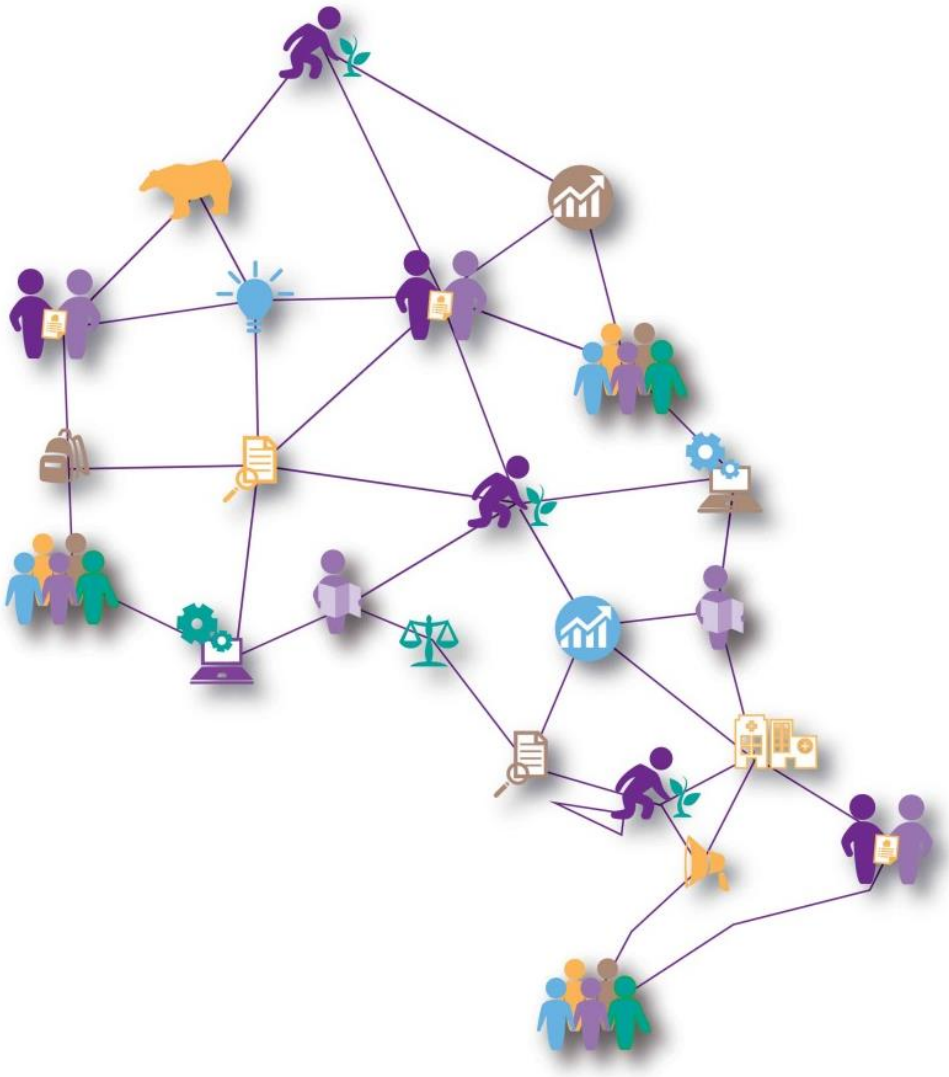
Implementing strength-based case management: The value of fidelity monitoring

December 8, 2021
1-2 PM

camh



CAMH Land Acknowledgement

CAMH is situated on lands that have been occupied by First Nations for millennia; lands rich in civilizations with knowledge of medicine, architecture, technology, and extensive trade routes throughout the Americas. In 1860, the site of CAMH appeared in the Colonial Records Office of the British Crown as the council grounds of the Mississaugas of the New Credit, as they were known at the time.

Today, Toronto is covered by the Toronto Purchase, Treaty No. 13 of 1805 with the Mississaugas of the Credit.

Toronto is now home to a vast diversity of First Nations, Inuit and Métis who enrich this city.

CAMH is committed to reconciliation. We will honour the land through programs and places that reflect and respect its heritage. We will embrace the healing traditions of the Ancestors, and weave them into our caring practices. We will create new relationships and partnerships with First Nations, Inuit and Métis and share the land and protect it for future generations.

Reference: https://www.camh.ca/en/driving-change/building-the-mental-health-facility-of-the-future

Language

We are committed to placing diversity, equity and inclusion at the centre of our work. We recognize that the words we use to discuss health, identities and populations can have a powerful impact. We strive to use language that is respectful, inclusive and free of bias. Language is constantly evolving. As societal values change over time, so does the language that is considered acceptable. Nuances can be challenging to understand and navigate (CPHA, 2019). Please feel free to share any recommendations for more appropriate terms or words.

Reference: (CPHA, 2019). https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/language-tool-e.pdf

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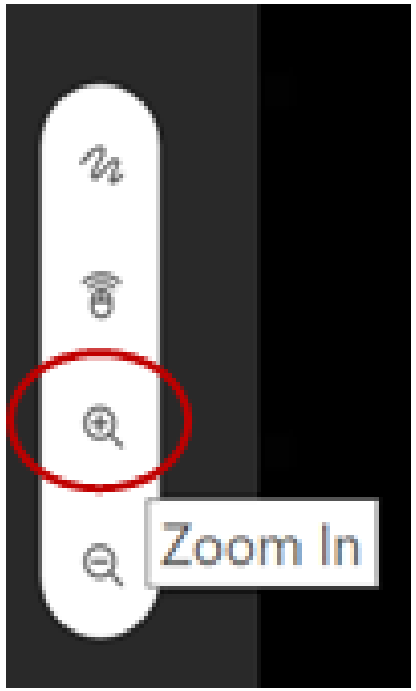
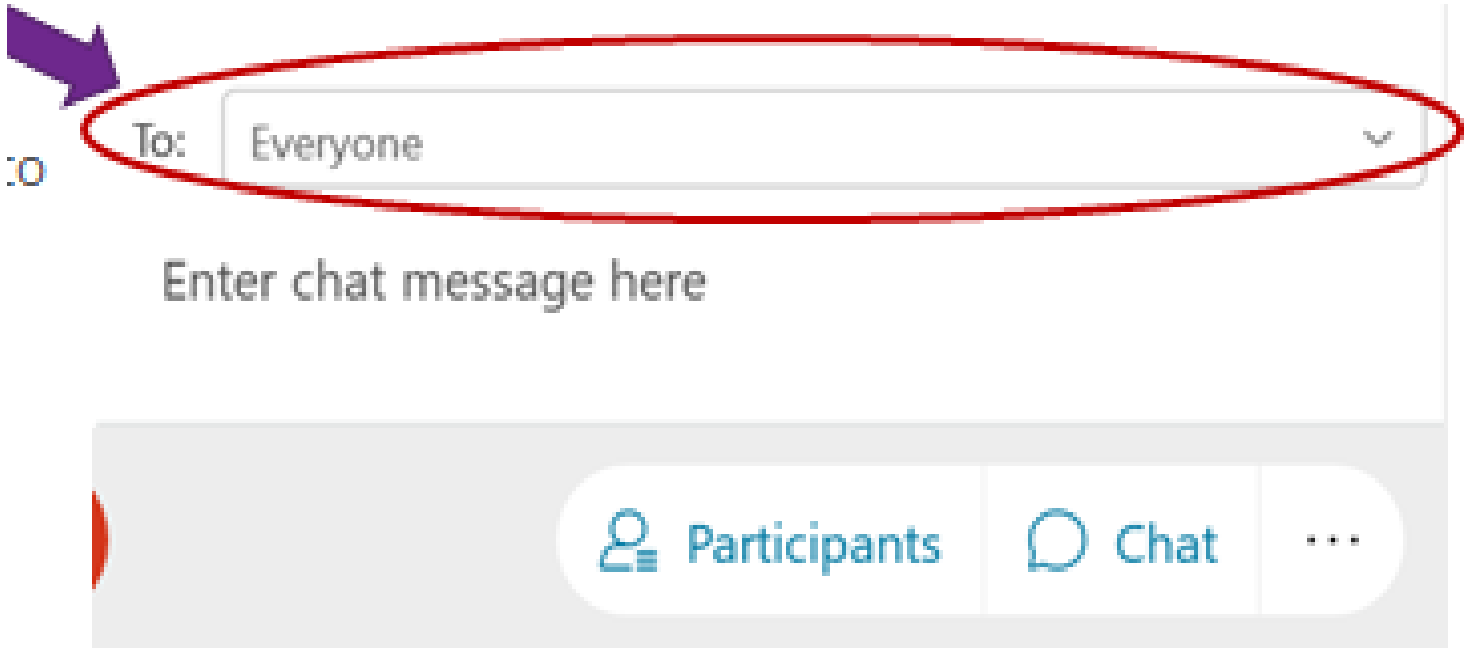
Use the magnifying glass to zoon in on the slides.





