LETTERS TO THE EDITOR

Home Grown International Psychiatry

Dear Editor,

The neuroscience of infancy makes it obvious that simple interventions during the early years have a profound effect on children's achievements in school and later functioning as adults. The crisis in Africa makes problems in Canada pale in comparison, with a high proportion of children orphaned by AIDs and basic infrastructure missing due to conflict and corruption. There is a tendency to think of this as beyond our ability to address and having little effect on us. I would argue that neither assumption is correct. If we each took on a small project then the outcome would be very different. As child and adolescent psychiatrists we have valuable skills, our income is well above that of the average Canadian's and we are wealthy in comparison to most Africans. We have the resources, if we choose to use them. Furthermore, the potential for disruption in our quality of life, due to global problems arising from millions of attachment disordered adults, should make it apparent that we should act, even if only for purely selfish reasons.

My involvement started almost by accident. Like many of us I sponsored children through charities. The first child, from when I was 18, kept in touch over the years. Ndungu never asked for anything more – just let me know how he was doing. When his daughter was born he asked if he could name her for me – a huge honor which meant I was, in effect, her grandmother. She did not do well and was eventually diagnosed with AIDs, presumably infected at birth in the hospital. Miraculously with co-trimoxazole, vitamin supplements and fortified baby formula, sent from Canada so it was not out of date, she survived. Eventually we were able to obtain antiretrovirals in a pediatric formulation. Meanwhile, it had become apparent that the family had other problems. Ndungu lost his job as he had to take so much time off to care for her. I started sending money, but this effected Ndungu's self esteem and the family had no security. If anything happened to me they would again be starving. So, I took out a loan, sent a lump sum, and paid this off each month. Ndungu was now a businessman, supporting his family. I thought I had done well, but when visiting in 2004 realised that they also needed land to grow food.

There were several times we thought we'd lose Pippa. She was extremely ill when we arrived in 2007, to find she had TB. This was treatable but complicated my return to work! The family had land, a house and a business; all seemed well, yet Pippa's parents struggled to find meaning in her suffering. Her mother, Damaris, started to volunteer at local orphanages and realized that no one wanted the AIDs babies; as Ndungu explained "Her soul cries out for justice." They decided God had taught them to care for sick children through Pippa's illness and wanted to set up an orphanage for AIDs orphaned and abandoned children. In Kenya an orphanage has to have over 20 children and we discussed attachment needs. Ndungu and Damaris replied, "We'll adopt the babies, as they need a family." They intended to do this alone, but my son insisted we should help and so Pippa's Place started – named for my granddaughter.

We formed a Kenyan Trust and set up an MOU with a Canadian charity; we have charitable status and fundraising is ongoing. The land is being developed and, after a delay caring for internally displaced children in 2007/8, we were ready for the first child. Pippa's Place is not a formal orphanage. This means that children can join the family slowly and in smaller numbers, more like a natural family. Our first baby entered the family in March '09. He's a happy child and is already catching up despite significant delays when he first came. He is fostered at present but will be adopted, his care being supported and funded by Canadians who wish to help. Other children will join the family slowly over the years to give each a time to have that special attention a baby needs. Tatamagouche school children bought a milk cow; a second is planned. We need to build more rooms and complete the perimeter wall. It has been hard work but fun. I am telling this story because, if a rural doc and a teenager (my son) can do this, anyone can.

If you would like to help, it would be most welcome, but other charities, or your own project, are options. Let's see what we can do as a profession. As Margaret Mead said, "Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has."

Indeed – and we are not that small a group!

Pippa Moss MB BS, FRCPC, Amherst, Nova Scotia

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Towards an understanding of communities of practice: objective measures of mechanisms of action and impact are needed

Dear Editor,

We would like to congratulate Barwick et al. for their recent paper *Getting to Uptake: Do Communities of Practice Support the Implementation of Evidence-Based Practice?* To our knowledge, this is the first cluster randomized trial assessing the impact of a community of practice (CoP). In their systematic review of communities of practice (CoPs) in health care, Li et al. (Li et al. 2009) were unable to identify any studies that used experimental, quasi-experimental, or observational designs, and that evaluated CoPs for improving health professional performance, health care organizational performance, professional mentoring and patient outcomes. Therefore, this review highlighted the importance of further research to define CoPs and to improve health care using CoP knowledge management mechanisms. In addition, it also highlighted the need for a validated scale to measure the intensity (e.g. dose-response relationship) of a CoP intervention.

