CHAPTER TWO

Evidence-Based Management in Child Welfare: Researchers and Decision-Makers Working Hand in Hand

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INTRODUCTION

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 2007). Additional partners include the Centre of Excellence for Child Welfare (CECW), l'Institut de recherché pour le développement social des jeunes, the Association des centres jeunesse du Québec (ACJQ), University of Toronto, University of Calgary, and the Alberta Ministry of Children Services. This chapter describes the EBM model and presents findings from a baseline survey used to examine how BYFCs managers use various forms of evidence to support their work.

The initiative is designed to develop and evaluate a child welfare knowledge mobilization model to support management and service delivery decisions in a child welfare agency. The EBM initiative is

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being deployed at BYFC, Montreal's anglophone child welfare agency, and focuses on the management group that includes approximately 80 managers, ranging from front-line supervisors (managers) to program coordinators and directors. Focusing on a single agency is the best approach 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 was to develop a management culture at BYFC where the question of evidence was at the forefront of all decisions. That is, the project endeavoured to develop a culture of practice in 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. 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 and Sharp 2003).

The specific research mobilization objectives for the project were to:

1. Improve service providers' capacity to access and analyze service and client information data to inform service and policy decisions;

2. Develop systematic mechanisms to integrate clinical expertise in service and policy decisions;

3. Assist service providers in accessing and appraising research findings to inform service and policy decisions;

4. Develop a joint research agenda that addresses high-priority knowledge gaps;

5. Support the development of a national knowledge mobilization network of child welfare service providers, policy makers, and researchers. At the time of writing, objectives 1, 2 and 3 were well underway.

RESEARCH SUMMARY

The EBM Model

The EBM model is designed to fully integrate the research team into the management decision making process at BYFC. Traditionally, the role of researchers in social service agencies takes on two forms: 1) academics with independent programs of research who approach agencies as sources of data or hosts to evaluate a particular intervention, or 2) consultants hired by the agency to address a specific question. While academic research usually includes a dissemination component and, increasingly, includes a consultation process in adapting the research question and design, the research is nevertheless designed to serve academic purposes first and foremost. In the case of consultation research, the research questions are formulated by the agency. In both instances, the researcher retains an external role as an independent expert and is expected to take responsibility for the findings as such.

The EBM model seeks to establish a less formal relationship, whereby the researchers are integrated as members of the agency's management team and bring their expert opinions and technical expertise to the decision making process. An informal relationship allows the researchers to share their expertise without having to formally endorse recommendations as independent experts, thus leaving the weighing of the evidence and the accompanying decisions to the whole team. To illustrate this less formal integrated approach, we use a backyard deck construction analogy by contrasting the immediacy of the informal opinion of an engineer friend who is helping with a weekend project to the cost and time required to obtain a signed engineering report. In this manner, we are developing a model where academic researchers are integrated into the management process and can respond in a timely and less formal way.

Building on existing models, including the National Health School Standard (NHSS) action-research experience (Sharp 2005), the Evidence-Context-Facilitation model (Kitson et al. 1989; Rycroft-Malone et al. 2004), and the work of the Canadian Health Services Research Foundation (CHSRF; Lomas 2003), the EBM initiative is based on the assumption that to develop a strong agency based research culture, knowledge mobilization must be driven by an understanding that: 1) the questions are ones that decision makers are faced with in their day to day activities (i.e., are relevant), 2) responses to these questions must be provided in a timely fashion (weeks or months, not years), 3) these responses answer the question(s) being asked (i.e., are accurate), and 4)

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 "timely, relevant, accurate and local" model is being used to assist Batshaw 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.

Tracking Client and Service Outcome Indicators

Client and service information is tracked at BYFC in a fully computerized client information system that 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. Following a preliminary analysis of the data fields available through PIJ, a number of key child welfare outcome indicators (National Outcomes Matrix: Trocmé, MacLaurin, Fallon et al. 2009) have been identified and are being extracted and analyzed. With the support of a programmer and a data analyst and input from a reference group, this information is being used to develop an agency-level public "status report" which, in turn, will become a key management tool in setting measurable targets for agency-wide and team-specific service improvements. Since the outcome indicators are being developed using the provincial client information system and in collaboration with other provinces using the National Outcomes Matrix (Trocmé, MacLaurin and Fallon 2000), the BYFC status reports will eventually allow for comparisons with child welfare agencies across Québec and the rest of Canada.