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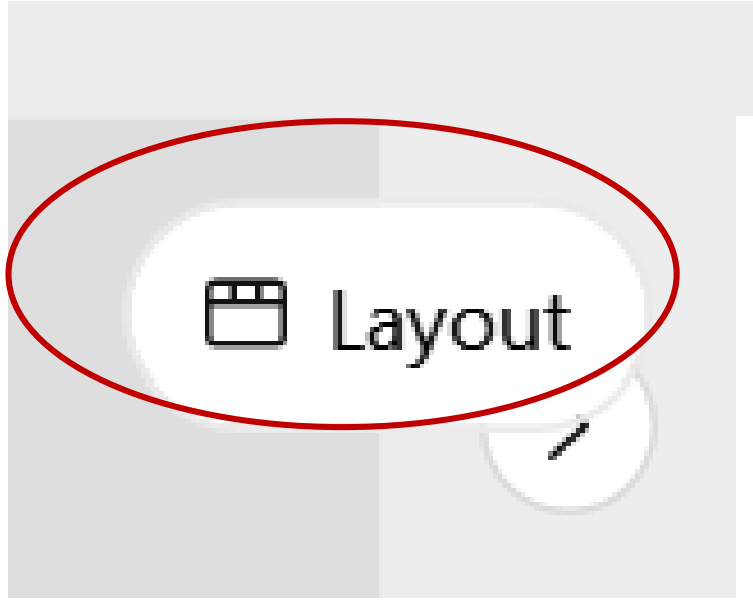

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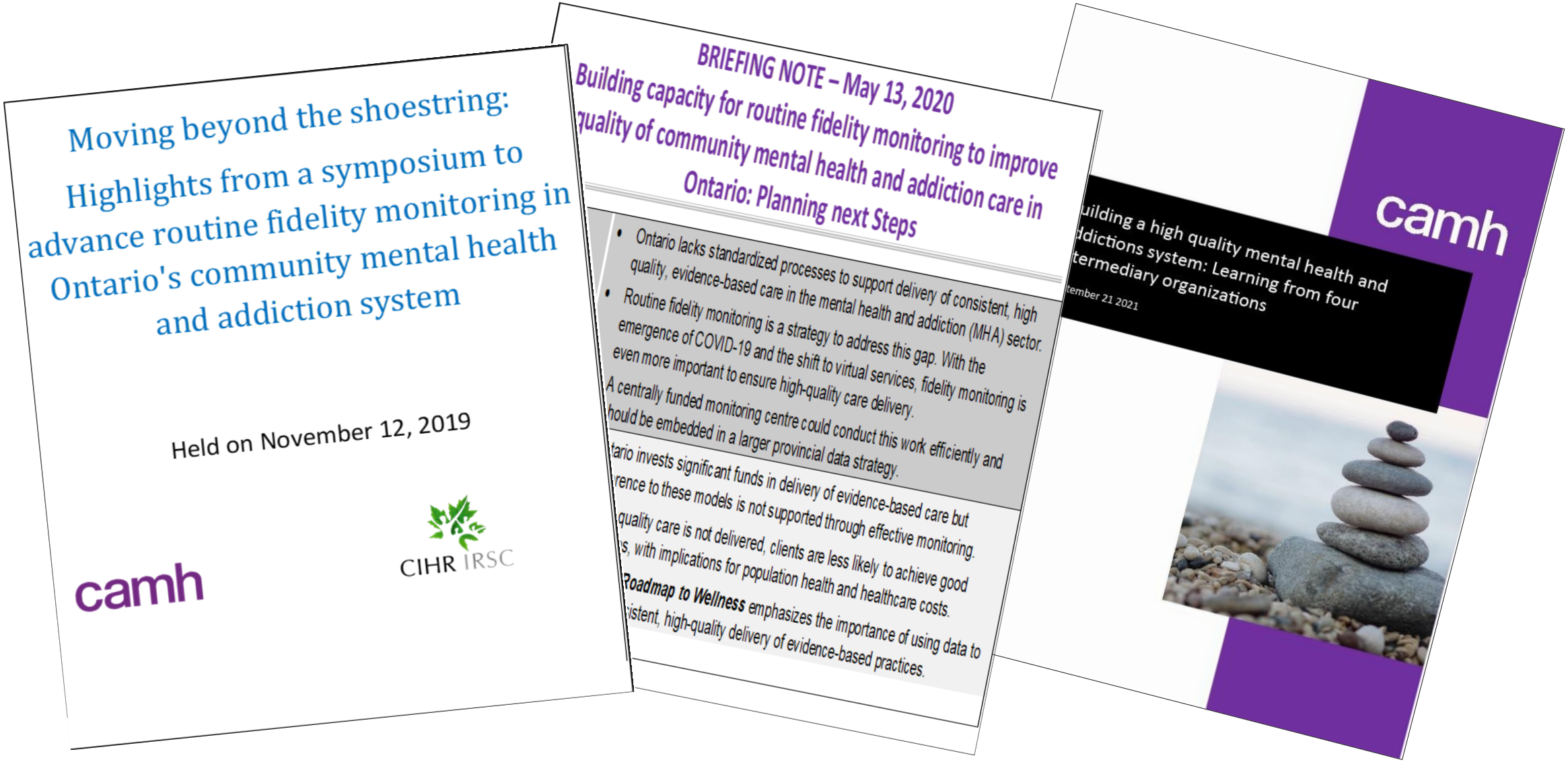
CAMH Provincial System Support Program (PSSP)

PSSP at CAMH works with communities, service providers and other partners across Ontario to move evidence to action to create sustainable, system-level change.

- PSSP provides capacity and expertise in a number of areas, including implementation, knowledge exchange, evaluation and data management.
- Join our community collaborative space on https://www.eenetconnect.ca/

Visit us at eenet.ca

Fidelity Monitoring in Ontario Community of Interest



Fidelity webinar series

1. Implementing strength-based case management: The value of fidelity monitoring (December 8, 2021)
2. The role of fidelity in assertive community treatment: Better fidelity means better outcomes (January 19, 2022)
3. Fidelity as part of a learning health care system: Lessons learned in Early Psychosis Intervention (February 2022)
4. Fidelity as part of a learning health care system: International and local perspective (March 2022)

Implementing strength-based case management: The value of fidelity monitoring

Presenters

Dr. Tim Aubry, Centre for Research on Educational and Community Services, University of Ottawa.

Dr. Eric Latimer, Douglas Mental Health University Institute and Department of Psychiatry, McGill University.

Dr. Donna Pettey, Canadian Mental Health Association Ottawa branch.

Dr. Maryann Roebuck, Canadian Mental Health Association Ottawa branch and Centre for Research on Educational and Community Services, University of Ottawa.

Evaluating the Strengths Model of Case Management for People with Severe Mental Illness: A Multi-Provincial Study

Eric Latimer, Principal Investigator
Douglas Research Centre
Department of Psychiatry, McGill University

Co-Investigators:
Tim Aubry, Christiane Bergeron-Leclerc, Catherine Briand, Catherine Vallée, Janet Durbin, Terry Krupa, Nancy Mayo, Alissa Setliff, Robert Whitley

Knowledge user:
Beverley Barrett

Consultants:
Rick Goscha, Ally Mabry, Matthew Bomhoff

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Funded by the Canadian Institutes of Health Research

2014-2018

Acknowledgments

- Christian Méthot and many other project staff
- Many program supervisors and managers who collaborated with the study at each of the sites – notably in Ottawa!
- Hundreds of clients who agreed to participate

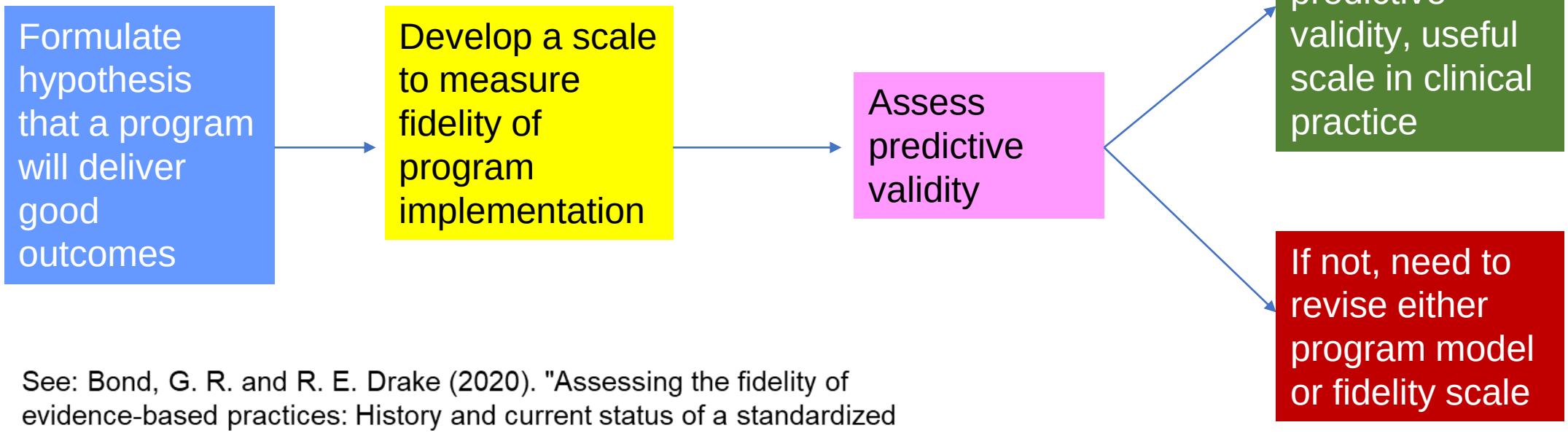
Introduction

- ACT model well defined
- But much variation in how ICM is implemented
- Among specific models of case management, SMCM is most promising
- Can we find additional evidence of its effectiveness in Canadian settings?

Initial Strategy

- Implement SMCM at several sites
- Measure degree to which programs reach SMCM standards, i.e., program fidelity
- Test for association between fidelity and outcomes