Barwick et al. (Barwick et al. 2009) have overcome some of these gaps in knowledge in their preliminary examination of a CoP in support of evidence-based practice. However, a few limitations hampered our ability to interpret their study's results. First, although there is a well detailed description of what the CoP did, there is no description of what the practice as usual (PaU) group did to implement the Child and Adolescent Functional Assessment Scale (CAFAS). There could be elements of a CoP present in the PaU organisms in their daily activities. As Wenger (Wenger 1998; Wenger et al. 2002) described, CoPs can be informal. The lack of a validated measure to assess the presence and intensity of CoP processes prevents the authors to measure and compare adequately the different mechanisms at play in both groups.

Second, an objective measure to assess the impact of the CoP (number of CAFAS ratings) is an important contribution to the advancement of the study of CoP. Unfortunately, the way this objective measure was reported by the authors does not permit the reader to understand the difference of the impact between PaU and CoP groups. The authors report an absolute difference in the number of ratings favoring the CoP group, but no information is given on the number of clinicians in each organism or on the total number of patients assessed with and without the CAFAS tool. The lack of a denominator makes it impossible to calculate the relative number of patients rated using the CAFAS tool or to perform any statistical analysis. In addition, one of the PaU organisms could not rate any of their patients with the CAFAS tool because of technical problems thus limiting the conclusions about the primary outcome. For this last element, the text on page 24 conflicts with the results in *Table 2*. The text states that one CoP organism could not rate any patients with the CAFAS tool, but the results in *Table 2* seem to report that it was one of the PaU organisms that had technical problems.

Nonetheless, we acknowledge that this study is among the first controlled clinical trials to assess the impact of a CoP on knowledge transfer. This is the first step in fully understanding the role of a CoP in the knowledge to action cycle (Graham and Tetroe 2007). Therefore, we look forward to reading more about the authors' proposed study of the impact of a wiki-based CoP.

Sincerely,

Patrick Archambault MD, FRCPC, MSc[1,2]
France Légaré MD, PhD, CCFP, FCFP[3,4]
Annie LeBlanc PhD(c)[5,6]
Stéphane Ratté MSI, PhD(c)[5,6]
Martine Magnan MSc, MBA[6]
Marc-André Pellerin BA, BSc.[5,6]

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[1]*Emergency and Critical Care Medicine Specialist, Centre hospitalier universitaire affilié Hôtel-Dieu de Lévis, Departments of Emergency Medicine and Anesthesia, Lévis, Quebec*
[2]*Post-doctoral fellow, Knowledge Transfer and Evaluation of Health Technologies and Interventions, Centre de recherche du Centre hospitalier universitaire de Québec, Quebec City, Quebec*
[3]*Scientific Director, Knowledge Transfer and Evaluation of Health Technologies and Interventions, Centre de recherche du Centre hospitalier universitaire de Québec, Quebec City, Quebec*
[4]*Chairholder, Canada Research Chair in Implementation of Shared Decision Making in Primary Care*
[5]*Department of Social and Preventive Medicine, Faculty of Medicine, Université Laval, Quebec City, Quebec*
[6]*Knowledge Transfer and Evaluation of Health Technologies and Interventions, Centre de recherche du Centre hospitalier universitaire de Québec, Quebec City, Quebec*

Response to Letter to the Editor: Towards an understanding of communities of practice: objective measures of mechanisms of action and impact are needed

Dear Editor,

We would like to respond to the comments of Dr. Archambault and colleagues regarding our recent paper *Getting to Uptake: Do Communities of Practice Support the Implementation of Evidence-Based Practice?* Dr. Archambault is correct in pointing out two limitations to our study and a typographical error.