Systematic Use of Clinical Expertise

Clinical expertise is often 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. The primary strategy being developed to capture this expertise is an iterative series

of consultations and surveys—named "Clinical Voices"—designed to identify emerging clinical trends and issues. During the first stage, a group of clinicians is identified through senior management; involving senior management from the outset is designed to ensure that the results of the consultations are integrated into the agency's strategic planning. Consultation meetings are then held with the selected clinicians, at which time emerging clinical issues are identified, and the research team helps them develop methods for further exploring and documenting these issues. Tools for gathering data could include tracking information using short data collection instruments as well as secondary analysis of administrative data or file surveys. The data collection portion of the strategy is designed to be time limited and specific to the issues being documented. Once collated by the research team, results are discussed with the clinicians and fed back to senior management for further consideration. A second method for capturing clinical expertise is being developed through Clinical Integration Groups (CIGs), as described further in this chapter.

Knowledge Brokers

In addition to assisting BYFC to make better use of the information it generates (i.e. administrative data and clinical expertise), knowledge broker teams have been deployed to assist BYFC in accessing and interpreting relevant research literature and identifying emerging practice models. Knowledge broker teams include a content expert, typically an academic, and a graduate research assistant. The knowledge broker team is assigned to committees or working groups developing or reviewing agency policies or practices. They assist in 1) formulating policy and practice questions, 2) accessing and interpreting relevant client service statistics from the administrative data system, 3) accessing and interpreting relevant published and unpublished research, and 4) where appropriate, linking decision makers to experts who can provide more specialized consultation through EBM partners such as the Centre of Excellence for Child Welfare's researcher network or the Association des Centres jeunesse du Québec.

The brokering model provides an interactive approach that tailors research and best practice reviews to the needs and timeframe of the users (Clark and Kelly 2005). The format of the briefings includes a short summary of the relevant material, an appraisal of the state of knowledge (including major methodological limitations), and copies of the most relevant studies and/or program descriptions. The format is

similar to what the CHSRF refers to as a research summary, as opposed to a synthesis or a systematic review (for more details, see http://www.chsrf.ca/keys/glossary_e.php).

Baseline Evaluation of the EBM Model

The effectiveness of the proposed strategy – including tracking service outcomes through the agency client information system, making more systematic use of clinical expertise, and embedding knowledge brokers in management teams – is being evaluated by examining changes in the managers' use of research and client outcome data in making decisions about policies and programs in the agency. To help guide the project and provide a baseline measure of information needs and use, we surveyed and held focus groups with managers from across the agency. The key findings from these surveys and focus groups are summarized in this chapter.

Baseline Survey Methodology

Focus groups were held in June of 2007 with 76 managers assigned to 9 groups on the basis of their roles and responsibilities in the agency. These included 2 senior management groups (Directors & Coordinators); 2 groups of intake and family service managers; 3 groups of residential and group home managers; and 2 groups of a range of managers, including reviewers, foster care, adoption, human resources, and professional services. At the beginning of each group, participants were asked to complete a four-page questionnaire that included questions about their professional experience and educational background as well as questions about their use of agency statistics, clinical expertise, and published research.

Results

BYFC managers are a highly experienced group of professionals with an average of almost 23 years of child welfare experience. Ninety-five percent have a university degree, including an MSW (41%), other MA/Sc (22%), and BSW (22%). For the purposes of this chapter, responses to the questionnaires are presented in terms of five managerial subgroups: Directors and Coordinators (D&C), Front-line Intake and Family Service Managers (Evaluation/Orientation & Application des Mesures: EO&AM), Residential Service Managers (Residential), Case Reviewers (Reviewers), and all other managers (Other).