The Concept of Program Fidelity



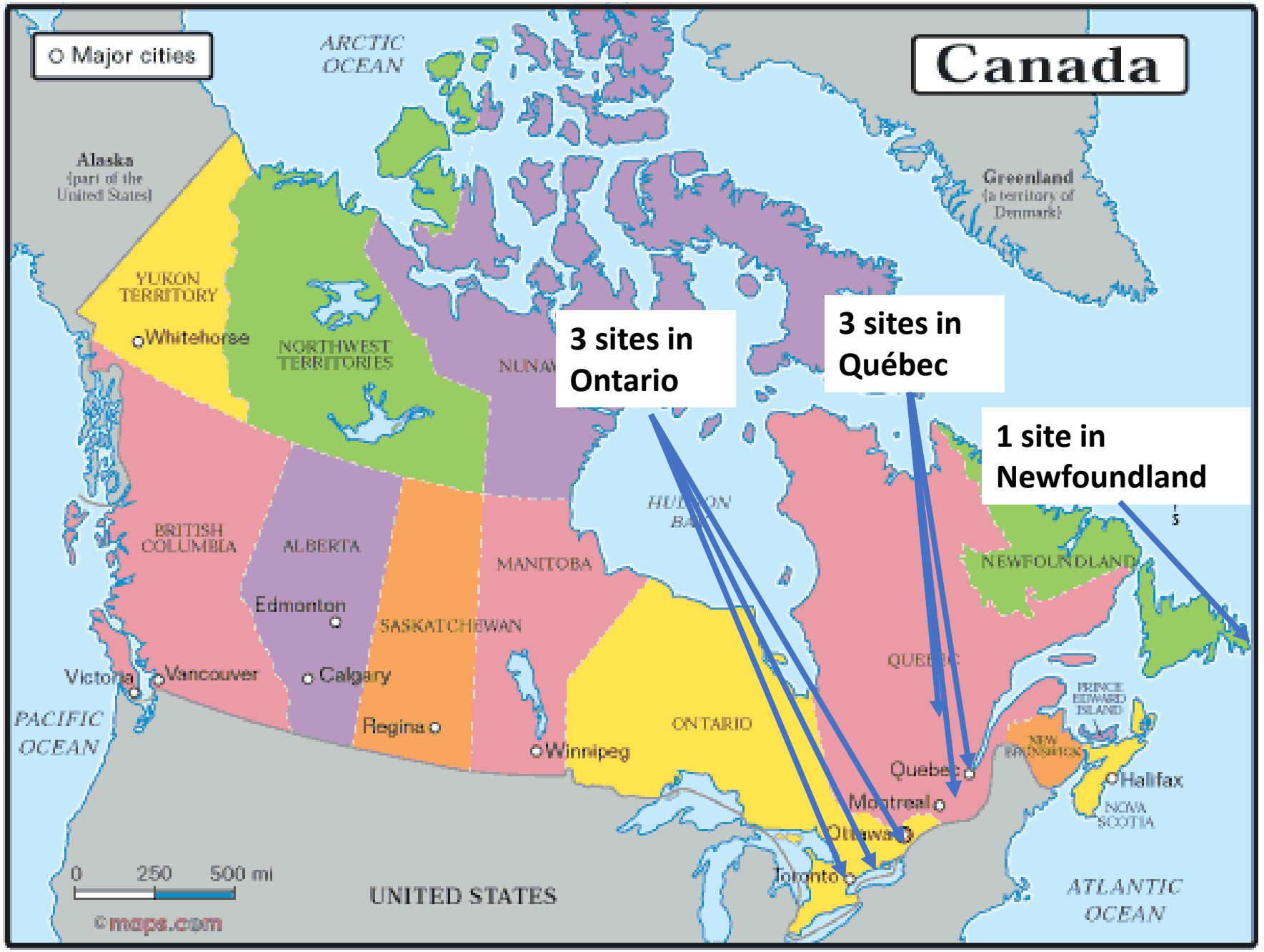
See: Bond, G. R. and R. E. Drake (2020). "Assessing the fidelity of evidence-based practices: History and current status of a standardized measurement methodology. ." Administration and Policy in Mental Health and Mental Health Services Research **47**: 874-884.

Example of fidelity assess-ment for SMCM

Fidelity Item	Baseline
Structure	**3.5**
1. Caseload size	5.0
2. Community contact	2.0
Supervision	**4.4**
3. Group Supervision	4.3
4. Supervisor	4.5
Clinical/Service	**2.8**
5. Strengths Assessment – quality	3.7
6. Strengths Assessment - Integration	2.0
7. Personal Recovery Plan	2.6
8. Naturally occurring resources	2.5
9. Hope inducing practice	3.0
Total Score	**29.6 (3.6 avg)**

Note: Many items have sub-dimensions, e.g., 9 for item 3

7 study sites



Objectives

- Test hypotheses that higher model fidelity is associated with:
  - 1) Increased quality of life, and also secondarily: higher hope functioning, and community participation;
  - 2) Lower costs
- 3) Evaluate facilitators, barriers, and strategies to overcome barriers, to successful implementation

Methods (objectives 1 & 2)

- Assess fidelity at baseline and 6, 12, 18, 24 and 36 months later
- Recruit new program clients and assess them at baseline, 4.5 months, 9 months, 13.5 months and 18 months

Measures and assess-ment points

DOMAIN	INSTRUMENT(S)	Baseline	4.5 mo	9 mo	13.5 mo	18 mo
Demographics	Custom	√				
Community Functioning	Multnomah Com-munity Ability Scale (MCAS)	√		√		√
Hope	Trait Hope Scale	√		√		√
Community participation	Temple U Comm. Part. Measure	√		√		√
Quality of life	Lehman QOLI-20; Patient Generated Index (PGI)	√		√		√
Resource use	Custom	√	√	√	√	√
Income	Custom	√	√	√	√	√
Relationships between CMs and clients	Recovery-promoting relationships scale		√		√	

Needed to ignore item 6

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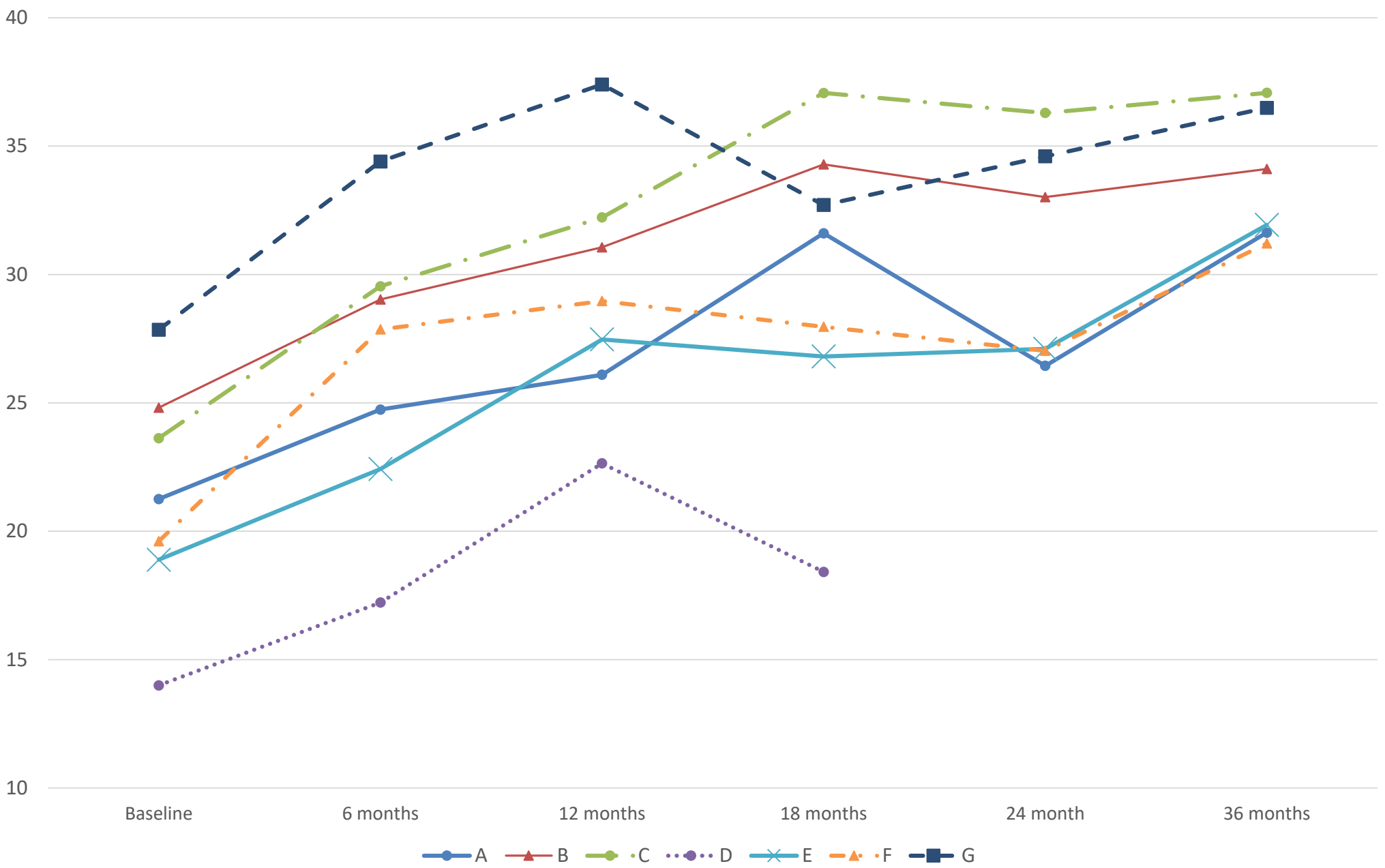
Results

Fidelity assess-ments



Sample size by site

Site	BS	4.5M	9M	13.5M	18M
Saguenay	20	19	18	16	12
Granby	34	31	29	26	24
Kingston	27	27	25	23	24
Ottawa	93	75	70	67	60
Quebec	46	39	38	35	32
St-John's	40	34	33	31	30
Toronto	51	49	48	48	48
Total	311	274	261	246	230

Demo-graphics

	Saguenay N = 20		Granby N = 34		Kingston N = 27		Ottawa N = 93		Quebec N = 46		St-John's N = 40		Toronto N = 51		Total N = 311	
	mean	SD	mean	SD	mean	SD	mean	SD	mean	SD	mean	SD	mean	SD	mean	SD
Age, mean (SD)	39.25	11.67	42.41	12.11	36.04	14.19	37.91	13.93	44.28	12.59	39.53	12.28	43.08	12.32	40.32	13.13
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	N	%
Male[g]	11	57.89	13	38.24	11	44	49	54.44	22	47.83	21	52.5	28	56	155	50.99
Born in Canada	20	100	33	100	26	100	78	97.5	44	97.78	39	97.5	40	90.91	280	97.22
Education																
Less than HS	6	30	14	41.18	5	18.52	51	54.84	11	23.91	8	20	10	19.61	105	33.76
Completed HS	4	20	5	14.71	5	18.52	16	17.2	6	13.04	10	25	9	17.65	55	17.68
Cegep/Trade school	5	25	9	26.47	13	48.15	11	11.83	17	36.96	12	30	20	39.22	87	27.97
University	5	25	6	17.65	4	14.81	15	16.13	12	26.09	10	25	12	23.53	64	20.58
In a relationship[a]	0	0	9	26.47	4	15.38	14	15.38	2	4.35	3	7.5	5	9.8	37	12.01
Ever continuously employed min[b] year	14	70	32	96.97	22	81.48	57	61.96	39	84.78	31	77.5	43	86	238	77.27
Current employment status																
Unemployed	8	44.44	24	70.59	13	59.09	64	70.33	34	73.91	26	68.42	43	84.31	212	70.67
Employed	1	5.56	8	23.53	4	18.18	7	7.69	4	8.7	5	13.16	5	9.8	34	11.33
Other[c]	9	50	0	0	5	22.73	8	8.79	7	15.22	5	13.16	2	3.92	36	12
Disabiliy[g]	0	0	2	5.88	0	0	12	13.19	1	2.17	2	5.26	1	1.96	18	6
Hospitalized for a mental illness[d]	1	5	1	2.94	1	3.7	19	20.43	3	6.52	2	5.13	1	2	28	9.06
Substance abuse treament[e]	3	15	6	17.65	7	25.93	48	52.17	16	34.78	9	22.5	12	23.53	101	32.58
Justice involvement[f]	3	15	2	5.88	3	11.11	14	15.05	4	8.7	2	5	3	5.88	31	9.97

[a] In a relationship includes married and civil unions;
b Ever continuously employed for 1 year;
c Other includes student, housewife, volunteer, retired d Hospitalized for at least 6 months during the past 5 years;
d Hospitalized for at least 6 months during the past 5 years;
e Substance abuse treament includes any treatment, counseling or harm reduction services for drugs or alcohol;
f Criminal justice involvement includes arrests for criminal activity, being imprisoned or serving probation or any community sanctions.

Testing hypotheses concerning QOL and other measures

- We do not find a direct association between fidelity and any outcome

Conclusions

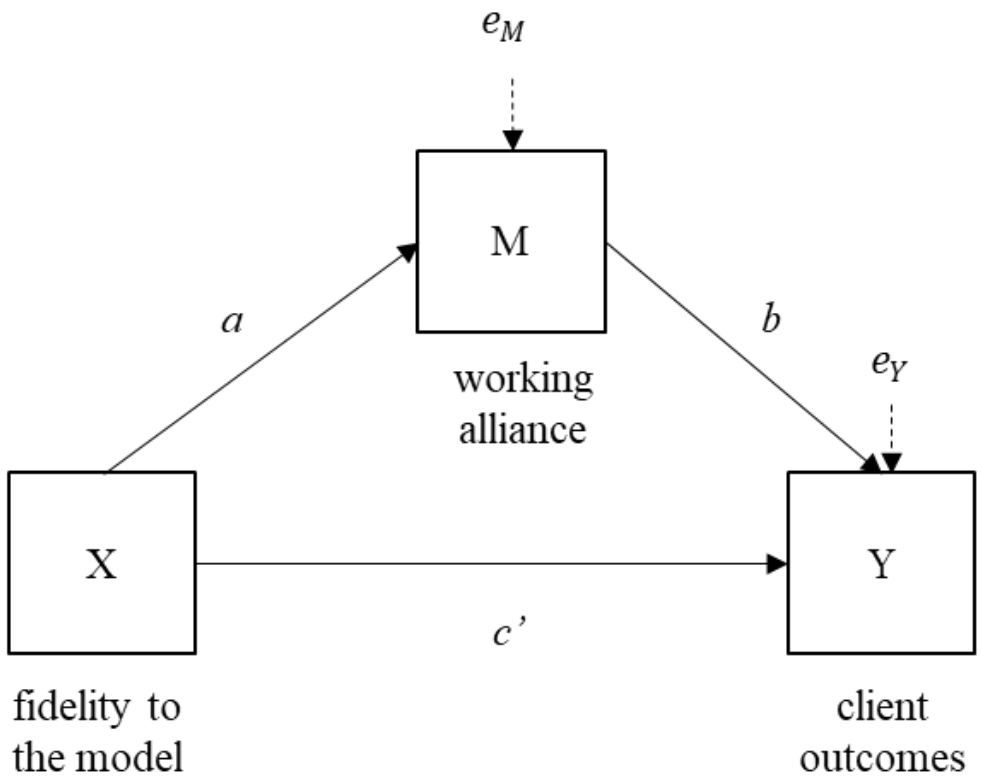
- The results do not provide support for our first set of hypotheses
- A more definite conclusion might have been achieved with a larger sample size
- Implementation study under review; narrative interviews and economic data still being analyzed

The Working Alliance as a Mediator Between Fidelity to the Strengths Model of Case Management and Client Outcomes

Dr. Maryann Roebuck

uOttawa CRSEC CRECS Canadian Mental Health Association *Mental health for all*

Simple Mediation Model



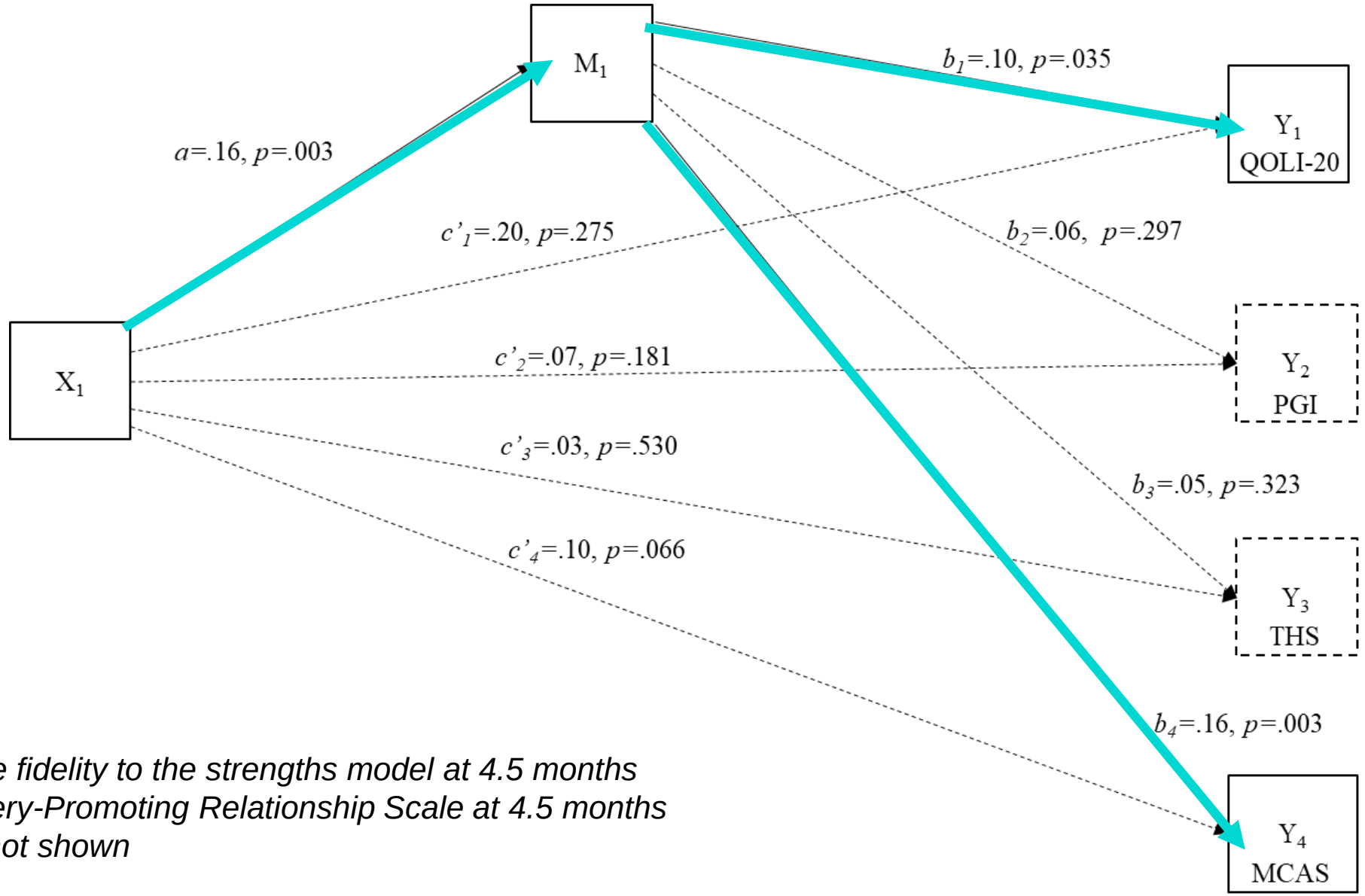
Measures

Quality of Life Interview (QOLI-20)
Patient-Generated Index (PGI)
Community Ability (MCAS)
Hope (THS)

Recovery-Promoting Relationship Scale

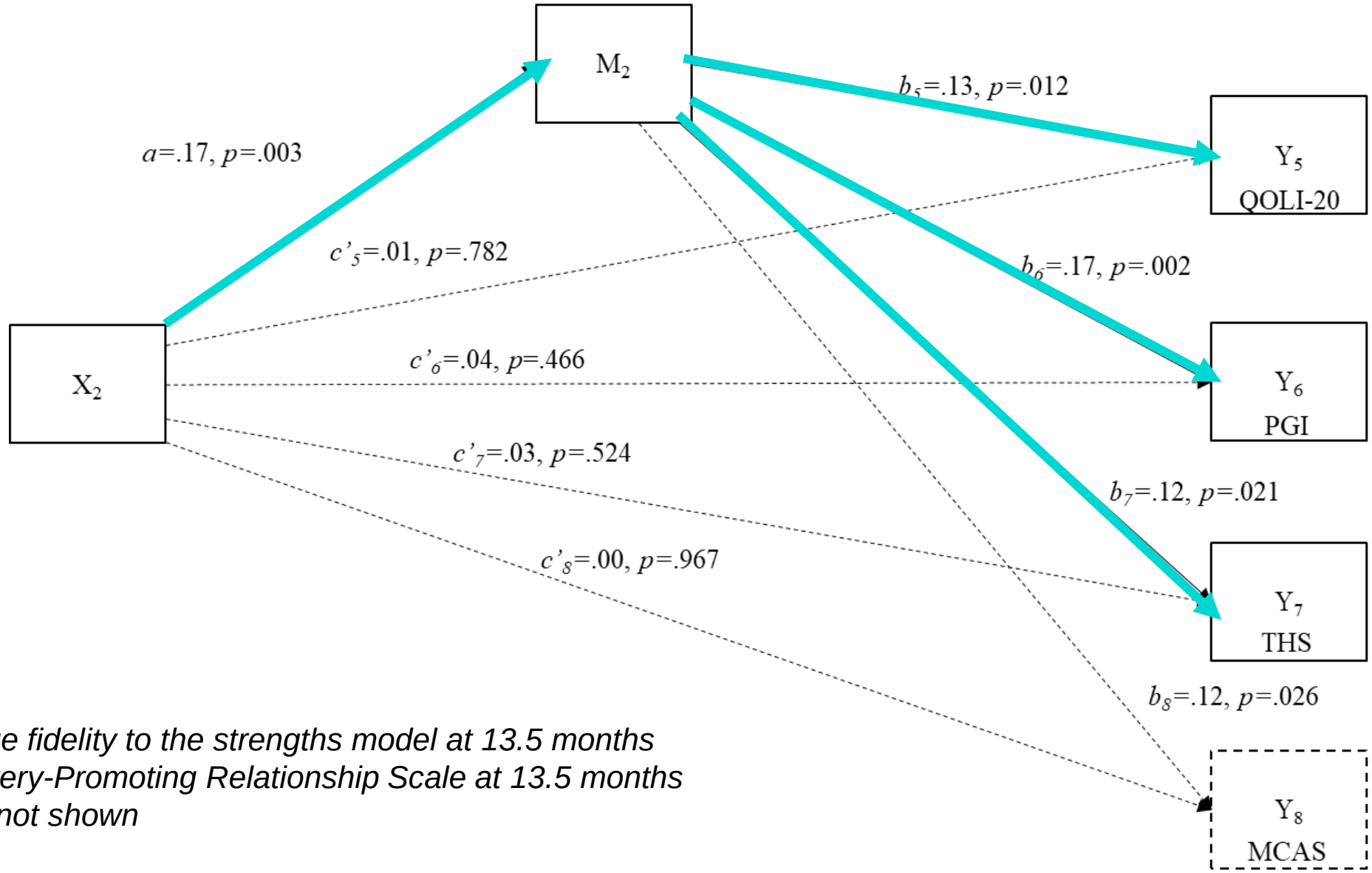
Analysis

Standardized Coefficients of Four 9-Month Mediation Models (tested separately), N = 311

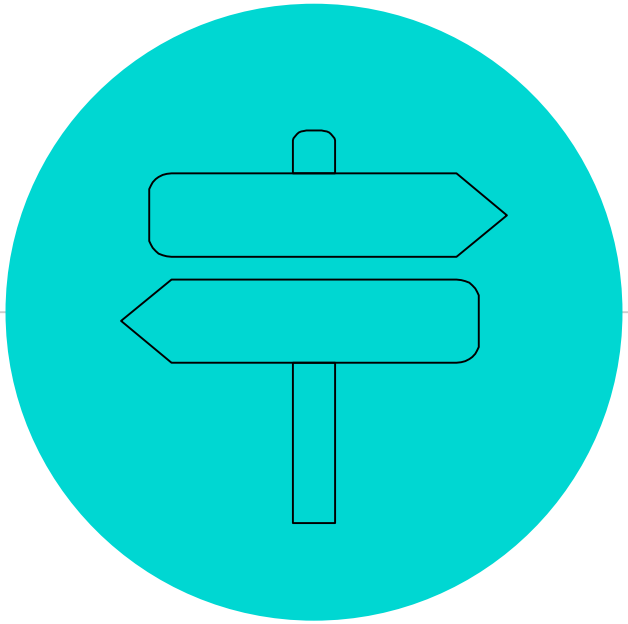


X_1 = average fidelity to the strengths model at 4.5 months
M_1 = Recovery-Promoting Relationship Scale at 4.5 months
Covariates not shown

Standardized Coefficients of Four 18-Month Mediation Models (tested separately), N = 311



X_2 = average fidelity to the strengths model at 13.5 months
M_2 = Recovery-Promoting Relationship Scale at 13.5 months
Covariates not shown



Facilitators and Barriers to Reaching High-Level Fidelity to SMCM

Methods

11 Implementation Visits

at each site

over 2 years

Ethnographic observations

Semi-structured qualitative interviews

Interviewers asked:

What are your initial thoughts on implementation of this model?

Tell me a story of what has changed now that your organization and you are implementing this model.

How do you envision the coming months?

Consolidated Framework for Implementation Research (CFIR)

Characteristics of the Intervention	Characteristics of Individuals (case managers)	Characteristics of Organization (inner setting)	Implementation Process	Outer Setting
Evidence	*Knowledge, competence*	*Structure*	*Timelines*	*Mental health authority*
Complexity	*Attitude, stage of change*	*Culture*	*Support of stakeholders*	*Service users and families*
Adaptability	*Personal attributes*	*Climate*	*Skills*	
Costs		*Readiness*	*Monitoring and Evaluation*	

Damschroder et al., 2009

Characteristics of the Intervention

Complexity

I would say that this is an approach that has also put a lot of pressure on us, in terms of paperwork, in terms of the fact that people are going to look at my file... It requires a certain rigour that has added pressure. (case manager)

Adaptability

I mean our clients haven't changed and the chaos and the crises still happen. So there's still the flexibility within this model to deal with whatever comes up. But when clients aren't in crisis, workers are more focused (…) they use this model and know what goal they're working on…(case manager)

Characteristics of the Case Managers

Attitude and Individual Stage of Change

Whether they like it or not, they don't realize it, but they're integrating it, it's going to be part of their reflex and their culture. It's come a long way... it's part of the notion of change anyway. At the beginning it's more difficult to swallow, but then slowly, slowly, not quickly, they see the usefulness, but it's a matter of at least a year and a half. (senior manager)

Characteristics of the Organization (inner setting)

Organizational Culture

We move from competitiveness, from individualism to something shared that gives rise to support and a more global vision of service or practice. Together, we are all responsible; a change of culture. (general director)

Implementation Readiness

We go step-by-step… one piece at a time. And then we take into account what the team is able to handle. (senior manager)

Implementation Process

Support

I think the leads have been really good in terms of just keeping people focused, and really learning the model… and spending time with staff. I think that's been really important. (senior manager)

Monitoring and Evaluation

The anxiety just went through the frickin' roof. Because people, all of a sudden, saw it as an evaluation of their personal business (…) And how they were conducting business because their notes were being evaluated and they were being asked questions. (case manager)

Outer Setting

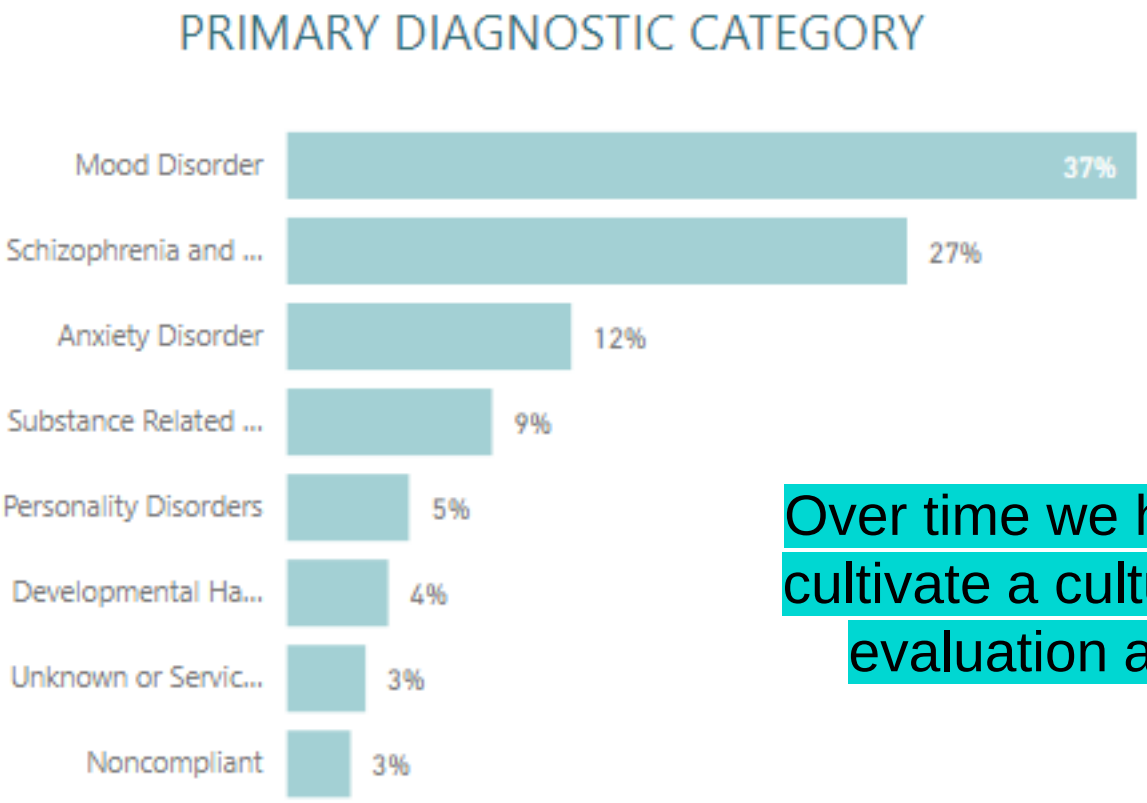
Training and Support

There was …a visit with [consultant] who really made us understand the approach better, so that it really clicked and then we understood where we were going... It was easier to use the tools and to integrate the approach into daily life. (case manager)

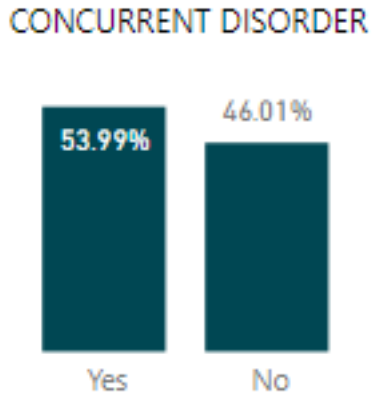
CMHA Ottawa's Fidelity Experience

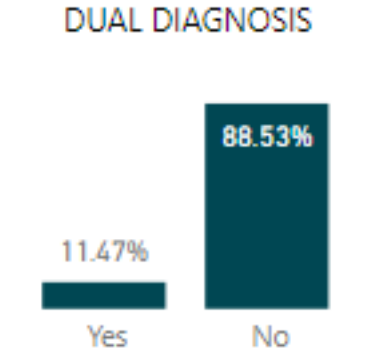
We serve people with a serious mental illness, who are homeless or vulnerably housed at referral.

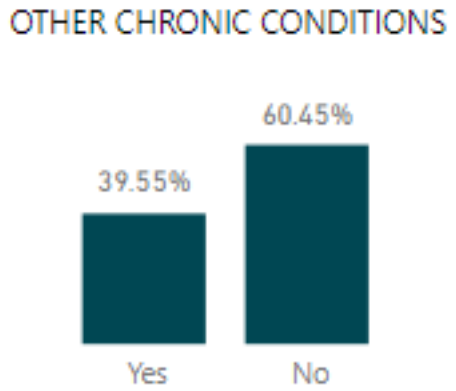
We have >180 employees



Over time we have worked to cultivate a culture of learning, evaluation and research







Note: Figures are 2019 numbers (N=1260)

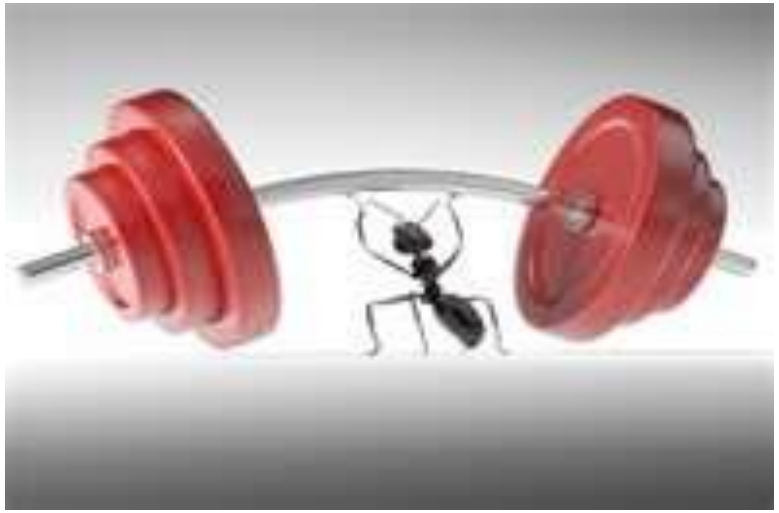
What Value Have We Experienced in Utilizing Fidelity Assessments?

- Fidelity measures and scales facilitate consistent implementation of standards and practice guidelines
- Helps to shape and standardize training, improves consistent practice within the agency across teams (and throughout the system)
- Increases practitioner skills, programme capacity
- Provides a structured (and mandated) means to incorporate client feedback
- Provides an external ‘voice’ to gain compliance
- At their best, fidelity scales can provide the ‘road map’ to modify and improve services
- Demonstrates Program Outcomes
- Can provide guidelines for closure

Challenges/risks of Utilizing Fidelity Assessments

- Many different, but similar fidelity measurements (e.g. HF and SMCM) related to Community Mental Health Practise
- Assessment or tool fatigue for frontline staff
- High fidelity implementation can be program resource intensive (e.g. training, supervision guidelines in SMCM)
- Ongoing maintenance of fidelity and resisting fidelity 'drift'
- No link to funding or existing Ministry monitoring (or resources to obtain/maintain high fidelity of different practises)
- How does a changing practise impact relationships with other MH/Addiction providers with the Network that may not have high fidelity (or be at a different stage of implementation)

How Do We Motivate Staff? Essential to Engage Staff and Provide feedback



Recognize All the Different Elements That Can Make Fidelity Scales Challenging, *From the Practitioner's Perspective*

Acknowledge Achievements & Keep Staff in the Loop

Summary of Findings

1. Fidelity to SMCM improved over the course of the study
2. Higher level of fidelity is associated with a stronger working alliance
3. Stronger working alliance is associated with improvements in QoL and Hope
4. Overall positive perceptions of SMCM but with areas
   that would benefit from continued support and
   practice change

Next Steps

- Dissemination of findings
- Diffusion of SMCM in Ontario
- Further fidelity assessments at participating agencies
- Training of new workers to SMCM?
- Ongoing technical support? COP?

Thank You!