First, although there is a detailed description of what the practitioners in the CoP group did, there is no description of what the practice as usual (PaU) group did to implement the CAFAS tool. They suggest that there could be elements of a CoP present in the PaU organizations in their daily activities and that the lack of a validated measure to assess the presence and intensity of CoP processes prevents us from comparing the different mechanisms at play in both groups.

Apart from questionnaire measurement, we did not track the implementation of the CAFAS tool in the PaU organizations using a process evaluation methodology. Our understanding of how CYMH organizations in Ontario implement the CAFAS tool stems from anecdotal evidence and nine years of cumulative experience with implementing CAFAS. We have come to understand that a proportion of organizations fail to implement CAFAS in practice following training in what would be considered a timely or systematic fashion; there is rarely an implementation plan per se, rather practitioners are sent for training and implementation is expected to be emergent. Moreover, practitioners in CYMH are overburdened with high caseloads that do not cycle through the system as rapidly as they could for a variety of reasons. This leaves little time for practice reflection, using a CoP format or otherwise. Also, many CYMH organizations deal with significant staff turnover and this presents a barrier to implementation because organizations have to conduct more frequent training for incoming staff.

We did track whether CoP and PaU organizations had CAFAS data to export and this is reported in Table 2 of our paper. Because the CAFAS is administered as an electronic tool and each administration is automatically relegated to a database on site, the lack of data exports suggests the tool was not used and the number of ratings is a strong indicator of use. Repeated requests for CAFAS exports are made to each organization by our data analysts and, thus, it is unlikely that these organizations had data but simply failed to export. In retrospect, it would have been informative to interview key informants in the PaU organizations in order to contextualize their CAFAS use or lack thereof over the year of study. Our recommendation for future research would be to capture change and process variables using a mixed methodology.

Second, Dr. Archambault and colleagues point out that the absence of a denominator – the number of cases that could have been assessed on CAFAS during the year - did not allow us to report more than an absolute value of CAFAS ratings conducted. We certainly understand this point, however we are not certain that we could have gotten clarity on this information from organizations. Organizations could have told us how many clients came into service during the implementation phase of the study. However, CAFAS user organizations in Ontario do not conduct a CAFAS assessment on every client that enters service. There are several reasons for this. First, many organizations do not feel they have staff capacity to rate CAFAS on each incoming client. Second, there are mandated exceptions to rating CAFAS for certain types of clients, namely clients must be between the ages of 6 and 17 years, 11 months; and clients meeting the following criteria are excluded: (i) children receiving services for which no detailed screening or assessment occurs (e.g. prevention, outreach, parenting education groups, support groups); (ii) children receiving services that are delivered in 1 to 3 sessions (e.g., crisis, early intervention, single-session intervention); (iii) children seen at an organization primarily to redirect appropriately to another organization; and (iv) children receiving service for problems other than a psychological, emotional, behavioural or substance abuse, e.g., developmental impairment. Each organization also decides whether to rate CAFAS for clients with comorbid developmental impairment and mental health problems. Assuming the organization had someone on staff capable of pulling the specific data from the client information system – and that is, in our experience, a pertinent assumption – the calculation would still be complex and unattainable (Denominator = Total number clients entering service within date parameter – age exceptions – client type exceptions – those simply not rated due to a lack of human resource capacity). Organizations do not capture these qualitative variables within their client databases, rather these distinctions are clinical in nature. In summary, while it would have been ideal to have such a denominator, it would have been unfeasible to arrive at one that was reliable and accurate.

A typographical error is identified on page 24, where it is stated that one of the *CoP* organizations could not rate any of their clients with the CAFAS tool because of technical problems and this is inconsistent with the date reported in table 2. This is a typographical error and should read that it was one of the PaU organizations who experienced technological problems.

We appreciate all of the comments offered by Dr. Archambault and colleagues, and look forward to continuing our program of CoP study within the context of web2.0.

Sincerely,

Melanie A. Barwick PhD, CPsych[1,2]
Julia Peters MA[1]
Katherine Boydell PhD[1,2]

[1]Community Health Systems Resource Group, Child Health Evaluative Sciences, The Hospital for Sick Children, Toronto, Ontario
[2]Department of Psychiatry, Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario