clinical review procedures are in place across the agency to provide case-specific consultation to social workers, there is no mechanism to aggregate this information at an agency-wide level. Two procedures have been developed to address this gap. The first, dubbed "clinical voices", uses a combination of focus groups and file surveys to identify and then quantify emerging issues. The first round of "clinical voices" focused on issues identified by the group of social workers who conduct independent reviews of all active cases. Two focus groups were used to identify emerging issues and to develop a small number of questions that the reviewers would use to track the frequency and severity of these issues. An electronic one page questionnaire was then developed by the research team, and completed by the reviewers on all the reviews conducted during a three month period (N=348). The results were analyzed and summarized with further input from the reviewers and reported to the senior management team. The reporting back and action phase has not yet taken place. The process proved to take longer than expected (13 months, not including the reporting back phase), although with this initial experience completed we have identified a number of mechanisms that should help accelerate the process.

The second method for building on the agency's clinical expertise has used specialized discussion and consultation groups, dubbed Clinical Integration Groups (CIGs), that bring together senior clinicians with common expertise and interests with researchers and graduate students who act as knowledge brokers. To date two CIGs have been set up, one focusing on sexual abuse and a second on conjugal violence. The groups meet on a

regular basis to discuss clinical issues as well as to review recently published research that applies to these issues.   In a field where policy decisions are driven more often than not by having to react swiftly to high profile tragedies, the CIGs and clinical voices initiatives moves the focus to a much broader array of positive and negative events that can serve to inform the development of new practices and policies.

(3) Accessing published research through knowledge brokers

Knowledge brokers are a central component to the EBM strategy. Knowledge brokers are academics and graduate students who assist agency managers in accessing relevant research. They assist in formulating answerable questions and then gather the necessary information to support decision-making in a timely fashion. The brokering model provides an interactive approach that tailors research and best practice reviews to the needs and timeframe of the users (Clark & Kelly, 2005). The format for the briefings will vary depending on the context for the review. In contrast to a more traditional consultation model, the brokers do not produce formal reports; rather they will identify and help appraise potentially relevant published research or assist in analyzing administrative data. The brokerage model helps to significantly speed up the response, allows the agency develop its capacity to understand and use research, and minimizes the costs of consultation. To date, eight knowledge brokers – three faculty members, four graduate students and one post-doc – have acted as knowledge brokers. In five instances they have become members of standing committees, including two CIGs, acting at times as research assistants and others as content experts. In another six instances they have provided time limited support with respect to specific questions that have arisen at various levels in the agency.

Linking to other initiatives across Québec and Canada:

The EBM initiative is serving as a pilot site for two broader initiatives: across Québec using the common administrative client information system and across Canada through the Federal Provincial and Territorial National Outcomes Matrix Working Group (FPT-NOM). In both instances, the focused scale of the EBM project allows for testing and consultation that cannot be as easily conducted at the provincial level. The outcome indicators that have been operationalized through the EBM project are being used to demonstrate their feasibility and utility at the provincial and national levels.

Evaluation

The BYFC-McGill EBM project is a knowledge mobilization initiative that focuses on placing university research resources and expertise at the disposition of the BYFC managers in order to assist the organization in shifting to an evidence-based approach to developing and monitoring its programs and policies. The effectiveness of the proposed strategy – including tracking service outcomes through the agency client information system, imbedding knowledge brokers in management teams, and increasing access to clinical expertise – will be evaluated by examining changes in managers' use of research and client outcome data in making decisions about policies and programs in the agency. Baseline knowledge utilization was assessed at the beginning of the project through a series of nine focus groups held with 76 BYFC managers, as well as their individual responses to a knowledge utilization questionnaire. The impact of the EBM project will be evaluated through follow-up focus groups and surveys, as well as through an analysis of the products generated by the project.

Conclusion

The paucity of research on the effectiveness of child welfare interventions can be attributed to a number of factors, ranging from lack of funding, to a weak research tradition in the social services, to the inherent complexity of conducting studies with crises-ridden multi-problem families. Rather than ask why researchers have not focused their attention in this area, it may be more pertinent to ask why service providers and policy makers are not demanding more research. Indeed, from a knowledge mobilization perspective, the engine for developing a stronger evidence base for child welfare rests with research users more than producers.

Knowledge mobilization emphasizes the importance of moving from unidirectional dissemination models to iterative models where researchers, service providers and policy makers work in partnerships; partnerships where service providers and policy makers are actively involved at every stage including the initial formulation of the questions to be studied. While such partnerships are a critical component of an effective knowledge mobilization strategy, they are not the objective of knowledge mobilization. In resource intensive initiatives of this sort there is always a risk that the process – i.e. the research partnerships – becomes confused with the objectives of knowledge mobilization. In viewing knowledge mobilization as an iterative process (i.e. a series of spiraling loops), there is similar risk that one might lose sight of the objectives of these types of initiatives.

The objective of knowledge mobilization is to use research that will assist decision-makers to select the most effective programs and policies. Success of knowledge mobilization strategies in child welfare can be assessed in terms of the extent to which

decision-makers make more use of research, develop quality assurance and outcome

tracking mechanisms, and eventually create a demand for more research on effective

services to help abused and neglected children. Knowledge mobilization in child welfare

requires a radical culture shift whereby decisions are guided first and foremost by

evidence about service effectiveness.

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