Use of agency statistics

Use of agency statistics, primarily through PIJ, varied significantly by managerial position and function. Whereas over 90% of front-line managers and reviewers primarily used information systems to track individual clients, directors and coordinators were more likely to use information to track agency trends over time. Nearly two-thirds (63%) of EO&AM managers reported using statistics to compare staff performance within their team, but only 38% reported making comparisons between teams or with other agencies, compared to 61% for directors and coordinators. Residential managers reported the most difficulty in accessing PIJ and also made the least use of agency statistics, with only 58% using information systems to track client data and none reporting using data for comparative analyses. Other than the access difficulties noted by residential managers, there were few significant differences in responses to questions about ease of access, relevance of statistics, and expectations with respect to use of statistics by managers. The EO&AM managers, followed by the directors and coordinators, reported the greatest satisfaction although, overall, even these two groups only reported moderate satisfaction, with averages ranging from 3.5 to 4.5 on a scale of 1 to 7. One noteworthy difference was that directors and coordinators reported having access to more help in interpreting agency statistics, although during the focus group interviews they noted that the available support was not sufficient to meet their needs.

Clinical expertise

On average, respondents reported making greater use of clinical expertise than other types of evidence, with responses averaging 4.5 on a scale of 1 to 7 with respect to inclusion of clinical expertise in decision-making, value given to clinical expertise, and inclusion in program planning and policy development. This positive inclusion of expertise was echoed in the focus group discussions, although many participants noted that consultation was selective and that they did not feel it was easy to bring emerging issues to the agency's agenda.

Use of published research

Responses to questions about accessing research were fairly uniform across all groups. On a scale of 1 to 7, the average response was 3.7 with respect to ability to keep informed and ease of access to research. Directors and coordinators, as well as EO&AM managers, reported hearing reference to research and the importance of research evidence more often than other groups. The three most often cited barriers to

accessing research were lack of time (90%), difficulty locating studies (50%), and unclear implications for practice (34%). Most BYFC managers accessed research via the internet (71%), through the BYFC Library (69%), and at conferences (66%). The BYFC library was also cited by many during the focus groups discussions as a key resource. Interestingly, there appears to be very limited access to research through other libraries, with only 13% of respondents identifying other libraries as a source of information.

Overall, we were struck by the thirst for better access to relevant research and interpretable agency statistics. Lack of time, complexity of information, difficulties accessing pertinent information in a timely fashion, and limited communication and sharing of expertise between departments and programs, were repeatedly cited as barriers. The objectives of the EBM project appeared to resonate strongly with managers, although there was little sense that managers were routinely expected to include agency statistics or research evidence in their activities. The baseline consultation confirmed, in particular, the importance of implementing within the agency a knowledge mobilization model that is "timely, relevant, accurate and local" as reflected in the EBM initiatives, including knowledge brokers, to facilitate access to research and agency statistics, support clinical consultation groups, and develop annual client and service outcome indicators.

PARTNERSHIP: VIEW OF THE AUTHORS-RESEARCHERS

Nature of the Partnership

From the outset, the EBM initiative has developed out of a partnership model. The impetus for the project came from BYFC. The agency approached McGill for help in developing their capacity to ensure that their work was informed by the best available evidence. The researchers, in turn, were looking for an opportunity to develop and test a knowledge mobilization model at an agency level.

All activities have been jointly planned and have involved staff from BYFC and McGill. The Principal Investigator, the BYFC Director of Professional Services, and the EBM Manager meet monthly to coordinate and evaluate all activities. Similar collaboration characterizes every aspect of the project from developing the knowledge brokerage model to analyzing data. In addition to the close partnership between the research

team and senior management, agency staff members are involved in a number of different reference groups, giving feedback on the various knowledge mobilization tools being developed. For instance, a group of eight to ten staff representing the key service delivery programs at BYFC are consulted regularly as outcome indicators are developed, both with respect to options for operational definitions and issues related to interpretation.

The SSHRC's Knowledge Impact in Society (KIS) granting program, which funds the EBM initiative, required significant financial contributions from SSHRC (50%), McGill (30%) and the community partners (BYFC + ACJQ = 20%). This stipulation required a more extensive level of engagement on the part of the university and community partners than is typical and served as an important institutional test of their commitments. In the case of BYFC, for example, written approval from the Board of Directors was required. It is important to note as well that the level of funding for this project is unusually high (approximately $200,000 / year over three years). This has meant, in particular, that the project has been able to provide staffing funds directly to the agency. Without such an investment, it would not be possible to sufficiently protect staff time to allow for the intensity of involvement required by such an active partnership. It has also meant that we have been able to provide academics who become involved as content experts (e.g. knowledge brokers) with research assistants who perform the literature searches, organize and summarize the materials, and keep minutes and arrange all meetings This ensures that the content expert's time is used as efficiently as possible. For the students who act as research assistants, this is an opportunity for focused applied research training.

Beyond the KIS funds, the partnership also benefits from infrastructure support from the BYFC, CRCF and the McGill School of Social Work. This will be particularly important, since the project must be self-sustained after the first three years of funding. The benefits of Evidence-Based Management will need to be sufficiently tangible for BYFC to absorb some of the data-extraction and analysis costs currently covered by the EBM grant. The Knowledge Broker model will need to be well-enough developed to be transferable to a format that can be integrated into Theses and Independent Studies Papers for McGill Master's students and their supervisors. With its endowed infrastructure, the CRCF is in a good position to provide the support needed to integrate the academic needs of McGill students with BYFC's information needs. As we approach the half-way point for the EBM project, sustainability is rapidly becoming a

key objective. Each component of the project will need to be adapted to ensure that it is sustainable by partner organizations.

Challenges

Supporting the use of research has proven to be more complicated than we had originally thought. BYFC has a well-established library infrastructure staffed by a part-time librarian. Feedback from staff was universally very positive about the library and the librarian's ability to respond to requests for information. Expanding on this resource, however, we ran into a number of unexpected obstacles. Although BYFC is the primary field placement agency for McGill social work students, we were surprised to discover that BYFC supervisors have not been given access to the McGill library. Negotiating access to a McGill library card for the librarian took close to three months. Navigating our way through the BYFC internet firewalls took another three months.

We then organized a journal club to assist staff interested in learning how to read journal articles more efficiently. The journal club was perceived by participants to be stimulating, and successful in teaching them more efficient and effective research reading techniques. However, because the group was researcher-facilitated, discussion focused far more on theory and methodology and less on practice and policy implications. To address this limitation, we have developed an alterative approach – attaching journal readings to practitioner groups organized around specific clinical issues. These "Clinical Integration Groups" are forums for discussing emerging clinical issues around a focal topic (e.g. sexual abuse) that includes both summaries from a systematic scan of leading research journals and clinical examples from BYFC. Each CIG is supported by a knowledge broker team, including an academic content expert and a graduate student research assistant.

We also discussed providing material to one of the standing committees with whom the research team has been working. However, it rapidly became evident that the committee members felt so overwhelmed by stacks of unread "interesting readings" on their desks that it was not realistic to start by adding even more material. We have offered instead to have research assistants summarize and organize their existing stacks of material, and then dedicate a meeting to reviewing the results of this exercise.

Delays and difficulties with respect to accessing administrative data through PIJ are typical of such projects: it takes longer than expected to extract data and, once extracted, the data often need more cleaning

than was anticipated; and missing data, common especially in historical files, is always a challenge. As expected, we also found at times that EBM data requests had to take a second place to more urgent agency data needs, ranging from ministry information requests to server problems, to the frequent introduction of new software modules. To free up the BYFC client information systems manager's time, the project ended up funding an extra position in his department.

Although these types of delays are to be expected in any agency-based project with frequent data requests, we also found that, at a conceptual level, developing indicators that were perceived to be understandable and useful for managers was more complicated than anticipated. For instance, we spent a whole year developing a method for tracking the number of placement moves experienced by children living in out-of-home care. Originally the research group had proposed a measure based on exit cohorts, the method used most often in the literature. This method measures moves in care by the average number of moves for children and youth leaving care in any specified year. In presenting preliminary findings to BYFC staff, however, a number of concerns arose about the utility of this indicator as a management tool, since the retrospective exit cohorts include children who had been in care for 10 or more years. Managers felt that, as a result, the data reflected practices that were not current enough to be useful to them. We then explored a number of alternative strategies over different timeframes and finally agreed to use three-year prospective cohorts, tracking moves in care within three years of a placement. A three year timeframe provided the right balance between the need to focus on relatively current practice and tracking placement moves over a long enough period of time to be meaningful from the child's perspective.

Overall, the challenges have been of the type one would anticipate from a partnership between organizations with different cultures and with access to different types of resources. These examples emphasize the critical importance of close collaboration and provision of enough resources to allow for experimentation with a range of different approaches in a limited enough timeframe to allow for meaningful feedback about the utility of the proposed approaches.

Benefits

The long-term benefits of the relatively intense EBM partnership model described in this chapter will be best evaluated upon completion of the project. We anticipate that the agency's use of information—administr

ative data, clinical expertise and existing research—will have increased, and that a sustainable research mobilization partnership will have been established between McGill and BYFC. We also anticipate that the agency's capacity to engage in and support research will have expanded, allowing the research team to engage more efficiently in research projects at the agency. Finally, we hope that the knowledge mobilization partnership will give McGill social work students opportunities to develop their research papers in an applied context where their work can have an impact beyond a strictly academic setting.

The short-term benefits of the partnership have been highlighted in several of the examples provided earlier in this chapter. Working in close partnership has meant that initiatives can be evaluated to ensure that they are meeting objectives. When redefining outcome indicators or adjusting the journal club format, both timely feedback from end-users and joint planning with senior managers are proving to be invaluable in implementing the EBM model at BYFC.

Conclusion

The EBM project is designed to adapt knowledge mobilization strategies developed in health care settings to the social service sector where there is a limited tradition of using research to guide practice. As with many social service agencies, BYFC does not have a research infrastructure. Although the agency provides training for a significant number of McGill social work interns, it does not have access to the types of resources nor partnerships that one typically finds in teaching hospitals. Recognizing the need to develop such structures in social service agencies, the Government of Québec has funded several agency-based research institutes, two of which are located in large francophone child welfare agencies. Although the agency based institutes have many benefits, the cost of developing such infrastructures is prohibitive for smaller agencies. In addition, there is always a risk that the research agendas of the institutes may not support the management needs of the agencies.

The EBM project is designed to develop a model for a sustainable research mobilization partnership between McGill and BYFC without necessarily having to develop a separate research infrastructure within the agency. The key measure of success for this initiative will be the extent to which the question of evidence is consistently posed and re-posed, at all levels of BYFC. If the project proves to be successful, it could provide a useful model for other social service agencies seeking

to gain better access to research and to academic institutions seeking to increase the impact of their work.

PARTNERSHIP:
A MANAGER'S POINT OF VIEW

Claude Laurendeau

If one were to ask managers in Batshaw whether it is a good idea to increase our capacity to integrate evidence into decision making processes, the answer would likely be a resounding, maybe even a unanimous but not an unconditional, "Yes!"

Managers would need to be confident that evidence is reliable, readily accessible, meaningful, and useful. They would need to sense a strong agency commitment and witness the allocation of the necessary resources. They would have to be willing and ready to alter the way work is organized, revise the allocation of tasks, and deal with potential disruptions. They would need to know that they can still manage the day-to-day pressures of service delivery.

Early on in the project, it became apparent that EBM would require a change in our culture—our way of doing things and our way of thinking about the complexities of child welfare issues. This would not happen overnight; it would require time and energy and an approach that is multi-pronged, interactive, and strength-based.

The multi-pronged aspect of EBM is the various spheres of activities (as previously described). The interactive component seeks the participation in these activities of managers and front-line staff knowledgeable about field issues as well as administrative and clinical processes. The strength-based approach challenges us to find potential leaders who will happily struggle to make the links between evidence and clinical interventions and programming. In an agency of over 1000 staff (700 of whom are "clinical"), such leaders most certainly exist but, often, they work in isolation.

The Clinical Integration Groups are a good illustration of the strength-based aspect of EBM. They build on clinicians' initiatives, passion for and interest in a clinical issue that they already care about (e.g. sexual abuse). Their thirst for knowledge, commitment and deep desire to seek and apply best practices are enhanced by the input of researchers and Knowledge Brokers. They benefit from management support and recognition that Clinical Integration Groups constitute a legitimate,

integral part of their work—not an activity they "do on the side" on their own time and only when waiting lists are down! Their work is further validated as they contribute to training, service, and program development.

The Knowledge Brokers are gradually infiltrating the organization; they have taken us a step further from the already much appreciated library services. The research summaries they provide serve to heighten managers' confidence in the quality of research findings they consider and, subsequently, in the decisions they make. For example, following our Accreditation process, my service took on a mandate to develop a system for surveying client satisfaction. The research summary helped establish a baseline for this work and identify both potential pitfalls and useful strategies. Knowledge Brokers respond to an individual manager's request on a given topic for the formulation of clinical policies or the development of a service. They can also act as integral members of committees, help formulate research questions, and retrieve useful information for the committee's consideration. This is the case, for example, in our agency's standing committee overseeing Permanency Planning. A year ago, the very concept of Knowledge Brokers was a foreign one; now, they are quickly becoming the subject of popular demand!

The Reference Group on Indicators brings to the table managers from all levels, front line staff, information systems experts, and researchers. As they interact, they struggle to develop indicators that are clinically and scientifically sound. Together, they decide on operational definitions; for example, for the indicator on recurrence we asked, "Will we measure every new report of abuse or a substantiated report? Do we measure reports coming in while services are provided or after and if so, how long after closure of the case?" Arguments could be made in support of one choice or another but, once the group settles on one definition, the need to go deeper and make each indicator "speak" some more emerges as do questions related to the implications for service delivery. The potential for generating research questions, for giving us a common starting point, and for questioning our practices has become increasingly evident.

Finally, the "Clinical Voice" project challenges our creativity and commitment to drawing out evidence from our own clinical expertise. In this new adventure, clinicians who review up to 1800 cases a year draw upon their "impressionistic" data and areas of preoccupation (i.e. permanency planning and family involvement) with respect to the needs of our clientele and our services. These "impressions" are transformed

by researchers into specific means of documenting what they see and subsequently the aggregation of this data is expected to point to areas of service delivery requiring attention. At the onset of this project, clinicians greeted the researchers with a "Where have you been all our life?"

With increasing clarity, I can see the day when the material generated through our indicators linked to PIJ (our client information system), the work of the Knowledge Brokers, the Clinical Integration Groups and "Clinical Voices" as well as other areas of activity likely to emerge as our project evolves will strengthen our ability to incorporate evidence into decision making. The potential for EBM to promote continuous quality improvement to our service delivery with respect to permanency planning, sexual abuse, and domestic violence, to name but a few of the challenges we in the field of child welfare face on a day-to-day basis, is endless. An EBM project that is multi-pronged, builds on strengths, and creates opportunities for researchers and service providers to interact may well meet the conditions put forth by managers and develop a culture where evidence becomes an integral part of service delivery.

ENDNOTES

i. A description of the project and results of the follow-up survey and evaluation are available at http://www.mcgill.ca/crcf/projects/outcomes/ebm/

ii. Launched in 2002, the focus has been on deployment of the original system and adapting upgraded modules.

iii. To date only one clinical voice project has been launched, it brings together the group of mandated case reviewers who are clinical managers at BYFCs.

iv. An 88% participation rate. All managers were invited, but 10 of 86 were unable to attend.

v. Even then, the project funds cover only a portion of agency staff activity.

vi. Academics are not compensated above their university salaries. While the principal investigators and co-investigators receive credit for their roles, it can be more difficult when asking for help from a content expert who was not initially part of a proposal, especially in a community partnership project where the expert must then participate in a series of on-site meetings. To date, we have approached two colleagues for such assistance and have tried to maximize efficient use of their time by providing as much research assistant support as possible.

vii. In contrast, a one-year follow-up timeframe while having the advantage of being even more current was not considered to represent a long enough period to judge the stability of a placement.

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